REPORT FOR SOCIAL CARE & HEALTH OVERVIEW & SCRUTINY COMMITTEE

14th September

TITLE OF REPORT	CCG Quality assurance role and actions taken following recent CQC Inspection at WHCT, with particular reference to Maternity Services.
PURPOSE OF REPORT:	To discuss the role of Walsall Clinical Commissioning Group (CCG) in identifying and responding to concerns about the quality of services with particular reference to the Care Quality Commission's (CQC) letter to Walsall Health Care Trust regarding Maternity Services. The report includes specific actions undertaken to support improvement in Maternity Services at the Trust. This report seeks to: 1. Describe the CCGs arrangement's to assure the quality of healthcare services commissioned from the Trust. 2. Update on the improvement actions taken by the CCG to support the Trust to address the CQC findings.
KEY POINTS:	• To clarify the Quality Assurance processes adopted by the CCG. • To set out the governance structure overseeing the work of the quality directorate of the CCG. • To provide assurance on the additional actions undertaken by CCG in response to the CQC letter to further strengthen its Quality Assurance arrangements. • To provide further detail with regards specific areas of concern within the Maternity Services as Identified in the CQC letter.
RECOMMENDATION TO THE COMMITTEE:	To receive the report
COMMITTEE ACTION REQUIRED:	For information and assurance

REPORT WRITTEN BY:	Sally Roberts: Chief Nurse, Director of Quality & Safety Yvonne Higgins: Assistant Director of Quality & Safety Janet Herrod: Quality & Safety Manager
REPORT PRESENTED BY:	Sally Roberts: Chief Nurse, Director of Quality & Safety
REPORT SIGNED OFF BY:	Simon Brake, Chief Officer

The CCG has a duty to promote the NHS Constitution. Please indicate which principles of the NHS Constitution this report supports	
The NHS provides a comprehensive service available to all	
Access to NHS services is based on clinical need, not an individual's ability to pay	
The NHS aspires to the highest standards of excellence and professionalism	
The NHS aspires to put patients at the heart of everything it does	
The NHS works across organizational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	
The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	
The NHS is accountable to the public, communities and patients that it serves.	

Positive general duties - Equality Act 2010 The CCG is committed to fulfilling its duty under the Equality Act 2010 and to ensure its commissioned services are non-discriminatory. This report is intended to support delivery of our duty to have a continuing positive impact on equality and diversity The CCG will work with providers, communities of interest and service users to ensure that any issues relating to equality of service within this report have been identified and addressed	
Please indicate if there have been any equality of service issues identified in this report	No

1.Walsall CCG Committee Structures

1.1 Quality & Safety Committee

NHS Walsall Clinical Commissioning Group has established the Quality and Safety (Q&S), Committee to ensure commissioned services are of a good quality and deliver safe effective care in line with its corporate objectives.

The committee is chaired by the Medical Director (GP) for Walsall CCG and its' core membership includes Lay Member representation, Public Health, General Practice and Performance and Quality Leads.

It undertakes the delegated responsibilities from the Governing Body, as set out in the scheme of delegation. These include approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes

The committee monitors strategies including; the Management of Serious Incidents Policy, Quality Improvement Strategy and Research and Innovation Policy.

The committee monitors the duty to promote research, duty for improvement in quality of services and the duty for safeguarding.

1.2 Clinical Quality Review Meetings

Clinical Quality Review meetings (CQR) are held with the CCG's main providers on a monthly basis and established in accordance with the requirements of the NHS Contract. These meetings allow a platform for clinical, quality of care and performance issues to be discussed but also to monitor any areas that are under performing.

Senior leaders from both the CCG and Walsall Healthcare Trust are represented on the CQR for our acute provider including the Medical Director (GP) for Walsall.

1.3. Quality Surveillance Group (QSG)

QSGs operate at two levels, locally, on the footprint of NHS England's sub regional teams and regionally, on the footprint of NHS England, Care Quality Commission (CQC), NHS Improvement and Public Health England (PHE). Healthwatch are also in attendance.

