How to make your Quality Surveillance Group effective

National Quality Board, 2nd Edition, March 2014

CONTENTS

1. Introduction and purpose 3
2. What is a Quality Surveillance Group? 5
3. Scope of Quality Surveillance Groups 8
4. Membership of Quality Surveillance Groups 9
5. The role of individual organisations in Quality Surveillance Groups 11
6. The role of NHS England in facilitating Quality Surveillance Groups 15
7. Planning and running your meetings 17
8. Information to support discussion 20
9. Actions available to Quality Surveillance Groups 22
10. Working with the local government sector 25
11. Recording and communicating conclusions 27
12. Further help and next steps 29

ANNEXES

Annex A Local QSG – draft model terms of reference 31

Annex B Regional QSG – draft model terms of reference 33

Annex C Local QSG - example agenda 35

Annex D Regional QSG - example agenda 36

Annex E Example QSG stakeholder reporting schedule and planned thematic reviews 37

Annex F Example CCG Report – Local QSGmeeting 38

Annex G Example QSG action log 40

Annex H Example Local QSG report to Regional QSG meeting 41

Annex I Example Local QSG outcome and surveillance log 42

1. Introduction and purpose

Quality Surveillance Groups (QSGs) were established in advance of the new health and care system going live on 1 April 2013. They were introduced following the publication of the National Quality Board's (NQB's) report *Quality in the New Health System: Maintaining and Improving Quality from April 2013*. The NQB brings together the leaders of national statutory organisations across the health system, alongside expert and lay members. This report sets out how different parts of the new system should 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.

The NQB were clear that in order to ensure that different parts of the health and care system do indeed work together, a network of QSGs should be established across the country, bringing health economies together locally and in the four regions. Initial guidance on how QSGs should operate, *How to establish a Quality Surveillance Group*[1], was published in January 2013.

However, the NQB recognises that the concept of QSGs is a new element to a system which itself is still in flux, and therefore is keen to ensure that the network is nurtured and supported so that it can be as effective as possible. A review of the QSG model, six months into its existence, has been undertaken by all of the organisations represented on the NQB and on QSGs, to understand how they are operating and identify where they could be supported to be more effective.

This second edition of this 'How to' guide reflects the conclusions of the review, which involved all QSGs and their members across the country. Where clarity was needed, this guide seeks to provide it. Where resources and examples of good practice were identified, this guide sets these out. Where decisions were needed nationally in order to enable QSGs regionally and locally to be more effective, national organisations have worked together to make those decisions and the conclusions are reflected in this guidance.

But the system is still changing and the QSG network will continue to evolve. This guide is meant to support QSGs to be as effective as possible but should not be a hindrance to groups locally and regionally working out how they can best work together and make that happen. The final chapter of this guide sets out the next steps in terms of providing the continuing support that QSGs say they need. This includes a resource pack to be held by QSG secretariats, containing more practical guidance in relation to record keeping and the management of meetings, and promoting the sharing of good practice.

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

[1] How to establish a Quality Surveillance Group

- **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 those using health services 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 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. QSGs 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, NHS England and Clinical Commissioning Groups (CCGs).

The need for Quality Surveillance Groups

Across the country, organisations within local health and care economies will 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 organisations 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 collectively agreed to establish a new network of QSGs which systematically bring together the different parts of the system to share information. They are 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.

2. What is a Quality Surveillance Group?

CHARACTERISTICS OF AN EFFECTIVE QSG

- **Patient focussed** – members are grounded in the fact that their purpose is to maintain good quality services for patients
- **High trust** – an environment which facilitates open and honest conversations about quality
- **Inclusive** – all members feel able to contribute to discussions
- **Challenge** – Members feel able to offer constructive challenge to colleagues to get to the bottom of the issues and identify suitable actions
- **Action orientated** – all members come away from meetings with clarity as to the actions agreed and who is taking them forward
- **Well informed** – QSGs receive reports and data-packs which present information in a useful and distilled format to members which enable them to identify the potential quality risks
- **Comprehensive** – QSGs have a planned and defined business cycle which enables them to consider potential risks in all providers within their geography, across all sectors

QSGs operate at two levels: locally, on the footprint of NHS England's 27 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) four 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.

A QSG should 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. QSGs enable these organisations to be able to discharge their functions more effectively, as they can do so in the knowledge of the information and intelligence held by other partners.

All organisations represented on QSGs should feel ownership and responsibility for the effective operation of their group. By collectively considering and triangulating information and intelligence, QSGs will work to safeguard the quality of care that people receive.

QSGs should not add another level of bureaucracy to the system. Commissioning, regulatory and oversight organisations should, as part of fulfilling their responsibilities, be sharing information and cooperating with other organisations as part of their business as usual, bilaterally and multilaterally. The QSG model creates 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 sit.

QSGs should be seen as a network of partners who work together and share information in the interests of patients and service users. This should not be confined to formal meetings. QSGs can act as a virtual network in between meetings, with members interacting with each other in smaller groups where appropriate.

QSGs at local and regional levels 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, ensuring discussions include those closest to the detail and most aware of concerns. They not only consider information and intelligence but also work together to take aligned and coordinated action to mitigate any potential risks to quality and drive improvement. Wherever possible, Local QSGs should seek to resolve issues at a local level (model terms of reference for Local QSGs are at **Annex A**).

