

GOVERNING BODY MEETING

Title of Subject:	Oversight of Quality during COVID-19 Pandemic
Date of paper:	June 2020
Prepared By:	Paper of Gill Gibson, Director of Quality and Safeguarding. Prepared by Lynn Jackson, Quality Lead Manager
History of paper:	The first paper describing oversight arrangements for quality during COVID-19 pandemic presented in May 20, this is the second Quality Oversight report.
Executive Summary:	<p>During the COVID-19 pandemic it is recognised that arrangements for quality and patient safety need to be focussed and proportionate to ensure oversight, rapid identification and escalation of significant quality issues.</p> <p>NHS England has advised on the quality and patient safety functions that providers and commissioners need to prioritise and those that can be paused in the interests of focusing clinical and managerial effort on incident response.</p> <p>The Quality team has worked with providers to ensure they have focused and proportionate arrangements for quality and patient safety are in place.</p> <p>Quality oversight is now moving towards the next phase of COVID-19; the initial crisis phase is reducing and, in line with these developments, we are beginning to consider how, as we live with COVID-19, we adjust and adapt our existing assurance arrangements.</p>
Recommendations required of the Governing Body (for Discussion and Decision)	Governing Body is asked to note the content of the report.
QIPP principles addressed by proposal:	NA
Has this been reviewed in line with the Governing Body Assurance Framework	<p>Yes</p> <p>The report provides assurance to the CCG that it has arrangements in place to for oversight of information about quality during the COVID-19 pandemic.</p>
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Oversight of Quality during COVID-19 pandemic

1. Introduction

1.1 During the COVID-19 pandemic it is recognised that arrangements for quality and patient safety need to be focussed and proportionate to ensure oversight, rapid identification and escalation of significant quality issues.

1.2 NHS England has advised on the quality and patient safety functions that providers and commissioners need to prioritise and those that can be paused in the interests of focusing clinical and managerial effort on incident response. Interim National and Regional arrangements were presented in May's Quality Oversight report and can be reviewed in Appendix 1.

1.3 The Quality team has worked with providers to ensure they have focused and proportionate arrangements for quality and patient safety are in place.

1.4 Quality oversight is now moving towards the next phase of COVID-19; the initial crisis phase is reducing and, in line with these developments, we are beginning to consider how, as we continue to live with COVID-19, we adjust and adapt our existing assurance arrangements.

2. Interim CCG Oversight Arrangements

2.1 The quality team has worked with providers to ensure focused and proportionate oversight arrangements for quality and patient safety. Any significant issues will be escalated into the virtual Quality Oversight Group.

2.2 The virtual Quality Oversight Group (Chaired by Clare Todd) meets monthly and ensure system oversight of quality and patient safety.

2.3 The quality team continue to maintain oversight of STEIs (Strategic Executive Information System) as the national system for serious incident reporting and management. Virtual STEIs panels are established to review newly submitted provider investigations to ensure fundamental learning has been met.

2.4 ICFT and PCFT have provided assurance about their interim arrangements for quality and patient safety oversight during the COVID-19 pandemic (Append 2). As we move into the next phase of living with COVID-19 the quality team will be working closely with both providers to ensure oversight is focused and with use of alternative methods of quality assurance.

3. Primary Care

3.1 Primary Care is now moving onto the next phase of COVID-19. The crisis phase is reducing and rather than reacting we are looking at how we live with COVID-19 and move to re-commencing routine quality of monitoring of practices, encourage Quality and Outcomes Framework (QOF) work and the routine management of long term conditions.

3.2 As part of the response to COVID-19 many contractual requirements of general practice were reduced to support safe and focused delivery. In addition, alongside CQC suspension of inspections, routine quality support to practices was suspended while we worked to respond to the crisis, with the exception of a quality incident reporting process that was put in place to help support communication during the initial response; it is expected that this process will continue. The link between work undertaken for QOF and payment for that work was suspended and still is. While some practices have continued undertaking this work in practices – using appropriate PPE – other practices have been working with those patients with poorly controlled long term conditions, initially remotely and holding face to face appointment were clinically needed and with appropriate PPE. Other practices have continued with annual reviews, but remotely.

