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Alison Mutch OBE
HM Senior Coroner
1 Mount Tabor Street
Stockport
SK1 3AG

Via email: [redacted]

14 November 2024

Our Reference: [redacted]
Your reference: [redacted]

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of John Francis Howlett.

Thank you for sending CQC a copy of the prevention of future death report issued following the sad death of Mr Howlett.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by the 1 November 2024 and would like to thank you again for agreeing to an extension for response until 29 November 2024.

The registered provider of The Lakes Care Centre is The Lakes Care Centre Limited. They have been registered with CQC as a service provider since 25 August 2023.

The provider's location, The Lakes Care Centre is located Off Boyd Walk, Lakes Road, Dukinfield, SK16 4TX. At the time of Mr Howlett's death, the provider was registered for the regulated activities: 'Accommodation for persons who require nursing or personal care' and 'Treatment of disease, disorder or injury'.

The Lakes Care Centre has not had a registered manager since 13 October 2023 to oversee and manage the delivery of the regulated activities at this location, in

contravention of the condition imposed on this provider's registration for this location, stating that they must have a registered manager in post.

The role of the CQC & Inspection methodology

The role of the Care Quality Commission (CQC) as an independent regulator is to register health and adult social care service providers in England and to assess/inspect whether or not the fundamental standards set out in the Health and Social Care Act 2008, and amendments, are being met.

The regulatory approach used during previous inspections of The Lakes Care Centre considered five key questions. They asked if services were Safe; Effective; Caring; Responsive; and Well Led. Inspectors used a series of key lines of enquiry (KLOEs) and prompts to seek and corroborate evidence and reassurance of how the provider performed against characteristics of ratings and how risks to service users were identified, assessed and mitigated.

The regulatory framework includes providers being required to meet fundamental standards of care; the standards below which care must never fall. We provide guidance to providers on how they can meet these standards (Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

On 6 February 2024 CQC's Operations Network in the North region went live with our new Single Assessment Framework. This approach covers all sectors, service types and levels and the five key questions remain central to this approach. However, the previous key lines of enquiry (KLOEs) and prompts have been replaced with new 'quality statements'. The quality statements are described as 'we statements' as they have been written from a provider's perspective to help them understand what we expect of them. They draw on previous work developed with Think Local Act Personal (TLAP), National Voices and the Coalition for Collaborative Care on Making it Real. They set clear expectations of providers, based on people's experiences and the standards of care they expect. We have introduced six new evidence categories to organise information under the statements; these are feedback from people, feedback from staff and leaders, feedback from partners, our observations, processes and outcomes. This approach will allow CQC to use a range of information to assess providers flexibly and frequently, collect evidence on an ongoing basis and update ratings at any time; tailor our assessment to different types of providers and services; score evidence to make our judgements more structured and consistent; use site visits and data and insight to gather evidence to assess quality and produce shorter and simpler reports, showing the most up-to-date assessment.

Background

We have reviewed all our records and cannot find that we received a statutory notification in relation to Mr Howlett's death. Failure to provide statutory notifications in accordance with Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 is a criminal offence and we have written to the registered provider to request an explanation for their failure to notify and will review their response and may take further action. Previous failings to submit statutory notifications have been subject to enforcement action against this registered provider. A review was conducted in respect of the specific incident and there are currently no reasonable grounds to suspect a criminal offence of a registered person.

Regulatory History

The Lakes Care Centre was registered with CQC under the current provider, The Lakes Care Centre Limited on 25 August 2023. Prior to this the service was managed by Blackcliffe Limited.

Under the previous provider, Blackcliffe Limited, there had been poor compliance with relevant regulations and CQC had taken numerous enforcement actions to drive improvement which had ultimately led to the service being rated 'Inadequate' overall and the provider going into administration. An inspection undertaken in February 2023 (published 13 April 2023) identified some improvements had been made to the service delivered. It was subsequently rated 'requires improvement' overall with conditions placed on the registration. This allowed the administrators to proceed with a sale of The Lakes Care Centre as a going concern. The Lakes Care Centre Limited commenced operating the home under a licence to manage agreement on 18 July 2023 and the sale of the home was completed on 22 September 2023.