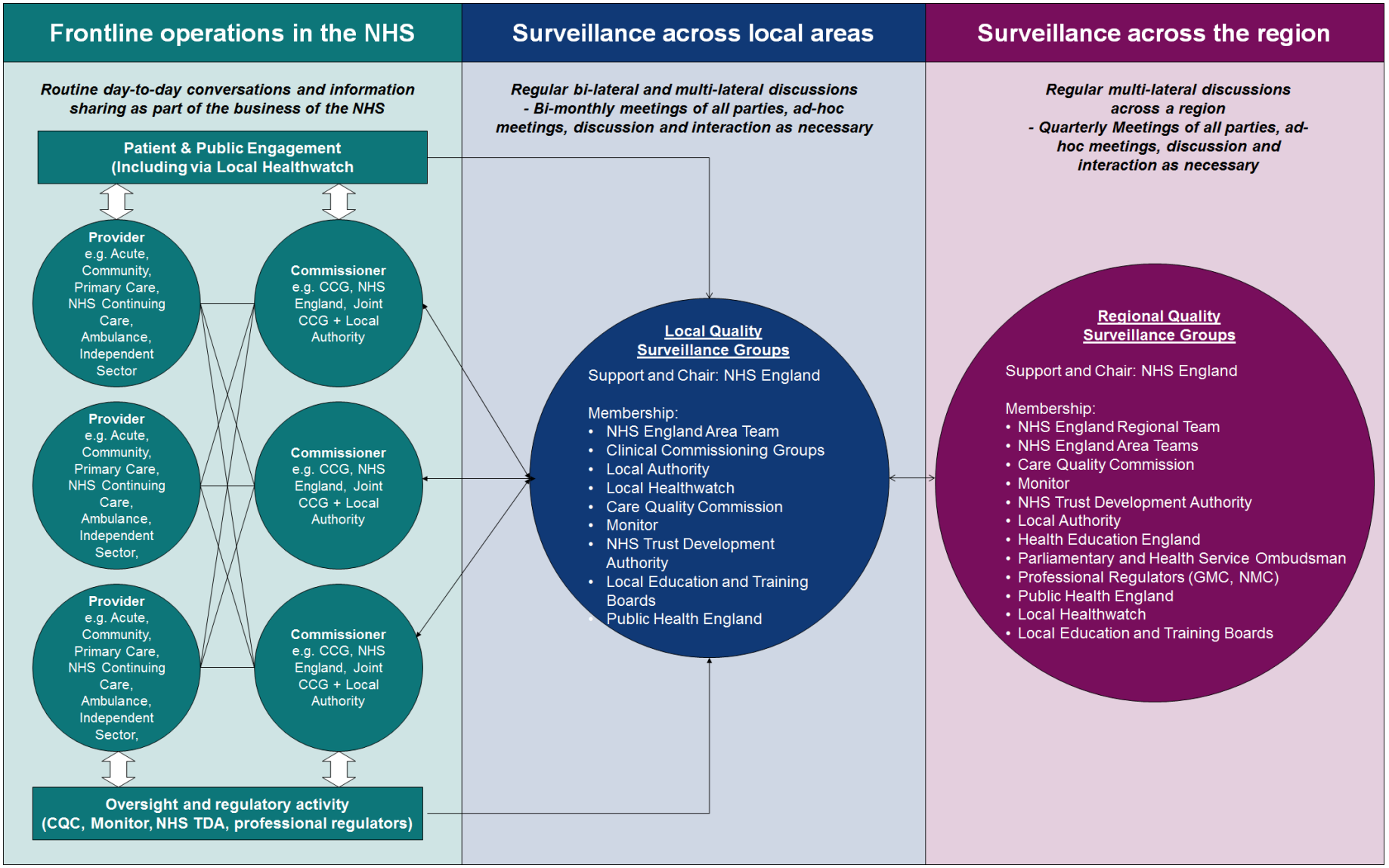
- **Regional QSGs** provide support and assurance to Local QSGs, ensuring that the network is operating as effectively as possible. They also offer an escalation mechanism for Local QSGs, as they can assimilate risks and concerns that arise from Local QSGs across the region, identify common or recurring issues that would merit a regional or national response, and share those issues across the national network. Wherever possible, Regional QSGs should seek to resolve issues at a local level (model terms of reference for Regional QSGs are at **Annex B**).

The diagram on the following page depicts the QSG network at a glance.

Once a QSG 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 and performance management 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. However, QSGs can take a range of actions as a result of the responsibilities of the statutory members around the table and work to resolve issues at a local level wherever possible.

THE QUALITY SURVEILLANCE GROUP NETWORK



3. Scope of Quality Surveillance Groups

QSGs are primarily concerned with NHS commissioned services (by CCGs and NHS England) - those services that are funded by the NHS, including relevant public health services, from:

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

They also consider those services that are commissioned by Local Authorities from providers of NHS care.

QSGs operate as a network of organisations locally and regionally who work together to act as an early warning system for quality. The QSG will operate both through formal meetings on a regular basis, meetings on specific issues as required, and as a virtual intelligence network on an ongoing basis in relation to quality.

The QSG's remit is to look to answer questions such as:

- 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 <u>not</u>:

- the quality of local government commissioned social care does not fall within the remit of the QSG;
- their purpose is not to performance manage 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.

Key to the success of QSGs, and an important benefit of their establishment, is the relationships that are built allowing organisations to gain a deeper understanding of each other's roles, responsibilities, the information they have and the actions they can take. Relationships should be nurtured as they are vital to the health and care system operating effectively in the interests of patients. Good relationships will support the creation of an environment of confidentiality and trust which will facilitate the effective sharing of information and intelligence on quality. This will be supported by the memorandum of understanding (see chapter 11).

4. Membership of Quality Surveillance Groups

Given that the purpose of QSGs 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 should:

- represent the information, intelligence and perspective of their organisation;
- be sufficiently senior and skilled to be able to actively participate in meetings, and to carry the weight of their organisation in collective decisions;
- bring to the table the information and intelligence from their organisation as is relevant to that area or region, and should take from the discussions, additional information and intelligence which will aid, supplement and deepen their organisations' understanding as to the quality of services being provided;
- seek to use the discussions to align their activities and interactions with providers with other commissioning, regulatory and supervisory bodies; and
- feedback to their organisations on the conclusions reached at the QSG meetings.

Membership of Regional QSGs

Organisation	**Representative**
NHS England	Regional Director (Chair) Nursing Director Medical Director Area Directors
Care Quality Commission	Deputy Chief Inspector
Monitor	Regional Director
Local Authority	Nominated representative
NHS Trust Development Authority	Director of Delivery and Development Clinical Quality Director
Professional Regulators (GMC, NMC)	Nominated representative
Public Health England	Regional Director
Health Education England	Local Education and Training Board representative
Local Healthwatch	Nominated representative

Other members, such as the Parliamentary and Health Service Ombudsman (PHSO) may be co-opted to provide support to the Regional QSG as appropriate.

Membership of Local QSGs

Organisation	Representative
NHS England	Area Director (Chair) Nursing Director Medical Director
Clinical Commissioning Groups	Accountable Officers Clinical Lead
Care Quality Commission	Head of Inspection
Monitor	Regional Manager*
Local Authority	Nominated representative
NHS Trust Development Authority	Nominated representative*
Public Health England	Centre Director / nominated Deputy from PHE or Local Government (to be agreed locally)
Health Education England	Local Education and Training Board Director of Education Quality
Local Healthwatch	Nominated representative

*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.