3.3 The Primary Care Standard Operating Procedure dated 29 May 2020 states, “...Practices should now be offering routine care as usual, wherever safe, making use of virtual options wherever that is possible.”

3.4 A Living with Covid operating group has been established, and working with that group we will develop guidance to support practices to safely re-introduce some of the suspended activities.

3.5 To support this work we are re-introducing quality visits with practices, which had been suspended in the initial phase of COVID-19, though these will take place remotely via Microsoft Teams.

4. Adult Care

4.1 Adult Social Care, in particular the Care Home Sector, has been and remains a high profile risk area during the COVID-19 pandemic. A Significant system wide package of support has been implemented to support the sector throughout this period including:

4.2 Enhanced Digital Health Offer.

4.3 T&G CCG have built on the Digital Health offer enhancing the capability with additional senior clinical decision makers to support personalised decision making for an urgent need and to facilitate a planned pathway in which the resident may require a diagnostic test without admission (e.g. radiological investigation following injury) to guide their subsequent care back in the care home.

4.4 We have also started to embed a proactive approach with daily updates on individual residents that enables early identification of residents who may be deteriorating. This facilitates discussions with the registered GP to prompt reviews and where necessary advance care planning before the need for a crisis intervention.

4.5 The Digital Health use of the ‘Core COVID-19 Data App’ developed from the established Safe Steps App in collaboration with Health Innovation Manchester enables daily review of

core data provided by care homes for each resident via a central dashboard to proactively identify residents by the following characteristics

- RAG acute illness status
- COVID symptoms
- Onset of delirium

4.6 A dashboard for the registered GP will support case finding and prioritisation for weekly proactive resident review in each home and across all of the care home system. The dashboard will also support whole home outbreak management in combination with the infection control team. The Neighbourhood MDT will be able to use the dashboard alongside the records held by the individual services to ensure effective care planning.

4.7 Daily Ring Round:

4.8 Providers of Adult Social Care including nursing & residential homes, supported living, homecare, and day care providers continue to be contacted on a daily basis to capture and escalate any concerns during the pandemic to Adult Social Care Senior Team. Additionally there is a Greater Manchester SitRep completed on a Monday and Wednesday of each week which includes questions relating to PPE stocks, Workforce capacity, Medication Issues and Bed availability. The Quality team continues to work in partnership with Derbyshire CC to ensure similar, but not duplicated arrangements, are in place for Glossop homes.

4.9 PPE stocks and supply chain have improved since the beginning of the outbreak; TMBC continues to provide additional resilience PPE ensuring providers have adequate supply. Workforce capacity has also stabilised with a reduction of staff self-isolating since early lockdown (March and April period). Close monitoring of cases of Covid-19 for both staff and residents continues via the daily ring-round. Additionally, monitoring of testing arrangements and results is in place for the Care Homes via a dedicated e-mail address and twice weekly phone check-ins with the Care Homes.

