National Quality Board

Third Edition, July 2017

Quality Surveillance Groups

National Guidance

This document has been developed by NHS England on behalf of the National Quality Board (NQB), which provides coordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health

For further information about the NQB, please see:
https://www.england.nhs.uk/ourwork/part-rel/nqb/

This document was developed with the additional involvement of Healthwatch England, the General Medical Council, the Nursing and Midwifery Council, the Local Government Association and the Association of Directors of Adult Social Services (ADASS).

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1. Introduction and context

Context for the third edition, July 2017

1. Quality Surveillance Groups (QSGs) bring together different parts of the health and care system, to share intelligence about risks to quality.

2. Initial guidance was published in January 2013, and a network of QSGs was established across England, bringing health economies together locally and in the four regions. Given the changes in the NHS at that time, a review of the QSG model was undertaken six months into its existence, and revised guidance was published in March 2014.

3. The health and care system has evolved significantly during the three years since the QSG model was last reviewed. Relationships between organisations have matured and developed. The National Quality Board (NQB) has therefore undertaken a further review of the QSG model, to understand how QSGs are operating across the country, to refresh their purpose and identify where they could be supported to be more effective.

4. The review was led by a working group with representation from the Care Quality Commission, Health Education England, Healthwatch England, NHS England, NHS Improvement, Public Health England, the General Medical Council, the Nursing and Midwifery Council, the Local Government Association and the Association of Directors of Adult Social Services (ADASS). The review included observation of QSG meetings and Risk Summits, interviews with a wide range of stakeholders including provider representatives, and a survey of all local and regional QSG members.

5. This edition of the guidance has also been revised in response to changes signalled in two other recent publications – the *NQB's Shared Commitment to Quality* (December 2016) and *Next Steps on the Five Year Forward View* (March 2017).

Next Steps on the Five Year Forward View

6. This guidance is published at a moment when further significant change has been signalled for the health and care system. *Next Steps on the Five Year Forward View* sets out a road map towards whole-system, place-based, integrated planning.[1] Sustainability and Transformation Partnerships (STPs) are developing in every area of the country. In some places this will lead to the creation of Accountable Care Systems (ACSs). These will be systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health.

7. This direction of travel has significant implications for the QSG model. However, *Next Steps on the Five Year Forward View* is also clear on how change should happen: evolution not big bang, 'horses for courses' not 'one size fits all'. The transition towards

[1] https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

ACSs is complex and requires careful management. And risks to quality can increase in health and care systems at times of transition. This means that the role of QSGs, to continue to provide a stable, ongoing mechanism to systematically focus on quality, is even more important. QSGs should consider the particular risks that may arise through transition, including quality risks arising from major service reconfiguration.

8. Boundaries of QSGs and membership should flex according to local circumstances. We are already seeing this in some places. For example, Greater Manchester has adapted its QSG terms of reference to include both NHS and local authority-commissioned services, and is increasing routine provider involvement through its Provider Federation. We expect that, across the country, QSGs will adapt pragmatically as STPs and ACSs develop.

How do QSGs fit into the wider NHS Quality Framework?

9. Improving quality – alongside health and wellbeing, finance and efficiency – is a key ambition of the *Five Year Forward View*, and underpins the development of Sustainability and Transformation Plans at a local level.

10. QSGs are one element of a wider framework to ensure that quality is the organising principle of our health and care service.

11. In December 2016, the NQB published the *Shared Commitment to Quality*, a new framework providing a nationally-agreed definition of quality (see Box 1), and a guide for clinical and managerial leaders looking to improve quality. The framework was agreed across NHS and social care organisations, to enable the system to work together more effectively across the country.

Box 1: A single shared view of quality

From the NQB's *Shared Commitment to Quality*

The areas which matter most for people who use services are:

Safety: People are protected from avoidable harm and abuse, and when mistakes occur lessons are learned.

Effectiveness: People's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Positive experience (caring, responsive and person-centred): Staff involve and treat people with compassion, dignity and respect. Services respond to people's needs and choices and enable them to be equal partners in their care.

To provide this high-quality care, providers and commissioners must work together and in partnership with local people and communities. They must be:

Well-led: they are open, collaborate internally and externally, and are committed to learning and improvement.

Sustainable: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.

Equitable for all: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

12. The *Shared Commitment to Quality* also sets out seven steps to maintain and improve quality (see Box 2 below). The steps are based on the evidence that, to enable a high-quality health service, it is important to predominantly focus on supporting and enabling improvement. However, it is also important to ensure that minimum standards of quality and safety are maintained. This is step five – maintaining and safeguarding quality. QSGs are a key element of this step. They focus on risks to quality, within a wider framework which focuses on improvement.

Box 2: Seven Steps to maintain and improve quality

From the NQB's *Shared Commitment to Quality*

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

2. What is a Quality Surveillance Group?

13. Across the country, 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. When organisations do not work together to share information and intelligence on the quality of care, this can have a devastating impact for patients and their families.

14. Across any 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 and held by various different organisations and individuals in that economy. 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.

15. 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. Often the information held by one party alone will not cause concern but, when combined with intelligence held by others, for example a regulator, might point to a potential problem that should be investigated further.

16. It is for this reason that we established a network of QSGs which systematically bring together the different parts of the system to share information. They are a proactive and supportive forum for collaboration and intelligence sharing. By triangulating intelligence from different organisations, they provide the health economy with a shared view of risks to quality, and opportunities to coordinate actions to drive improvement.

Characteristics of an effective QSG

- **Person-centred** – members are grounded in the fact that their purpose is to maintain good quality services for people.
- **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 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.

17. QSGs operate at two levels: local and regional. There are currently 28 local QSGs, and four regional QSGs. Some local QSGs have changed their footprint since 2014, and we envisage that others will flex pragmatically depending on local circumstances.

18. The aim of QSGs is to identify risks to quality at as early a stage as possible. The QSG should ensure that action is taken to mitigate these risks, resolve issues locally where possible and drive improvement in quality in an aligned and coordinated way.

