Joint ADASS, ADPH, LGA and SOLACE response to the review of Quality Surveillance Groups

Introduction

This is a joint response from the Association of Directors of Adult Social Services (ADASS), the Association of Directors of Public Health (ADPH), the Local Government Association (LGA) and the Society of Local Authority Chief Executives (SOLACE). Collectively, ADASS, ADPH, LGA and SOLACE represent the key professional and political leaders in local government and as such, we consider that a joint response will reinforce our observations on QSGs in their first six months of operation.

We welcome the opportunity to contribute to the review of Quality Surveillance Groups (QSGs) and hope that our shared views make a positive contribution to NHS England's understanding of the effectiveness of the QSG model and how it could be more effective and to ensure appropriate support is being provided by the system.

We have provided responses to some of the questions that are specifically addressed to local government and added some general observations based on local government experience QSGs in their first six months of operation. Our response is drawn from our collective 'soft intelligence' from the local government sector.

Added value

Many local government participants in QSGs welcome the opportunity to exchange information about local services. For example, some QSGs have considered system-wide issues such as children's services and residential care homes, albeit on a superficial basis that did not result in agreement on action required. Some local authority representatives consider that QSGs play an important role in relationship building between local government, CCGs and PHE.

We recognise that the QSG model is relatively new, as are many of the participating organisations. It is inevitable that they will take time to develop a clear and shared view of their role and purpose. The message from the local government sector is that there is a wide degree of variation in their effectiveness. But we are clear that they must do more than simply bring together all those who currently have responsibility for quality and safety for an area far wider than most local authorities. We seriously question whether QSGs add value to existing mechanisms for ensuring quality and safety of health and social care services. Moreover, we also question whether such duplication of roles represents the best use of public resources: given the number and seniority of people involved in QSGs, this will be a significant cost.

It would be helpful, therefore, if NHS England could provide examples of good practice to demonstrate that QSGs have successfully identified and addressed quality and safety concerns, or referred previously unknown quality

risks to appropriate existing channels, for example local safeguarding boards. It would also be helpful for examples of good practice to show how QSGs have contributed to improving quality on a system-wide basis.

One area where QSGs could add value is in ensuring that information is shared across CCGs and local authorities that are covered by some of the large NHS providers. Patient flows often cross QSG boundaries (especially outside London) and quality issues within London need to be understood by areas outside.

One final point on added value, it is important that each QSG agrees a small number of priority areas for attention. Some QSGs have taken this approach but all need to be more discriminating and analytical in focusing on what needs to change to improve quality by drawing on quantitative and qualitative evidence to support their priorities. Otherwise, there is a danger that QSGs offer false reassurance through simply existing.

Clarity of purpose of QSGs

We appreciate that QSGs were established as part of the response to the system-wide failure to identify and address poor quality raised by the Francis Inquiry. We share a commitment to working with partners on a whole-system basis to improve quality. But further work is needed to clarify their role and remit in relation to existing structures for addressing quality and safety issues. We strongly recommend that NHS England work with stakeholders, including local government, to reach a clear understanding of the purpose of QSGs before endorsing their continuation.

Further clarification is necessary on the following issues:

- **Primary purpose of QSGs** – there is a lack of clarity as to the primary purpose of QSGs. Should they be the first responder to crises in relation to poor quality or are they merely an opportunity to share information about system-wide quality issues? Local government representatives reported that, in their experience, QSGs were effective in sharing information but that their first responder role was less well developed and understood.

- **Integration** – the renewed drive for integration provides an opportunity for QSGs to be the principal driver of system-wide understanding of 'what good looks like' in quality and what needs to be done to ensure consistent quality of health and care services. Increased integration means that we will require mechanisms that span health and social care. But such mechanisms will need to recognise and be responsive to differences between NHS and local government – including differences in geography or more complex issues such as developing an agreed model for improvement. Currently, local government and the NHS operate very different approaches to improvement support (the section on Local Government Improvement Activity addresses this issue in more detail) and this difference needs to be fully understood and respected.

