How to Establish a Quality Surveillance Group

– Guidance to the new health system

First Edition, January 2013

CONTENTS

ANNEXES

1. Why are we establishing Quality Surveillance Groups?

The National Quality Board (NQB) brings together the leaders of national statutory organisations across the health and care system, alongside expert and lay members. Our role is to provide leadership for quality and align the system to support quality improvement.

In 2008, following the Healthcare Commission's report into serious failings at Mid Staffordshire NHS Foundation Trust, we conducted a review into the systems and processes in place for safeguarding quality in the NHS. Our report was published in February 2010[1], and sets out the roles and responsibilities at every level of the system for safeguarding quality. The report also set out how different parts of the system needed to work together, as part of a culture of open and honest cooperation, to identify potential or actual serious quality failures and take corrective action in the interests of protecting patients.

As we move to the new system, many new organisations are being established and existing organisations are taking on new responsibilities and functions. There will be new relationships to be built, roles and responsibilities to be understood and interdependencies to be appreciated. We therefore decided to review and update our 2010 report to ensure that there continues to be clarity around roles and responsibilities for quality once the new system goes live from April 2013. This was published in draft in August 2012[2], and is published in final form alongside this guidance, having taken on board comments from people working in and using the NHS. We will review this report in light of any relevant findings and recommendations arising from the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The NQB used this opportunity to think about what more the system could do collectively to support collaboration and to bring us closer to achieving a culture of 'open and honest cooperation'. They set out that in order to ensure that different parts of the health system do indeed work together, a network of Quality Surveillance Groups should be established across the country, bringing health economies together locally and in the four regions.

How do we define quality?

There are three dimensions to quality, all three of which must be present in order to provide a high quality service:

- clinical effectiveness – high quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- **safety** – high quality care is care which is delivered so as to prevent all avoidable harm and risks to the individual's safety; and
- **patient experience** – high quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

Quality is systemic. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider organisations, commissioners, system and professional regulators and other national bodies

[1] *Review of early warning systems in the NHS*, National Quality Board, February 2010.
[2] *Quality in the new health system – maintaining and improving quality from April 2013*, draft report, National Quality Board, August 2012

including the Department of Health. It is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system.

The system's collective objectives in relation to quality are:

- ensuring that the essential standards of quality and safety are maintained; and
- driving continuous improvement in quality and outcomes.

Both of these objectives are equally important. Quality Surveillance Groups are primarily aimed at supporting the system to ensure the former – that essential standards of quality are met. In terms of the latter – driving continuous quality improvement – there are tools and levers across the system focussed on this element, and duties on the Secretary of State for Health, the NHS Commissioning Board (NHSCB) and Clinical Commissioning Groups (CCGs).

The need for Quality Surveillance Groups

Across the health and care system, we know that there are excellent examples of where organisations within local health and care economies have built strong working relationships, where there is an active dialogue about quality and where concerns or risks are raised promptly and dealt with collectively in a coordinated way. But this is not the picture everywhere. We have seen the devastating impact for patients and their families of different parts of the system not working together and sharing the information and intelligence on quality that they have.

Across a health and care economy, there will be a wealth of information and intelligence, gathered formally and informally, about the providers of services to that population. Often the information that one party alone has will not cause concern. However, when combined with intelligence that, for example, a regulator may have, might point to a potential problem that should be investigated further.

There will be various different organisations and individuals in a health and care economy who will hold such information. For example, it is likely that a single provider will be commissioned by a number of local commissioners, and that any one commissioner will commission from a number of local providers, from the public sector, private sector and not-for-profit organisations. The distinct roles and responsibilities of different organisations in the system means that no one organisation will have a complete picture on the quality of care being provided. It is for this reason that we have collectively agreed to establish a new network of Quality Surveillance Groups (QSGs) which will systematically bring together the different parts of the system to share information. They will be a proactive forum for collaboration, providing the health economy with:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality; and
- opportunities to coordinate actions to drive improvement, respecting statutory responsibilities of and ongoing operational liaison between organisations.

This document provides initial guidance on establishing QSGs, and has been informed by a series of pilots in the Midlands and East region. The guidance will be kept under review and updated in light of further learning as QSGs are rolled out across the country and in light of any relevant findings and recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry. An updated version of this guidance will be published during the autumn 2013.

This guidance should be read in conjunction with the National Quality Board's report Quality in the new health system – maintaining and improving quality from April 2013, which is published alongside this guidance.

2. What is a Quality Surveillance Group?

QSGs will operate at two levels: locally, on the footprint of the NHS Commissioning Board's 27 area teams; and regionally, on the footprint of the NHS Commissioning Board, Care Quality Commission (CQC), Monitor, Public Health England (PHE) and the NHS Trust Development Authority's (NHS TDA) four regional teams.

A QSG will act as a virtual team across a health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning, and regulatory activities. By collectively considering and triangulating information and intelligence, QSGs will work to safeguard the quality of care that people receive.

The creation of QSGs should not be seen as adding a level of bureaucracy to the system but as a vital part of acting in the interests of patients and service users. In many areas, such information sharing and cooperation is already part of their business as usual, bilaterally and multilaterally. This model will create a network which encourages and creates an expectation of open and honest cooperation, in every local area, in a regular and tangible way. Where it is already happening, the model provides a wider network in which existing relationships will sit.