19. A QSG should act as a virtual team across a health and care economy, bringing together member 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.

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

21. **QSGs should not add another level of bureaucracy to the system**. Commissioning, regulatory and oversight organisations should be sharing information and cooperating with other organisations as part of their **business as usual** responsibilities, bilaterally and multilaterally. The QSG model builds on this by formalising a network in every local area, in a regular and tangible way, which encourages and creates an expectation of open and honest cooperation. 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.

22. Issues should only be brought to the local QSG when they cannot be solved as part of business as usual, and where action is required by more than one organisation.

23. 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. It is important to remember that QSGs are not statutory bodies; they have no legislative status, nor formal powers. However, QSG members 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. More information on the type of action that can be taken and by whom is in section 10.

Local and Regional QSGs

24. 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 and triangulate 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. They should generally focus on major themes across the region, rather than on individual organisations. Model terms of reference for Regional QSGs are at **Annex B**.

25. Local QSGs should escalate issues to the Regional QSG which have potential regional or national implications, or which merit a regional or national response.

26. Local and Regional QSG secretariats should ensure that there is clarity on whether submissions to the Regional QSG are for information (to share across other local QSGs), or for action.

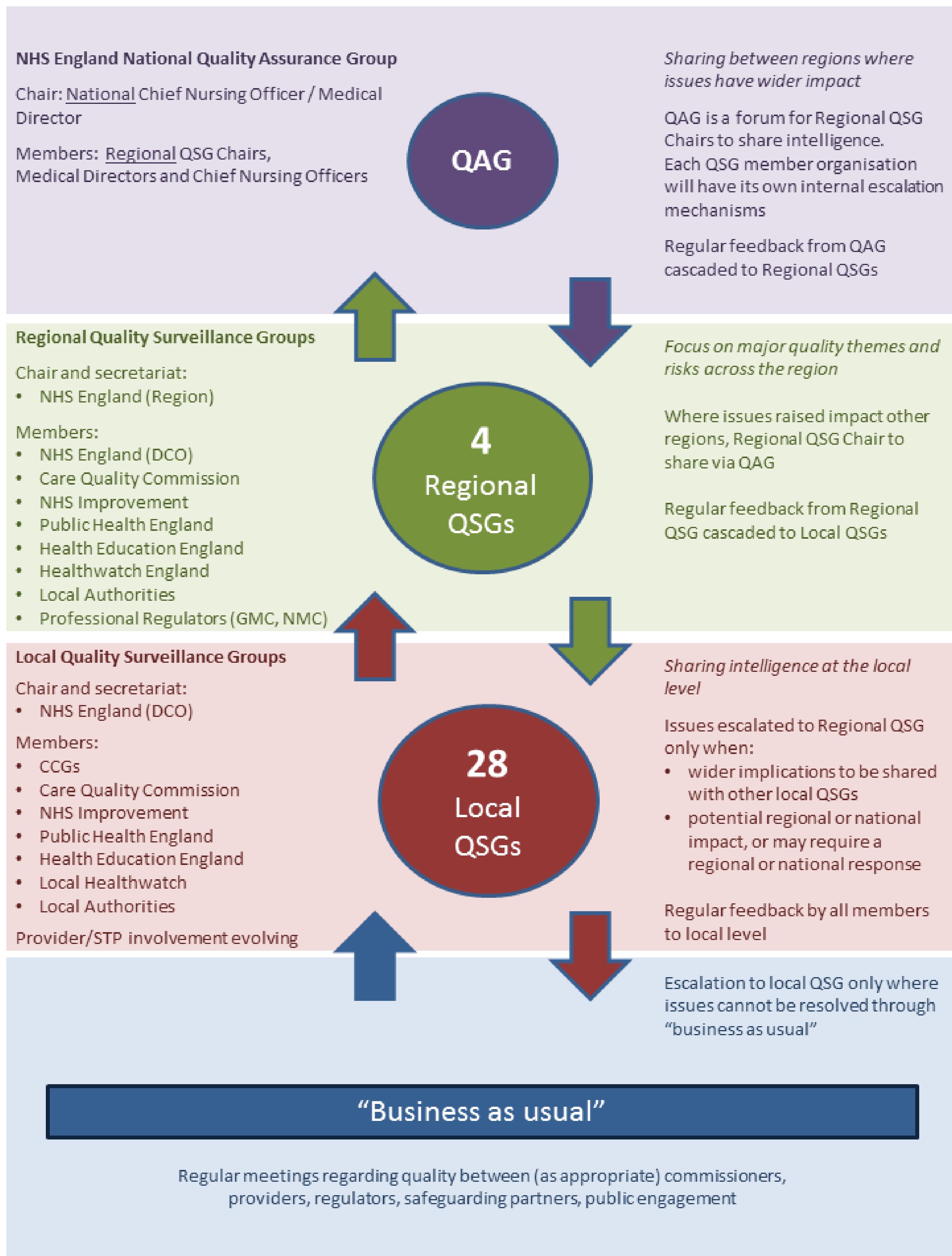
National coordination and intelligence sharing

27. The NHS England Quality Assurance Group brings together the chairs of the four Regional QSGs at the national level. It is chaired by the Chief Nursing Officer for England, with the National Medical Director acting as Deputy Chair. Its membership includes NHS England Regional Directors, Regional Chief Nurses and Regional Medical Directors.

28. Regional QSGs should report quality issues or risks to the QAG where these have national implications, or implications for other regions. This is a mechanism to enable appropriate intelligence sharing on quality between regions and to escalate concerns that fall within NHS England's remit for response. Depending on the nature of the quality concern, where action is needed at the national level, it may be best led by any of the national oversight bodies. Individual QSG members will escalate issues for national attention within their own organisation as appropriate.

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

Quality surveillance of health and care services in England at a glance



3. Scope of QSGs

30. QSGs are concerned with services commissioned by the NHS (either by CCGs or NHS England) and with those commissioned jointly by the NHS and local authorities. They also consider services that are commissioned by local authorities from providers of NHS care.

