HSCA Further Information
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[redacted]

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

[redacted]

8 June 2021

[redacted]

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Alan Massam.

Thank you for sending the Care Quality Commission ('CQC') a copy of the prevention of future death report dated 26 April 2021 following the sad death of Alan Massam.

We note the legal requirement upon the CQC was to respond to your report within 56 days, by the 14 June 2021.

Mr Massam was resident at Lisburne Court, a location registered with CQC at Alfreton Road, Offerton, Stockport, SK2 5LU. The Registered Provider in operation of Lisburne Court at the time of Mr Masson's death was Borough Care Limited (The Provider). The Provider is registered for the regulated activity: Accommodation for persons who require nursing or personal care. There are conditions on the registration for this location, namely;

1) The Registered Provider must not provide nursing care under accommodation for persons who require nursing or personal care at Lisburne Court; and

2) The Registered Provider must only accommodate a maximum of 48 service users at Lisburne Court.

The registered manager at the time was [redacted] who has been registered as the Registered Manager of Lisburne Court since 10/02/2020.

The role of the CQC & Inspection methodology

The role of the CQC as an independent regulator is to register health and adult social care service providers in England and to inspect and report on whether or not the fundamental standards are being met.

Our current regulatory approach involves inspectors considering five key questions. They ask if services are Safe; Effective; Caring; Responsive; and Well Led. Inspectors use a series of key lines of enquiry (KLOEs) and prompts to seek and corroborate evidence and reassurance of how providers perform against characteristics of ratings and how risks to people are identified, assessed and mitigated. Sources of evidence for the KLOEs can be found on our website along with our KLOEs and characteristics of ratings. https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services

The regulatory framework requires registered persons to meet fundamental standards of care, 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) (the 'Regulations'). https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Regulatory History

Borough Care Ltd were registered to carry on a regulated activity at Lisburne Court in January 2011.

At our last comprehensive inspection of Lisburne Court (published 11 February 2020) the service was rated as Good and there were no breaches of regulation. Lisburne Court was rated Requires Improvement at the previous inspection (published 17 February 2017).

Matters of concern for CQC

On 20 January 2021 the CQC received information from the Coroner enquiring if we were investigating in this case. An initial assessment was carried out into the circumstances of Mr Massam's death by Inspectors from both the adult social care directorate and the hospitals directorate. Both Inspectors concluded based on the information available to them at that time that there was insufficient evidence to suspect a failure to provide safe care or treatment at registered persons level (breach of Regulation 12(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Coroner was informed that the CQC was taking no further action at that time.

We noted Mr Massam's preliminary cause of death was recorded to be;

1a) Lower respiratory tract infection
1b) Multiple rib fractures

1c) Falls
II) Chronic subdural haematoma, advance dementia, recurrent falls

The specific matters of concern raised by the coroner in the Regulation 28 report issues to CQC are:

1. **The inquest heard that the care of Mr Massam was complex due to his needs but there was no clear agreement or arrangements between agencies as to how to effectively share information in complex cases. In this case mental health services were involved as was the acute trust, GP and the care home but there was limited evidence of a joint approach to ensure his care was optimised.**

Whilst the CQC have no direct remit in developing policy and procedures to support integrated care and optimal communication, during inspection of a service the CQC will look at joint arrangements and how systems work to facilitate the transfer of care from one setting to another. This is considered against Regulation 12 (1) (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 which states;

CQC commenced a cross directorate process in May 2021, to ensure regulatory risks relating to the local health and social care systems are discussed, responded to and acted upon across CQC directorates within each of the seven local systems in the North. Representatives from operational directorates meet on a monthly basis in order;

- To facilitate integrated cross directorate working within local systems.
- To share information on key or potential cross directorate / system issues.
- To ensure cross directorate consistency of regulation within a system.
- To identify, collate and escalate risk themes and key connections within a local health and social care system.
- To explore opportunities for greater regulatory effectiveness through coordinated activity, including inspections.
- To report findings to the Regional Escalation & Co-ordination group.
- To feed in effectively to ICS / systems meetings as appropriate for wider engagement opportunities.

In line with our future strategy, we make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care to improve.

Care and treatment must be provided in a safe way for service users. Where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other

appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

Where the CQC find evidence that local systems are not as effective or robust as they should be, we would judge the failings in respect of the impact this may have on people, and work with registered providers, commissioners and other external stakeholders to strengthen and support effective communication and collaboration.