QSGs at local and regional levels will perform distinct roles as part of a nation-wide network:

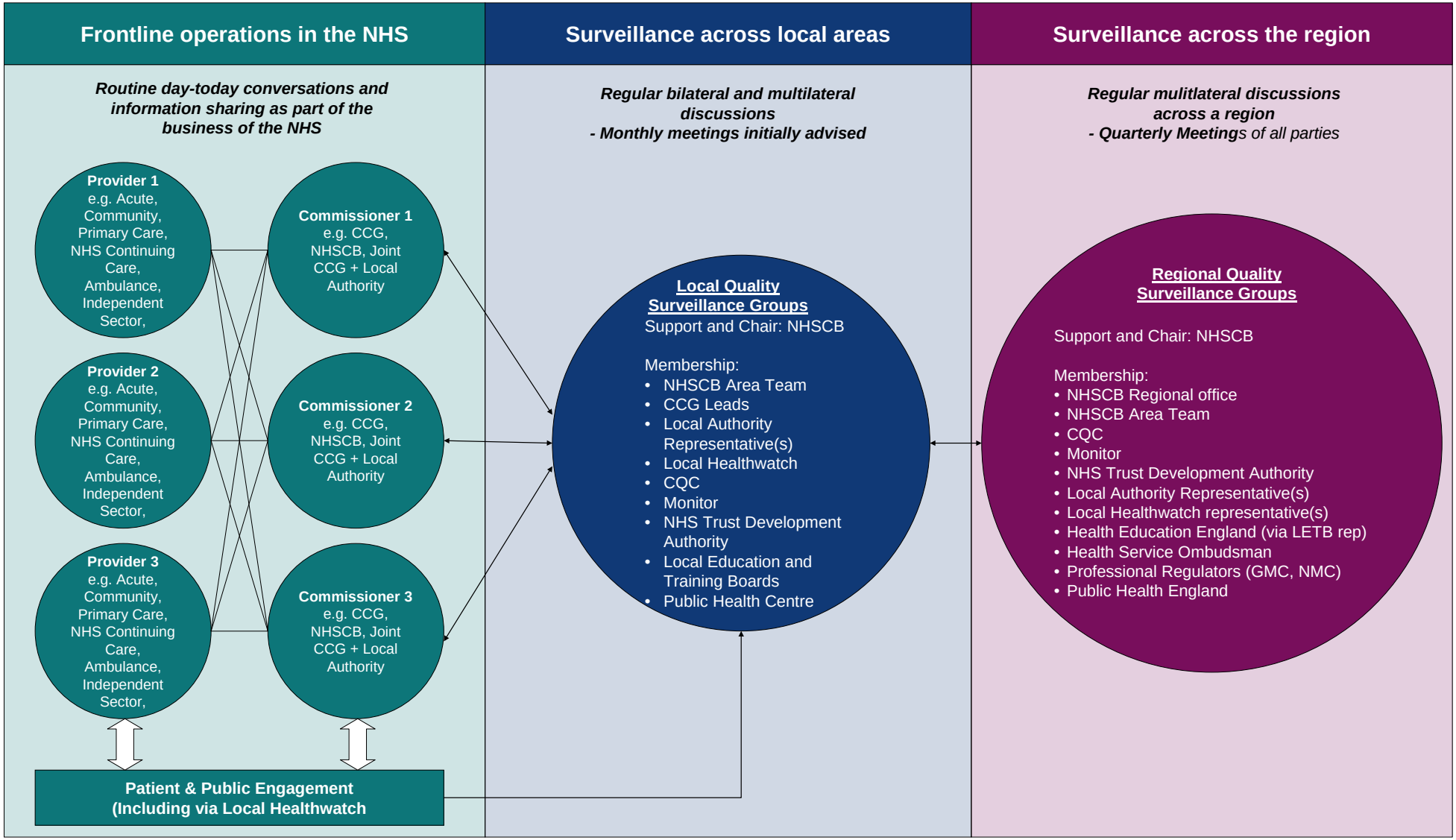
- Local QSGs are the backbone of the network. They engage in surveillance of quality at a local level by those closest to the detail and most aware of concerns. They will not only consider information and intelligence but also be able to work together to take coordinated action to mitigate quality failure.
- Regional QSGs provide an escalation mechanism for Local QSGs. They assimilate risks and concerns from local QSGs, identifying common or recurring issues that would merit a regional or national response. The will also have a key role, particularly in 2013/14, in assuring the effective operation of local QSGs.

The diagram on the following page depicts the Quality Surveillance Group network at a glance. Quality Surveillance Groups provide a forum for multilateral information sharing, and collaboration, and opportunities to build strong working relationships across a health economy. They need not replace existing bilateral arrangements for information sharing where they are useful, such as those that are established in many areas between CQC and Local Authorities, CQC and commissioners, and CQC and Monitor.

Once a Quality Surveillance Group identifies concerns about the quality of care being provided in their area, members can take contractual action, regulatory/enforcement action and/or provide improvement support in line with their existing responsibilities. More information on the type of action that can be taken and by whom is in chapter 9.

In considering the role of QSGs, and the actions that they can take, it is important to remember that they are not statutory bodies, they have no legislative status, nor formal powers. QSGs are simply a forum through which different organisations who do have statutory powers and responsibilities can come together to discharge their responsibilities in a more informed and collaborative way. QSGs will only be effective if all those sitting around the tables exhibit the values and behaviours that put patients and service users first.