However, it is essential that where a QSG discusses a particular provider and draws conclusions about their quality risks, or where actions are agreed in respect of that provider, that provider is informed. The QSG chair will agree which organisation is responsible for communication back to the provider at each meeting. For example, CCGs may do this through their regular contact with providers, or Monitor / NHS TDA through their accountability arrangements.

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, including Risk Summits, can be found in Chapter 9.

5. The role of individual organisations in QSGs

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) commission the majority of NHS funded health services: planned hospital care; rehabilitative care; urgent and emergency care (including out of hours services); most community health services; and maternity, mental health and learning disability services. In commissioning these services, CCGs are responsible for securing a comprehensive service within available resources, to meet the needs of their local population. They are a vital member of Local QSGs.

CCG Accountable Officers / Clinical Leads attend Local QSG meetings to share information and intelligence about quality within provider organisations in order to spot potential problems early and manage risk. If they have concerns about whether providers are meeting the essential standards of quality and safety, they should raise this with the CQC and with any other parts of the system with an interest through the QSG. This should include concerns they have about providers from whom they do not commission services, such as primary care providers, but with whom they interact.

Care Quality Commission

The Care Quality Commission (CQC) makes authoritative judgements on the quality and safety of health and care services, according to whether they are safe, effective, caring, responsive and well-led. The Chief Inspectors rate the quality of providers' accordingly and clearly identify where failures need to be addressed. CQC also uses its regulatory powers to require improvement where care does not meet regulatory standards.

CQC is represented on both Regional and Local QSGs, where it will share information and intelligence about providers with other parts of the system, and use information and intelligence from others to inform their judgements on quality.

Monitor

Monitor is the sector regulator for healthcare in England. Representatives from Monitor attend Local and Regional QSG meetings to share and receive information on NHS foundation trusts and to better understand other concerns or pressures within the wider local health economy. At QSG meetings, the Monitor representative provides and explains Monitor governance and finance risk ratings for NHS foundation trusts and, where appropriate, summarises the status of Monitor enforcement action against NHS foundation trusts.

The NHS Trust Development Authority

The NHS Trust Development Authority (NHS TDA) oversees all NHS trusts. Its role is to ensure that trusts deliver high quality, sustainable services thereby helping trusts to achieve NHS foundation trust status or another more appropriate organisational form. Ensuring that NHS trusts provide the highest quality services is central to the work of the NHS TDA, and it has an important role in supporting the development of NHS trusts in this area.

The NHS TDA is responsible for holding NHS trusts to account for the quality of care being delivered and supporting them to improve where necessary. As part of this, the NHS TDA has set a clear approach for dealing with NHS trusts in special measures, including the appointment of an Improvement Director, peer support from high performing Trusts and structured board-to-board sessions. As such the NHS TDA attends both Local and Regional QSGs to exchange information and intelligence about providers with other parts of the system.

NHS England

NHS England is a commissioner of primary care, specialised services, offender and military health services and has a role in supporting and enabling CCGs to be the best commissioner they can be.

NHS England supports, facilitates and is a member of Regional and Local QSGs - the role of NHS England in facilitating QSGs is set out at chapter 6. If NHS England has concerns about quality, it should raise them with the relevant commissioners, with the CQC and with other parts of the system with an interest through the QSG.

Local Healthwatch

Local Healthwatch is the consumer champion for health and social care in England and is represented on Local and Regional QSGs. Representatives hold a valuable source of information and intelligence on providers and are uniquely placed to add patient experience intelligence to information gathered in relation to clinical effectiveness and patient safety. They are members of Local QSGs, where they should share their intelligence gathered from their area and participate in risk summits. Local Healthwatch organisations have been issued with guidance which highlights the importance of their involvement with QSGs. Attendance is locally determined by local Healthwatch organisations.

Public Health England

The role of Public Health England (PHE) is to protect and improve the nation's health and to address inequalities. QSGs require oversight of quality issues relating to public health services provided by NHS and independent sector providers registered with the CQC and commissioned under either the section 7A agreement by NHS England or commissioned by local government through the public health grant.

Directors of Public Health in upper tier local authorities and PHE will work together to contribute to local and regional QSGs, providing information on the quality of public health services provided by NHS and independent sector providers, and bringing local insight about the relationship between health and wellbeing of the local population and the provision of healthcare services locally. PHE's role is particularly key in areas with multiple Local Authorities and in relation to PHE embedded staff, ensuring that there are effective liaison arrangements between and within organisations to ensure that areas of concern can be drawn to the attention of the QSG.

Health Education England / Local Education and Training Boards

Health Education England (HEE) is responsible for ensuring that the workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and to drive improvements. It supports healthcare providers and clinicians to take

greater responsibility for planning and commissioning education and training through its Local Education and Training Boards (LETBs), which are statutory committees of HEE.

HEE is represented by its LETBs on Regional and Local QSGs. As part of monitoring the quality of education and training, HEE may have information and intelligence about the quality of care being provided within provider organisations, any concerns about which should be shared with QSGs.

Local Government

Local authorities are increasingly jointly commissioning services with health and have an interest in collaborating with health partners around key areas, such as: nursing, care homes and home-based services, 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 authorities may wish 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.

Local authorities have statutory responsibilities with regard to the overview and scrutiny of local health services and services which impact on health and wellbeing (including social care). They may have useful intelligence on the quality of local health services and may also wish to conduct scrutiny reviews of services and care pathways where quality concerns have been raised. Safeguarding Boards are likely to have considerable intelligence about the quality of local services.

In most 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 the 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 (see page 28).

Further information on working with local government can be found at chapter 10.

The General Medical Council

The General Medical Council (GMC), the regulator of the medical profession, is a member of the four Regional QSGs and is represented by its Employer Liaison Service. Revalidation data and any concerns about medical training are provided to the Regional QSGs; the GMC is looking at how best to share fitness to practise data in a meaningful way. The published results of the annual National Training Survey are made available to the Regional QSGs, as are any reports into specific services.

The GMC uses information from the Regional QSGs to inform regulatory action, participates in risk summits and works closely with CQC, NHS England and others to address shared concerns.

