To: **National Quality Board**

For meeting on: 07 June 2017

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Paper for:

Decision	Discussion	Information
X		

Title: **NQB Review of Quality Surveillance Groups and Risk Summits – final report**

Summary:

This paper sets out findings from the NQB review of Quality Surveillance Groups (QSGs) and Risk Summits, and recommendations for how the guidance should be revised in response.

The review found that QSGs are still widely valued as a mechanism to share intelligence and maintain relationships, particularly given current pressures on the system. As STPs develop, they will need to adapt pragmatically. We recommend that they continue for the coming period, and that revised guidance clarifies their purpose in a changing context.

On Risk Summits, there was a clear consensus that – used very sparingly and intelligently – they are an important tool to have available, to bring the system together very quickly where there is a serious, specific risk to quality.

We will develop briefing for QSGs, summarising the findings of the review, and changes in the guidance. We are also developing plans for facilitating peer support between QSGs, to help QSGs to learn from each other and further improve the way they work.

Purpose:

The NQB is asked to:

1) **Approve** the findings of the review;

2) **Approve** the revised guidance documents (appended).

ALB Involvement in development and sign-off of paper:

NHS England	Care Quality Commission	NHS Improvement	NHS Health Education England
X	X	X	X

Public Health England	NICE National Institute for Health and Care Excellence	NHS Digital	DH Department of Health
X			

ADDENDUM

The final guidance documents were published in July 2017 and are available via the following links:

Quality Surveillance Groups - National Guidance

Risk Summits - National Guidance

NQB review of QSGs and Risk Summits – findings and approach to revised guidance

Purpose of this paper

1. This paper sets out findings from the NQB review of Quality Surveillance Groups (QSGs) and Risk Summits, and recommendations for how the guidance should be revised in response.

Review process

2. The NQB agreed the scope for a review of Quality Surveillance Groups (QSGs) and Risk Summits on 30 November 2016. The aim of the review was to:

- understand how local and regional QSGs and Risk Summits are operating across the country;
- revisit and clarify the purpose of QSGs (both local and regional) and Risk Summits, refreshing the common principles that should be in place;
- share best practice on how QSGs and Risk Summits can be effective in achieving these purposes; and
- develop updated national guidance reflecting findings.

3. A working group was established for the review with representation from all QSG member organisations (NHS England, CQC, HEE, Healthwatch, NHS Improvement, Public Health England, the GMC and NMC). LGA and ADASS are representing local authorities, and the General Pharmaceutical Council are included to give a perspective from a regulator who does not attend QSGs.

4. A survey was cascaded through QSG secretariats to all local and regional QSG members. It was open for three weeks, and 181 responses were received, representing all QSG member organisations except for the NMC. All four regions were represented, including at least one response from every local QSG.

5. Observation of QSG meetings and Risk Summits. The review team attended meetings of all four regional QSGs, and at least two local QSGs in each of the four regions. The team also attended a Risk Summit in the Midlands and East, and a Quality Improvement Group meeting in the South.

6. Interviews. We undertook structured conversations with over sixty individuals representing a wide sample of stakeholders. This includes people attending local and regional QSGs across all members organisations, as well as non-QSG stakeholders including provider chief executives and directors of nursing, safeguarding board chairs and other local authority colleagues.

7. Risk Summits. To assess the impact of Risk Summits, the working group conducted a retrospective review of the Risk Summits which took place over the last year.

8. Publication of revised guidance. The review working group has now provided final comments on the guidance documents. We are aiming for publication in early July.

9. Communicating findings to QSGs, and additional support. Over the coming weeks we will develop briefing for QSGs, summarising the findings of the review, and changes to the guidance. We are also developing plans for facilitating peer support between QSGs.

Findings and recommendations

10. This section sets out major findings from the review and the approach to revised guidance.

Purpose of QSGs in the current system context

11. Many QSG members told us that they value QSGs for sharing intelligence and maintaining relationships. People also expressed concern about whether QSGs have an impact commensurate with the resource involved, including a small minority who suggested that QSGs should be discontinued. On balance, the consensus was that the value of QSGs as an intelligence-sharing forum should not be underestimated: that there is an inherent value to a stable, ongoing mechanism that brings the system together to focus on quality. There was a view that QSGs could become more important as pressures on the system grow.