31. As areas move towards greater integration between health and social care, health and care systems may decide to expand the scope of their QSG to include local authority-commissioned services. This is for local determination.

32. They consider the full range of services within this scope, including relevant public health services, from:

    - public, private, not for profit and third sector providers;
    - primary care including general practice, dental, optometry and pharmacy;
    - community services;
    - secondary and tertiary services;
    - mental health;
    - health and justice;
    - military health and veterans services; and
    - specialised services.

33. QSGs should 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 more information?
    - Where is there a lack of information?

34. Where routine surveillance is well-established and effective outside of QSG meetings, QSGs should increase their focus on thematic discussions.

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

    - their purpose is not to performance manage CCGs or any other organisations;
    - they should not interfere with the roles of constituent organisations e.g. through contractual relationships with providers or regulatory responsibilities;
    - they will not substitute the need for individual organisations to act promptly when pressing concerns become apparent; and
    - they are not primarily focused on promoting and sharing best practice, although this may be a positive outcome of their existence and the networks they create.

Maintaining strong relationships

36. In order to maintain a trusting group dynamic within a QSG, where QSG representatives feel able to share emerging intelligence, **member organisations should identify one individual who can consistently attend the QSG.** 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.

Learning from experience

37. If a risk to quality has arisen unexpectedly, QSGs should look back to understand what was known or discussed before the event. They should consider whether anything was missed, and whether lessons can be learned.

4. Membership of QSGs

38. Given that the purpose of QSGs is to bring together all organisations with information and intelligence on quality, getting the membership right is crucial. There are certain organisations which will need to be represented – listed below – in all QSGs across the network. Each QSG may then decide to include other organisations according to local circumstances.

39. Local communities and voluntary sector organisations have a wealth of intelligence on quality. The views of patients, families and carers are directly represented in QSGs by Healthwatch. However, all QSG organisations should have strong ongoing mechanisms for patient and public engagement, to ensure that the views of people who use services are central in the QSG's work.

Individual QSG representatives

40. Member organisations should identify one individual as their QSG representative, and support that individual to attend QSG meetings as consistently as possible. Organisations should have mechanisms in place internally, to ensure that their QSG representative is adequately briefed across the whole of their organisation's remit.

41. Individual QSG representatives should:

- represent the information, intelligence and perspective of their organisation;
- be sufficiently senior and skilled to be able to actively participate in meetings;
- be authorised to represent their organisation in collective decisions and in offering commitments;
- report back to their organisation with information and intelligence to aid, supplement and deepen their 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 where appropriate; and
- feed back to their organisations on the conclusions reached at the QSG meetings, sharing intelligence as necessary but with regard to its sensitivity.

Organisational membership of Local QSGs

Organisation	Representative
NHS England	Director of Commissioning Operations (Chair) Nursing Director Medical Director
Clinical Commissioning Groups	Accountable Officers Clinical Lead
Care Quality Commission	Head of Inspection
NHS Improvement	Regional Manager
Local 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

Organisational membership of Regional QSGs

Organisation	Representative
NHS England	Regional Director (Chair) Nursing Director Medical Director Directors of Commissioning Operations
Care Quality Commission	Deputy Chief Inspector
NHS Improvement	Regional Director
Local Authority	Nominated representative
General Medical Council	Nominated representative
Nursing and Midwifery Council	Nominated representative
Public Health England	Regional Director
Health Education England	Local Education and Training Board representative
Healthwatch England	Regional representative

42. Other members, such as the Parliamentary and Health Service Ombudsman (PHSO) or the National Institute for Health and Care Excellence (NICE) may be co-opted to provide support to the Regional QSG as appropriate.

43. NICE regional field teams can support QSGs to improve quality through their interactions with providers and QSG member organisations. They can also support QSGs by ensuring alignment of NICE quality improvement activities, including quality standards, measurement initiatives and shared learning.

Provider organisations

44. As STPs develop, and in some places evolve into ACSs, provider involvement in quality surveillance arrangements will also evolve.

45. Currently, provider organisations are not generally included in the membership of QSGs for reasons of pragmatism. 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.

46. **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**.

47. 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 NHS Improvement through their accountability arrangements.

48. If a QSG has a specific concern about quality, it may decide to convene a meeting (sometimes referred to as a "Single Item QSG" or a "Risk Review") which involves the provider in question. If there are serious concerns, the QSG may decide to trigger a Risk Summit, which would also usually involve the provider. (Further details on the actions that QSGs can take, including Risk Summits, can be found in section 10.)

Intelligence from other professional regulators

49. The Health and Social Care Regulators Forum, chaired by the CQC, is developing an escalation protocol between professional regulators (plus other partners e.g. the Parliamentary and Health Services Ombudsman and Local Government Ombudsman) for sharing quality concerns. The proposal is for a nominated person in each regulator to have responsibility for escalating concerns to ad hoc regulatory review boards when needed. The review boards would feed concerns into QSGs as appropriate. This work is being piloted with the aim of being finalised in October 2017.

5. The role of individual organisations in QSGs

NHS England

50. NHS England as a commissioner of primary care, specialised services, health and justice and military health and veterans' services has a role in supporting and enabling CCGs to commission high quality, safe and effective services for local populations. NHS England supports, facilitates and is a member of both Regional and Local QSGs. The role of NHS England in facilitating QSGs is set out in section 7.

Clinical Commissioning Groups

51. 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.

52. 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, but with whom they interact.

Care Quality Commission

53. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The 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.

Health Education England

54. Health Education England (HEE) supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values, behaviours and training, at the right time and in the right place.

55. HEE is represented by its local offices on Local and Regional 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.

Healthwatch

56. Healthwatch exists to ensure that people’s needs are at the heart of health and social care. It listens to what people like about services, and what could be improved, and shares it with those with the power to make change happen. There is a local Healthwatch in every area of England and a national Healthwatch England.

57. Local Healthwatch organisations listen to the views of local people and share them with those with the power to make local services better. They also share them with Healthwatch England, to help improve the quality of services across the country. Local Healthwatch are members of Local QSGs.