The aim of QSGs is to identify risks to quality at as early a stage as possible. They do this by proactively sharing information and intelligence between commissioners, regulators and those with a system oversight role. Having identified any potential risks or concerns, the QSG should ensure that action is taken to mitigate these risks and drive improvement in quality in an aligned and coordinated way and to resolve issues locally where possible. Walsall NHS Trust is currently on enhanced surveillance in Birmingham, Solihull and Black Country QSG, with bimonthly reports being presented.

2. Maternity Services at Walsall Healthcare NHS Trust

2.1 CQC Inspections and Reports

In September 2015 the Care Quality Commission (CQC) undertook a comprehensive inspection of services at Walsall Healthcare NHS Trust. The subsequent report highlighted a significant number of areas of concern, including Maternity Services. In June 2017 a

further inspection was undertaken which again highlighted areas of concern within Maternity Services.

2.1.1. Actions

As a result of the findings of the inspection, the Maternity Service was rated inadequate. An immediate action undertaken by the trust and CCG was to agree to restrict maternity activity to ensure a safe service. Births were capped at 4000-4200 births to ensure a midwife to birth ratio of 1:28.

The trust undertook a range of immediate actions across maternity services. These included the development of a Maternity Task Force to oversee the development of Maternity Services in response to the findings of the CQC report; this group is chaired by the Chief Executive Officer and has representation from the Clinical Commissioning Group.

Plans were put in place to expand the Neonatal Unit to accommodate 18 cots. A review of the risk management and governance of Maternity Services was undertaken and a Quality and Patient Safety lead and a Risk Coordinator were employed in addition to the existing team. Senior leadership was reviewed and a new Divisional Director of Midwifery, Gynecology and Sexual Health employed.

CCG Actions taken by in response to the 2015 inspection

The majority of CQC findings had previously been reported by the CCG as areas of concern and scrutiny, however in response to the findings the approach to quality systems and processes related to patient safety and quality were strengthened further.

This included:

- CCG internal processes:
    - Review of TOR of Quality Safety and Performance Committee with intensified emphasis on quality and safety. Operational performance is now undertaken through a separate committee.
    - The quality and safety team capacity has strengthened clinical leadership and capability.
    - The reporting schedule and assurance framework were reviewed to ensure more rigorous oversight and targeted approach to quality and safety.
    - A Medical Director was appointed to work alongside the Chief Nurse.
    - Job roles were reviewed to support the role of an Assistant Director of Quality and Safety within the structure.
    - A revised visit schedule ensures that regular clinical quality visits take place to providers, these are used to provide assurance related to services and to stress test action plans developed by the Trust.

- Joint Walsall CCG & Walsall Healthcare NHS Trust:
    - Immediately:
    - Maternity Patient Care Improvement Plan devised and monitored through Quality Oversight Committee, Maternity taskforce and Clinical Quality Review meetings (CQRM).
    - A review of birth activity for trust was completed and a review of capacity

across Black Country and Staffordshire was agreed. Bookings at the Trust were capped to ensure safe and effective services for the short term.
- o Equality Impact Assessments to determine safe transfer of service for expectant mothers was undertaken.
- o Clinical group meetings were established to determine safe and appropriate pathways for all pregnant mothers and babies.

- CCG Ongoing:

- o Robust communication and engagement plan developed.
- o Contribution to and attendance at the Maternity Taskforce Committee
- o The Maternity Patient Care Improvement Plan was received and monitored monthly through the CQRM
- o The maternity dashboard is received and monitored monthly through the CQRM
- o Scrutiny and challenge and attendance at RCAs for serious incidents pertaining to maternity services.
- o Staffing ratios monitored monthly through CQRM, with evidence of improving capacity until spring 17
- o Unannounced visits undertaken to MLU and maternity wards, with formal feedback and suggested actions to the Trust
- o Working as part of the quality oversight committee to review and see maternity improvement in action
- o Quality spotlight updates at Quality and Safety committee from Head of Midwifery with regards maternity improvement plan, opportunity for further scrutiny and challenge with regards to sustainability of improvement.
- o Walsall CCG has reviewed and supported independent quality and safety reports
- o MBRRACE Surveillance Report review, which evidences positive improvements for Walsall against other Black Country trusts.
- o Opportunity through STP footprint to review and better understand capacity and flow for maternity local systems and formalise pathways and arrangements for a Local Maternity System.
- o Walsall CCG Q&S committee flagged to Walsall CCG board some concerns with regards staffing capacity on Delivery Suite in July 2017, high sickness levels were understood to be impacting on staffing capacity. In addition the sudden illness of the Clinical Director and the non-appointment of some senior midwifery posts had created a leadership capacity issue that the Trust was rapidly trying to address.