The Lakes Care Centre has been in a multiagency concern (MAC) process led by Tameside MBC since 23 May 2022. This process brings together key stakeholders including commissioners, health services, CQC and the provider to oversee and support the provider and to share information both positive and negative about the service delivered and progress towards improvements in performance.

Matters of concern

1. **The inquest heard that on arrival at A and E at Tameside Hospital Mr Howlett spent 22 hours in a corridor despite suffering from an infection and the distress that this caused. The inquest was told that this was due to the demands on the department and the challenges of moving patients onto**

wards due to capacity issues. The inquest was told that this was not unique to that particular day or indeed to the hospital and was the picture across the country at that time.

We have given careful consideration to this point and have come to the conclusion that the concerns identified, namely, that Mr Howlett spent 22 hours in a corridor despite suffering from a chest infection due to demands on the department and capacity issues, a situation not unique to that particular day or hospital, sits outside of CQC remit. We note that this report has also been sent to the Secretary of State for Health and Social Care and believe they will be of greater assistance in addressing this aspect of your concerns.

2. **The evidence before the inquest indicated that the care home in question had been of concern in relation to the care offered to residents for some time. It was indicated that action plans were in place particularly in relation to safeguarding concerns given the vulnerability of residents. However, despite those steps being in place and the concerns the systems were not in place at the care home to robustly monitor his nutritional status and fluid intake. He became increasingly frail with decreased physiological reserves as a consequence.**

An assessment of The Lakes Care Centre was commenced on 22 April 2024 following concerns in relation to the care and support people were receiving. The key questions of 'Is the service safe?' 'Is the service effective' and 'Is the service well led?' were reviewed and the overall rating for these key questions and the service overall was 'requires improvement'. At the time of this assessment The Lakes Care Centre had recently stopped operating as a nursing home but was still registered to deliver the regulated activity of 'Treatment for Disease, Disorder or Injury'. The provider was asked to submit a notification to deregister from this regulated activity at the location and this was completed on 26 September 2024. The Lakes Care Centre continues to be registered for the regulated activity of 'Accommodation for people requiring nursing or personal care'.

At the assessment in April 2024 inspectors reviewed quality statements under the key questions cited above. The quality statements describe the standards of care that people should expect. The quality statement scores are the basis of the key question scores and ratings. Quality statements are scored out of 4, with 1 being the lowest score and 4 being the highest.

We looked at the quality statements for the key question 'Is the service effective?'. We found that under the quality statement 'Assessing needs' whilst assessment processes

required improvement to ensure they were detailed and up to date, staff were aware of people's needs and understood how to meet these needs. This was scored a 2 to indicate improvements were needed.

With regard to the quality statement 'Delivering evidence-based care and treatment' we received positive feedback from families with people being supported effectively to maintain good nutrition and hydration and families noting that people were gaining weight. At the time of the assessment, information about people's needs in relation to eating and drinking were found to be in place and food and fluid intake charts were in place for those at risk. However, shortfalls in the use of records to demonstrate people were having correctly modified diets were found. This quality statement was scored a 2 to indicate improvements were needed.

When reviewing the quality statement 'Supporting people to live healthier lives' we found that suitable processes were in place to refer to partner agencies including dietetic services for advice and input into people's care, although partner agencies noted that concerns had not always being escalated in a timely manner. Shortfalls in medical partners' oversight of some people were in the process of being addressed with the reintroduction of 'ward rounds'. This quality statement was scored a 2 to indicate improvements were needed.