4.10 Infection Prevention and Control Offer

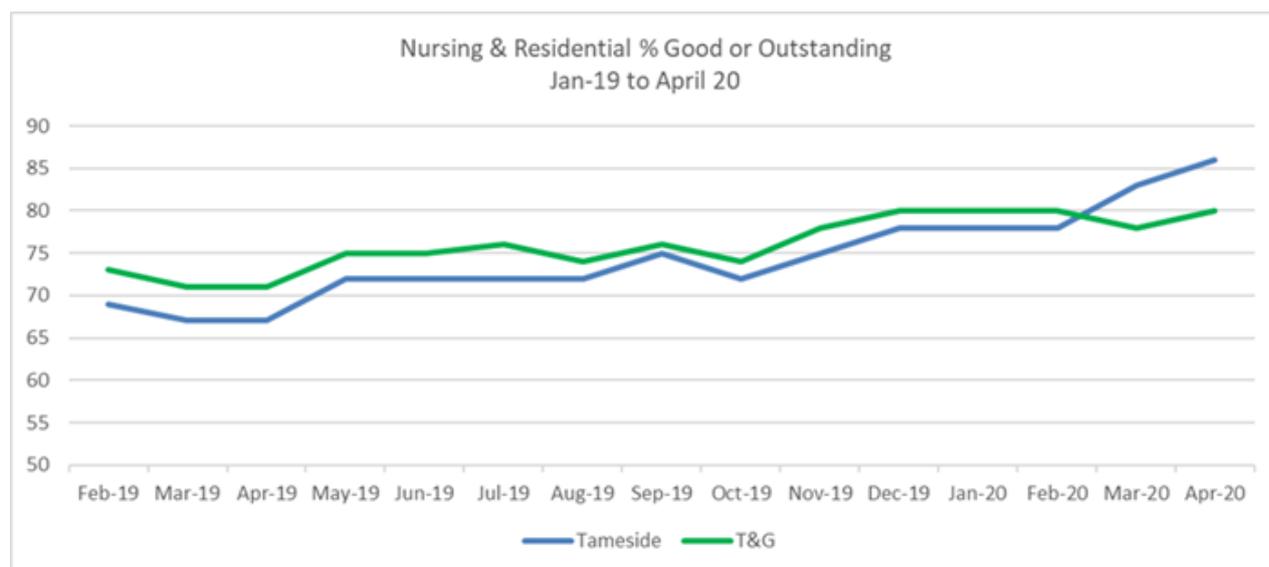
4.11 Tameside and Glossop have infection prevention services commissioned for the care home and domiciliary care sector. They have provided support in not only responding to outbreaks but in teaching doffing and donning of PPE and other basic infection prevention via interactive webinars. We will continue to build on this approach, following the call to action from the CNO.

4.12 The Quality and Safeguarding Directorate are also providing additional support in this area with the delivery of a number of online Infection Prevention and Control webinars for the sector, FITT Testing Clinics for FP3 masks, for those providers providing care to patients with AGP (Aerosol Generating Procedures) and training re swabbing for testing.

4.13 Adult Care CQC Update:

Nursing and residential providers - % rated good or outstanding:

4.14 Tameside nursing and care homes continue to see an improved trajectory and have 86% of homes rated as good or outstanding by CQC. As a T&G locality 80% are rated good or outstanding; the figure is slightly different as this figure includes Glossop homes.



4.15 Inadequate Providers:

Jabulani (residential care – Glossop – Derbyshire County Council)

The Home received its second Inadequate rating on 17 April following inspection by the CQC on 18 February. The CQC issued the provider with a Notice of Decision to Cancel Registration. As reported previously the CCG had been holding regular commissioner meetings with the Home, and considerable support has been provided by the Quality Improvement Team. Following a second inadequate decision and CQC decision to cancel registration the Strategic commission made the decision to cease the contractual relationship with the provider. All residents have now been moved to suitable alternative accommodation.

Adult Social Care - CQC Updates

The following providers have all received a good rating published between 1 March – 31 May 20

- St Lawrences Lodge (TMBC)
- Yew Trees (TMBC)
- The Sycamores (TMBC)
- Affinity Trust Domiciliary Care (TMBC)
- Downshaw Lodge (TMBC)

- The Richmond Fellowship (TMBC)

The following providers have received a Requires Improvement rating between 1 March – 30 April 20

Regency Hall (Derbyshire County Council)

The home received a Requires Improvement rating on 13 March following inspection on 6 February 2020. The home received a good rating in the responsive, effective and caring domains but a requires improvement in Safe and well-led. Improvement was noted as being required in relation to medicines management and governance.

Pendlebury Court (Derbyshire County Council)

The home received a Requires Improvement rating on 13 March following inspection on 6 February. The home received an RI rating across all domains. Improvement was noted as being required in a number of areas including medicines management, governance, assessments/reviews, and activities.

NB: Pendlebury Court and Regency Hall are sister homes under Pendlebury Care Homes limited.

Millbrook House (Derbyshire County Council)

This provider received a Requires Improvement rating on 17 March following inspection on 28 January. The home received an RI rating in the Safe and Well-led domains. Improvement was noted as mainly being in relation to governance.

Moss Cottage (TMBC)

The provider received a Requires Improvement rating on 1 May following inspection on 3 March 20. The Home received an RI rating across the Safe, Effective and Well-led domains. Improvement was noted as being required in relation to management of medicines, record keeping, person-centred planning, and effective governance systems including audit and quality checks.

