Walsall Clinical Commissioning Group

REPORT FOR SOCIAL CARE & HEALTH OVERVIEW & SCRUTINY COMMITTEE

10TH MARCH 2016

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 quality of services with particular reference to the Care Quality Commission's report into services at Walsall Health Care Trust. The report includes specific actions proposed to support improvement in Maternity Services at the Trust. This report is set out in three sections and 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. 3. Propose a set of additional arrangements to improve and stabilise maternity services at the Trust.
KEY POINTS:	• To describe key elements of the CCG Quality strategy and its relationship to Quality Assurance. • To clarify for the committee, 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 evidence how the CCG's early warning system operates. • To provide assurance on the additional actions undertaken by CCG in response to the CQC report to further strengthen its QA arrangements. • To provide further detail with regards specific areas rated inadequate as a result of CQC inspection outcomes, with particular reference to maternity services.
RECOMMENDATION TO THE COMMITTEE:	To receive the attached report
COMMITTEE ACTION REQUIRED:	For information and assurance
REPORT WRITTEN BY:	Paul Deeley Brewer Sally Roberts

	Yvonne Higgins
REPORT PRESENTED BY:	Salma Ali/Sally Roberts
REPORT SIGNED OFF BY:	Sally Roberts

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

NHS
Walsall
Clinical Commissioning Group

Quality & Safety
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1 Quality in Healthcare

The Health and Social Care Act 2012 placed a duty on CCGs as prescribed NHS bodies to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.

The role of the CCG at a local level is complementary to national regulation because together they are part of a strong system to protect patients. CCGs should use CQC's and Monitor's assessments of provider quality and governance to assure themselves that providers deliver good care at a local level. This should then drive the CCG's more ambitious work with local providers to go beyond these standards. The CCG's role is therefore to be assured of the care quality of its providers but more importantly lead their improvement. It uses its contracts, relationships and system role to achieve that *(NHS Clinical Commissioners, 2013)*.

2 Committee Structures

2.1 Safety, Quality & Performance Committee

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

The SQP committee focus its work around the successful delivery of the CCG corporate objectives:

1. Improve health outcomes and reduce health inequalities
2. Provide the right care, in the right place, at the right time
3. Commission consistent, high quality, safe services across Walsall
4. Secure the best value for the Walsall pound and deliver public value

It undertakes to oversee the delegated responsibilities from the Governing Body as set out in the scheme of delegation providing Governing Body assurance and promoting a culture of continuous improvement and innovation with respect to safety of services and clinical effectiveness.

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

2.2 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 Clinical Quality Lead (GP) for Walsall

CCG, Director of Governance, Quality & Safety (WCCG), Medical Director (WHT), and the Director of Nursing (WHT).

2.3 Quality Surveillance Group (QSG)

QSGs operate at two levels, locally, on the footprint of NHS England's area teams and regionally, on the footprint of NHS England, Care Quality Commission (CQC), Monitor, Public Health England (PHE) and the NHS Trust Development Authority's (NHS TDA's) regional teams.

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.

2.4 Special Measures

As a result of the overall inadequate rating by Care Quality Commission Walsall Healthcare NHS Trust has now been placed into special measures. As a result the following areas are mandated and will include CCG support/action:

- Statutory Arrangements for CCGs unchanged
- Regular Ministerial Briefings on progress of improvement by TDA
- Quality Summit 1st February – Now completed
- Detailed Improvement Plan to be developed – to include system wide approach
- Improvement Director to be appointed to trust
- Board to Board review to be undertaken by TDA,
- TDA funded support for board development, expertise & governance
- Capacity & Capability review of WHCT Board will include CCG AO interview
- "Buddy" organisation(s) to be appointed (max 2)
- CQC revisit to review ratings / inspection notice outcomes
- Monthly oversight meetings chaired by TDA, to include a range of stakeholders including CCG, CQC, Health watch, HWBB chair and Local council representatives.

3 Walsall CCG – Quality Assurance Framework

The quality framework below (figure 1) sets out how Walsall CCG manages and sources the quality intelligence required to gain assurance in a systematic, organised manner to comply with its duty for quality improvement. The framework provides a formal structure that describes how the CCG manages quality improvement to:

1. Bring greater clarity to quality and planned quality improvements
2. Measure quality;
3. Publish performance about quality;
4. Recognise and rewarding quality; raising standards;
5. Safeguard quality;
6. Support and promoting innovation.

In order to provide assurance of our actions and those of our providers to improving quality it is important that we are also clear about respective and joint accountabilities and responsibilities for commissioning arrangements, these include specialised commissioning arrangements, public health commissioning arrangements and future commissioning arrangements for integrated working practices. These responsibilities are reflected within our governance framework.