As an example of data that can be shared, for example the first set of revalidation data reports, can be found at chapter 12.

The Nursing and Midwifery Council

The role of the Nursing and Midwifery Council (NMC) is to safeguard the health and wellbeing of the public. It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.

The NMC is participating in Regional QSGs and developing its understanding of the intelligence afforded by the new quality and risk infrastructure in England. They also participate in risk summits when requested. They do not currently have a regional structure but one is planned and scoping work is underway. Another priority for the NMC is to enhance its capacity to understand and use its own data and that of others. Developing and improving Memoranda of Understanding with system regulators and other key national bodies is contributing to better understanding of the systems and processes that support good collaborative working and information exchange.

A link to education service specific reports can be found at chapter 12.

6. The role of NHS England in facilitating Quality Surveillance Groups

NHS England provides support and facilitation to Local and Regional QSGs. NHS England Area Teams provide this support at a local level, and the Regional Teams provide the function for the QSGs in each of the four regions. NHS England 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.

Role of the Chair

WHAT MAKES AN EFFECTIVE QSG CHAIR?

- Open and inclusive
- Facilitative
- Action focussed
- Actively seeking to maximise time at meetings
- Strong relationships with all QSG members
- Respectful of individual and organisational views, roles and responsibilities

NHS England provides the chair for QSG meetings regionally and locally. Locally, the Area Director fulfils this role, and regionally it is fulfilled by the Regional Director. The Chair's role is to ensure that meetings are orderly, that everyone has their say, and that actions are agreed, clearly understood 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.

A key objective for the Chair is 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 Local and Regional Teams

The role of NHS England includes:

- providing facilities and technology to support the effective operation of QSGs. This will include providing meeting rooms / 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 the sharing of information, and supporting the QSG with analytical resource. This will involve providing a data pack for each formal QSG meeting, which sets out an overview / summary of data from the NHS England Quality Dashboard and any other data provided by

QSG members in advance of each meeting. This summary will then provide an input to discussion at QSG meetings alongside reports from QSG members (see chapter 8).

- ensuring that the group develops and agrees ways of working and a business cycle / plan which guides its work and agendas. This should ensure that the QSG considers all providers across all sectors over a particular period, and has sufficient opportunity to share soft intelligence (see chapter 7); and

- providing a record of the discussions and agreed actions, and maintaining suitable records (see chapter 11).

7. Planning and running your meetings

The routine operation of a QSG will see regular bilateral and multilateral communications, and regular opportunities for all members to meet more formally. Local QSGs should come together formally every two months. Regional QSGs should meet formally once every three months. Example agendas are at **Annexes C and D**.

Formal meetings are primarily opportunities to share information and intelligence about the quality of services being provided to communities in that area or region. They should be conducted in an environment of confidentiality and trust, where members feel able to speak frankly and openly about concerns. However, they must also be action focussed and conclusions from discussions must be explicit and understood by all parties.

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. This will require the QSG to develop a business cycle / plan, which all members can contribute to.

The sharing of concerns and soft intelligence needs to be set within the context of some statutory organisations having a duty to act on information that may raise quality issues. For example, if information shared amongst QSG members suggests potential concerns about an individual medical practitioner, the GMC may need to investigate in line with their procedures**.**

Business cycle / plan

The QSG, supported by its secretariat and chair, should have in place a business plan which maps out the cycle of business it wishes to conduct (an example stakeholder and planned thematic review reporting schedule is at **Annex E**). This should ensure that all providers and groups of providers are discussed within a given period by the QSG, and that any themes or topics of particular timely or geographic relevance are discussed at the appropriate point. It can be informed by where there are areas of risk within the patch, and what the QSG determines are the appropriate levels of surveillance. All QSG members should be able to suggest themes and issues for discussion in the QSG fora which can be included in the business plan.

This will inform the publication scheme (see chapter 11)

Preparation

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

- a datapack with an overview / a summary of relevant data from NHS England Quality Dashboard and other sources, prepared through analytical support to QSGs provided by NHS England;

- reports from CCG areas (for Local QSGs) or from NHS England Area Teams (for Regional QSGs). These will set out a summary of quality issues / concerns related to that geography which it is useful for other QSG members to be aware of and discuss. The reports should follow a consistent structure and format. Example report templates are provided at **Annex E**;

- information and intelligence provided in advance from regulatory and supervisory bodies;

- 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

Tips on running your QSG meetings:

- Create an environment of confidentiality and trust amongst members so that they feel able to openly and honestly share information and concerns. 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. The Chair can support this by setting clear ground rules for discussions at the outset and being specific about where issues are particularly sensitive.

- Ensure meetings are following the cycle of business agreed in the QSG's business plan so that all providers are considered at some point, but discussions are useful.

- Ensure that actions and conclusions from discussions at formal meetings are clear and meetings are formally constituted and recorded. It is vital that all parties have a common understanding as to the risks identified, surveillance required and actions to be taken forward by whom.

- Allow sufficient time for members to share soft intelligence systematically on a geographical basis. This could be on a CCG-by-CCG / Area-by-Area basis, using the pre-circulated reports as the starting point. The opportunity to verbally share soft intelligence and concerns is a significant added benefit to the system of QSGs, and this opportunity must be maximised.

- Have thematic discussions (see below), rather than just local / regional discussions as these have been found to be a good way of identifying risks.

- At the end of meetings, explicitly summarise the conclusions as to surveillance required across the providers that have been considered. Chapter 9 provides more information on actions available to QSGs and chapter 11 on recording discussions from meetings.

- From time to time, it can be useful to take time to reflect at a QSG meeting on the effectiveness of the discussion and consider what could be done differently to make the QSG's future discussions more effective.

Thematic discussions

The review identified thematic discussions as a good way of identifying risks. Through the review it was observed that a number of QSGs are already taking this approach to either consider information that is available across a whole pathway of care or a very specific aspect of quality for a particular population.

Examples of thematic discussions could be:

Population groups

- long term conditions pathway
- frail older people
- people with learning disabilities

Provider type

- primary care
- maternity services
- community services
- out of hours services
- safety in care homes
- high cost providers
- independent sector providers

Quality issue

- pressure ulcers
- healthcare associated infections
- serious untoward incidents
- mortality statistics
- never events

8. Information to support discussion

Quality is systemic: that is, it depends upon many different individuals, inputs, processes 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.

