NHS England

Surveillance Report to Regional Quality Surveillance Group Meeting

Enc 3

Date: **16 November 2016**

Title: **NHS England North (Cheshire & Merseyside) Exception Report 01 August – 31 October 2016**

Report of: **Hazel Richards, Director of Nursing**

Purpose

The purpose of this paper is to provide the North Regional Quality Surveillance Group, (RQSG), with information relating to the Cheshire and Merseyside QSG held on 04 October 2016

Section 1: Key areas for review and consideration for action by Regional QSG.
Section 2: Information/updates on areas being managed locally within the Cheshire and Merseyside QSGs.
Appendix 1: Cheshire and Merseyside Quality Surveillance Levels (October 2016)
Appendix 2: Review of Trusts in Enhanced Surveillance for >3 Quarters

Section One: Key Areas for Review; Consideration and Action by Regional QSG

1	**Areas arising from the Cheshire and Merseyside QSG**
1.1	The Cheshire and Merseyside QSGs have merged to form one group, which met for the first time in October 2016. The newly formed Cheshire and Merseyside QSG will meet bi monthly. No areas were considered to be required for review and action at the North Region QSG meeting.

Section Two: For Information

2	**Quality Themes**
2.1	**Public Health England - Screening and Immunisation** Cheshire and Merseyside Screening and Immunisation (S&I) Team support the recognition and management of screening and immunisation incidents. There are two groups: • Level One Incidents; which are internally managed incidents in providers, which are investigated and handled in proportion to significance. The commonest occurrences in this category are cold chain (fridge) vaccine failures in general practice or community clinic setting. Cold chain failures are reported about once per month, and may involve just a few vaccines at a cost of less than £ I&S or can involve large stocks or expensive vaccines to values of over £ I&S . This cost is to the public purse, via the PHE vaccine procurement budget. During the past two years, no revaccination of any individuals has been required. Most of these incidents are not predictable and relate to loss of power or fridge failures, however some do relate to inadequate fridge maintenance or bad vaccine storage. S&I co-ordinators work closely with GP practices and Clinical Commissioning Groups (CCGs) Quality Leads to learn from cold chain failures. Screening Incidents at this level are known as Screening Safety Incidents. The level of incident is agreed between the provider, the Regional Screening Quality Assurance Service, and the S&I Lead. Typical incidents are interval cancers or false positive/ negative results of tests (where these are linked with a failure of process, they will be escalated to reportable incidents). Other recent incidents have related to inadequate technical support to screening programmes, such as pathology services. The S&I team works closely with providers to manage and learn from

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	seen, there are some concerns regarding pace. Locally, the Direct Commissioning Team are working closely with CCG Primary Care Leads to address areas of concern and escalating issues to the regional management team when appropriate. This remains on the Cheshire and Merseyside Risk Register.
2.3	**NHS England: Specialised Commissioning** **Fresenius E16 Renal Dialysis** A series of rapid response visits were carried out across the North in July 2016 by the Quality Surveillance Team, including the Southport and Warrington units. For Warrington; six immediate risks and two serious concerns were raised and for Southport; four immediate risks and two serious concerns were raised. There were similar themes across both sites including; • an over reliance on technology, with no pre and post patient assessment • medication checking processes requiring attention • staff overriding alarms • lack of governance framework • in- house training programmes assurance Action plans for the immediate risks have been received from Fresenius and these are being monitored by the Specialised Commissioning Team.
2.4	**Countess of Chester Hospital** The Trust alerted commissioners to concerns raised by members of the Neonatal Team, which included higher than expected mortality. Commissioners, NHS Improvement (NHSI) and the Neonatal Network agreed a plan to downgrade three neonatal cots to Level 1, whilst a comprehensive investigation is carried out. In addition the Trust has commissioned an independent review of their neonatal service from the Royal College of Paediatrics and Child Health and the Royal College of Nursing. The initial feedback is that no immediate risks to patient safety have been identified, however the reviewers have recommended a forensic deep dive into a number of identified incidents, to be undertaken by an independent external consultant and this is currently being arranged. There are ongoing discussions locally as to whether the Neonatal Unit should be placed on enhanced surveillance.
2.5	**Liverpool Women's Hospital** Further analysis regarding the Trust persistently high Hospital Standardised Mortality Rate (HSMR) has been sought from the North Analytical Team. NHS Liverpool CCG is aware of the concern and is currently working with the Trust to understand the reasons for the raised measure. The Trust has previous been subject to a high perinatal mortality alert by CQC; however this has recently been closed.
2.6	**Cheshire Wirral Partnership NHS Foundation Trust** Due to concern regarding the numbers of incidents relating to self-harm, being reported by the Trust, further analysis was requested from North Analytical Team. This analysis has highlighted that the Trust has reported one of the highest totals of self-harm incidents when compared to other providers of mental health services. In addition the analysis has highlighted that the numbers of days between incidents is reducing. The reason/s for the above noted changes need to explored further, the changes may simply indicate an enhanced and improving reporting culture however further work will be undertaken with CCGs to exclude any actual or emerging safety issues.
3	**Updates on Provider Quality Themes and Surveillance**