THE QUALITY SURVEILLANCE GROUP NETWORK



3. Scope of Quality Surveillance Groups

Quality Surveillance Groups are primarily concerned with NHS commissioned services: those services that are funded by the NHS, including relevant public health services:

- from public, private, not for profit and third sector providers;
- of primary, secondary, and tertiary services;
- operating in the community and in acute settings; and
- of mental health, dentistry, general practice, offender and military health services.

QSGs will look to answer questions such as:

- What does the data and soft intelligence we have tell us about where there might be concerns about the quality of services being provided to our community?
- Where are we most worried about the quality of services?
- Do we need to do more to address concerns, or collect information than we are already?
- Where is there a lack of information and so a need for further consideration and/or information gathering?

In understanding the role of QSGs, it is important to recognise the limitations of their scope, i.e. what they are not:

- QSGs are not concerned with issues related to the quality of local government commissioned social care;
- their purpose is not to performance manage Clinical Commissioning Groups (CCGs) or any other organisations;
- QSGs should not interfere with the statutory roles of constituent organisations e.g. contractual powers or regulatory responsibilities
- they will not substitute the need for individual organisations to act promptly when pressing concerns become apparent; and
- QSGs are not primarily focussed on promoting and sharing best practice, although this may be a positive outcome of their existence and the networks they create, once they are fully established.

Key to the success of QSGs, and an important benefit of their establishment, will be the relationships that are built allowing organisations to gain a deeper understanding of each others' roles, responsibilities, the information they have and the actions they can take.

4. Membership of Quality Surveillance Groups

Given that the purpose of Quality Surveillance Groups is to bring together all organisations with information and intelligence on quality, getting the membership right will be crucial. There are certain organisations which will need to be represented – as listed below – in all QSGs across the network. Each QSG may then decide that they wish to include other members according to local circumstances. QSG members are nominated by their organisation to represent the information, intelligence and perspective of that organisation, according to whatever nomination process that organisation determines necessary. Representatives should be sufficiently senior and skilled to be able to actively participate in meetings, and to carry the weight of their organisation in collective decisions.

Membership of Regional QSGs:

- NHSCB Regional Director (Chair), Nursing Director and Medical Director
- NHSCB Area Directors
- CQC Regional Director
- Monitor Portfolio Director
- Local Authority representative(s)
- NHS Trust Development Authority Director of Delivery and Development and Clinical Quality Director
- Public Health England Regional Director
- Local Healthwatch representative(s)
- Health Education England (via Local Education and Training Board representative)
- Professional Regulators (GMC, NMC)
- Health Service Ombudsman

Membership of Local QSGs:

- NHSCB Area Director (Chair) , Nursing Director and Medical Director
- CCG Accountable Officers
- Local Healthwatch representative(s)
- CQC Compliance Manager
- Monitor Compliance Manager*
- Local Authority representative(s)
- NHS Trust Development Authority representative*
- Public Health England Centre Director
- Local Education and Training Board Director of Education Quality

*these organisations are full members of Local QSGs and should be included in all correspondence and information/intelligence sharing. They will attend meetings as is necessary taking account of available capacity and consideration of risk but will ensure they are fully briefed on any concerns arising out of QSG meetings where they are not in attendance.

Provider organisations

Provider organisations are not included in the membership of QSGs. Local and Regional QSGs will at any one meeting be discussing a number of providers or groups of providers. To include those providers in the discussion would mean the group becoming very large, and discussions would be impractical. If there are serious concerns, the QSG may decide to trigger a risk summit, to which the provider in question may be invited if appropriate. Further details on the actions that QSGs can take can be found in Chapter 9.

Role of local government in QSGs

Local authorities are increasingly jointly commissioning services with health and have an interest in collaborating with health partners around key areas, such as: nursing and care homes, safeguarding and overview and scrutiny arrangements. In addition, local authorities have a wealth of knowledge about the health and wellbeing of their local communities and, through their interactions with health commissioners, providers and the public, will hold information and intelligence about health services which could be of value to other QSG members.

Local authorities are the local leaders of public health and so will commission public health services from NHS providers and from third and independent sector providers.

Local government's involvement in QSGs is voluntary; however, local authority representative organisations[3] encourage Chief Executives and Council Leaders to ensure that their authority is represented on their local and regional QSGs as local authorities will both add and derive value from being involved at local and regional level.

In some places, local QSGs will span across several local authorities. In this situation, local authorities may wish to nominate one, or several, individuals to represent all local authorities within the area. It is recommended that this representative(s) remains constant in order to aid the development of trusting relationships across the QSG. It is at the discretion of authorities locally to determine which Senior Officer(s) has the most comprehensive oversight of the health and care system locally and is therefore best placed to sit on the QSG.

Local government should also be represented in some capacity on regional QSGs to ensure there is a local government input into and ownership of decisions affecting provision at local level. Regional involvement could also help to ensure that decisions taken to address quality concerns take into account the Overview and Scrutiny functions of local authorities. It is the view of local authority representative organisations that this representative(s) should be an already recognised regional lead.

How QSGs will interface with arrangements for quality improvement and safeguarding in the local government setting are still under consideration, and will be tested through the pilots, in advance of further guidance being issued.

