

Health and Care Quality Systems in practice

A guide for local leaders

Foreword

Improving the quality of the health and care for our citizens is a priority for us all and there are many organisations at national, regional and local level that have responsibilities for oversight and improvement of quality. We have produced this guide for system leaders to navigate this sometimes complex landscape and to ensure that they understand how they can make the most impact on driving up quality. The provider landscape is also changing as the drive for integration, personalisation and choice continues.

As chair of my local health and wellbeing board and Chair of the Local Government Association's (LGA) Community Wellbeing Board, I understand that vital contribution of regulators, providers and advisory groups in local oversight of quality. They can use their networks and contacts with communities – especially those that are least often heard – to provide the local health and care system with a unique user perspective on the quality of local services.

The health and care system in England has recently been through significant change at a national and local level, as have those elements focussed on quality. Whilst the component parts of the system to assure quality are now beginning to settle, understanding how the system works can still be quite challenging. We hope this guide will help leaders in the system and their partners understand their role in the local systems and maximise their effectiveness.

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Executive summary

Quality is 'everyone's business' and different players have different roles in the system. This guidance suggests that the key to success is to ensure effective coordination at local level, whilst making sure everyone is doing their own job well.

There are many ways of achieving this, and of ensuring wide involvement of local people in this work; this guidance, and the materials linked to it, are intended to give prompts and examples for local leaders who have responsibilities in this area.

The checklist below summarises the responsibilities of different local groups and agencies – and might help in the design of your local quality system.

Checklist

All those with leadership responsibility at local level should:

- champion the importance of good quality services
- champion the importance of providing channels for people to feed back about their experience, and listening to their views and embed co-production as a principle when designing services
- promote a culture of openness and continuous learning, amongst all the relevant organisations
- challenge provider organisations about their internal quality assurance processes and ensure they are accountable to the public
- challenge commissioning organisations about how they are monitoring quality, and ensure they are accountable to the public.

Health and wellbeing boards (HWBs) should:

- make themselves aware of how quality is being monitored locally, and of the priority issues and concerns in their locality
- where necessary, ensure action is taken and reported on those priority issues,
- ensure a joined up approach, and good information-sharing, between agencies
- be aware of the work of the quality surveillance group for their area – which coordinates quality assurance activity for the NHS
- identify the priorities for fuller scrutiny (eg by Healthwatch and/or the overview and scrutiny committee).

Local Healthwatch should:

- keep in touch with local people's experience of services
- channel information from networks of voluntary and community groups, identifying any key themes or trends
- alert commissioners and planning and scrutiny bodies (including the health and wellbeing board and overview and scrutiny committee) to any significant concerns
- carry out bespoke research into people's experience in priority areas, having consulted about what these priorities are
- report to local providers, commissioners and planning and scrutiny bodies on their findings.

Overview and scrutiny committees should:

- act as a 'bridge' between politicians, professionals and the local community, so the voices of local people are heard and responded to
- consider whether new local policies and planned service changes will work in people's best interests
- check on how these policies and change programmes are working in practice
- carry out proactive qualitative reviews to inform policies and services
- in doing so, ask Healthwatch and other community voice and patients' organisations to help gather people's views
- make recommendations to local organisations including the HWB, the council and NHS and ask them to respond to these recommendations.

To help put this work into practice, this guidance is supported by three annexes.

Annex A looks at five major health and care services; in each case, it explains who is involved in assuring the quality of these services, and suggests useful questions that could be asked by those responsible for the strategic oversight and scrutiny of those services.

Annex B gives two case studies of where overview and scrutiny committees have developed their work and improved their partnership working.

Annex C details about legal frameworks and accountabilities.

1. Introduction

‘Quality...is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system.’

National Quality Board 2014¹

This statement from the National Quality Board sums up what is needed for quality to be assured.

Those involved in delivering health and social care have the primary responsibility for ensuring that their own services are of good quality. However, to provide extra assurance to the public, other agencies and bodies are required to carry out checks – or provide oversight and leadership – to make sure that people whose circumstances make them vulnerable (whether in a hospital, care home or their own home) are receiving high quality care.