Each QSG is responsible for considering and identifying the information it needs to fulfil its role in understanding potential quality risk. The following may 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, therefore context is important - any presentation of data should include a summary of the purpose, source, data period covered, intended audience, confidentiality status, known issues or constraints with the data set and an indication of what good would look like, where possible;
- with the help of analytical support from NHS England, QSG members should, over time, 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;
- 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 at every meeting. But all providers should be discussed at some point in the QSG business cycle. There may be certain data that is regularly looked at collectively, e.g. never events, serious untoward incidents, or as soon as possible to its publication, e.g. mortality data.

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.

Sources of information and intelligence

It is vital that QSGs triangulate data, information and intelligence from a wide range of sources, both hard and soft. It is for QSGs to determine which information it finds most important, based on the issues they are interested in resolving and the questions they are seeking to address, however, the following information sources may be helpful:

- CCG / NHS England commissioning data
- Data on the quality of primary care
- CQC enforcement activity and judgements on quality
- Local Education and Training Board (LETB) / Deanery reports
- Monitor risk ratings
- Healthwatch intelligence
- NHS TDA assessments of NHS trust
- output from peer reviews
- staff feedback, e.g. from surveys

- intelligence from the professional regulators
- PHE intelligence and intelligence from local authority public health team
- PHSO complaints data
- complaints received by providers and commissioners
- information provided to the QSG from Health and Wellbeing Boards, Children and Adults Safeguarding Boards, Clinical Networks and Senates, local authority overview and scrutiny committees
- information from Local Supervising Authority Midwifery Officers
- information from Commissioning Support Units
- Never Events data

Different information will be appropriate to consider locally and regionally. It is good practice for QSGs to consider the above sources regularly (a summary of useful sources can be found in the resource pack). Regional QSGs will predominantly consider short reports produced by each Local QSG in their region, presented by the Local QSG Chair, 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. 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 (for concerns over record keeping, please see chapter 11). Creation of an environment of confidentiality and trust is vital in this context.

NHS England Quality Dashboard

The NHS England Quality Dashboard will be rolled out later this year, with a high-level prototype available around April 2014.

Currently each Region is using different variations of the Dashboard. The aim of the NHS England Quality Dashboard will be to provide a consistent approach for defining and measuring quality to support improvement, consolidating the bespoke regional approaches into a single presentation of core quality indicators. It will help to:

- highlight specific areas of risk for further investigation by the QSG; and
- provide information as further context to the softer intelligence QSGs have available.

It will not duplicate CQC's overall ratings, nor replicate old-style performance dashboards.

Initially the Dashboard, which has been developed with involvement from key stakeholders, will provide a high-level Regional and Area team view of the indicators, to be followed by more detailed trust and indicator views. The early version will cover acute providers, however the intention is that over time a suite of Dashboards will be developed to cover other providers: mental health, community care; and, primary care. The Dashboard will use the most up-to-date relevant data possible.

Further design changes will follow on the basis of feedback from users of the Dashboard, and to include more detailed views at trust / indicator level. QSG members will be kept informed of developments via their QSG secretariats.

9. Actions available to Quality Surveillance Groups

QSGs are ideally placed in the system to take action to understand risk, and ensure that aligned and coordinated action is taken to mitigate those risks. They do not have any statutory powers, but can take a range of actions as a result of the responsibilities of the statutory members around the table and work to resolve issues at a local level wherever possible.

Local

Local QSGs can take action in the following form:

- **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. The QSG can agree that member organisations individually, bi-laterally or multi-laterally should gather and analyse this additional information to provide further insight on potential quality risks to the group;

- **keeping the provider under review** – where there are concerns about a provider that do not yet merit triggering a risk summit, the provider should be considered as a matter of course at each QSG meeting until the QSG feels that the concerns have been adequately addressed;

- **focussed discussion about a particular provider** – bringing organisations together in the form of a single-issue QSG meeting or as a teleconference;

- **actions / investigations by individual member organisations**, e.g. the commissioner(s), CQC, Monitor, PHE, the LETB or the NHS TDA. CQC has capacity in its inspection programme to take requests for inspection from a QSG / Risk Summit; and

- **triggering a Risk Summit** – where there are concerns that a provider is potentially or actually experiencing serious quality failures.

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 to 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 outside of their region to ensure that these concerns are shared and acted upon.

Regional

Regional QSGs can take action in the following form:

- asking questions of and making recommendations for consideration to Local QSGs;

- identifying issues for a regional or national response, sharing these with other regions and nationally;

- identifying support for a Local QSG where they are not able to function effectively;

- agreeing actions / investigations to be taken forward by individual organisations , e.g. CQC, Monitor, Public Health England, NHS Trust Development Authority, professional regulators; and

- triggering Risk Summits – this will normally be the role of the Local QSG, but there may be occasions where a Regional QSG feels necessary to do so.

Regional QSGs should also produce a summary report to share with the other Regional QSGs following each meeting to ensure key information is shared nationally. This could follow a similar format to the Local QSG report to the Regional QSG meeting at **Annex H**, ensuring that it is made clear what quality concerns other Regions should be aware of, and any good practice to share across the network.

Risk Summits

QSGs provide routine and ongoing surveillance and assurance for quality. From time to time, concerns that there could be a serious quality failure or the potential for there to be a serious quality failure, within a provider organisation may arise.

Risk Summits bring together QSG members relevant to the provider in question to give specific, focussed consideration to the concerns raised. This should facilitate rapid, collective judgements to be taken about quality within the provider organisation in question.

It is for the CQC to determine whether regulatory action is required as a result of a serious quality failing within a provider organisation. However, in the event of a serious failure, or where a quality problem has not yet become that serious but risks are becoming so, other parts of the system (commissioners, other regulators or supervisory bodies) may also need to take action to safeguard patients and improve quality of care.

A Risk Summit provides these different parts of the system with an opportunity to align their actions with each other so that they do not duplicate, or fail to act on a misapprehension that others are acting. Alignment of actions should be with a view to protecting the interests of patients and minimising regulatory burdens on providers.

Separate guidance has been developed on *'How to run a risk summit'*[2]. This is being updated. Risk Summits are a valuable and vital part of the new health and care system, but their overuse risks their impact being diluted and so QSGs and individual organisations should carefully consider their use of a risk summit.