[3] SOLACE (The Society for Local Authority Chief Executives and Senior Managers), the LGA (Local Government Association) and ADASS (The Association for Directors of Adult Social Services)

5. The role of the NHS Commissioning Board in convening and facilitating Quality Surveillance Groups

The NHS Commissioning Board will provide a support and facilitation role to local and regional QSGs. The NHSCB Area Teams will provide this support at a local level, and the Regional Teams will provide the function for the QSGs in each of the four regions.

The NHSCB is well placed to fulfil this role on behalf of the commissioning function, as it is commissioners who have responsibility for the population of that area or region. The NHSCB will lead the establishment of QSGs so that by 1 April 2013, there is a comprehensive network in place across the country.

Role of the Chair

The NHS Commissioning Board will provide the chair for QSG meetings regionally and locally. Locally the Area Director will take on this role, and regionally it will be fulfilled by the Regional Director. The Chair's role is to ensure that meetings are orderly, the everyone has their say, and that actions are agreed and recorded. Other QSG members are in no way accountable to the Chair and the Chair cannot direct members in how they discharge their statutory responsibilities.

The Chair's primary objective, especially as the QSG is being established, will be to foster a sense of collaboration and inclusion amongst members, ensuring that strong working relationships are built across the local area or region. In doing so, they should look to ensure that the operation of the QSG, in meetings and outside, meets the needs of all members, and that unnecessary burdens are not placed on organisations.

Support required from Area and Regional Teams

The role of the NHS Commissioning Board will include:

- providing facilities and technology to support the effective operation of QSGs. This will include providing meeting rooms and virtual meeting spaces and arranging meetings;
- proactively ensuring that all parties who need to be involved in the QSG, are involved. This means seeking out new representatives where they are needed or where personnel changes, and keeping up to date contact lists;
- facilitating sharing of information, and supporting the QSG with analytical resource. This will involve providing an overview / summary of data from the National Quality Dashboard and any other data provided by QSG members in advance of each meeting. This summary will then provide a starting point for discussion at QSG meetings. It will be important for the NHSCB to ensure that there is sufficient time on agendas to share soft intelligence;
- ensuring that the group develops and agrees ways of working and a business cycle / plan. This should ensure that the QSG considers all providers over a particular period; and
- providing a record of the discussions and agreed actions, and maintaining suitable records.

All Quality Surveillance Groups should be established by 1 April 2013, and should have had their initial meeting in advance of that date. A process for assuring the establishment of QSGs and whether they are fit for purpose in advance of 1 April 2013 is set out at Annex A.

6. Your Quality Surveillance Group's first meeting

The first meetings of Quality Surveillance Groups will necessarily be of a scoping nature, and are unlikely to involve the proactive risk sharing and assessment that will take place once the group is up and running. This scoping is essential to build a common understanding as to the role of the QSG in the region or local area, consensus around membership and composition of the group, and to allow people to get to know each other. Discussions should seek to:

- clarify roles and responsibilities – of different organisations around the table. Explaining each organisations' role in respect of quality may be helpful to ensure everyone understands where the different members fit, from where they derive their information and what actions they are able to take;
- establish ground rules – each QSG will wish to agree some basic principles as to how they wish to operate. This will be useful in building a sense of common ownership and to overcome any initial concerns or reluctance to be involved;
- agree how and what information and intelligence will be shared – more detail on information is included in Chapter 8. It will be important at the first QSG meeting to discuss what information different organisations will have to contribute, what will be shared in advance of meetings, or frequently between meetings, and in what form. It will also be essential to familiarise members with the National Quality Dashboard (see chapter 8 for more details); and
- reflections on the meeting – at the end of the first meeting, it will be useful to seek views on how the meeting has gone, and whether preparations were helpful and appropriate, to feed learning into future meetings

Local and regional QSGs have different roles and so will need to cover different topics in their discussions. Example agendas for the initial and future meetings at local and regional levels are included as annexes. Some suggested areas for discussion during the inaugural meeting include:

Regional

- Core membership – is representation appropriate and consistent across different organisations? What constitutes the QSG being quorate?
- Receive and review reports from local QSGs – is the information provided fit for purpose?
- Review the operation and emergence of local QSGs in the region – are they establishing themselves appropriately?
- Consider recommendations for local QSGs
- Identify any initial issues for national or regional response
- Consider what information / report is relayed to national tiers

Local

- Core membership – is representation appropriate and consistent across different organisations? What constitutes the QSG being quorate??
- Receive and review initial reports, where relevant, from NHSCB area team, CCGs, CQC, Monitor, NHS TDA, PHE etc – is the information provided fit for purpose?
- National Quality Dashboard – are members familiar with , and understand, the dashboard?
- Identify current principal concerns/risks
- Agree key issues to report to the regional QSG

7. Ongoing operations

The routine operation of a QSG will see regular bilateral and multilateral communications, and regular opportunities for all of the members to meet more formally. Local QSGs should come together monthly for the first three months, and should meet every two months thereafter. Regional QSGs should meet quarterly.

Each QSG will not necessarily be able to discuss each provider within its local area every time it comes together. It is likely that QSGs will wish to consider different groups of providers over a range of meetings or discussions, for example, according to type of provider or by district. Such discussions will be risk and evidence-based to help ensure early consideration of priority areas. The QSG will wish to ensure however, that it discusses each provider within its area at some stage over a given period.