58. Healthwatch England champions the views of people who use health and social care services in England. It works to ensure that health and social care services, and the government, put people at the heart of care. It supports local Healthwatch to listen to people’s views about services and shares them with those running and designing services. It has the power to make sure that people's voices are heard. Healthwatch England is a member of Regional QSGs.

NHS Improvement

59. NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. It provides strategic leadership, oversight and practical support for the provider sector, and supports NHS trusts and NHS foundation trusts to give patients consistently safe, effective, compassionate care within local health systems that are financially and clinically sustainable. It works alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation. NHS Improvement attends both Local and Regional QSGs.

Public Health England

60. The role of Public Health England (PHE) is to protect and improve the nation’s health and to address inequalities. PHE holds epidemiological data on infections, including healthcare associated infections at provider and community levels. PHE also quality assures screening services commissioned by NHS England. PHE provides this information to QSGs to contribute to the overall picture of the healthcare system.

61. PHE also contributes a population level perspective to issues being considered by QSGs. For example, PHE brings a population understanding to variations in dementia rates, the contribution of variations in cancer care to overall outcomes, the trends in the ageing population with multiple morbidities or the pressures seen on an urgent care system over winter. PHE also brings specific expertise in areas, such as, tackling healthcare infection rates, reducing winter pressures and tackling antimicrobial resistance.

Local Government

62. 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. They commission public health services from NHS providers and from third and independent sector providers.

63. 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.

64. Further information on working with local government can be found in section 6.

The General Medical Council

65. The General Medical Council (GMC), the regulator of the medical profession and all postgraduate medical education training environments, is a member of the four Regional QSGs. It is represented by its Employer Liaison Service. Revalidation data and any concerns about medical training (including emerging provider/site specific concerns and information about education programmes identified by the GMC's visit teams or its enhanced monitoring process) are provided to the Regional QSGs; the GMC is looking at how best to share fitness to practise data in a meaningful way.

66. The GMC also provides insights and intelligence from its Regional Liaison Service which works directly with employers, patient groups, educators and doctors to support the quality of medical practice. The GMC uses information from the Regional QSGs to inform regulatory action, participates in Risk Summits and works closely with CQC, NHS England, HEE, NHS Improvement and others to address shared concerns. The published results of the annual National Training Survey are made available to the Regional QSGs, as are any reports into specific services.

The Nursing and Midwifery Council

67. The Nursing and Midwifery Council (NMC) is the regulator for nursing and midwifery professions in the UK. It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.

68. The NMC is a member of the four Regional QSGs, represented by its Regulation Advisers. The NMC is developing its capacity to understand and use its own data and that of

others. It is developing and improving Memoranda of Understanding with system regulators and other key national bodies to enable better understanding of the systems and processes that support good collaborative working and information exchange. These functions are underpinned by the Regulatory Intelligence Unit which analyses data and identifies themes and areas of serious regulatory concern.

6. Local authority involvement in QSGs

69. Systematic local authority involvement in the QSG network is important, and mutually beneficial. This involvement can be arranged in a number of ways. In some areas, local authority representatives regularly attend QSGs. Where this is working well, it should continue. However, it is recognised that many local authorities find it challenging to consistently attend QSG meetings. Where this is the case, alternative arrangements should be agreed.

70. QSGs should ensure that, in their local area or region, they have in place:

- strong ongoing relationships between the QSG chair and local authority representatives;
- a clear route for local authority concerns about quality to be fed into the QSG on an exception-reporting basis; and
- clear triggers for when local authority representation at a meeting is needed.

71. Local authority QSG representatives should be able to act as the ongoing link point between the QSG and their local authority and liaise with safeguarding boards, Health and Wellbeing Boards and overview and scrutiny committees.

Local safeguarding arrangements

72. It is recognised that where poor quality is found, there is the potential for individuals to suffer harm as a result of neglect or abuse. Where abuse or neglect is suspected or identified through a QSG, it is essential that these concerns are reported into the relevant multi-agency safeguarding process, for either children or adults, so that appropriate action can be taken.

73. 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.

74. QSGs should ensure that they have mechanisms in place to share information and intelligence to support safeguarding boards in the discharge of their duties and functions. Statutory Guidance on the Care Act requires SABs to make appropriate links to QSGs.[2]

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#using-the-care-act-guidance

75. LSCBs were established under section 13 of the Children Act (2004).[3] Each LSCB has a range of statutory functions that were set out in the Local Safeguarding Children Board Regulations (2006) 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 (2015);
    - quality assure practice; and
    - monitor and evaluate the effectiveness of training to safeguard and promote the welfare of children.

76. Although SABs have been in existence in most areas for some time, the Care Act 2014 made it a **statutory** requirement for local authorities to establish SABs. These statutory Boards are required to meet their objectives by co-ordinating and ensuring the effectiveness of what each of its members does.

77. 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 is aware of their accountability and responsibility with regards to safeguarding children and adults within their local area, and how safeguarding processes work to support those at risk of, or suffering from, abuse or neglect.

78. NHS England Director of Commissioning Operations (DCO) Teams, CCGs and Local Authorities are key partners at safeguarding boards and QSGs.

79. 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, local QSGs should have 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 the relevant Safeguarding Board chair, or through the chair of the QSG writing to the Safeguarding Board chair. This action should be agreed and recorded in the QSG meeting minutes.

80. Organisations that are members of both safeguarding boards and QSGs should routinely consider whether any information or intelligence shared at safeguarding boards may be relevant to QSGs. Where the QSG representative and safeguarding board representative is not the same person, organisations should have internal mechanisms in place, to ensure that the QSG representative is briefed appropriately. Where a safeguarding board wishes to raise a quality matter with a QSG, this can be done either through the

[3] Local arrangements for safeguarding children will be changing over the coming 18 months, following legislative changes in the Children and Social Work Act 2017. QSGs should ensure that they continue to have appropriate mechanisms in place to work with safeguarding partners under the new arrangements.

relevant Local Authority QSG representative, or through the chair of the safeguarding board writing to the QSG chair.