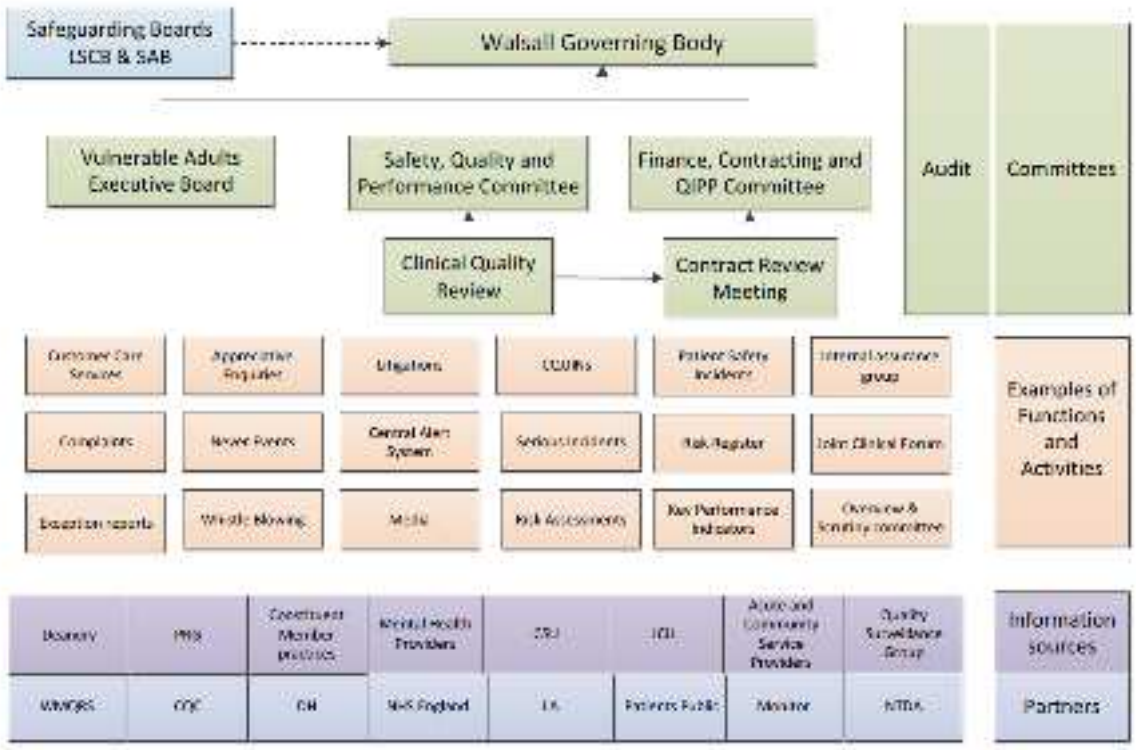

Figure 1

4 Quality Strategy

The CCG Quality Strategy has been established to ensure we create an environment that supports and encourages a culture where the values and behaviours enable robust systems and processes to monitor, manage performance and regulate quality of care in a transparent and open manner. It sets out the following quality principles:

- The patient comes first – not the needs of the CCG or Provider organisations.
- Quality is everybody's business – from the ward to the board, from the supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers.
- If we have concerns we speak out and raise questions without hesitation.
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised, we listen and 'go and look'

The strategy outlines the approach to ensure that high quality care and outcomes are achieved and maintained whilst setting out the commissioning requirements and responsibilities for quality. It describes Walsall CCGs arrangements to deliver its quality duties as detailed in the Walsall CCG constitution.

5 Early Warning System

An early warning system needs to be sensitive, timely and responsive to small variances in the quality of services to alert the CCG that there are potential issues that need to be checked. Walsall CCG works with regulatory bodies to share information and intelligence on risk, being seen as a source of advice and support in the event of concerns being raised, and visibly work together to support improvement where actual or potential failures in the quality of care being provided to patients is identified.

A number of metrics are used as part of the early warning system including intelligence from serious incidents, complaints, audits and responsive visits. Figure 2 below shows the actions taken in relation to Maternity Services following early warning system concerns.

