NHS
Kent and Medway

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[redacted]

Catherine Wood
Area Coroner for Kent and Medway
Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
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Kent
ME16 8AE

Sent via email

7 April 2026

Dear Ms Wood

Regulations 28 and 29 Reports regarding Barbara Wingate

I write in response to the Prevention of Future Death Report dated 10th February 2026, sent pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 concerning the death of Barbara Wingate on 21st May 2025.

The Coroner raised the following concern(s):

1. Evidence heard at the inquest revealed that the resuscitation department where Mrs Wingate should have been admitted was full and the evidence indicated that this was and is almost a daily occurrence at the Trust. The court heard that the main issue is trying to discharge a patient to a suitable area in the hospital to free up a cubicle or bay in the resuscitation department. This in turn is due to beds being occupied by patients who are medically fit to be discharged. On any given day the court heard that up to a third of the hospital beds can be filled with patients who are fit to leave hospital.

2. The court heard that the main delay is in discharging patients to appropriate settings or placements and the Trust have taken all steps they can internally to improve the flow of patients through the hospital. From the evidence it would appear that those responsible for providing care in the community including both the social care providers and the community healthcare providers are not providing either timely appropriate care packages in the patient's home or a bed in an alternative placement be that a nursing home or residential home placement. The evidence suggested that where patients were self-funding the delays in discharge were less acute.

3. This means patients are kept in hospital for longer and thus are more at risk of contracting hospital acquired illness themselves which could lead to their own death but are also blocking beds which are needed to treat patients who require acute care. This is leading to patients being kept longer in the emergency department and reducing available space to receive new critically ill patients. Both of these options can lead to death as seen in this case and there is clearly a risk of death for others requiring clinical care in an acute hospital.

I am responding on behalf of NHS Kent and Medway Integrated Care Board (ICB) to the concerns in your Regulation 28 and 29 reports. The concerns relate to the risk to critically unwell patients when emergency departments (EDs) are congested and transfer to an appropriate inpatient bed is delayed.

NHS Kent and Medway takes your findings very seriously and we offer our heartfelt condolences to the family of Mrs Barbara Wingate.

While the majority of patients leave our hospitals when they are well enough to go home, we know more needs to be done to prevent the delays that some experience. These delays can be for a number of reasons from internal hospital processes to the complexity of arranging ongoing care before a patient can be safely discharged.

I would like to outline the steps we have taken to reduce unnecessary bed occupancy by improving the discharge process and how ongoing support is organised.

As you are aware, NHS Kent and Medway has a statutory oversight role in making sure providers of care, including acute hospital trusts, meet the standards set out in the NHS Constitution.

The Medway Care Transfer Hub now acts as the single coordination and escalation point for the Local Authority and Health to support patients requiring new residential or nursing placements. This ensures consistent, person-centred decision making and removes delays associated with variable processes. The Hub provides weekly reports to the ICB on performance, issues, and escalations.

Discharge pathways

Over the last six months we have taken coordinated actions with Medway Council, Medway Foundation NHS Trust (MFT) and wider system partners to make several improvements to the main, nationally agreed pathways, which are used by the hospital for discharge. The pathways have been developed to address individual patient need and circumstances:

1. Strengthening same-day discharge (Pathway 0, the national discharge definition, simple discharge home) – MFT have implemented a structured daily approach to maximise safe same-day discharge once a patient is deemed medically fit. This includes senior clinical review, early identification of patients suitable for discharge, and prompt resolution of simple barriers. This process is now fully operational and monitored through daily hospital management mechanisms.

2. Expanding the Home First/short-term support capacity (Pathway 1, Discharge home with short-term support) – capacity for short-term care at home has been increased so more people can leave hospital safely with e necessary support. Oversight of capacity, flow and performance is provided through the Medway System Discharge Group, a local MDT approach supporting discharge.

3. Increasing access to short-term community rehabilitation beds (Pathway 2) and reducing transfer delays – work is underway to expand access to short-term community rehabilitation beds improving onward flow for patients who no longer need acute inpatient care. A new bed-coordination (brokerage) function will be operational by quarter three of 2026 ahead of winter with clear accountability for timely allocation and progress monitored monthly through ICB assurance routes.

The ICB and MFT have also jointly identified a programme of work focused on reducing hospital avoidable delays for patients whose discharge is delayed by internal processes or hospital-based constraints. This work runs in parallel to the community pathway improvements described above.

The Medway Care Transfer Hub now acts as the single coordination and escalation point for patients requiring new residential or nursing placements. This ensures consistent, person-centred decision making and removes delays associated with variable processes. The Hub provides weekly reports on performance, issues, and escalations.

NHS Kent & Medway ICB acknowledges that delays in discharge increase the risk of harm for people waiting in the ED for specialist inpatient care. The actions set out above constitute the system's agreed, time-bound programme reviewed with the national team on a quarterly basis to address those risks. Oversight arrangements ensure that delivery continues to be monitored closely, with escalation through formal governance routes where necessary.

If you require any further information or clarification, I would be happy to provide this.

Yours sincerely

[redacted]

Chief Nursing and Quality Officer