5. Learning Disability Health Checks:

5.1 People with a learning disability have a right to good health, yet they still face many health inequalities, often resulting in worse health than the general population.

5.2 Sadly, people with a learning disability can have poorer physical and mental health than other people and studies have shown that they can die on average 20 years younger than the rest of the population. People with a learning disability are three times more likely to die from causes of death that could have been avoided with good quality healthcare. Many of these deaths are avoidable and not inevitable.

5.3 A whole health and care stakeholder group has been working collaboratively to drive this agenda and increase the number of people on GP Learning Disability Registers, from age 14 years, who receive an Annual Health Check.

5.4 The CQC published a press release during the COVID-19 period about a targeted piece of analysis to better understand the impact of coronavirus (COVID-19) on people with a learning disability, some of whom may also be autistic, and how the number of deaths during this period compares to the number of deaths last year. Further information can be read [here](#)

5.5 It is important that annual health assessments continue in order to identify undetected health conditions early and to ensure the appropriateness of ongoing treatments and promote health in this population. The Primary Care Standard Operating Procedure dated 29 May 2020 states 'Practices should now be offering routine care as usual, wherever safe, making use of virtual options wherever that is possible'. A proposal to PRMG (Pandemic Resilience Management Group) supporting a phased approach to the completion of the annual health check, including virtual options where possible, will support delivery of this agenda.

5.6 NHSE have asked for LeDer reviews on all Learning Disability death during the COVID-19 period to be completed by the 8th July 2020.

6. SAFEGUARDING

6.1 The impact of the Coronavirus pandemic is a challenge to the way we deliver services internally and across partnership organisations, in particular Statutory Safeguarding duties and our responsibilities to safeguard children. Partnership working is crucial at this time and multi-agency statutory safeguarding work will need to continue although it will be undertaken in a different way to comply with social distancing requirements. The CCG Designated Nurses are facilitating local safeguarding groups to monitor and review local response to national guidance and briefings and to ensure there is effective communication between agencies during this time and create escalation routes of any issues. Groups report to the TSCP and TSAB weekly meetings and also designated nurses link in via sliver command. We are working closely with providers and partners across the economy to ensure that safeguarding duties continue and business continuity plans include safeguarding as core business.

7. Small Value Contracts

7.1 Providers have suspended services which require face to face contact with patients. Support is provided by telephone or visual communication apps. A member of the team is contacting these providers on a regular basis to ensure any concerns can be escalated to appropriate commissioner.

8. Out of Area Individualised Commissioned Placements

8.1 The team has contacted all host lead commissioners to confirm existing arrangements as per the Out of Area protocol remain in place for oversight and escalation of concerns.

Appendix 1) National and Regional Oversight Arrangements.

1. National and Regional Arrangements

Below is the agreed approach to quality oversight at a local and regional level during the COVID-19 pandemic.

2.1 Overall, all quality oversight meetings need to be focussed and proportionate. There should be the rapid escalation of any issues, to Regional Management Teams using a proportionate version of existing local and local quality architecture. Regional Medical Directors or Regional Chief Nurses are still responsible for notifying the Executive Quality Group (EQG) secretariat (england.executivequalitygroup@nhs.net) of any issues that need national escalation and coordination. Issues that relate to COVID-19 must also be taken through regional EPRR processes/Regional Cells and nationally via the Incident Coordination Centre.

2.2 Regional teams should be working closely with CQC (regionally via the link Deputy Chief Inspector) and local authorities – through regular oversight calls to discuss emerging issues, and should also be linking with HEE and professional regulators where practical to share intelligence about issues on the ground.

2.3 Regional Joint Strategic Oversight Group (JSOG) and Regional Quality Surveillance Groups (QSG) should be brought together and should cover the whole system (primary, secondary care, social care etc.) in order to provide an opportunity for regulators and local organisations to come together to share information/concerns and agree actions – it is suggested that these run as brief calls every 6 weeks.

2.4 Decisions on whether to continue Local QSGs and Risk Summits or to put in place alternative oversight arrangements should be made by the Regional team.

2.5 Decisions on whether to continue or stop improvement boards should be made by the Regional team, in agreement with CQC.