12. However, people are also aware that as we move in the direction of whole-system, place-based integration and planning, QSGs will need to adapt. In particular, they will need to move towards greater provider involvement. But, in line with the vision for STPs and ACSs in *Next Steps for the Five Year Forward View*, this should be a pragmatic, staged process of change. Boundaries of QSGs and membership should flex according to local circumstances. We are already seeing this in some places. For example, Greater Manchester's QSG has changed its terms of reference to cover both NHS and local authority-commissioned services, and is increasing provider involvement by adding the GM Provider Federation to its membership. It should be noted that some people felt, given considerable change and pressure in the system, that QSGs could also offer some stability.

13. Given this, our recommendation is that QSGs should continue, with revised guidance refreshing the purpose in the current context, and with the expectation that the QSG model will adapt pragmatically as STPs develop. We should also be mindful of the increased risk to NHS services in periods of transition, such as we are entering with STPs. QSGs should consider particular risks that may arise through transition, including quality risks arising from major service reconfiguration.

14. Locating QSGs within the wider quality framework. We also recommend revising the QSG guidance in line with the Shared Commitment to Quality. QSGs are a key element of step five of the seven steps to quality (maintaining and safeguarding quality). This helps to clarify that while QSGs focus on risks to quality, they are part of a wider framework that focuses on improvement.

Local QSGs – effectiveness

15. Many local QSG meetings are well-chaired, well-attended, purposeful and engaging meetings. Some are less so. As with any mechanism of this kind, the effectiveness of the meeting is greatly dependent on the skill and capacity of the chair and the group, and the relationships between members.

16. To ensure that (where appropriate) concerns raised at QSGs are acted on, QSGs need to be clear about what each organisation brings. There should also be clarity about which issues should – and should not – be brought to QSG. If regular "business as usual" meetings (between commissioners and providers, commissioners and regulators, safeguarding partners etc) are working well, then only when these partnerships cannot resolve an issue does it need to come to QSG. In well-functioning QSGs, members bring issues by exception: i.e. where an issue requires action by more than one organisation to resolve. The role of the QSG is then to agree this, and ensure that actions are followed up.

17. Doubt has been expressed as to whether QSGs can be said to act as an "early warning system" given the timing of meetings and available data. (That is, the data and intelligence available to QSGs cannot reliably identify providers performing well but at risk of problems. They can, however, identify problems as they arise and bring a rapid system-wide response to these. QSGs are not realistically able to predict problems, but aim to mitigate their impact). Revised guidance should emphasise intelligence sharing and triangulation. Where routine surveillance is well-established outside QSG meetings, it may be appropriate for QSGs to shift their focus to thematic work.

18. In order to maintain a focus on effectiveness, QSGs should routinely look back when issues arise unexpectedly, to consider if anything was missed, and what can be learned.

Regional QSGs – effectiveness

19. There are marked differences between the style and atmosphere of the four regional QSGs. It may be useful for regional QSG chairs and secretariats to attend meetings in other regions to compare practice. In terms of the guidance, we should clarify the purpose of regional QSGs – in particular that they should focus on major themes across the region, rather than individual organisations. More clarity is also needed on effective escalation from local to regional QSGs.

Scope and focus

20. Most QSGs cover all sectors of NHS-commissioned services in their discussions; but in many the focus tends to be more on large NHS Trusts, and less on primary care and care services – in part due to availability of data, and the difficulty of covering large numbers of small providers. The current guidance asks QSGs to produce a business cycle/plan of themed discussions, which includes the requirement to ensure focused discussions on all sectors over the course of a year.

We propose increasing the emphasis on thematic discussions in the revised guidance.

