Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
www.cqc.org.uk

Mr Heming
H.M. Senior Coroner for Cambridgeshire and Peterborough
Lawrence Court
Princess Street
Huntingdon
PE29 3PA

8 December 2017

Private and Confidential

By Email: coroners@cambridgeshire.gov.uk

Care Quality Commission
Our Reference: MRR1-4422151912

Prevention of future death report following inquest into the death of Mr Sam Crick.

Dear Mr Heming

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

CQC has contacted the provider Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report. BHRUT are due to conclude their serious incident investigation into the death of Mr Crick this week and will share their findings with CQC accordingly.

We note the legal requirement upon BHRUT to respond to your report within 56 days.

In your report you have additionally asked CQC to provide further clarity on a few points that I have dealt with individually below:

Increase in number of Regulation reports raising concerns over number of deaths at BHRUT

The CQC, in communication with the trust and relevant stakeholders, have recognised the increase in frequency of Regulation 28 reports relating to BHRUT. With a view to addressing this at a trust-wide level, the CCG has implemented an enhanced programme of review with the trust. The CCG have been provided with a quality risk profiling tool by NHS England which includes self-assessment by the trust and assessment from their regulatory stakeholders (CCG, CQC, NHSE), which is based on the Key Lines of Enquiry (KLOEs) of the CQC. This is a means for the trust to evaluate and score their performance in relation to risk management in key areas, while a similar score is completed by stakeholders. The scores gathered from this process are then discussed in a mediated meeting. Where there are discrepancies between self-assessment and assessment from stakeholders, action plans for improvement are put in place.

Members of the trust senior leadership team attended the first meeting in November where CQC were present. There was not enough time to discuss all the matters of concern and a follow up meeting, which will include a focus on Regulation 28 reports, is to be planned for early January.

Recent inspection of BHRUT and related findings:

In 2016, we carried out a focused inspection of a number of core services that had previously been rated as requires improvement. The neurosurgery provision would fall under the core service of surgery, which was not included in our most recent inspection of the trust, as our intelligence monitoring did not lead us to have specific concern about surgery services at this time. However, this is an agreed priority for future inspections.

The radiology provision was covered under the outpatients department, where the main concern was around medical staffing vacancies in the radiology department. Recent stakeholder engagement (particularly with the CCG) has raised concern in relation to risk management and governance.

The Trust recently returned their Provider Information Return (PIR), a location level assessment that provides essential data and information to support the ongoing monitoring of quality of care and to plan and inform inspections. Along with other sources of intelligence, we considered the PIR at a regulatory planning meeting (RPM) in early December where proposals for inspection were discussed and agreed.

The previous mortality alert concerning septicaemia shunting in hydrocephalus where the hospital review found no deficits in clinical or operative quality that was referred to in the 2013 CQC inspection report of BHRUT:

The CQC outliers team reviewed the information the Trust provided at the time. It was noted that a case note review had been undertaken for the 13 patients identified in the [redacted] analysis and that the reviewers concluded that in none of the cases of external ventricular drainage was there any evidence that drain placement was a factor in the patients' death. Subsequently, additional enquires were not undertaken.

Future regulatory action:

Following the recent RPM, we are planning to inspect specific core services at BHRUT in the first part of 2018. As part of our next phase inspection methodology, this will include specific consideration to how well-led the trust is; hence, we are scheduling a further 3 day in-depth inspection of the leadership and governance of the trust.

Please do let me know if you require any further information in relation to any of the above. We will be happy to update you in due course.

Yours sincerely

[redacted]
CQC Head of Hospital Inspection, London