This publication is intended as a practical guide for people who have leadership and oversight responsibility for the quality of services in their communities. It is designed for anybody who is exercising new responsibilities in relation to the quality of their local services.

This guide looks at and describes:

- what ‘quality’ means
- which national and local organisations are involved in assuring quality, and their roles and responsibilities
- how local quality assurance can work.

It suggests questions that local leaders should ask about how their local system is currently working, and illustrates ways of making local systems more effective. It is supported by more detailed information to help those responsible for strategic oversight or scrutiny of five specific services and by case studies.

Local partners also have responsibilities and duties to ensure that people in their area are protected from serious quality failures, including neglect and abuse. There are other resources available to support local areas develop the ways in which quality improvement processes interface with safeguarding activity.

2. What is quality?

‘In care and support, quality starts from what matters most to enable people to live their lives in the way they want.’

Think Local Act Personal 2013

A useful guide² on this subject by the ‘Think Local Act Personal’ (TLAP) national partnership provides an essential starting point for understanding ‘quality’. Health and care services cater for a diverse range of people of all ages, in a huge variety of settings. A ‘one size fits all’ approach cannot work, since people’s expectations and wishes vary so considerably.

On the other hand, the national definition of quality in the NHS Constitution has three main dimensions:

- **Individual or patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible. This includes recognition of the person’s own aspirations and preferences, and being treated with compassion, dignity and respect.
- **Effectiveness** – quality care is care that is delivered according to the best evidence

as to what is effective in improving an individual’s outcomes. (For health services, this encompasses the notion of ‘clinical effectiveness’ – the treatments and interventions that are proven to work best, delivered in the right way.)

- **Safety** – quality care is care that is delivered so as to prevent all avoidable harm and risks to the individual’s safety (whilst allowing people to retain maximum personal control).³

In practice, many services either develop their own quality standards or adopt standards prescribed by others, such as the National Institute for Health and Care Excellence (NICE). What these agencies tend to have in common is their emphasis on ‘person-centred’ approaches – understanding that ‘quality’ is ultimately about being responsive to each person as an individual.

‘Foster a common culture shared by all in the service of putting the patient first.’

Francis Report 2013

3. Quality as ‘everyone’s business’

‘Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.’

Berwick Report 2013

Although all organisations need standards, systems and processes to ensure quality, there is widespread recognition that quality improvements depend largely on the culture of organisations – the attitudes, behaviours and practices of managers and staff at all levels.⁴

To continuously improve quality (and to safeguard patients and users), health and care organisations should be open to feedback, and willing to learn from it.

Specifically, they should:

- seek out the patient, user and carer voice – and use this to inspire improvements
- be transparent about their quality and safety record – making data and information available in an accessible form to the public
- welcome external challenge and be committed to continuous learning.

Within local communities, several agencies and bodies (including health and wellbeing boards, Healthwatch and overview and scrutiny committees) are charged with responsibility for organising and offering this feedback and challenge. These agencies are collectively responsible for ensuring that local systems develop in a way that delivers high quality care and support.

Most importantly, perhaps, they are responsible for listening to the voices of people using services and should be committed to ensuring those voices are heard by those responsible for planning, managing and delivering care in order to embed real co-production of services into the system.

4. Which organisations and agencies are responsible for ensuring quality?

A range of national, as well as local, organisations play a role in the new quality system. A useful Quality Initiatives Map of these organisations (and associated initiatives) has been developed by TLAP.

An adapted version of this map – focussing on the key **local** agencies – is set out in **Table 1** below. A fuller description of the roles and activities of the main local players, and of how they inter-relate, is included in **Annex B**. More detail about their legal frameworks and accountabilities is included in **Annex C**.

Several **national agencies** have responsibility for setting and enforcing standards in health and care, including the statutory regulators of services, and the regulators responsible for particular professional groups.^{5,6}

For example, the Care Quality Commission (CQC) publishes standards and frameworks for assessing all its registered services; its ‘fundamental standards’ are reproduced in **Annex A** of this document. All of CQC’s inspections ask whether services are: safe, effective, caring, responsive, and well-led.

