NHS England

Ms Alison Mutch
Senior Coroner
Greater Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 September 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Marion Nickson who died on 14 February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 July 2023 concerning the death of Marion Nickson on 21 July 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Marion's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Marion's care have been listened to and reflected upon.

In your Report you raised concerns around inpatient falls and the use of observable bay nursing practices.

NHS England commissions the National Audit of Inpatient Falls (NAIF) as part of the Falls and Fragility Fracture Audit Programme via the Healthcare Quality Improvement Partnership UK (HQUIP) which is delivered by the Royal College of Physicians (RCP). NHS England's Patient Safety Team are significantly involved in this programme at advisory, audit design & delivery level. The RCP has and continues to produce a significant number of quality improvement resources using audit learning to support providers with the care offered to people at risk of, or who have, fallen and sustained injury in hospital. The NAIF 2023 Annual Report is due to be published in November. This will include further recommendations around preventing inpatient falls and post-fall checks.

The topic of observation is covered in the e-learning training module 'FallSafe' produced by the RCP and NHS England. The module is freely available and is widely publicised and used across the NHS and covers the knowledge needed to identify and reduce patient and environmental risk factors to assist with reducing inpatient falls as well as post fall management.

Regarding the management of head/brain injury following an inpatient fall, NHS England has also recently worked with the RCP to inform their successful re-application to the audit tender, the scope of which will now be widened to include such injuries. We anticipate that future learning from the audit results will support further quality improvement initiatives and resources to support providers.

You also raised the issue of appropriate levels of resourcing within observable nursing bays. In June this year, the NHS published its Long Term Workforce Plan, setting out

how we will ensure that staffing is put on a sustainable footing over the next fifteen years to improve patient care. The plan sets out three core priorities; to improve training and education, ensure that we retain more staff, and to reform. The plan is underpinned by the biggest recruitment drive in NHS history.

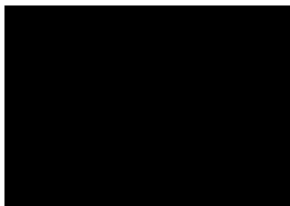
NHS England has also engaged with the Greater Manchester Integrated Care Partnership on the concerns raised in your report and they have advised that Stockport NHS Foundation Trust have taken learnings and actions from Marion's fall and their subsequent internal investigation. The Trust have made recommendations to include ensuring that staff have a refresher on the protocols and assessments available and that there are divisional leadership walk rounds with a focus on bay nursing, adherence to policy and the wearing of tabards.

The Trust have also shared the learnings from Marion's death via various forums, such as ward meetings, the Respiratory Clinical Group Meeting, the Ward Managers Governance Meeting and the Division of Medicine and Urgent Care Quality Group.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director