Where there are significant and serious concerns that there are or could be quality failings at a provider organisation, it is appropriate to trigger a Risk Summit. However, there may be other

[2] How to organise and run a Risk Summit

mechanisms that are more appropriate for dealing with the issue at hand, as such the local safeguarding mechanisms, professional regulatory routes or breach of contract proceedings.

Quality Summits

Risk Summits should not be confused with Quality Summits, which will be held at the end of the CQC inspection. Quality Summits will bring together partners within the health economy and local authority to develop a plan of action and recommendations based on the Inspection Team's findings.

10. Working with the local government sector

As set out at chapter 5, local government's involvement in QSGs is voluntary; however, local authorities may wish 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 addition, QSGs should routinely consider whether information and / or intelligence shared at the QSG may be relevant to the roles and functions of safeguarding boards, Health and Wellbeing Boards and local authority overview and scrutiny committees.

Local Safeguarding Arrangements

Whilst the focus of QSGs at both a local and a regional level is the quality of services commissioned by the NHS, it is recognised that where poor quality is found, there is the potential for patients to suffer harm as a result of neglect or abuse. Where abuse or neglect is suspected or witnessed, it is essential that these concerns are fed into the relevant multi-agency safeguarding process, for either children or for adults, so that any required protection can be arranged.

Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs) are the key mechanisms for agreeing how the relevant organisations within a local authority footprint co-operate to safeguard and promote the welfare of children and adults in their locality, and for ensuring the effectiveness of the safeguarding arrangements within these organisations. QSGs need to make sure that they have mechanisms in place to share information and intelligence to enable safeguarding boards in the discharge of their duties and functions.

LSCBs were established under section 13 of the Children Act (2004). Each LSCB has a range of statutory functions that were set out in Regulation 5 of the Local Safeguarding Children Board Regulations (2206) and in order to fulfil their statutory functions, an LSCB is required to:

- assess the effectiveness of help being provided to children and families;
- assess whether LSCB partners are fulfilling their statutory obligations set out in Working Together to Safeguard Children (2013);
- quality assure practice; and
- monitor and evaluate the effectiveness of training to safeguard and promote the welfare of children.

Although Safeguarding Adults Boards have been in existence in most areas for some time, for the first time, the Care Act 2014 will make it a **statutory** requirement for local authorities to establish Safeguarding Adult Boards (SABs). These statutory Boards will be required to meet their objectives by co-ordinating and ensuring the effectiveness of what each of its members does.

Like QSGs, LSCBs and LSABs do not have the power to direct other organisations and each Board partner retains their own existing line of accountability. It is expected, however, that each QSG member would recognise their own responsibility for making referrals into either the safeguarding adults or safeguarding children's process in their local area, to ensure the protection of a child or adult at risk. If it becomes apparent in a QSG meeting that such a referral is required, it should be agreed who will make the referral and this agreed action can be minuted.

NHS England Local Area Teams, CCGs and Local Authorities are key partners at safeguarding boards and QSGs.

QSGs should routinely consider whether information and / or intelligence shared at the QSG may be relevant to the roles and functions of safeguarding boards. To facilitate appropriate decision making and communication from a QSG to a safeguarding board, the QSG Chair may wish to consider a standing agenda item that prompts the group to consider any issues that need to be communicated and the responsible member. Where it is agreed that a strategic matter should be raised with a local safeguarding board (as opposed to a referral being required), this can be done either through a member of the QSG raising the matter with a board of which they are a member, or through the chair of the QSG writing to the Board chair. This action can be agreed and minuted in the QSG meeting.

Organisations that are members of safeguarding boards and QSGs should routinely consider whether any information and / or intelligence shared at the safeguarding boards may be relevant to the QSGs. Where the QSG representative and safeguarding board representative is not the same person, organisations should develop mechanisms to ensure that the QSG representative is briefed appropriately. Where it is agreed that a quality matter should be raised with the QSG by a local safeguarding board, this can be done either through a member of the board who is also a member of the QSG, raising the matter with the QSG, or through the chair of the Board writing to the QSG chair. This action can be agreed and minuted in the Board meeting.

Health and Wellbeing Boards

Other than providing assurance on the quality of services, identifying risks and any action required to address these, QSGs also have a role in coordinating actions to drive improvement. Health and Wellbeing Boards – which provide a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area - are a key vehicle for driving health improvement in local areas and promoting integration and therefore need to be fully involved in discussions on quality of local health and care services. Moreover, the priorities in the joint health and wellbeing strategy will inform local commissioning plans for all health and care services, including concerns on quality.

Health overview and scrutiny

Local authority overview and scrutiny has an important contribution to play in raising quality issues in health and social care services and may have information about quality concerns. It would be helpful for the QSG to establish contact with relevant overview and scrutiny committees and provide them with an opportunity to participate.

Local authority representatives on the QSGs should provide the link with relevant overview and scrutiny committees. Health overview and scrutiny committees can make a submission of information to the QSG through their local authority representation or by letter.

11. Recording and communicating conclusions

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 agreed actions should be produced (example action log at **Annex G**).

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”.

It is vital that all members of QSGs have a common understanding as to what the surveillance levels used by their QSG mean, and how they are applied in practice. The Chair should ensure that surveillance levels are agreed and clearly recorded (example QSG outcome and surveillance log at **Annex I**).

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 is 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.

When 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 to ensure that these concerns are shared and acted upon.

As mentioned previously, Local QSGs should inform the Regional QSGs of the actions / conclusions they have agreed as part of their reports. A suggested Local QSG report to a Regional QSG meeting as at **Annex H**. Regional QSGs should also produce a summary report to share with the other Regional QSGs following each meeting to ensure key information is shared nationally. This could follow a similar format to the Local QSG report to the Regional QSG, ensuring that it is made clear what quality concerns other Regions should be aware of, and any good practice to share across the network.

Record Keeping

The NHS England Local Area or Regional Team should provide appropriate administrative support to ensure reliable record keeping and the generation of reports.

QSGs will wish to be as open and transparent as possible as part of their routine so that those with an interest understand the QSGs business as far as possible.

It is therefore advised QSGs produce:

- a **statement of intent** setting out the aim of QSGs to improve the quality of patient care through the sharing of information between local commissioners and that commissioners

need to be able to share soft intelligence such as concerns that have been raised by unconfirmed and informal complaints. The statement should:

- recognise the importance of improving public understanding of the work of QSGs;
- recognise the need for the public to have confidence in the NHS; and
- explain that the QSG will publish what information it can bearing in mind the need to maintain a safe space for commissioners to share concerns.