The quality statement 'monitoring and improving' outcomes noted staff understood the importance of promoting and encouraging independence and there were suitable processes in place to monitor people's safety and wellbeing. We noted that there had been some shortfalls in how people's needs were monitored but the necessary improvements had been implemented and at the time of assessment these needed time to become embedded. This was scored a 3 to indicate the service was meeting our expectations under this quality statement.

The key question 'is the service safe?' was reviewed and shortfalls in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found due to gaps in how risk was managed and mitigated and how lessons were learnt. The quality statement 'Learning culture' was scored 2 as improvements were needed and the process for analysis of incidents where things had gone wrong to ensure learning, was not being used effectively to ensure people were kept safe.

The key question' Is the service well led?' was rated 'requires improvement' following the inspection of April 2024 and a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified.

For the quality statements ‘Governance management and sustainability’ we found that although areas for improvement were noted as being needed, the process for oversight were not effective and audits did not lead to issues being identified and the required action being taken. The quality statement ’Learning, improvement and innovation’ was scored 2 to indicate improvements were required. We found that whilst the service was committed to making improvements, progress was slow.

During our assessment we identified areas for improvement in terms of care plans, risk assessments and staff understanding of using the electronic care planning and recording system used at The Lakes Care Centre. The registered provider was already aware of this and was arranging additional training which will lead to enhanced oversight of issues such as fluid monitoring. Areas for improvement in relation to governance and oversight were identified during this assessment, that we will continue to monitor and assess on an ongoing basis.

The coroner noted in this regulation 28 report that despite action plans being in place in relation to safeguarding concerns, systems were not in place at the care home to robustly monitor Mr Howlett’s nutritional status and fluid intake. Our assessment finding indicated there continued to be some areas for improvement shortly after Mr Howlett’s death, but that action was being implemented and embedded at that time. Enforcement action was taken in response to these findings and CQC continue to monitor the service to identify if concerns around the service are escalated and require further action.

The Lakes Care Centre has been subject to close monitoring by both the local authority and CQC since 2021. During this time the management of provider oversight has changed on several occasions with a new provider, The Lakes Care Centre Limited taking ownership and providing the regulated activities since September 2023, with a new management structure of systems and processes implemented. The location and provider continue to be subject to close scrutiny at the time of this Regulation 28 response by both CQC and the local integrated care board.

At the time of Mr Howlett’s death CQC were involved in the MAC process and attended a MAC meeting in January 2024 but no significant causes of concerns were identified or shared at that time. The following meeting in March 2024 identified more significant issues in relation to record keeping and timeliness of progress being made. It was not until The Lakes Care Centre had made a decision to stop delivering nursing care that the extent of concerns in relation to the delivery of nursing care was noted, at which point an inspection of the service was already pending.

Whilst there is evidence there were numerous failings in the care delivered at The Lakes Care Centre, which included elements of poor care and poor record keeping as noted through the safeguarding investigation, the provider of the service has subsequently focused on improving the support and training offered to staff. They are also looking at how they work with other professionals (CQC have referred to this in our response to your Regulation 28 report regarding Mr Fredrick Boyd)

At the time of Mr Howlett's death, The Lakes Care Centre was operating as a nursing home, but the service has now ceased to deliver the regulated activity of 'Treatment for Disease, Disorder or Injury'. This means that any service user requiring a nursing intervention will be under the care of the district nurses, which CQC believes mitigates some risks to the residents of this service as the people being cared for will generally not have such complex health conditions.

At the time of our visit there was no registered manager in post and there have been changes to the home manager. Upon the provider identifying a suitable candidate for the registered manager role, an application has been accepted by CQC's registration team and we will seek to register this individual as soon as possible.

We will continue to monitor the service.

It is well documented that there have been some shortfalls in the systems and processes following the roll out of our new regulatory platform and provider portal. There has and continues to be a significant amount of work to make the improvements to ensure we have the best oversight of all health and social care services and are effective as the regulator.

Yours sincerely,

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Deputy Director of Operations

Network North, CQC