5.1 Maternity Services Actions

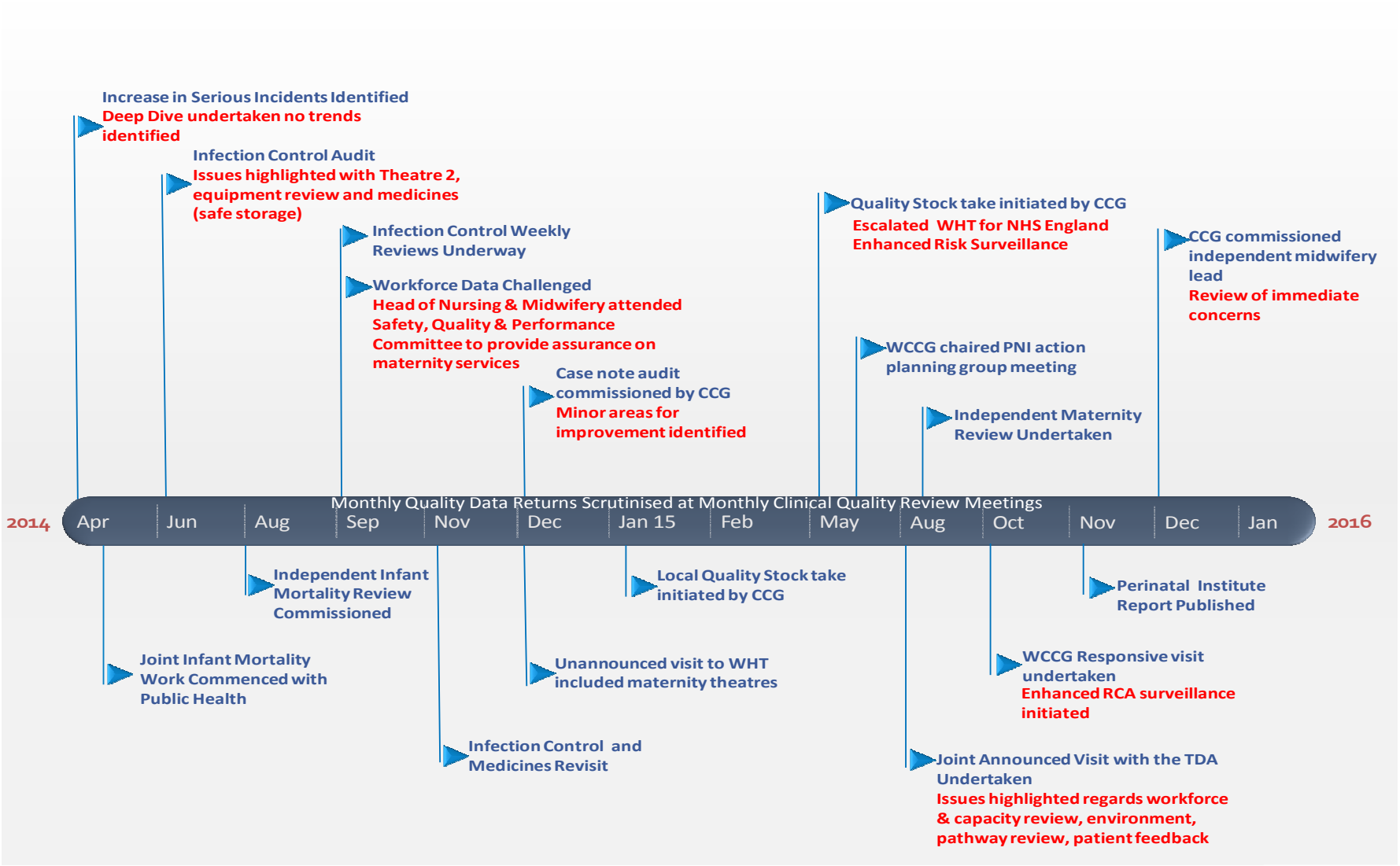

Figure 2

6 CQC Findings:

The recent publication of the Care Quality Commission (CQC) report following a comprehensive inspection of services at Walsall Healthcare NHS Trust highlighted a significant number of areas of concern including Maternity Services and Emergency Department.

6.1 Maternity Services:

In respect of Maternity services the CQC identified:

- Multiple issues with staffing, delivery of care and treatment and people were at high risk of avoidable harm.
- Ratio of Midwifery staff to births was worse than the England average of 1:28
- Staffing on the delivery suite was nine midwives per shift
- Concerns regarding 1:1 care at Labour
- Relocation of staffing from other areas onto the delivery suite often compromised the provision of postnatal wards, as this formed the first part of the escalation
- Concerns regarding the physical capacity and estate to manage the number of births at the Trust
- Concerns regarding staffing levels and the negative impact this could have on patient experience and patient safety.
- Concerns about the lack of specialist midwives
- Concerns regarding the level of activity within the service
- Capacity issues impacted on induction of labour. Elective Caesarean section lists were frequently interrupted to accommodate emergency cases.
- Delays in patient care had occurred because staffing number were not sufficient to safely manage activity levels
- The Neonatal unit was cramped and posed potential safety risk when capacity was above 15 patients
- Concerns regarding the risk management and governance within the Maternity department

As a result of the findings of the inspection, the maternity service was rated inadequate. Immediate review has identified the requirement to restrict maternity activity at Walsall Healthcare Trust to ensure an immediate safe service. Analysis has identified capping activity needs to be around 4000-4200 births (currently 4920) and that excess activity will need to be redistributed, to ensure safe staffing levels of 1:28 are maintained.