Preparation

In advance of meetings, it can be helpful to prepare and circulate:

- a summary of relevant data from the National Quality Dashboard and other sources, prepared through analytical support to QSGs provided by the NHS Commissioning Board;
- information from other QSG member organisations where these add value. It is important to balance the benefit that other organisations' data can add in advance of meetings, with the additional burden that this may place on those organisations. It may be that over time, QSGs develop a summary template/pro forma through which member organisations would submit their data in advance of each meeting;
- actions / meeting note from the previous QSG meeting and any follow up documentation; and
- any relevant recommendations or feedback from the Regional QSG.

Running meetings

Through the pilot QSGs, certain learning has been derived which can support the effective ongoing operations of QSGs:

- ensure meetings are following a 'business plan' so that all providers are considered at some point, but discussions are useful – this should be developed in early meetings, determined by where the QSGs agrees the principal concerns are in the patch, and what level of surveillance is required
- ensure the meetings are formally constituted and recorded. This adds to the weight of discussions, and support actions being agreed and pursued;
- have thematic discussions, e.g. long term conditions pathway; frail older people, people with learning disabilities; safety in care homes; high cost providers;
- allow sufficient time for members to share soft intelligence, rather than focussing overly on hard data. The opportunity to share verbally soft intelligence and concerns is a significant added benefit to the system of QSGs, and this must be respected;
- 'create a 'high trust' environment where members feel able to share worries, even if not supported by hard data. This needs to be set within the context of some statutory organisations having a duty to act on information that may raise patient safety issues. For

example, if information shared within the QSG framework suggests potential concerns about an individual medical practitioner, the GMC may need to investigate in line with their procedures.'

- it can be useful at the end of each meeting to take time to review the effectiveness of the discussion and consider what steps could be taken to make their next discussion more effective.

Output from meetings

For each QSG meeting, a meeting note (including attendees and duration of attendance), summarising the key issues / concerns that were identified with individual providers and the actions that it was agreed should be taken should be produced.

This note should include conclusions on providers discussed in terms of the level of surveillance required, e.g. “risk summit required”, “regular review” or “further information required”. These categories are defined in chapter 9.

The note should be agreed by the QSG to ensure that it is a collective reflection of discussions and decisions. Where the QSG is unable to reach agreement as to their conclusion on a particular issue or provider, the QSG should agree what further steps need be taken, for example, what further information is needed. If a consensus is not forthcoming and the disagreement(s) material, the Chair should take stock and decide whether to go with the majority view or not. This of course cannot overrule the statutory responsibilities of member organisations.

As part of considering actions, where concerns are raised by commissioners about quality in provider organisations that are not directly commissioned by the CCGs within that local area, the local QSG should give consideration to liaison with other local QSGs within or outwith their region to ensure that these concerns are shared and acted upon.

Record Keeping

The NHSCB Area or Regional Team should provide appropriate administrative support to ensure reliable record keeping and the generation of reports. The records will need to be explicit and unambiguous. Fear of Freedom of Information (FOI) requests should not inhibit frankness. QSG documentation will be subject to the Freedom of Information Act but there are provisions in the Act that may enable confidential and sensitive material to be excluded from release. Requests for information will need to be considered on a case by case basis.

8. Information to support Quality Surveillance Groups

Quality is systemic: that is, it depends upon many different individuals, inputs, process and organisations. It is also, to a degree, subjective. The information and intelligence required to assess quality, therefore, needs to be drawn from many different sources, both hard and soft, to ensure that QSGs are appropriately informed.

Throughout the work of the QSGs, patient identifiable data should be protected and confidentiality preserved. This will include similar consideration of information pertaining to staff.

Through the QSG pilots, several principles have emerged which will be helpful in guiding how QSGs use the information and intelligence available to them:

- It is important to balance the need to summarise/digest data to make it more manageable with the risk of over summarisation leading to concerns being missed;
- data should be used with appreciation of its limitations. QSG members over time should become familiar with quality indicators and be able to digest information more routinely;
- benchmarks, trends, variance and comparisons are essential in order to interpret the data and put it in context;
- the information should be timely and as up to date as possible
- all sources of information (Quality Dashboard and other organisations' information) should be considered but with clear recognition of where information from different organisations is effectively duplicate.
- of the unique benefit of QSGs is their ability to assimilate hard data with soft intelligence through their discussions. In this context, data should not be a reassurance of quality where other intelligence suggests concerns; and
- all information need not be discussed / considered every meeting. But all providers should be discussed at some point in the QSG business cycle. There may be certain data, e.g. mortality data, that is looked at collectively each time and/or as soon as possible after it is published.

National Quality Dashboard

One key source of information will be the National Quality Dashboard, which provides data on quality in a form which can be considered at a CCG, area, regional and national level.

The metrics used to populate the National Quality Dashboard should be seen as a catalyst for QSGs' consideration of quality. It is built from a small number of high level indicators (included as an annex) of quality, under the categories of the five domains of the NHS Outcomes Framework.

It does not provide judgements on the quality of a provider but does highlight how they are performing against their historical trends and how they are performing against their peers or the national norm. The National Quality Dashboard is interactive and will require interrogation before a summation of the key issues can be identified. Users will require training and a grasp of statistical process control methods. Training will be made available by the NHS Commissioning Board.