2.2.1 June 2017

In June 2017 the CQC undertook a further full inspection of Walsall Healthcare NHS Trust. Following the inspection a letter was sent to the Trust by the CQC regarding concerns related to Maternity Services. This was followed by an unannounced inspection 05 July 2017. Following this second visit a further letter was sent to the Trust as it was considered that the patient safety concerns had not been addressed by the Trust.

2.2.2 Response:

The CCG Chief Nurse and Chief Officer met rapidly with CEO and NHSI Turnaround Director to gain some immediate assurance with regards the findings and report form CQC. The trust were able to share a detailed plan in response from which the CCG requested weekly copies of the returns being sent back to CQC. The weekly information return is shared between the CCG and CQC and details capacity and safety indicators for maternity

services.

The CCG actions include:

- The capping of maternity bookings remains in place
- Scrutiny, challenge and review of weekly data returns
- Weekly review of staffing levels against the assurance provided by the Trust utilising a new acuity tool
- Review and scrutiny of maternity dashboard and request for further assurance as required
- Support to the Trust to help improve the safety of patients
- Go and see - unannounced and announced visits to maternity services, liaising with staff and women and families and gaining valuable feedback on progress
- Regular reporting to QSG and escalation as required
- Review and comment to RCOG terms of reference to ensure robust review
- Recent unannounced visit required a full report and further assurance from the Trust, relating to HDU care, epidural management, staffs perception of acuity tool and associated staffing and the use of badger net system. A formal response from the trust is awaited, with immediate actions arising from the report being undertaken by the Trust.
- CCG have requested further assurance and understanding of safeguarding training figures pertaining to maternity services – due September.

Conclusions

The CCG is responsible for commissioning Maternity Services for the population of Walsall, and in doing so must ensure that the service provided to expectant mothers, their babies, and their families is safe, adequate, effective & sustainable. In order to be assured of this, the CCG has recently met with the Trust, NHSI & NHSE, along with the CQC and discussed our concerns and the Trust's response, as well as the issues raised in the CQC's inspection reports and its several regulatory intervention letters. We will also ensure that the CQC's final inspection report and conclusions, due in the next several weeks, is incorporated into our programme of commissioning for this service, as well as the breadth of healthcare provision by the Trust.

The CCG will also participate in the forthcoming RCOG review that is scheduled for the autumn of 2017, and continues to attend and actively participate in the Oversight group meetings, led by NHSI. At the most recent meeting of the Oversight group, held in late August 2017, the CQC expressed a number of concerns which are broadly shared by the CCG, and although the agreed action plan addresses these over a range of timescales, we are remaining actively involved in the operational oversight of the service during its implementation, as we consider Quality & Safety to be of the utmost importance. Along with the Trust, we are due to meet with NHSE & NHSI in late September to discuss performance, quality and strategy in Walsall, and progress on the improvements required of the maternity service will be a core part of that discussion.

These opportunities for oversight and support, along with the Trust's action plan and the CQCs regulatory action, should lead to the improvements that are required for the service. The CCG will continue to closely monitor and review the Trust's progress in improving the service, and will intervene through the appropriate route if we are concerned or believe that progress is insufficient in improving the safety, quality and sustainability of the service. As the responsible commissioners for the service, we will continue to review and revise our commissioning strategy as we believe is necessary in order to gain assurance of the quality and safety of provision of maternity services for the population of Walsall.