Internally, inspection managers from across all operational directorates within the CQC (adult social care, hospitals and primary medical services) meet monthly to ensure that regulatory risks relating to the local health and social care systems are discussed, responded to and acted upon across CQC directorates within each of the seven local systems in the North.

2. Mr Massam was discharged back to the care home by the acute trust. The inquest heard that the home would not have accepted him back if they had been spoken to as they did not feel they could meet his needs. The inquest heard that there is no national guidance/protocol about what an acute trust should do if attempts to contact a home are unsuccessful or about the obligation to ensure the home can accept him back in such circumstances as these.

When Mr Massam arrived in hospital on 13 October 2019, there was no accompanying documentation or phone call made from the care home to advise the hospital team of the care home staff opinion that they could not meet his needs. As Mr Massam was seen and treated in the emergency department, the trust subsequently told us that a 'discharge' summary would not routinely be provided, as he was not admitted to a bed on a ward. It is however good practice to send a copy of a treatment summary back to someone's place of care. We understand from the trust that a family member was present with him in hospital on 13 October and they did not express any concern about the care home managing his needs.

The acute hospital team carried out an inspection of Stepping Hill in January and February 2020 and found significant improvement was needed in several areas. For example, we found the emergency department did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment at all times, and particularly during periods of heavy demand on the service. A warning notice was issued following the inspection. We inspected the hospital again on 24 and 25 August 2020 and found the trust had made improvements to urgent and emergency care. We needed to ensure improvements made were embedded in the service. Therefore, we continue to monitor the trust and have held regular engagement calls with them. They have informed us of a process now in place to monitor how information is shared after treatment in the emergency department. We have requested information from

the trust with regards to the above process and will review their response to identify if any regulatory action is required.

CQC is part of a system improvement board where the post inspection action plans are reviewed and monitored. Other partners include the Clinical Commissioning Group, NHSE/I and other care providers. This improvement board has a specific focus on patient flow and improvements in the emergency department.

3. **The staff at the home were aware of the prescribing of medication including antibiotics. However, when he refused them and fluids there was no defined escalation process which would ensure that the risk this presented was recognised and acted on.**

Upon receipt of the concerns raised within the Regulation 28 report issued to CQC by the Coroner on 26 April 2021 a decision was made to undertake an unannounced targeted inspection of Lisburne Court. The findings of this inspection will be shared with the Coroner. This will be completed to ensure that the circumstances of Mr Massam's death do not reflect any ongoing risk to people currently living at the home.

The inspection will be focused in three key questions; Is the service safe? Is the service effective? And it the service Well-led? The inspection will focus on the specific areas raised in the Regulation 28 report. As part of the inspection we will consider the effectiveness of Lisburne Court's pre-assessment process, the monitoring and management of falls, escalation protocols should people refuse to take fluids and medicines, how the service communicates with relatives and how the service works with other healthcare agencies to optimise people's care.

We will also look at infection prevention and control (IPC) as part of the thematic inspection methodology CQC is undertaking as part of the response to the Covid-19 pandemic. This will be reported under the key line of enquiry; Preventing and controlling infection.

In the interim period before we inspect, we are meeting with the Chief Executive and the new Nominated Individual of Borough Care Limited to discuss the issues raised and seek assurances around lessons they have learned. We are continually monitoring the service and liaising with the Local Authority to review any ongoing risks and feedback.

4. **Once the initial home could not manage Mr Massam and served notice on the family there was a significant pressure to find another home that would accept him. Whilst the search was undertaken he remained in a home where staff felt they could no longer safely meet his care needs. The inquest heard that this search was exacerbated by a national shortage of suitable beds within the adult care sector for complex cases such as Mr Massam.**

The CQC have no direct remit relating to the number of suitable beds within the adult social care sector for complex cases such as Mr Massam's. However, if the CQC receives information that staff at a registered service feel they can no longer safely meet a person's needs we will refer the case to the Local Authority under our safeguarding protocols. The CQC will also seek assurances from the care home about how they intend to keep the person safe whilst a more suitable placement is found.

Should you require any further information then please do not hesitate to get in touch.

Yours sincerely,

Head of Inspection – Adult Social Care