Health and wellbeing boards

81. Health and Wellbeing Boards 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 in order to support QSG's role of coordinating actions to drive improvement. They provide a forum for local discussions and the priorities in the joint health and wellbeing strategy will inform local commissioning plans for all health and care services, including concerns on quality.

82. As outlined above, local authority QSG representatives should provide the link with Health and Wellbeing Boards.

Health overview and scrutiny

83. It would be helpful for the QSG to establish contact with relevant overview and scrutiny committees and provide them with an opportunity to participate. Where an overview and scrutiny committee wishes to raise a quality matter with a QSG, or submit information, this can be done either by the relevant Local Authority QSG representative, or by letter to the QSG Chair.

7. The role of NHS England in facilitating QSGs

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

Role of the Chair

What makes an effective QSG Chair?

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

85. NHS England provides the chair for QSG meetings regionally and locally. 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.

86. 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.

Facilitation

87. 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 (see also section 9). In addition to routine reporting, analysts will work with QSGs at a regional level to support their analytical requirements. This may involve providing a data pack for each formal QSG meeting, which sets out an

overview / summary of data from the NHS England Quality Dashboards and other relevant data sources. Additional topic-based analysis may also be provided;

- 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 emerging intelligence (see section 8); and

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

Sharing intelligence across the QSG network

88. When QSGs identify issues that may affect other areas or regions, they should ensure that this intelligence is appropriately shared across the QSG network.

89. Local QSG Chairs meet regularly at Regional QSG meetings, and the four Regional QSG Chairs meet regularly through NHS England's National Quality Assurance Group (QAG). Regional QSG Chairs are responsible for feeding back to Regional QSGs any relevant issues from QAG, and Local QSG chairs are responsible for feeding back to their Local QSG any relevant issues from Regional QSG.

90. Regional QSG secretariats should ensure that "feedback from QAG" is a standing agenda item, and local QSG secretariats should ensure that "feedback from Regional QSG" is a standing agenda item.

8. Planning and running your meetings

91. 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.

92. 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. They must also be action focused and conclusions from discussions must be explicit and understood by all parties.

93. The sharing of concerns and emerging 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 – thematic discussions

94. Over the four years that they have been running, QSGs have increasingly found that thematic discussions are a helpful way to consider risks to quality. Examples of themes include:

    - Population groups (e.g. frail older people, children and young people, people with learning disabilities, long-term conditions pathway);
    - Provider type (e.g. primary care, maternity, community, out of hours, care homes, high-cost providers, independent sector providers); and
    - Quality issue (e.g. pressure ulcers, healthcare associated infections, Serious Incidents, Never Events).

95. Where routine surveillance is well-established outside of QSG meetings, QSGs should increase their focus on thematic discussions. The QSG, supported by its secretariat and chair, should have in place a business plan that maps out the cycle of business it wishes to conduct / areas on which it wishes to focus. 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 to be included in the business plan.

Preparation

96. As far as possible, it is helpful to make clear in advance of the meeting which sectors, organisations or sites will be discussed. This makes it easier for QSG representatives to ensure they are appropriately briefed.

97. In advance of meetings, it can be helpful for the QSG secretariat to prepare and circulate to all QSG representatives:

    - 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 Local QSGs (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. They should include details of any providers that are failing to support or cooperate in multi-provider Serious Incident investigations. The reports should follow a consistent structure and format. Example report templates are provided at Annexes C and F;

    - 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 feedback from the Regional QSG.

98. Briefing packs should be kept as short as possible. Reports for QSGs should be written with all QSG members in mind – in particular, NHS colleagues should ensure they are not using jargon which can be inaccessible to those from outside the NHS.

Running meetings

99. 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 emerging 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 emerging intelligence and concerns is a significant added benefit to the system of QSGs, and this opportunity should 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. Section 10 provides more information on actions available to QSGs and section 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.

9. Information to support discussion

Why is measuring quality important?

100. The routine measurement of quality can identify providers which are outliers and be an early warning of emerging issues. In concert with local emerging intelligence it can lead to an enhanced understanding of the system and inform actions and behaviours. Deeper analysis of known risks and issues can test theories, identify causal relationships, and lead to novel solutions and so is essential in underpinning the systematic assessment of risk.

101. Measuring quality is also an important part of supporting quality improvement and sharing good practice as outlined in the NQB's *Shared Commitment to Quality*.

Which indicators qualify as quality indicators?

102. As set out in the *Shared Commitment to Quality*: to people who use services, quality comprises safety, effectiveness and positive experience, and for those providing services, quality care relies on services being well-led, sustainable and equitable.

103. The information and intelligence required to assess quality, therefore, needs to be drawn from many different sources, both hard data and emerging intelligence, to ensure that QSGs are appropriately informed.

Ways of using data

Routine quality monitoring

104. NHS England analysts produce a range of data presentations such as the NHS England Acute and Mental Health Quality Dashboards, which provide a consistent approach for defining and measuring quality to support improvement using a core set of indicators. They can be used to:

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

105. The Acute and Mental Health Quality Dashboards can be used to identify issues across a provider or providers and across a number of different topics. Where appropriate, the dashboards identify statistical outliers for each indicator and include a trend. When considering a provider, outliers should be noted and the connection between multiple outliers. The trend charts can provide an early warning of deterioration in performance or help to understand the process of recovery. The dashboards will be improved to make identifying recurrent outliers and deterioration easier for users to identify.

106. The Dashboards will evolve to ensure continued alignment with CQC and NHS Improvement, and wider quality system partners in terms of definition of metrics. We will continue working with the NQB to improve efficiency and reduce duplication in gathering and presenting data and indicators, with a view to supporting a 'single' consistent view of quality.

107. Dashboards will use the most up-to-date relevant data possible. It is recommended that relevant dashboards and reports for routine quality monitoring should be circulated with the agenda of QSG meetings, though it should be for QSGs to determine locally whether they are discussed directly at the meeting or just used for additional context to discussions.