It is vital that data presented in the National Quality Dashboard is triangulated against additional sources of information and intelligence, from QSG members. The QSG pilots found it most useful to

interrogate the National Quality Dashboard live during the meeting, rather than relying solely on extractions from the dashboard on paper. The NHSCB should ensure that this facility is available for all QSGs.

Other sources of information and intelligence

It is vital that QSGs triangulate data from the National Quality Dashboard with information and intelligence from a wide range of other sources, both hard and soft. This includes but is not limited to:

- CCG / NHSCB commissioning data
- Data on the quality primary care
- CQC warning notices and inspection activity
- Deanery / Local Education and Training Board reports
- Monitor risk ratings
- Healthwatch intelligence
- NHS Trust Development Authority assessments of NHS Trusts
- Output from peer reviews
- Staff feedback, e.g. from surveys
- Intelligence from the professional regulators
- Public Health England Intelligence
- Health Service Ombudsman complaints data
- Information provided to the QSG from Health and Wellbeing Boards, Safeguarding Boards, Clinical Networks and Senates
- Information from Local Supervising Authority Midwifery Officers

Different information will be appropriate to consider locally and regionally. Local QSGs should be considering all of the above sources regularly. Regional QSGs will predominantly consider short reports produced by each local QSG in their region, summarising their concerns and any actions being taken, alongside any intelligence they consider important from the above sources.

QSG members will need to take a balanced approach between what information is set out in writing (either circulated in advance or tabled at meetings), and intelligence that they feel more appropriate to share verbally. This will be determined by the certainty of their understandings or concerns, the sources and sensitivity of the information / intelligence. The key consideration is that members should not be dissuaded from sharing information / intelligence that could be useful to QSGs' discussions by consideration of how it will be reported, and so should feel able to share it in whatever form they consider most appropriate.

Another key learning from the pilots is that there is no single formula as to what information should be considered by QSGs in advance of or during meetings. It will be different for different QSGs according to the circumstances of their health economy. This guidance does not go into detail as to specifically what data or indicators it may be useful to consider, in what formats, or according to what frequency. More work is needed by the national orgnisations represented on QSGs to understand this, informed further by the pilots and as other QSGs are established. Further advice will be issued in due course on information.

9. Actions from Quality Surveillance Groups

Quality Surveillance Groups do not have any statutory powers. The actions that can be taken as a result of discussions are limited to the confines of the remits of their member organisations.

Local

Local QSGs can take action in the following form:

- actions / investigations by individual member organisations, e.g. the commissioner(s), CQC, Monitor, Public Health England, NHS Trust Development Authority;
- triggering Risk Summits (which may include the provider(s) in question) – where there are concerns that a provider is potentially or actually experiencing serious quality failures;
- deciding to keep the provider under review – where there are concerns about a provider that do not yet merit triggering a risk summit, and so they should be considered as a matter of course at each QSG meeting until the QSG feel that the concerns have been adequately addressed; and
- collecting further information about a provider for consideration at a future QSG meeting – where there is the potential to have concerns but more information is required.

As previously explained, local QSGs should inform the regional QSGs of the actions / conclusions they have agreed as part of their reports.

Where the QSG is unable to reach agreement as to their conclusion on a particular issue or provider, the QSG should agree what further steps need be taken, for example, what further information is needed, in order to reach consensus.

As part of considering actions, where concerns are raised by commissioners about quality in provider organisations that are not directly commissioned by the CCGs within that local area, the local QSG should give consideration to liaison with other local QSGs within or outwith their region to ensure that these concerns are shared and acted upon

Regional

Regional QSGs can take action in the following form:

- actions / investigations by individual organisations, e.g. CQC, Monitor, Public Health England, NHS Trust Development Authority, professional regulators;
- making recommendations for consideration by local QSGs;
- identifying issues for a regional or national response and then following this up; and
- triggering Risk Summits (which include the provider) – this will normally be the role of the local QSG, but there may be occasions where a regional QSG feels necessary to do so.

10. Conclusion

The mechanisms to encourage the different parts of the system to come together locally and regionally that we describe in this guidance should be useful in supporting the system to identify actual or potential serious failures and to deal collectively with those situations, putting the safety of patients and service users first.

However, they do not provide a 'silver bullet'. Safeguarding quality requires commitment, endorsement and leadership from every part of the system, from national to local levels. It must be seen as the business as usual of organisations individually and collectively. The model we describe will not take away the risk of there being another serious failure in the NHS. There will always be an inherent risk of a serious failure occurring which can only be mitigated by providers, commissioners and regulators seeing quality as their business, everyday, and making quality improvement and the achievement of essential standards their priority.

Whilst legislation and guidance is helpful, the NHS is made up of people, and it is the values and behaviours of those people that will determine our success or failure. When in doubt, the following operating principles should be used as a guide to action, alongside the values and behaviours set out in the NHS Constitution:

- The patient comes first – not the needs of any organisation.
- Quality is everybody's business – from the ward to the board; from supervisory bodies to 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'.

This guide is designed to support local and regional health economies come together to support each other in exercising judgement and applying common sense to what will be complex situations, where the impact of the decisions made will be profound for individuals, families and communities.