Local partners work alongside the providers and the CQC in taking responsibility for the quality of provision. Local leaders can play a key role in reinforcing the need for collective responsibility for the quality and safety of services locally.

HWBs in particular can help build the system leadership to ensure that every local partner is clear what their responsibilities are and communicates how the national and local system works for local people.

Table 1. The key players in the local quality system

Providers	Commissioners
Examples <ul style="list-style-type: none"> • NHS foundation trusts • NHS trusts • Primary care • Local authorities • Private and voluntary agencies • Social enterprises 	Examples <ul style="list-style-type: none"> • NHS England • Clinical commissioning groups (CCGs) • Local authorities • Individuals using Personal Budgets/ Personal Health Budgets or their own money
Key activities <ul style="list-style-type: none"> • having effective governance and decision-making processes • implementing quality assurance processes • working with patient liaison groups (including Healthwatch and Patient Advisory Liaison Services (PALS)), and maintaining effective customer feedback mechanisms • collecting and publishing quality data to increase transparency and choice, and to use as a driver for improvement 	Key activities <ul style="list-style-type: none"> • engaging with local people to plan services in a locality • commissioning sustainable services of high quality • contract monitoring • voluntary accreditation schemes • purchasing services to meet personal needs (within agreed care plans)
Regulators	Planning and advisory bodies
Examples <ul style="list-style-type: none"> • CQC • Ofsted • Monitor • Trust Development Authority (TDA) 	Examples <ul style="list-style-type: none"> • HWBs • Healthwatch • Overview and scrutiny committees • Safeguarding boards • Quality surveillance groups
Key activities <ul style="list-style-type: none"> • Registration • Inspection • Enforcement of standards • Oversight of performance 	Key activities <ul style="list-style-type: none"> • giving a voice to patients and users • ensuring public accountability • scrutinising outcomes and patient experience – to influence policy and service design • considering evidence on the quality of care services • developing and reviewing safeguarding plans • identifying and escalating risks and concerns

5. Ensuring an effective local system

With so many agencies having a role to play in assuring quality, there is potential for confusion and overlap.

However, multi-agency boards (such as HWBs) are well placed to ensure the development of a coherent and effective local system, in which each agency understands their unique contribution and how they can work with each other.

An obvious early imperative is to map your local landscape, by (a) identifying the main organisations responsible for quality, (b) understanding the services they are responsible for, and (c) understanding the methods they use and the evidence they

collect. In practice, HWBs might wish to work with their local Healthwatch to establish what evidence exists and how this is routinely collected.

TLAP have produced 'Making it Real'⁷, a framework co-produced with people who use services to embed a culture of co-production into the way that services are designed and commissioned, capturing the input of people who use services throughout this process to ensure that services are high quality and meet their users' needs.

Useful questions

Which local organisations and advisory bodies fit into our local quality system?

How does each organisation monitor quality, and what standards and measures do they use?

Specifically:

- How well does each organisation gather and use the experience and insights of patients and people who use services? (What methods do they use to find out what people think?)
- How does each organisation respond in cases where a patient, service user, carer or member of staff expresses a concern (or makes a formal complaint)? (What policies and procedures are in place?)

- How do they report on quality, and to whom? (Are their reports publically available and accessible – and if not, why not?)
- Who holds them to account, and how? (See the quick guide in Annex C.)⁸
- Do some parts of the system benefit from better quality assurance than others?
- Are there common themes and issues (or particular services) that are currently of concern in our locality?
- Is your local area signed up to the 'Making it Real' markers to demonstrate a commitment to engaging local communities, people who use services and carers in the design, development and delivery of local services?

6. Agreeing priorities and avoiding duplication of effort

This initial mapping should give you a clearer picture of the systems and methods currently being used to assure the quality of care and support in your locality. It might also surface evidence about services or areas where there are currently concerns, and give ideas about priorities to focus on.

One reason why it is important to start by taking stock is that there is some risk of duplication between agencies. In most areas, you will find that there is already a lot of quality assurance activity going on – exercised through various forms of scrutiny, regulation, and contract monitoring as well as via organisations' internal processes.