- a **publication scheme** setting out what information the QSG will routinely publish, including timescales for publication (for example, meeting dates, agendas and the names of attendees). Consideration should also be given to the publication of a statement if / when discussions have led to concerns being substantiated and appropriate action taken; and

- a **memorandum of understanding / protocol for QSG participants**, setting out the ground rules about how information shared at the QSG may be used, for example:
  - how any FOIA requests for QSG information should be handled by QSG bodies;
  - how to handle media requests;
  - what QSG bodies can do with the information they obtain through the QSG, including who will raise any points with providers;
  - a separate procedure to be followed if information is particularly confidential;
  - when matters should be shared / escalated.

QSGs should not feel restricted by the potential for a Freedom of Information request. They should record the information they need to, and should not be tempted to make vague statements due to concerns about having to disclose information.

As QSGs are not public bodies in their own right, they are not subject to the Freedom of Information Act 2000 (FOIA). However, the public bodies that attend them will be subject to FOIA and could therefore be asked for information they hold that has been obtained at QSG meetings.

As there are provisions in the Act that may enable confidential and sensitive material to be excluded from release subject to the public interest, requests for information will need to be considered on a case by case basis.

12. Further help and next steps

Further information

Resource Pack

A resource pack containing more practical guidance in relation to record keeping, the management of meetings, and sharing good practice has been developed. This will be held by QSG secretariats.

GMC

An example of the data the GMC can share is the first set of revalidation data reports which covers the period between the start of revalidation on 3 December 2012 and 30 September 2013.

Subsequent sets of operational reports will be published quarterly.
http://www.gmc-uk.org/doctors/revalidation/revalreports.asp

Education service specific reports can be found at: http://www.gmc-uk.org/education/23174.asp

Details of the GMC National Training Survey and access to the information can be found at:
http://www.gmc-uk.org/education/surveys.asp

NMC

Education service specific reports can be found at: http://www.nmc-uk.org/Educators/Quality-assurance-of-education/

Next steps

This guidance will be reviewed in a year's time to ensure it is relevant to QSGs as the model continues to evolve.

The Resource Pack will be reviewed every six months to reflect changes in the model and to support continual sharing of good practice.

More practical support will also be provided, including:

- Regional workshops to cover the key messages gathered from the review, subsequent changes to the guidance and support available;
- shadowing opportunities for chairs, particularly to share good practice from more established QSGs; and
- training for secretariats, including minute taking.

ANNEXES

A: Local QSG – draft model terms of reference

B: Regional QSG – draft model terms of reference

C: Local QSG - example agenda

D: Regional QSG – example agenda

E: Example QSG stakeholder reporting schedule and planned thematic reviews

F: Example CCG report – Local QSG meeting

G: Example QSG action log

H: Example Local QSG report to Regional QSG meeting

I: Example Local QSG outcome and surveillance log

Annex A

Local Quality Surveillance Group - draft model terms of reference

Purpose

The purpose of the Quality Surveillance Group (QSG) is to systematically bring together the different parts of the system to share information. The QSG will be a proactive forum for collaboration, providing:

- 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.

Objectives

The QSG will collectively consider and triangulate information and intelligence to safeguard the quality of care. In particular, the QSG will consider:

- what the data and soft intelligence is indicating about where there might be concerns regarding the quality of services;
- where the QSG is most worried about the quality of services;
- whether further action is required to address concerns, or collect further information; and
- where is there a lack of information and so a need for further consideration and / or information gathering.

Scope

The QSG will be 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;
- of mental health, dentistry, general practice, offender and military health services; and
- specialised services.

They also cover those services commissioned by Local Authorities from the NHS

The QSG does not have executive powers and will not:

- performance manage CCGs or any other organisations;
- interfere with the statutory roles of constituent organisations e.g. contractual powers or regulatory responsibilities; or
- substitute the need for individual organisations to act promptly when pressing concerns become apparent.

Membership

The core membership of the QSG will include the following representatives:

- NHS England Area Director (Chair) , Nursing Director and Medical Director
- CCG Accountable Officers and / or Clinical Lead
- Local Healthwatch representative(s)
- CQC Head of Inspection
- Monitor Regional 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 that they are fully briefed on any concerns arising out of QSG meetings where they are not in attendance.

Working Arrangements

The QSG will meet at least bi-monthly. The frequency of the meetings will be reviewed annually. The NHS England Local Area Team will be responsible for:

- providing facilities and technology to support the effective operation of QSGs;
- co-ordinating meeting agendas and papers; and
- providing a record of the discussions and agreed actions, and maintaining suitable records.

Annex B

Regional Quality Surveillance Group - draft model terms of reference

Purpose

The purpose of the Quality Surveillance Group (QSG) is to systematically bring together the different parts of the system to share information. The QSG will be a proactive forum for collaboration, providing:

- 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.

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The QSG will collectively consider and triangulate information and intelligence to safeguard the quality of care. In particular, the QSG will consider:

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- whether further action is required to address concerns, or collect further information; and
- where is there a lack of information and so a need for further consideration and / or information gathering.

Scope

The QSG will be 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;
- of mental health, dentistry, general practice, offender and military health services; and
- specialised services.

They also cover those services commissioned by Local Authorities from the NHS.
The QSG does not have executive powers and will not:

- performance manage CCGs or any other organisations;
- interfere with the statutory roles of constituent organisations e.g. contractual powers or regulatory responsibilities; and
- substitute the need for individual organisations to act promptly when pressing concerns become apparent.

Membership

The core membership of the Regional QSG will include the following representatives:

- NHS England Regional Director (Chair), Nursing Director and Medical Director
- NHS England Area Directors (Local QSG chairs)
- CQC Deputy Chief Inspector
- Monitor Regional Director
- Local Authority representative(s)
- NHS Trust Development Authority Director of Delivery and Development and Clinical Quality Director
- Public Health England Regional Director
- Health Education England (via Local Education and Training Board representative)
- Professional Regulators (GMC, NMC)

Other members, such as the Parliamentary and Health Service Ombudsman (PHSO) may be co-opted to provide support to the Regional QSG as appropriate.