This will need to be an immediate measure and is likely to be in place for at least 12 months from commencement. This will enable the agreement for managing future demand with other neighbouring providers and enable the trust to assess estate impact in more detail, with some immediate estate works being agreed.

Since inspection the trust has undertaken a range of immediate actions across maternity services, these include the launch of an improvement plan in June 2015, development of a maternity Task Force, which oversees the development of Maternity services in response to the findings of the CQC report; this is a senior

group chaired by the Chief Executive Officer and has representation from the Clinical Commissioning Group and the local authority.

Plans are in development to expand the Neonatal unit to accommodate 20 cots; this is currently commissioned to provide 15 cots and is regularly oversubscribed as identified in the inspection.

Architects have been commissioned to look at options for expansion of the Maternity estate to include a reconfiguration of existing services.

The delivery suite has 11 midwives on shift every day and this is monitored daily. An additional 19 midwives were recruited prior to inspection and further recruitment is ongoing with success.

A review of the risk management and governance of Maternity services is currently underway, a senior manager is leading the review with independent support, and further investment is being made in a Quality and Patient Safety lead and a risk co-ordinator. This is over and above the existing team.

Actions taken by CCG

Walsall CCG is now leading a Black Country wide sustainable maternity services meeting, with attendance from NHSE, Maternity network specialists and the inclusion of Staffordshire commissioners.

Agreement sought that activity capping is now required to ensure safe and effective services for the short term.

Review of birth activity for trust now complete and a review of available capacity across Black Country and Staffordshire being agreed.

Equality Impact Assessments to determine safe transfer of service for expectant mothers underway.

Birth activity analysis will be used to determine the cohort of pregnant mothers to be given the option to deliver at alternative maternity units.

Clinical group meeting to determine safe and appropriate pathways for all pregnant mothers and babies.

Robust communication and engagement plan developed.

6.2 Emergency Care:

CQC identified capacity issues as having an impact on patient safety and quality and also identified that the triage process was ineffective. To support the Emergency Department, CCG has led process mapping work with the trust and urgent care provider to refine Urgent Care Centre triage processes ensuring effective triage is taking place at the front door to ensure appropriate cohort of patients are attending the Emergency Department. Workforce review has identified gaps in funded establishment and a recruitment exercise is underway by the trust. A similar task

force approach to ED improvement is also being put in place by the trust. Immediate clinical concerns for example pain management in ED have already been addressed by the trust.

7 Next Steps

The overall rating for the trust was inadequate and the trust has now been placed into special measures. As a result of this WCCG has reviewed its systems and processes related to patient safety and quality and whilst recognising the majority of CQC findings were already identified as areas of concern and scrutiny has strengthened further its approach to quality assurance and quality improvement. This includes:

- Reviewed terms of reference for its Quality Performance and Safety Committee, with a more intensified emphasis on quality and safety. Operational performance will now be undertaken through a separate committee.
- Reviewed quality and safety team capacity and strengthened clinical leadership and capability within the quality and safety directorate.
- CCG will shortly be appointing a medical director, to work alongside the Executive lead for Quality and Safety
- Review of job roles to support the role of an Assistant Director of Quality and Safety within the structure.
- The review of the contracting quality schedule for 15/16 has reinforced a wide range of quality metrics with increased emphasis on metrics for improvement, outcome based measures and stretch targets for areas of concern.
- The reporting schedule and assurance framework have also been reviewed to ensure more rigorous oversight and targeted approach to quality and safety.
- CQUINs are being developed to ensure a SMART and outcome based improvement, in line with some of the more fundamental issues of system and process in particular with regards clinical standards and clinical leadership.
- A revised visit schedule has been developed which will ensure that regular clinical quality visits take place to our providers. These regular announced and unannounced visits will inform key lines of enquiry for follow up with providers at the appropriate level for example Clinical Quality Review Meetings and the intelligence gathered will be used to triangulate submitted data from our providers.
- The visit schedule will be a “living” document with opportunities for system leaders to contribute to the quality agenda to target any areas of concern with a clinical quality visit.

WCCG is committed to the highest standards of patient safety and is in the process of finalising its 3 year plan to save lives and reduce harm for patients as part of our registration with the “sign up to safety” campaign. Duty of candour is expected and reviewed for every incident reported and, where necessary, challenged through WCCG safety arrangements. Work has commenced with Health watch colleagues to ensure a more co-ordinated collaborative approach and response where required.

Preventing problems, detecting problems quickly and taking action promptly is a key priority in the CCG Quality Strategy. WCCG has established and will continue to maintain an early warning system that is sensitive, timely and responsive to variances in quality of services. This includes setting out a system wide procedure to enable WCCG to respond in a rapid, coordinated and collaborative manner to failings in quality whilst safeguarding patients and service users.