108. Routine dashboard reporting has progressed to cover an increased range of settings and topics across, for example, acute care, mental health and primary care. Further development needs have been highlighted particularly across other settings including community care, care homes and patient experience. It may be most appropriate to fulfil these needs through locally provided information whilst national data sets are not able to meet them (see "Other sources of information and intelligence" below).

Thematic reviews

109. Thematic reviews and deeper analysis of known risks and issues may focus on a particular care setting, pathway or topic. Topics for further analysis may be highlighted in several ways, including: national priority setting, discussions at local or regional QSGs, or through discussion about wider operational issues. The data required to inform a review is likely to be drawn from a wider set than the indicators used to routinely monitor quality. NHS England regional analysts can assist in the production of thematic reviews providing signposting and/or expertise.

110. Some regions are already trialling the development of a routine bipartite (NHS England and NHS Improvement) report which combines analysis and operational commentary on key themes. The intention is for the key themes to change over time in response to the needs of the region and enable a deeper, shared understanding of the issues. Such reports can be made available to QSGs and would benefit from QSG input in shaping a consistent system-wide approach to measuring quality. Exceptional issues and themes which require a system response should be discussed in the Regional QSG and/or Local QSG meeting and actions agreed to address them.

Systematic risk assessment of a provider

111. When persistent and/or increasing quality concerns have been identified in a provider and assurance has not been gained through routine or enhanced quality assurance processes and targeted quality / monitoring assurance visits, the Quality Risk Profile Tool can be used to form a shared and systematic view of the risks in a provider which combines qualitative and quantitative intelligence.

112. The Quality Risk Profile tool uses data from the NHS England Quality Dashboards and other sources and is populated with local intelligence from a range of stakeholders.

113. The metrics included in the Quality Risk Profile have been developed over a number of years with providers and expert groups to ensure their validity and there is a process in place to review the metric selection on an annual basis.

How should QSGs use data and information?

114. 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:

- 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, the data protection and confidentiality status, known issues or constraints with the data set and an indication of what good would look like, where possible;

- analytical support from NHS England will enable QSG members to become more familiar with the breadth of quality indicators available to support their discussions;

- benchmarks, trends, variance and comparisons are essential in order to interpret the data and put it in context;

- data should not drive the agenda of the meeting and areas where data is not readily available, or is of poor quality, should not be overlooked;

- the unique benefit of QSGs is their ability to assimilate hard data with emerging 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.

115. Throughout the work of the QSGs, person-identifiable data should be protected and confidentiality preserved. On the few occasions where QSGs use person-identifiable data they must ensure that there is a lawful basis for doing so, that the data is protected and confidentiality maintained. This applies to both discussions around patients as well as to staff and clinicians. Colleagues will be aware of the statutory duties of organisations to investigate safety issues and ensure quality, providing a legal gateway to using identifiable data alongside the importance of maintaining confidentiality and protections. Careful note taking will be required with identification properly managed. For example, where necessary, the use of an annexe with restricted circulation where the identity is disclosed even if this is not done in the main text. Remember that any

discussions will be subject to the provisions of the Freedom of Information Act and Subject Access Requests under Data Protection legislation. The usual considerations still apply.

Other sources of information and intelligence

116. It is vital that QSGs triangulate data, information and intelligence from a wide range of sources, both hard data and emerging intelligence. 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
- HEE Local Office / Postgraduate Deanery reports
- NHS Improvement ratings
- Healthwatch intelligence
- Relevant GMC National Training Survey data
- 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 Commissioning Support Units
- Never Events data

117. Different information will be appropriate to consider locally and regionally. It is good practice for QSGs to consider the above sources regularly. Regional QSGs will 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.

118. 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 section 11). Creation of an environment of confidentiality and trust is vital in this context.

10. Assessing and responding to quality risks: actions available to QSGs

119. QSGs are ideally placed in the system to understand risks to quality, and to ensure that aligned and coordinated action is taken to mitigate those risks. They do not have any statutory powers, but can recommend a range of actions to be taken. Care should be taken to ensure that if an organisation has statutory responsibility for a decision or service, the views of that organisation are not overridden by other QSG members. QSGs should work to resolve issues at a local level wherever possible.

Shifting the focus from providers to systems

Currently, QSGs generally assess risks to quality (and manage their surveillance log) at the level of single providers. As Sustainability and Transformation Partnerships develop and boundaries between providers and commissioners evolve, QSGs will need to flex their approach pragmatically.

However, even while the focus remains on single providers, it is important to be aware that, although risks to quality may manifest in one provider, the causes and solutions are usually system-wide. QSGs should have this in mind when considering action in response to quality concerns.

Assessing risks to quality

120. Local QSGs must have a robust approach to assessing risks to quality across their local health and care system. They should have an ongoing overview of where there are quality concerns within their area. This should be recorded by maintaining a surveillance log. (A basic template can be found at **Annex E**).

121. They should also categorise by level. The table below provides a simple categorisation of "surveillance levels". All members of a QSG should have a common understanding of:

- What the surveillance levels used by their QSG mean, in terms of an assessment of risks to quality; and
- For each level, what kinds of action the QSG will take in response.

QSG Surveillance Levels

Level	What does this mean? What is the assessment of risks to quality?	What actions may be taken by the QSG in response to this assessment?
Routine	No specific concerns identified	Schedule for routine discussion as part of QSG business cycle
Further information required	Potential for concern. More information required to determine the level of risk	Agree who will follow up to gain necessary information to assess risk
Enhanced	Quality concerns identified	Agree actions, and schedule for discussion at each QSG meeting until concerns are resolved
Risk Summit	Serious, specific risk to quality identified, including where there is a need to act rapidly to protect patients or staff	Trigger Risk Summit process

122. Many QSGs have found the Quality Risk Profile Tool (QRPT – see below) to be helpful in assessing risks to quality. Where the QRPT is not used, local QSGs should ensure that similarly robust processes for assessing risks to quality are in place.

