HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

HM Senior Coroner
Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

29 September 2023

**Care Quality Commission**
[redacted]

Dear HM Senior Coroner

**Prevention of future death report following inquest into the death of Marion Nickson**

Thank you for sending the Care Quality Commission (CQC) a copy of the prevention of future death report issued following the death of Marion Nickson.

This response seeks to address the concerns raised in your report.

> *"The inquest heard evidence that to deal with the risk of falls in patients deemed to be high risk the concept of observable bay nursing had been introduced at both Trusts. At both Trusts Mrs Nickson fell whilst unobserved due to the challenges of maintaining the bays as observed bays…. The evidence was clear that if observable bays could not function as intended then across the NHS there would continue to be avoidable falls and consequential deaths. If bay nursing could not effectively delivered due to resourcing then other options to keep patients safe needed to be explored by Acute Trusts"*

In accordance with CQC's regulatory remit in the context of this registered provider CQC highlights to Trusts identified breaches of the relevant regulations, and in particular under the Health and Social Care 2008 (Regulated Activities) Regulations 2014 ('Regulated Activities Regulations'). We also require compliance where those breaches have been identified and take civil (and/or criminal) enforcement action in line with CQC's published Enforcement Policy where it is appropriate to do so. However, while the fundamental standards contained in the Regulated Activities Regulations set out the relevant standards that registered providers must meet, they do not prescribe how exactly and what

exactly registered providers must do to meet them; those are things that the registered provider, and the Trust in this context, must determine in order to meet the standards and duties set out in the Regulated Activities Regulations. It is therefore not for CQC to include or prescribe detailed standards and expectations about each specific condition and potential need in our regulatory framework. The CQC through its website signposts Trusts to relevant guidance on how they can meet relevant regulations, including the fundamental standards under the Regulated Activities Regulations. However, under CQC's regulatory model it is for registered providers, including Trusts, to determine how it will meet and implement good practice standards, including in consultation with third-party expert organisations, as required who produce national guidance and may consult on local guidance. Such organisations include, for example, NHS England, Department of Health, Royal College of Nursing, National Institute for Health and Care Excellence and the General Medical Council.

As part of our inspections of Trusts, staffing forms part of the assessment we make when we ask our key question "Is the service Safe?" There are a number of Key Lines of Enquiry in our inspection assessment framework that ask:

- How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours?

- How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence?

- Do arrangements for using bank, agency and locum staff keep people safe at all times?

- How do arrangements for handovers and shift changes ensure that people are safe?

- Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?

- How do staff identify and respond appropriately to changing risks to people, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations?

- How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?

Inspectors explore staffing and how this is managed to ensure people receive safe care and treatment by enough staff who have the qualifications,

competence, skills and experience to do so safely. Our assessment would identify where staffing levels do not support appropriate standards of care, for example, for patients to be appropriately observed to prevent falls.

CQC have not identified bay nursing as a national issue because it is not a patient safety issue in and of itself. However, we do identify workforce pressures and staffing levels as a national issue as this is a cause of patient safety risks. When staffing levels fall below acceptable standards any clinical intervention becomes a safety issue, we would indicate our findings on this. We highlight this in our reports and ratings demonstrating the level of risk, and appropriate regulatory action taken in response.

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 completed. We recognise there are currently some challenges for CQC in being able to analysis large qualitative datasets, but we are looking at developing methodologies to deal with this, albeit recognising that consistency of information reported by Trusts may be a challenge CQC will need to consider in seeking to make those improvements.

CQC has contacted Stockport NHS Foundation Trust and East Cheshire NHS Trust to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report.

We will consider the response of Stockport NHS Foundation Trust and East Cheshire NHS Trust to our request as part of our monitoring function in respect of this registered provider and specifically whether and to what extent their response gives rise to any further regulatory actions.

We also note the legal requirement upon NHS England to respond to your report within 56 days. We will review NHS England's response to your Regulation 28 report to consider whether and what further discussion or action may be required to seek to address the concerns identified in your Regulation 28 report.
As you may be aware from 1 April 2015 CQC is the lead enforcement body for health and safety incidents in the health and social care sector. Following the Inquest, we are reviewing the facts and evidence in relation to Ms. Nickson's sad death to determine whether there are grounds to suspect that a criminal offence may have been committed, and whether a formal criminal investigation will be undertaken by the CQC.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

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Deputy Director of Operations
Network North