



Department
of Health &
Social Care

*From the Rt Hon Andrew Stephenson CBE MP
Minister of State for Health and Secondary Care*

*39 Victoria Street
London
SW1H 0EU*

[REDACTED]

HM Coroner David Ridley
Wiltshire and Swindon Coroner's Office
26 Endless Street
Salisbury
Wiltshire
SP1 1DP

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9 May 2024

Dear Mr Ridley,

Thank you for the Regulation 28 report to prevent future deaths of 17 November 2023 about the death of Raymond Eggleton. I am replying as Minister with responsibility for health and secondary care, and the NHS workforce.

Firstly, I would like to say how saddened I was to read of the circumstances of Raymond Eggleton's death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

The report raises concerns over the lack of resilience in the system to adapt dynamically to changing patient needs due to the challenges in getting commensurate staffing levels to safeguard patients, particularly where there are short notice changes in patient circumstances. It also raises concerns about the initial falls risk assessments which did not take advantage of all the available information which led to an incorrect assessment of Mr Eggleton's supervision needs.

Safe staffing

Responsibility for staffing levels remains with clinical and other leaders at a local level, responding to local needs, supported by evidence-based guidelines by national and professional bodies and overseen and regulated in England by the CQC. Reaching the right staff numbers and mix should depend on an evidence-based approach and the exercise of real-time, risk-assessed, professional judgements by day-to-day leadership and a multi-professional approach.

The CQC checks for compliance with regulations¹ that require regulated providers to ensure there are enough suitably qualified, competent, skilled and experienced people, who are supported, to provide safe care and treatment to patients. Where staffing is having an impact

¹ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 18

on patient outcomes, whether due to a lack of staff or an incorrect mix, the CQC can take enforcement action. It means that regulated providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times, in accordance with the legislation and reflecting guidance where it is available.

NHS Workforce

The NHS Long Term Workforce Plan (LTWP), published by NHS England in June 2023 sets out the steps the NHS and its partners need to take to deliver an NHS workforce that meets the changing needs of the population over the next 15 years. The plan outlines the action needed to ensure we train and retain more staff, and reform medical education and training to put the NHS workforce on a sustainable footing for the future. By significantly expanding domestic education, training and recruitment, we will have more healthcare professionals working in the NHS. This will include more nurses and doctors alongside an expansion in a range of other professions, including more staff working in new roles.

The LTWP sets out the aim to increase adult nursing training places by 92%, taking the number of total places up to nearly 38,000 by 2031/32. To support this ambition, we will increase training places to nearly 28,000 in 2028/29. This forms part of our ambition to increase the number of nursing and midwifery training places to around 58,000 by 2031/32. We will work towards achieving this by increasing places to over 44,000 by 2028/29, with 20% of registered nurses qualifying through apprenticeship routes compared to just 9% now.

Managing the risk of falls in hospitals

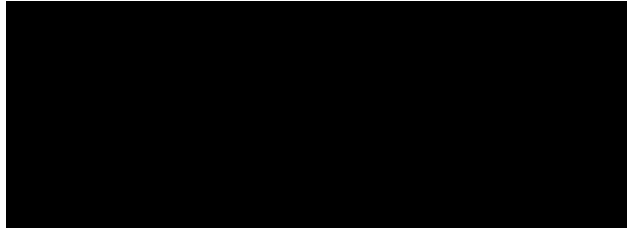
You have raised concerns about managing the risk of falls and sustaining injuries in hospitals. Falls are common and occur in 30% of adults aged over 65 years annually. The ageing of the population has meant that the incidence of traumatic injury in older people is rising in both absolute numbers and as a percentage of national trauma admissions annually. Trauma services for older people, and especially older people living with frailty, are organised depending on the structure of local services. There are 22 Adult Major Trauma Centres in England predominantly in Teaching Hospitals. District General Hospitals have Trauma Units most commonly in a surgical ward of the hospital. Care for each patient should be bespoke, dependent on nature and severity of injury and co-morbidities including frailty.

NHS England advise that the risk of falls is an ongoing priority for providers and continues to be an active area of developing research and evidence. The current NICE guidelines *Falls in older people: assessing risk and prevention. Clinical guideline [CG161]* describes evidenced based practice. This guideline is currently being updated and due to be published in March 2025. The Royal College of Physicians also provides evidenced based guidance on preventing falls and serious injury in *Falls in hospital*. Further, the British Geriatrics Society was included in the international membership that has developed guidelines on falls prevention and management: *World guidelines for falls prevention and management for older adults: a global initiative*. The report contains a section specifically on falls in hospital.

I know that Great Western Hospitals NHS Foundation Trust have already responded to your report setting out what they are doing to improve recruitment and retention of nursing staff, a review of enhanced supervision procedures, falls improvement work and additional training on the falls risk assessment.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,



**THE RT HON ANDREW STEPHENSON CBE MP
MINISTER OF STATE FOR HEALTH AND SECONDARY CARE**