The Quality Risk Profile Tool

NHS England (North Region) has developed a Quality Concerns Trigger Tool (Trigger Tool) and Quality Risk Profile Tool (QRPT), to assist commissioners and QSGs in assessing risks to quality. These tools provide a framework to ensure a consistent approach to assessing risk by all stakeholders. They provide:

- a systematic risk-based methodology, which identifies areas where further assurance or support may be required; and
- the basis for shared decisions about a managed and proportionate response to quality concerns.

Where commissioners or other QSG members have concerns about quality in a provider or wider system, the Trigger Tool provides a framework for making decisions about appropriate risk escalation, and may include working through the QRPT.

The QRPT is worked through in partnership with the relevant provider, to enable all parties to reach a shared understanding of where there are risks to quality, as well as identifying areas of good practice. The tool provides a structured way to consider a wide range of data and information, to reach a balanced assessment.

Training and support for using the Trigger Tool and QRPT is available to all QSGs. QSG members should contact their QSG secretariat for more information.

Actions available to local QSGs

123. Where local QSGs have identified quality concerns about a provider or wider system, and escalated monitoring of the provider to "enhanced surveillance", the following actions are available:

- **Keeping the provider under review**. A provider on enhanced surveillance should be considered as a matter of course at each QSG meeting until the QSG agrees that the concerns have been appropriately addressed.

- **Focused discussion with the provider**. Where there are significant concerns, but the QSG agrees that a Risk Summit is not yet merited, QSGs may wish to arrange a focused discussion about the concerns, and action to be taken. This may involve some or all QSG members as appropriate, and would usually involve the relevant provider. This meeting may be referred to as a "Single Item QSG" or a "Risk Review".

- **Actions / investigations by individual member organisations**, e.g. commissioner(s), CQC, NHS Improvement, PHE or HEE.

- **Triggering a Risk Summit**. If there are serious, specific concerns about potential or actual quality failures, including where there is a need to act rapidly to protect patients, public or staff.

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

125. Where concerns are raised about quality in provider organisations that are commissioned by CCGs outside of the Local QSG area, the QSG secretariat should liaise with the relevant QSGs to ensure that these concerns are shared and appropriate action taken.

126. Once quality concerns have been addressed, QSGs should, as appropriate, **return providers to a "routine" level of surveillance**. If a provider has been on enhanced surveillance for more than three consecutive quarters, it is good practice for the local QSG secretariat to review the position, and report the rationale for remaining on enhanced surveillance to the Regional QSG.

127. Local QSGs should update their Regional QSG regarding levels of surveillance and actions taken on a minimum of a quarterly basis. This can be done by sharing the Surveillance Log for information.

Actions available to Regional QSGs

128. As set out in section 2, the function of Regional QSGs is to assure and support Local QSGs, and identify and share issues across the region or country. They should generally

focus on major themes across the region, rather than on individual organisations or services. Regional QSGs can take action in the following ways:

- Assuring and challenging Local QSGs. 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 needed;
- Agreeing actions / investigations to be taken forward by individual organisations, e.g. CQC, NHS Improvement, Public Health England, professional regulators; and
- Triggering a Risk Summit. This will normally be the role of the Local QSG, but there may be occasions where it is appropriate for a Regional QSG to do so.

Risk summits

129. For practical guidance on whether and how to organise and run a Risk Summit, please see the separate National Guidance document.[4]

[4] https://www.england.nhs.uk/ourwork/part-rel/nqb/

11. Recording and communicating conclusions

Output from meetings

130. For each QSG meeting, a meeting note should be produced. This should include attendees and duration of attendance, a summary of key issues/concerns discussed, and actions agreed.

131. QSGs should maintain a running Action Log and Surveillance Log. Basic templates for these are at **Annexes D and E**. For more information on understanding levels of surveillance, see section 10 of this guidance.

132. The meeting 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 on a particular issue, 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, each QSG member will need to consider what steps it should take, informed by the QSG discussions. Care should be taken to ensure that if an organisation has statutory responsibility for a decision or service, the views of that organisation are not overridden if it is in the minority. Any disagreement should be noted, along with any actions committed to by individual members and the reasons for the disagreement.

133. Each Local QSG should produce a short report for the relevant Regional QSG (suggested template at **Annex F**) and each Regional QSG should in turn produce a report to share across regions via the NHS England Quality Assurance Group (standard template at **Annex G**).

134. The purpose of these reports is to share quality intelligence (concerns or good practice), escalate concerns where necessary and provide assurance that mechanisms are in place to identify, manage and escalate quality issues / risks.

Record keeping

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

136. QSGs should be as open and transparent as possible. 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 make vague statements due to concerns about having to disclose information.

137. 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.

138. As there are provisions in the FOIA 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.

Annexes

A: Local QSG – draft model terms of reference

B: Regional QSG – draft model terms of reference

C: Example CCG report to a Local QSG meeting

D: Example QSG Action Log

E: Example Local QSG Surveillance Log

F: Example Local QSG report to Regional QSG

G: Template: Regional QSG reports for sharing across regions via NHS England Quality Assurance Group

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 and supportive forum for collaboration, providing:

- a shared view of risks to quality through sharing intelligence; 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 emerging 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; and
- where is there a lack of information and so a need for further consideration and / or information gathering.

If risks to quality have arisen unexpectedly, the QSG will look back to consider whether lessons can be learned about its own role in quality surveillance.

Scope

The QSG is concerned with services commissioned by the NHS (either by CCGs or NHS England) and with those commissioned jointly by the NHS and local authorities. They also consider services that are commissioned by local authorities from providers of NHS care.

The QSG does not have executive powers and will not:

- performance manage CCGs or any other organisations;
- interfere with the roles of constituent organisations e.g. contractual relationships 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 Director of Commissioning Operations (Chair) , Nursing Director and Medical Director
- CCG Accountable Officers and / or Clinical Lead
- Local Healthwatch representative(s)
- CQC Head of Inspection
- NHS Improvement Regional Manager
- Local Authority representative(s)
- Public Health England Centre Director
- Local Health Education England Director of Education Quality

While it will sometimes be necessary to deputise, organisations will endeavour to field a consistent representative, to maintain a trusting group dynamic where people feel able to share emerging intelligence.