Working Arrangements

The QSG will meet quarterly. The frequency of the meetings will be reviewed annually. The NHS England Regional Team will be responsible for:

- providing facilities and technology to support the effective operation of QSGs;
- co-ordinating meeting agendas and papers; and
- providing a record of the discussions and agreed actions, and maintaining suitable records.

Annex C

Local QSG – example agenda

X Local Quality Surveillance Group

EXAMPLE AGENDA

1.	Welcome & Introductions	Chair
2.	Apologies for absence	Chair
3.	Minutes of previous meeting	Chair
4.	Declaration of interests	All
5.	QSG action log	Chair
6.	Update from Regional QSG	Chair
7.	Focussed reports / thematic reviews	All
8.	Review of CCG reports and principal concerns (with contributions from all stakeholders)	All
9.	Agree surveillance levels / principal concerns	All
10.	Issues requiring escalation to Regional QSG	Chair
11.	Issuers requiring escalation to other groups / boards (e.g. safeguarding boards)	Chair
12.	Areas of good practice participants wish to share	All
13.	Reflection on meeting effectiveness	All
14.	Any other business	All
15.	Date, time and venue of next meeting:	

Annex D

Regional QSG – example agenda

X Regional Quality Surveillance Group

EXAMPLE AGENDA

1.	Welcome & Introductions	Chair
2.	Apologies for absence	Chair
3.	Minutes of previous meeting	Chair
4.	Focussed reports / thematic reviews	All
5.	Review of Local QSG reports and principal concerns (with contributions from all stakeholders)	All
6.	Agree surveillance levels / principal concerns	All
7.	Issues requiring escalation to other groups/boards (e.g. safeguarding boards)	Chair
8.	Issues requiring communication to other Regional QSGs (e.g. specific Regional QSGs or all Regional QSGs for sharing key information nationally)	Chair
9.	Areas of good practice participants wish to share	All
10.	Reflection on meeting effectiveness	All
11.	Any other business	All
12.	Date, time and venue of next meeting:	

Annex E

Example QSG Stakeholder Reporting schedule and planned thematic reviews

Reporting DATE	QSG Meeting DATE	QSG: Thematic Reviews/Business Cycle
Tuesday 14th May 2013	Tuesday 21st May 2013	1. Maternity and Neonates – thematic review report
Friday 19th July 2013	Friday 26th July 2013	1. Mental Health Serious Incidents - Overview 2. Quality in Workforce – Winter Planning
Friday 20th September 2013	Friday 27th September 2013	1. Quality in Primary Care
Friday 22nd November 2013	Friday 29th November 2013	1. Quality in Community Services
Friday 24th January 2014	Friday 31st January 2014	1. Quality in Care Homes
Friday 21st March 2014	Friday 28th March 2014	1. Quality in Out of Hours provision

Annex F

Example CCG report – Local QSG meeting

X Local Quality Surveillance Group Meeting

Date:

Title: **X CCG Report**

Report of: **Name of Author**

PURPOSE

Suggested narrative *"The purpose of this paper is to provide intelligence from X Clinical Commissioning Group (CCG) in relation to Clinical Quality and Safety issues across the NHS (add CCG area) Health Economy. "*

The report should include issues relating to any provider including Acute Trusts, Community Trusts, Independent Providers, Nursing Homes, Primary Care Contractors and any other organisations. It may also include specific areas of care in general where the CCG feels there is an issue which needs to be addressed. **The report should ideally be restricted to one or two sides of A4.**

KEY POINTS/ISSUES OF CONCERN

This section should contain a brief overview of any **significant risks/principal concerns** the CCG are aware of and actions being taken to remedy the situation. Examples might include:

Acute Trust A (insert name)

Outlier for the 4th quarter around HSMR but number of actions in place to remedy and action plan being monitored by CCG.

Community Provider B (insert name)

Significant concerns about pressure ulcer management, in comparison with other community providers. New CQUIN in place for 2013/14 and new Director of Nursing appointed to lead on pressure ulcers for the Trust.

Nursing Home C (insert name)

There are a number of concerns about medicines management. CQC aware and recent inspection has taken place and actions identified.

GP Practice D (insert name)

High number of complaints about the Practice, particularly in relation to access, following the departure of two GPs. Surgery has taken necessary steps to increase capacity.

SUMMARY/RECOMMENDATIONS

This section should state if issues raised in the report are for noting only or if any requests for action are being made.

Annex G

Example QSG Action Log

Status: O = open C= closed
Priorities: 1=High Priority Open 2=On Target Open 3=Closed

Date raised	Status (O,C)	Priority (1,2,3)	Issue	Owner	Resolution	Due date	Comments

Annex H

Example Local QSG report to Regional QSG meeting

Agenda Item xx
Regional Quality Surveillance Group Meeting

Date:

Title: **XX Local QSG report**

Report of: **Name of Author**

1.0 PURPOSE

The purpose of this paper is to provide feedback following the **x Local** QSG meeting(s) and to summarise key issues for the attention of the Regional QSG. The minutes of the meeting(s) are enclosed.

2.0 KEY ISSUES FOR THE ATTENTION OF THE REGIONAL QSG

This section should include a short summary of the main quality concerns discussed at the area QSG and the actions agreed.

This section should also include a summary of any significant interventions resulting from a quality concern such as a risk summit, rapid responsive review and/orregulatory enforcement.

3.0 ISSUES REQUIRING REGIONAL QSG SUPPORT/RESPONSE

Please state none if none identified. This section can include points that Local QSG are seeking further clarity on

4.0 SUMMARY/RECOMMENDATIONS

State if report is to note or for action and set out any specific recommendations that the Regional QSG need to consider.

Annex I

Example Local QSG outcome and surveillance log

Provider	Sector	Current level of Surveillance	Previous level of Surveillance	Trend	Actions/Comments
X Hospital NHS Trust	Acute	Enhanced			Further information sharing meeting agreed
Y Community Trust	Community	Routine			Schedule for routine discussion May 2013

Levels of Surveillance

- **Further information required** – further information required to determine when provider will next be considered by the QSG.
- **Routine** – no specific concerns identified, schedule for routine discussion as part of business cycle.
- **Enhanced** – quality concerns identified, schedule for further discussion at each QSG.
- **Risk Summit** – significant concerns leading to a QSG request for a risk summit.