3. National level:

3.1 National JSOG will continue in the coming months to share information and concerns about the most challenged systems and providers with the purpose of understanding how support can be most effectively directed.

3.2 National EQG will continue, but work in a different way as Regions focus on the response to Covid-19. Regional cells may, for example, ask for support with responsive policy work relating to Covid-19 or 'normal' activity (e.g. cancer). It will be the responsibility of Regional Medical Directors and Chief Nurses to escalate issues to Executive Quality Group, while also observing regional EPRR escalation processes. The bi-monthly reporting regime will be put on hold, with the expectation that requests for support are escalated as and when required.

Extraordinary meetings will be run as and when required. – These meetings will be based on any insights from:

- Regional escalations
- Reporting to national JSOG
- Intelligence from patient safety reporting
- Any instructions from EPRR

3.4 National Regulation 28 Working Group will not meet, however there will still be some agreement by correspondence on pressing patient safety concerns raised by Coroners

3.5 National Quality Board still meets to provide an opportunity for cross-system discussion, but at an appropriate time on a condensed basis (1 hour) and focused on the short and long term response to Covid-19.

Appendix 2)

Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT)

The Trust has put in place the following interim quality and patient safety oversight arrangement during COVID-19 pandemic:

- Developed a new “safer care daily report” that allows trust to have oversight of quality and safety and to quickly identify any trends quickly and mitigate as required. This is shared with the command and control structure in place in the Trust.
- Implemented a system that maintains business critical patient safety functions such as the daily triage of reported clinical incidents, and where required the further investigation/swarm type approach is undertaken in order to determine whether Trust’s systems and processes are safe. This means they would be communicating with senior leaders/managers to determine the facts of any serious incident with a view to assuring themselves that they are safe or taking action if required to make them safe. At this time, they would be generating 72 hour reports to capture the action taken and assurance provided, but in line with National guidance would not be undertaking formal investigations at this time.
- Monitoring concerns received through the PALS and Complaints Team and any received via social media and platforms such as Care Opinion.
- Holding virtual Quality and Governance Committee meetings, in line with National recommendations.
- Communicating with the CQC via weekly short catch up calls.
- Maintaining communication channels with all key stakeholders and partners
- Developed action cards and guidance for staff that are easily accessible that are designed to support the delivery of effective high quality care.
- The Trust also reports to the Tameside Silver Command.

Pennine Care NHS Foundation Trust (PCFT)

The Trust has put in place the following interim quality and patient safety oversight arrangement during COVID-19 pandemic:

Established a Response Oversight Team, led by the Chief Executive and Executive

Directors, is leading the Trust’s overall strategic response as well as critical operational and staffing issues. In addition, there are gold and silver tactical arrangements in place responsible for the day-to-day response, planning and coordination across the Trust and at borough / service level.

Established an internal clinical and ethics group that is meeting daily to deal with, make decisions or advise gold command on clinical matters, guidance, training, legal and ethical issues. A clinical and ethics group has been convened with GMMH, meeting twice a week, to discuss issues and agree consistent approaches.

The Board has recognised that its response needs to be proportionate, reasonable and streamlined, and so has decided to amend its committee arrangements and established a time-limited 'Combined Assurance Committee', the purpose of which will be to oversee and seek assurance regarding the organisational response and impact of Covid-19 in terms of quality, people and workforce, performance and finance.

The Quality Group, chaired by Clare Parker, will continue to meet, but will move to twice a month, to examine relevant data plus capture and review all clinical and ethical decisions.

The Trust's central patient safety team continues to function without interruption and includes the scrutiny, review, escalation, communication and decision-making processes as business as usual.

The Trust's statutory Duty of Candour processes continue as business as usual with communication with families about serious patient safety incidents recorded and processed. The template will also support services and the Trust to identify further immediate actions planned to ensure patient safety and the safety of others.

The Trust is maintaining their Quality Lead role with individual Boroughs albeit on a reduced basis as some time is taken from their role into supporting in-patient areas; this is a dynamic and moving situation that is reviewed via the Trust's daily situation reports about service's current status in terms of staffing and pressures.

The Trust is maintaining an overview on aspects of quality by moving established groups to virtual groups e.g. Patient Safety Improvement Group (PSIG); Ligature Review Group.