Working Arrangements

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

- providing facilities and technology to support the effective operation of QSG meetings;
- 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 Regional Quality Surveillance Group (Regional QSG) is to systematically bring together the different parts of the system to share information about quality across the region. The Regional QSG will be a proactive and supportive forum for collaboration, providing:

- a shared view of risks to quality through sharing intelligence; and
- opportunities to coordinate actions to drive improvement (respecting statutory responsibilities of and ongoing operational liaison between organisations).

The Regional QSG provides support and assurance to the Local QSGs across the region, ensuring that the network is operating as effectively as possible.

Objectives

In order to support and assure the Local QSGs across the region, the Regional QSG will:

- Consider regular reports from each Local QSG;
- Identify common or recurring issues that may merit a regional or national response; and
- Ensure that those issues are shared across the region or nationally as appropriate.

Scope

In line with Local QSGs, the Regional QSG is concerned with services commissioned by the NHS (either by CCGs or NHS England) and with those commissioned jointly by the NHS and local authorities. They also consider services that are commissioned by local authorities from providers of NHS care.

The Regional QSG will generally focus on major quality themes across the region, rather than on individual organisations.

If risks to quality have arisen unexpectedly, the Regional QSG will routinely look back to consider whether lessons can be learned.

The Regional 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 Regional QSG will include the following representatives:

- NHS England Regional Director (Chair), Nursing Director and Medical Director
- NHS England Directors of Commissioning Operations (Local QSG chairs)
- CQC Deputy Chief Inspector
- NHS Improvement Regional Director
- Local Authority representative(s)
- Healthwatch England, Regional Representative
- Public Health England Regional Director
- Health Education England, Regional Representative
- General Medical Council, Regional Representative
- Nursing and Midwifery Council, Regional Representative

While it will sometimes be necessary to deputise, organisations will endeavour to field a consistent 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.

Working Arrangements

The Regional 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 Regional QSG meetings;
- co-ordinating meeting agendas and papers; and
- providing a record of the discussions and agreed actions, and maintaining suitable records.

Annex C: Example CCG report for a Local Quality Surveillance Group meeting

XXX Local Quality Surveillance Group
Date:
Title: XXX 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 Hospital Standardised Mortality Ratio (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. CCG continuing to work closely with the Trust. 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.

Serious incidents – multiple provider investigations

Acute Trust X, Ambulance Trust Y and Community Trust Z are each undertaking Level 2 Investigations into a Serious Incident (SI), the perinatal death of a mother and baby. Acute Trust X declared the SI, although it is likely that there is learning for all providers involved. Despite the efforts of Acute Trust A, supported by the CCG, none of the other providers involved have been forthcoming in sharing information or agreeing a coordinated approach, and the development of a single investigation report is proving to be challenging.

SUMMARY/RECOMMENDATIONS

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

Annex D: Example Quality Surveillance Group 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 E: Example Local QSG Surveillance Log

Definitions

F	**Further information required**	Further information required to determine when provider will next be considered by the QSG
R	**Routine**	No specific concerns identified. Schedule for routine discussion as part of business cycle
EN	**Enhanced**	Quality concerns identified. Agree actions, schedule for further discussion at each QSG
RS	**Risk Summit**	Serious, specific risk to quality identified

		Previous surveillance levels				
Sector	**Provider or system**	**[Date]**	**[Date]**	**[Date]**	**Current level**	**Actions/Comments**
Acute	X Hospital NHS Trust	R	R	EN	EN	Further information sharing meeting agreed
Community	Y Community Trust	EN	EN	EN	R	Schedule for routine discussion

Please see Section 10 of the QSG Guidance for more information on understanding surveillance levels.

Annex F: Example Local QSG report to Regional QSG

Agenda Item xx
Regional Quality Surveillance Group Meeting

Date:
Title: XX Local QSG report
Paper Author: 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/or regulatory 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 G: Template for Regional QSG reports to NHS England Quality Assurance Group

REGIONAL QUALITY REPORT TO THE
QUALITY ASSURANCE GROUP

For meeting on: DD Month YYYY

Region: North / South / Midlands & East / London

Paper author(s): Insert

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1. PURPOSE

1.1 The purpose of this paper is to summarise the key quality issues, risks and concerns within the region and provide assurance to the QAG that mechanisms are in place to identify, manage and escalate these. These are issues, risks or concerns that the region feel require national escalation and/or wish to share with other regions. [Please note: Regional QSG minutes do NOT need to be attached]

2. FOR NATIONAL SUPPORT AND/OR RESPONSE

2.1 For national escalation within NHSE

2.1.1 Short summary of specific issues, risks or concerns that the region feel require national escalation for national NHSE support and/or response (nationally or across multiple regions). This could include proposed actions, including suggested action owners and timeframes. This section may also include points that the region are seeking further clarity on.

2.1.2 If none have been identified please state "No specific issues, risks or concerns identified for national escalation".

3. FOR THE ATTENTION OF QAG

3.1 Cross-system and/or regional issues

3.1.1 Summary of any cross-system or region issues, e.g. workforce, including the actions agreed and progress against these.

3.1.2 If none have been identified please state “No cross-system or regional issues identified for the attention of QAG”.

3.2 Organisations/Systems at Risk Summit level of surveillance

- **Organisation/System Name** – Summary of quality intelligence on this organisation/system, including the actions agreed and progress against these.

- **Organisation/System Name** – Summary of quality intelligence on this organisation/system, including the actions agreed and progress against these.

3.3 Key Quality Issues in Other Selected Organisations/Systems

- **Organisation/System Name** – Summary of quality intelligence on this organisation/system, including the actions agreed and progress against these. [Please note: Issues should be raised by exception only]

- **Organisation/System Name** – Summary of quality intelligence on this organisation/system, including the actions agreed and progress against these. [Please note: Issues should be raised by exception only]