HM Coroner
The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull
HU1 2AA

11 April 2024

Dear HM Coroner (Mrs Sally Robinson, Assistant Coroner)

Regulation 28 Report following the inquest into the death of Mrs Reed

We provide the formal response of the Care Quality Commission (CQC) to the Regulation 28 Preventing Future Deaths report made by HM Coroner (Mrs Sally Robinson, Assistant Coroner) following the inquest into the death of Mrs Reed. ('the Regulation 28 Report').

In the Regulation 28 Preventing Future Deaths report HM Coroner raised the following concerns:

(1) H130 is on the 13th floor of Hull Royal Infirmary. It has an East and a West wing and spans the full floor. It was opened in response to winter pressures. At that time, in January 2023, Hull Royal Infirmary was placed under significant pressure in terms of admissions and staffing. The ward been open only a matter of some two weeks by the time Mrs Reed was transferred to that ward. Despite being medically fit for discharge upon arrival on that ward Mrs Reed's condition worsened and family raised concerns as best they could, but they reported that the ward was chaotic, and that staff would tell them they had only just found out they were working on the ward before their shift started and there was no consistency of nursing staff on the ward.

Mrs Reed was dehydrated, and family reported that there was a paucity of personal care afforded on that ward. There was a risk of cross infection as patients' personal effects such as toiletries were not with the right patients and had to be located by family. There was no established cohort of permanent staff on the ward at that time and no signposting to the ward sister or matron and therefore no way of patents, their friends, or their families being able to have a clear escalation pathway to ventilate concerns. Although HUTH now have an established team and leadership chain on Ward H130 there is a real concern that wards opened in response to winter pressures in the future in any busy hospital may give rise to the same peripatetic staffing regime, that is to say, agency staff and no fixed team in place and a lack of visible leadership. This could lead to the deterioration of patients not being recognised if there is no continuity of care by the same team of nursing staff.

(2) An issue with the Lorenzo electronic patient record keeping system has been identified in respect of the system not auto populating the identification of the author of any changes made in the immediate discharge letter (IDL) after it has been finalised.

This could lead to miscommunication of critical issues and difficulties in establishing who made what decisions which could lead to delays in treatment in the next post discharge setting which in turn could lead to future deaths.

The trust's last comprehensive inspection was in November 2022 and the report was published in March 2023. CQC rated the trust as "Requires Improvement." A copy of the report can be found on our website - Trust - RWA Hull University Teaching Hospitals NHS Trust (23/03/2023) INS2-13905362001 (cqc.org.uk)

The trust subsequently provided CQC with a copy of their post inspection action plan detailing the immediate action taken in response to the concerns raised at inspection. The trust provided details of the longer-term actions required to ensure the improvements made would become sustained and embedded.

CQC has had regular monthly engagement with the trust, reviews evidence and closely monitors their progress against all action plans to ensure sustained improvement.

CQC first became aware of the death of Mrs Reed's death on 8 March 2023. Holy Name Community Rehabilitation Centre submitted a statutory notification to report Mrs Reed's death as an expected death on 1 March 2023. The notification stated Mrs Reed had been referred for a level 4 rehabilitation bed on the 26 February 2023 following a therapy assessment. Staff identified Mrs Reed's health was deteriorating naturally and she was put on an end of life pathway. Mrs Reed and her family were aware that palliative care had commenced, and staff offered support and comfort. CQC had no concerns regarding this expected death based on the information received on this notification.

Following receipt of the preventing future deaths report CQC held a management review meeting on 20 February 2024. CQC agreed to request and review the inquest medical evidence bundle in line with CQC specific incident guidance. In addition, CQC asked Hull University Teaching Hospitals NHS Trust to provide evidence of any action they had taken to date following the tragic death of Mrs Reed by Thursday 7 March 2024.

CQC noted the information supplied at the inquest that H130 ward had only been open for 2 weeks when Mrs Reed was admitted in January 2023. The ward had been opened due to the significant pressures and demands on the trust.

The trust began its "Discharge to Assess" (D2A) transformation programme in January 2023, bringing together care partners across Hull and the East Riding of Yorkshire to reshape and improve discharge processes and care planning.