21. However, in practice the skew of focus towards large trusts is likely to remain an ongoing challenge. We are considering how QSGs may need to be supported on this. One option could be to ask QSGs to appoint a lead member for primary care, children, social care etc, who takes responsibility for ensuring due consideration of these areas, and leading the thematic review.

Membership

22. Organisations. There is general consensus that the current organisational membership of local and regional QSGs is appropriate. Local authority attendance remains patchy (this is discussed at para [XX] below). A number of organisations who do not currently sit on QSGs have expressed an interest in having a route to feed in / hear from QSGs, including wider professional regulators (see para [XX] below) and the NHS Litigation Authority (now NHS Resolution). The current guidance gives flexibility for QSGs to include other members according to local and regional circumstances – this should be re-emphasised.

23. 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 be attended by representatives of the professional regulators, and would feed concerns into QSGs as appropriate.

24. There is a specific question about how STP leaders should be involved in QSGs. Again, we recommend local flexibility on this. QSG chairs should work with STP leaders to find a pragmatic solution, which we would expect to evolve over time.

25. Involving providers. Some provider representatives expressed frustration that QSGs discuss risks without involving them. However, others said they understood the value of commissioners and regulators meeting without providers in the room. There is also understanding that the number of providers within any QSG area would make the logistics of routinely involving providers in all QSG meetings impractical. Since 2014, one way in which QSGs have increasingly involved providers is through Single Item QSGs (called Risk Reviews in the Mids & East). These are meetings involving the provider where the QSG has a specific quality concern, but are short of a formal Risk Summit.

26. The current guidance states that where a QSG draws conclusions about quality risks at a provider, the provider should be informed. This does not appear to be routinely happening (if QSGs do not decide to call a Single Item QSG), and we will clarify this requirement with QSG chairs.

27. Individual representatives. There seems to be a somewhat widespread issue that individuals who attend QSGs are not always adequately briefed across the whole of their organisation's remit. For example, we have heard that some CQC hospital inspectors are unable to comment on the care home or primary care sectors; and some CCG representatives aren't briefed on issues raised at safeguarding boards. All QSG member organisations should ensure that internal mechanisms are in place to ensure that the QSG representative is able to fully speak on behalf of the whole organisation. We will also emphasise the importance of one person acting as a regular representative, to maintain trust within the group.

Working with Local Government

28. Very few QSGs have consistent Local Authority attendance. Many LA representatives who have attended QSGs have felt that they have little to contribute to the discussions, as meetings are largely NHS-focused. The footprint of QSGs (both local and regional) generally do not correspond to local authority boundaries, and LA representatives feel unable to adequately represent or have detailed knowledge of NHS-commissioned services beyond their own LA area.

29. As we move towards greater integration through STPs, we might expect LA involvement in QSGs to further evolve. However, during transition, the review working group agreed that it was unrealistic to expect LAs to send a representative to every QSG meeting. Instead, we propose asking QSGs to ensure:

- a clear route for LA concerns about quality to be fed into the QSG on an exception-reporting basis;
- clear triggers for when LA representation is needed; and
- strong ongoing relationships between QSG chairs and LA leaders with responsibility for oversight of quality, including safeguarding boards, health and wellbeing boards and health overview and scrutiny arrangements.

Role of NHS England in facilitating QSGs

30. We have seen examples of excellent chairing by NHS England colleagues, as well as excellent note-taking, which makes a real difference to the efficacy of the group. Good chairs frame the discussion as confidential, and draw all partners into the discussion. We have also seen less-good examples, and clearly there will always be variation.

31. Thematic discussions were widely reported by QSGs to be a helpful way to consider quality and risk.

32. Many QSG members have asked if meeting papers could be reduced, and circulated further in advance. This is clearly something to work towards, but we recognise that creating a shorter pack may take additional time and skill, and that secretariats have conflicting pressures.

33. Questions have been raised about the frequency of meetings, the appropriate footprint for QSGs, and how far these issues should be left to local discretion. Most local QSGs are still meeting formally every two months, and regional QSGs every

three months. The London regional QSG has moved to meeting three times a year. A number of QSGs have merged or changed boundaries since 2014. Some secretariats have suggested moving to a six-monthly meeting across a larger area, with more regular QSGs on STP footprints. As above, we recommend that this is left to local discretion.