- **Quality and safeguarding** – QSGs and their constituent bodies need to have a clear and shared understanding the distinction between issues of quality and issues of safeguarding (the section on Safeguarding addresses this issue in more detail)**.**

- **Principal of subsidiarity** – We believe that QSGs should adopt the principle that QSGs should perform only those tasks which cannot be performed effectively at a more immediate or local level. Some QSGs have adopted this approach: for example, one county authority encourages collaboration between local CCGs and local authorities to address quality concerns locally rather than escalating to the regional level. However, this appears to be an isolated example and we would welcome further guidance that QSGs should adopt the principle of subsidiarity.

- **Accountability** – there needs to be greater consideration of and clarity about the accountability of QSGs. What are QSGs are accountable for exactly, and to whom? This is especially the case for QSGs covering large geographical areas with several participating CCGs and local authorities.

Relationship with existing structures

We consider that it would be useful for all local stakeholders to have a clear and shared picture of all the organisations and structures locally for improving quality. Some health and wellbeing boards have already taken a strong lead on this. For example, one health and wellbeing board has undertaken an audit of all local mechanisms for improving quality to ensure that they are coordinated and that they do not duplicate activity. We strongly advise the NHS England to provide a 'quality improvement' map to support QSGs to understand how they relate to existing structures and processes.

- **Local Adult and Children Safeguarding Boards –** In many areas there appears to be significant duplication between the role of Local Adult and Children Safeguarding Boards and QSGs. We are clear that if an individual is at risk, the channel for action is through appropriate referral for investigation and oversight via Safeguarding Boards**.** Their role is to ensure that there are agreed local policies and procedures that set out how referrals are made. Furthermore, safeguarding enquiries should take priority over QSG processes as the parameters of these are well established. Local Safeguarding Boards have agreed standards which are well understood between relevant agencies and enable consistent implementation of safeguarding enquiries. Furthermore, they are the place where all strategic, policy and procedural issues to do with the local safeguarding system reside.

- There is considerable scope to improve the system understanding of when cumulative quality concerns become legitimate and appropriate concern of safeguarding boards rather than QSGs. ADASS and CQC are developing

an approach to this which, when completed, will be shared with all partners.

- Safeguarding enquiries operate at an individual level rather than a whole population or whole hospital level. Furthermore, it may be more appropriate for Local Safeguarding Boards to take on responsibility for support the quality of care in the providers of health care in its local area.

- **Health and wellbeing boards (HWBs)** – As the key vehicle for driving health improvement for local areas and promoting integration, HWBs need to be fully involved in discussions on quality of local health and care services. Moreover, the priorities in the joint health and wellbeing strategy will inform local commissioning plans for all health and care services, including any concerns on quality.

- **Health overview and scrutiny** – Local authority overview and scrutiny has an important contribution to play in raising quality issues in health and social care services and may have information about quality concerns. It would be helpful for the QSG to establish contact with relevant overview and scrutiny committees and provide them with an opportunity to participate. Though this may be happening in some areas, we have not been able to identify any examples of overview and scrutiny involvement.

- **CQC** – The relationship between QSGs and CQC also needs to be better explained and developed.

Furthermore, there is a lack of clarity on what power, authority and resources do QSGs have to address any underperformance or quality concerns.

Representation

Representation on QSGs presents a real challenge for local authorities. We acknowledge that local authority representation is variable, with some QSGs reporting strong and consistent local authority representative while others have reported poor local authority representation. The geography of QSG is problematic as QSGs cover several local authorities and does not correspond with the local government regional groupings. For example, one local authority chief executive reported that her local QSG covered eight local authorities. In other areas, each local authority is invited to send a representative, which means meetings are too large for any meaningful discussion and resolution of quality issues. Another local government representative reported that the large size and constantly changing representatives on QSGs meant that it was difficult to develop a shared understanding of their purpose.

In most cases, there will be only one or two local authority representatives in a large group, which is often dominated by discussions on medical issues, to which local authority representative feel that they can make little meaningful

contribution. Equally, supporting papers for QSG meeting can be inaccessible to participants that come from outside the NHS.