In June 2023, the trust permanently opened two "no criteria to reside wards" H130 East and H130 West on the 13th floor at Hull Royal Infirmary as part of its "Discharge to assessment" model. This model is staffed by a multidisciplinary team which includes therapists, nurses, medics, social workers, and pharmacists. Once patients are assessed as medically fit, they are transferred to these wards to have an assessment with a plan for a same day discharge. The discharge team has been relocated to be close to these wards.

Since the last inspection, the trust made improvements to their staffing on medicine wards. All associated post inspection action plans for staffing have been completed. CQC regularly monitors staffing in terms of fill rates (planned vs actual), reduction in the number of vacancies, improved turnover rates and improved sickness rates. CQC continues to monitor staffing levels to ensure these actions are fully implemented, embedded, and sustained.

The trust submitted further assurance around the current staffing levels for the 13th floor which includes wards H130 East and E130 West. There is now an established team including leadership, nursing, and medical teams. A funding request has been submitted to the board for a permanent third registered nurse as this additional post has demonstrated improved performance in relation to medicines management and quality of patient care. A non-clinical coordinator role has also been introduced to support these wards. The trust is now over-recruited against its nursing staff which reduces the need for bank and agency staff.

CQC have not been informed of any further staffing concerns from medical care wards but will continue to monitor the trust if they are any further wards opened at short notice.

The trust conducted their own internal multidisciplinary inspection to ensure the new “discharge to assess” model for H130 East and E130 West was embedded. The trust provided assurance that lessons have been learnt and improvements have been made from when the wards was first opened in January 2023.

CQC regularly monitors the access and flow of patients in and out of medical care wards. There has been measured improvements with a reduction in patient moves, improved length of stay, reduction in delayed discharges and improved patient pathways. All associated post inspection action plans have been completed.

The trust now has clear escalation pathways to review patients who deteriorate and transfer them to an acute medical ward if considered appropriate. Staff on these wards are fully aware of this model and also have clear escalation and communication channels with medical teams.

The trust submitted additional assurance that personal care is provided on these wards. There is now a cohort of volunteer staff and activity champions to support patients and relatives. Patients also have visits from therapy dogs. The trust were exploring how to make patients feel more comfortable and had requested funding for televisions and radios. The trust have also established a “relative” clinic to ensure good communication with families. In addition, staff are being supported to complete appropriate care training.

The trust has made improvements with communication with patients and their families. The ward sisters are present on wards; H130 East and E130 West on a daily basis. They have set up a “relatives clinic” which provides dedicated time for patients or relatives to meet with ward sisters and ask questions, seek advice, or raise concerns. The wards promote positive feedback using the Friends and Family Test (FFT) and display feedback, results and any action taken. There are clear contact details available for PAL’s, complaints, and the ward matron.

Following the Lorenzo System related incident the trust sent out communications to reinforce the process that needs to be followed when completing Immediate Discharge Summaries (IDS) for patients using the Trust's Electronic Patient Record (EPR) on Lorenzo. The trust's digital team are also in the process of exploring further system functionality that may improve the current process and help to mitigate further issues. In the meantime, the trust's digital team will continue to work with the clinical teams to reinforce and embed current processes and provide support or additional training as needed.

In addition to our inspection activity, inspectors regularly monitor the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), reviewing a Trust's National Patient Safety Incident Reports and Serious Incident investigations data. Currently these data sources are going through a significant transformation, as NHS England implements the new Learn from Patient Safety Events system, which limits CQC's ability to carry out further national analysis until this has been completed.

CQC will continue to monitor information we receive about the service. Where CQC identifies that regulations are not being met, we will use our enforcement powers to require improvements to be made.

CQC will also check the provider's compliance with the regulations on our next inspection of the service using our new single assessment framework methodology in accordance with the CQC regulatory remit. CQC will highlight any repeated or new breaches of regulation and ask the trust to make necessary improvements.

CQC's next inspection of the service is not yet confirmed, however we have adopted a more risk based approach to inspections should CQC receive negative intelligence or have further concerns about the service we would carry out responsive inspections.

CQC hope that this response addresses your concerns.

Yours sincerely

Deputy Director of Operations

Network North