This guidance recognises that the model of QSGs is still evolving, and so it will need to be flexible and adapt over time. The national organisations represented on QSGs, through the national Steering Group will review the operation and effectiveness of the model during the Summer of 2013, and will update this guidance in the Autumn in light of their findings. This will include further detailed advice on the most effective information to support QSG discussions, and how the QSG model should interface with mechanisms in local government concerned with quality improvement and safeguarding.

ANNEXES

Annex A - Quality Surveillance Groups Assurance Process

Annex B - Indicators in the National Quality Dashboard

Annex C - Example Regional QSG Agenda

Annex D - Example Local QSG Agenda

Annex A Quality Surveillance Group Assurance Process

How QSGs operate in practice will evolve over time, and according to local needs. There will be some standard elements to ensure consistency of purpose and utility, but there will be room for local areas to determine some elements of the operating model. The information and intelligence that is reviewed and considered by QSGs will evolve over time and QSGs will be encouraged to continue to explore new and better ways of looking at quality.

Nationally, the overarching assurance requirement is for the four Regional Teams of the NHS Commissioning Board (NHSCB) to assure itself that robust plans exist to implement the operating model for QSGs at regional and area team level from April 2013. Implementation checklists for NHSCB regional and area directors are included.

A national, cross-system Steering Group will seek assurance form the NHSCB Regional Directors that the following will be in place prior to April 2013:

- Core membership for each QSG has been identified and agreed
- QSG chairs have been identified and briefed
- QSG core members have received appropriate training in the use of the NQB dashboard
- QSG operating model guidance and support materials have been received and considered
- Processes for providing information and intelligence to the QSGs have been agreed
- QSGs have been established at area team and regional level and have met at least once
- Outline QSG agendas have been agreed
- A schedule of meeting dates has been agreed in accordance with the guidance
- Local and regional quality assurance processes and plans have been updated to take account of the role of QSGs.

The Steering Group will be providing support to QSGs as they develop, identifying where there are common support needs, where there are issues requiring clarification and seeking to provide that clarification nationally.

Assurance pro-forma and statement of readiness

Prior to April 2013, regional and area team directors will be asked to complete a pro-forma template (included) and statement of readiness confirming that the appropriate steps have been completed within their geographical area for the establishment of QSGs from April 2013. Each region and area team will be required to submit progress against the pro-forma monthly between January and March 2013.

The QSG model and how it is applied will evolve over time and it is important that QSGs should are free to improve and become more effective.

Implementation Checklist – Local QSGs

JANUARY 2013

The area team Director has received QSG operating model guidance ☐

QSG core members identified and approached:

- NHSCB local area team members (Chair and support) ☐
- CCG Accountable Officers ☐
- Local HealthWatch ☐
- CQC ☐
- Monitor ☐
- NHS Trust Development Authority ☐

Discussion with Local Authority regarding engagement/representation ☐

Guidance distributed/discussed with potential QSG core members ☐

Set meeting dates for QSGs commencing March 2013 ☐

Arrange Webex/training sessions for NQB dashboard during Jan/Feb ☐

FEBRUARY 2013

Agree information framework for first meeting ☐

Agree process for developing area team analysis and reporting of quality to QSG ☐

Agree outline QSG agenda ☐

Schedule meeting dates in accordance with guidance ☐

Consider chair attending Midlands and East area team QSG as an observer ☐

Establish governance arrangements for meetings ☐

Teleconference with core members to prepare for initial meeting ☐

MARCH 2013

Inaugural QSG meeting	☐
Agree business cycle to ensure all providers/sectors are considered	☐
Review and adjust information framework as required	☐
Post meeting review	☐

Please note, the post meeting review will feed into the further development of the national QSG guidance.

In summary:

By April 2013, all local QSGs will have identified membership from all key member organisations; meeting dates in diaries for the next period; and will have had their first meeting.

Implementation Checklist – Regional QSGs

JANUARY 2013

The regional Director has received QSG operating model guidance ☐

Regional QSG core members identified and approached:

- NHSCB regional team members (Chair and support) ☐
- Area team QSG Chairs ☐
- National HealthWatch ☐
- CQC ☐
- Monitor ☐
- NHS Trust Development Authority ☐
- Professional Regulators (GMC, NMC) ☐

Guidance distributed/discussed with potential QSG core members ☐

Arrange Webex/training sessions for NQB dashboard during Jan/Feb ☐

Check QSG implementation progress with area teams ☐

FEBRUARY 2013

Agree information framework and contribution from QSG members ☐

Agree process for analysis and reporting of quality to regional QSG ☐

Agree outline QSG agenda ☐

Schedule meeting dates in accordance with guidance ☐

Establish governance arrangements for meetings ☐

Teleconference with core members to prepare for initial meeting ☐

Check QSG implementation progress with area teams ☐

MARCH 2013

Check QSG implementation progress with area teams	☐
Inaugural Regional QSG meeting	☐
Agree business cycle to ensure all providers/sectors are considered	☐
Post meeting review	☐

In summary:

By April 2013, all regional QSGs will have identified membership from all key member organisations; meeting dates in diaries for the next period; and will have had their first meeting.