34. Publication scheme. The current guidance asked QSGs to produce a publication scheme, setting out what information would be routinely published. In practice, this never took off, and QSGs have not routinely published papers or information. Pragmatically, we propose deleting this requirement in the revised guidance.

Data and information

35. The survey identified a number of concerns about data. However the review as a whole did not indicate a need for fundamental changes to the Acute and Mental Health Quality Dashboards produced by NHS England regional analysts. There are variable levels of awareness and use of the Dashboards across the country, but those QSGs who do use the dashboards find them to be a useful routine monitoring tool. The dashboards can currently be thought of as a kind of safety net – a snapshot at one point in time across a decent range of indicators. Analysts are thinking about how to move towards a more pro-active early warning system, looking at trends and patterns over time to spot deterioration.

36. The Quality Risk Profile Tool (QRPT) developed in the North has been found to be a useful way of creating a shared understanding of risk in a single organisation, when concerns have not been mitigated through other routes. NHS England analysts will be working with the North regional team to ensure that the tool can be supported by consistent data through quality dashboards, to complement local soft intelligence.

37. The NQB Measuring Quality Group is also considering how NHSE, NHSI and CQC can have a more efficient approach to using data and measurement. Progress in this group will inform the actions outlined above. We recommend that revised guidance indicates a direction of travel on data as above, and that the current dashboards continue broadly as they are for the time being, with further development driven by cross-system alignment and user needs.

Assessing and responding to risk

38. Consistency and clarity around assessing and responding to risk is something that all QSGs have been grappling with.

39. On methods for assessing risk, many QSGs are now using the Quality Concerns Trigger Tool and Quality Risk Profiling Tool (QRPT), and are finding these helpful. The Midlands and East region have, separately, developed an escalation process which focuses on risk-based assessment and allows partners to raise system issues as well as issues with a particular organisation. We propose adding information on the QRPT to the revised guidance, and requiring that, where the

QRPT is not used, that local QSGs should ensure that similarly robust processes for assessing risks to quality are in place.

40. On what action QSGs should take when quality concerns are identified, challenges have included:

- ensuring a common understanding within and across QSGs of the meaning of different “surveillance levels”;
- clarity around what actions QSGs should consider when quality concerns have been identified, and monitoring of the provider or system is escalated to “enhanced surveillance”;
- ensuring that monitoring is returned to a “routine” level of surveillance, once quality concerns have been addressed (and that providers/systems do not stay indefinitely on “enhanced surveillance”).

41. We propose redrafting the guidance to clarify definitions where possible, while maintaining an emphasis on the importance of local judgement.

Risk Summits

42. All regions have seen a reduction since 2014 in the number of Risk Summits they call. In 2016, London, the South and Mids & East each held five Risk Summits, and the North held three. With regional colleagues, we reviewed the impact of all 18 Risk Summits which were held during 2016. In 15 cases, QSG chairs were confident that it had been right to call a Risk Summit. In the remaining three cases, it was judged that they might better have been managed as a Single Item QSG.

43. The review found a clear consensus that it is useful to retain Risk Summits in their current form, to ensure that we have a mechanism available to bring the system together very quickly where there is a serious, specific risk. There is also consensus that Risk Summits need to be used sparingly and intelligently in order to preserve their impact. We propose updating the Risk Summits guidance on this basis.

44. Currently, risks to quality are generally assessed at the level of single providers. We also propose redrafting the guidance to shift the focus from providers towards systems. As Sustainability and Transformation Partnerships develop and boundaries between providers and commissioners evolve, the way that local systems approach Risk Summits will need to be flexed pragmatically.

45. However, even while the focus often remains on single providers, it is important to be clear that, although risks to quality may *manifest* in one provider, both the causes and the solutions are usually system-wide, and Risk Summits should be approached by all parties on this basis. The guidance should emphasise that they are a mechanism for different parts of the health and care system to come together to find system solutions.