We acknowledge that local authorities need to work on a collaborative basis to provide representation at QSGs, with local authorities covered by the QSG area taking shared responsibility for attending meetings, reporting concerns and feeding back decisions, though this may be difficult to achieve in some areas such as London. But this will only address some of our concerns regarding local authority representation and contribution.

We have identified several concerns regarding representation of particular groups, organisations or professional interests. Again, the picture is patchy but our overall impression is that the following groups are under-represented on QSGs:

- **Healthwatch** – We recognise that local Healthwatch organisations are relatively new and are developing their role and relationships. However, the local Healthwatch representatives may need support and information to make an effective contribution to QSGs. Clearly, Healthwatch England has a role to play but QSGs need to value and encourage the contribution from representatives of patients and the public.

- **Elected members** – In a minority of areas elected members have attended QSG meetings but their role and contribution needs to be better understood by other QSG participants. Lead members for adult social care, children's and young people and chairs of HWBs (the majority of which are senior elected members) have responsibility on all aspects of system leadership and improvement, including quality, and as such need to be involved in discussions about quality concerns.

- **Director of public health (DsPH)** - In some areas, DsPH are well represented and make a useful contribution to QSGs. However, the general picture is that DsPH have not been invited to QSGs and often have no connection with them. They are responsible for mandatory public health functions, many of which are provided by local health trusts, and as such they should be core QSG members. This is particularly crucial in areas where there are concerns about the quality of local authority commissioned public health services.

- DsPH also support providers and commissioners (e.g. CCGs) with population healthcare services advice and expertise and, therefore, need to be closely involved in service quality discussions.

Local authority commissioned services (adult social care, children's services and public health)

We agree that QSGs have the potential to make a useful contribution to identifying and raising concerns about local authority commissioned (and, in some cases, provided) services where these concerns cross several local

authority boundaries. Local authority commissioners have well established processes for addressing quality issues and these should take precedence where the issue occurs in a single local authority area. Moreover, we have an established agreement at national level with the Department of Communities and Local Government that all concerns about the quality and performance of local authority services (with the exception of some clinical public health commissioned services such as sexual health) will be referred to the LGA to be addressed through our sector-led improvement and support activity.

Finally, there needs to be recognition of the financial context for health and social care services, which may lead to services being reduced or decommissioned entirely. It is important that QSGs do not become a 'lobbying forum' around prioritisation of local authority commissioned services.

Jointly commissioned services

The drive to greatly escalate and the scale and pace of integration, primarily through the Integration Transformation Fund, is a real opportunity for QSGs to facilitate a shared understanding of what needs to be done on a system-wide level to improve quality. In order to do this, QSGs will need to develop a clear appreciation of how integration of services, or the lack of it, impacts on the patient and public experience of services and their perception of service quality.

With greater integration and the growth of jointly commissioned services comes the need for greater clarity on who is accountable for quality of services, and which improvement and support stream (local authority sector-led improvement or NHS England regional improvement activity) should come into play.

Local government quality improvement activity

Local government has developed a sector-led approach to supporting councils to improve commissioning and provision of services. The approach is widely supported by political and professional leaders in councils who endorse the key principles, on which it is based, that:

- councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area

- councils are primarily accountable to local communities and stronger accountability through increased transparency helps local people drive further improvement

- councils have a collective responsibility for the performance of the sector as a whole

- the role of the LGA is to maintain an overview of the performance of the sector in order to identify potential performance challenges and opportunities – and to provide tools and support to help councils take advantage of this new approach.

The ethos of sector-led improvement does not sit easily alongside a regime where concerns are escalated for regional consideration and actions are imposed from above. The review of QSGs needs to consider the interface between QSGs and sector-led improvement and the way in which this is being established and led in each region.

Examples of good practice

We agree that examples of good practice that demonstrate the added value of QSGs would be useful. Any revised guidance should, therefore, include examples of good practice, and clearly explain the respective responsibilities and contributions of health and wellbeing board, overview and scrutiny, local safeguarding boards and patient and public voice in improving quality.