ASSURANCE PRO-FORMA REGION

Region:
Date:
Form completed by:

1a. QSG Chair agreed			Name of Chair Person
1b. Core membership agreed:			
i. NHSCB regional office (members and support)			Names and roles
ii. Area Team QSG representation			Names
iii. Local HealthWatch representative(s)			Names
iv. Care Quality Commission			Name
v. Monitor			Name
vi. NHS Trust Development Authority			Name
vii. Professional regulators (GMC/NMC)			Names
viii. LETBs			Names
viii. Health Service Ombudsman			Name
ix. Local authority engagement/involvement discussed			Date and outcome of discussion
2a. QSG guidance received and circulated to core members			date circulated
2b. NQB dashboard training received by core members			Dates of training

3a. Outline agenda agreed			draft agenda
3b. Information framework agreed with QSG members			summary of information to be supplied to QSG by members
3c. Process in place for region to produce report of analysis of quality			Name of responsible person/team
3d. Schedule of meeting dates agreed			meeting dates
3e. Annual business cycle agreed			business cycle
3f. Meeting governance (paper submission & circulation, minutes, reporting arrangements) agreed			outline governance arrangements
4. Governance			
4a. Existing quality assurance policies/procedures updated to take account of the role of QSGs			name of policies/procedures updated

ASSURANCE PRO-FORMA - LOCAL QSG

Area Team::
Date:
Form completed by:

1a. QSG Chair agreed			Name of Chair Person
1b. Core membership agreed:			
i. NHSCB regional office (members and support)			Names and roles
ii. CCG Accountable Officers			Names
iii. Local HealthWatch			Names
iv. Care Quality Commission			Name
v. Monitor			Name
vi. NHS Trust Development Authority			Name
vii. LETBs			Name
viii. Local authroity engagement/involvement discussed			Date and outcome of discussion
2a. QSG guidance received and circulated to core members			date circulated
2b. NQB dashboard training received by core members			Dates of training

3. QSG meeting set up			
3a. Outline agenda agreed			draft agenda
3b. Information framework agreed with QSG members			summary of information to be supplied to QSG by members
3c. Process in place for area team to produce report of analysis of quality			Name of responsible person/team
3d. Schedule of meeting dates agreed			meeting dates
3e. Annual business cycle agreed			business cycle
3f. Meeting governance (paper submission & circulation, minutes, reporting arrangements) agreed			outline governance arrangements
4. Governance			
4a. Existing quality assurance policies/procedures updated to take account of the role of QSGs			name of policies/procedures updated

Annex B INDICATORS INCLUDED IN THE NATIONAL QUALITY DASHBOARD

	Deaths within 30 days of elective admissions
	Deaths in hospital from conditions amenable to healthcare intervention
	% of ambulance arrivals to Cat A calls after 8 mins
	% of Unplanned admissions to hospital for adults with chronic long term conditions
	% of Unplanned admissions for asthma, diabetes, and epilepsy in under 19's
	% of Emergency admissions for acute conditions that should not usually require hospital admission
	% of Emergency admissions that occur within 30 days of discharge from previous spell in hospital
	% of patients not seen with 4 hours at Type 1 A&E units
	% of patients not seen with 18 weeks with known clock start (admitted adjusted pathways)
	% of patients not seen with 2 weeks
	Net Promoter score (rolling 24mths) (NHS Choices)
	Rate of patients who become infected by either MRSA, C Diff, MSSA or Ecoli per 1,000 bed days
	Rate of serious incidents reported per 1000 bed days
	Rate of never events reported per 1000 bed days
	Rate of unexpected deaths reported per 1,000 Bed Days
	Percentage of patients who are recorded as having not suffered any of the four harms
	Average Daily Percentage of beds in use
	Number of qualified Nurses per bed
	Percentage Sick Leave
	Ratio of Qualified Doctors to Patients Treated
	Number of CQC compliance notices issued
	Trust Rating

Annex C [REGION] Quality Surveillance Group Meeting

Example Agenda

[DATE] [TIME]
[VENUE]

Dial in details: [TELECONFERENCING NUMBERS]

1. Welcome and Introduction — Regional Director (NHSCB / Chair)

[FOR INTITIAL MEETING INCLUDE 2-4 AS BACKGROUND]

2. Scene Setting – Purpose of QSGs

3. Core Membership

4. Information on Quality:
   A basis for briefing on Quality Surveillance Groups

5. Overview of regional information — All

   Multi-professional Deanery Quality Report
   Healthwatch Briefing
   NHS Midlands & East Survey of Quality
   Risk Ratings

6. Reports from LAT QSGs — LAT Directors
   [AREA]
   [AREA]
   [AREA]
   [AREA]
   [AREA]

7. Any additional information participants wish to share to build on current knowledge

8. Reflection and of summary of the information known and shared

9. Reflection on meeting process and information supplied

10. Confirm consensus on areas of good practice and concern and agree next steps

11. Date and format of future meetings

Annex D [Local area] Quality Surveillance Group

Example Agenda

[DATE] [TIME]
[VENUE]

1.	Welcome & Introductions	Area Team Director
2.	Previous Minutes & Matters Arising	Area Team Director
3.	Update from regional QSG	Area Team Director
4.	Overview of local information	All
	Standard Reports / Updates (verbal or in writing): Area Team overview report CCG reports CQC Monitor Deanery/LETB Healthwatch Local Authority (if applicable)	
5.	Any additional information participants wish to share to build on current information	All
6.	Reflection and summary of the information known and shared	All
7.	Agree principal risks or concerns	All
8.	Confirm consensus and agree next steps	All
9.	Date, time and venue of next meeting:	