Where external agencies (such as regulators) are not adequately coordinating their activities – or where different commissioners are monitoring the same service but not sharing their findings – service providers can sometimes feel overwhelmed by their requirements. (These problems can be exacerbated in cases where services straddle local authority boundaries, and are therefore subject to scrutiny by more than one council and Healthwatch organisation).

In such a context those with local leadership responsibilities need to 'add value' to the system, by considering the unique role they can play, separately and together. Ensure that:

- services have a proportionate amount of scrutiny
- all services are included in scrutiny of quality, including specialist services for people who cannot express their own views easily, or people whose support needs are challenging
- sufficient attention is paid to individuals' actual experience, as well as outcomes for wider cohorts of people who use services
- focussing people's experience as well as specific services – for example, look at how the processes for getting help, being assessed, waiting for a response, and being referred from one agency to another, are key elements of a high-quality 'system'
- local communities, people who use services, and carers are actively engaged in the design, development, commissioning and delivery of services
- the correct channels are used for escalating any issues, such as working with the service provider and/or local commissioner before escalating to national agencies
- recommendations are prioritised and followed through effectively.

Useful questions

- How are local health and care organisations working together to share intelligence and identify and address problems? In the NHS, is the quality surveillance group fulfilling its role in this respect? If not, how can we help to develop its work further?)
- Specifically:
 - How – and how well – are provider organisations communicating with regulators, especially about changes or incidents that may have implications for the quality of their service? Are these relationships open, trusting and honest?
 - How are regulators communicating with each other, and with other agencies, about their findings and concerns?
 - If there were ‘warning signs’ that suggested a risk of quality failure in a particular service or group of services, would lay people (including HWB and Healthwatch members) know about this? How would they find out?
- Is there a system-wide plan for engaging with people about the quality of services, and for pooling the intelligence that is gathered? Are all agencies coordinating their engagement activity and avoiding duplication? Are new, innovative methods being developed? If not, how can we help to achieve improvements?
- Do we know enough about the experiences of people who are hard to engage with, or who struggle to express themselves, or who need very specialist care and support?
- What strategic quality reviews (or scrutiny exercises) have been carried out recently, and by whom? Have they addressed the right issues and priorities? What impact have they had?
- How can we get local agencies to agree on a future plan for assuring quality? Is there a consensus about the early priorities?
- In developing our own plan, do we need to liaise with neighbouring councils (and/or their Healthwatch organisations) so we are not duplicating each other’s activity?

7. Getting the right elements in place

As a result of your stocktake, you may decide that there are particular services that require ongoing focus because of quality concerns.

However, an alternative approach might be to concentrate on getting the right elements in place across the system as a whole. The evidence suggests that a range of factors contribute to the achievement of high quality care and support⁹; some of the most important of these are discussed below.

Leadership¹⁰

Senior managers and leaders – whether of single organisations or multi-agency boards – should be visible and proactive. They should continuously communicate about the importance of quality, and convey this to their staff. They should role model an open and honest (and ‘no blame’) approach, which emphasises learning from complaints, external scrutiny and challenge.

Useful question

Do we have effective local leadership development programmes (or do we access good national ones) to help promote the right attributes and behaviours amongst our leaders?

Culture change

Organisations need to cultivate an ethos which is person and relationship centred – recognising that the interaction between staff and patients/users is perhaps the most important element of people’s experience. There should be a practical emphasis on dignity, empathy and compassion – but also on promoting independence, and putting people in control of their own lives.

Useful questions

How can we champion the right values, and promote culture change across organisations? Perhaps we could sign up to one of the national campaigns that are raising awareness of quality issues?¹¹

How can we promote culture change amongst communities themselves – so people better understand their rights and responsibilities to themselves and others?

Accountability

The boards of all organisations should have excellent quality assurance processes (including feedback mechanisms) in place, and be clear about who is ultimately responsible for making these work effectively. This should include fair processes for staff and patients/people who use services to voice their concerns. Leaders of organisations should personally inform themselves about the standards being achieved (and have governance arrangements that include clarity about where the buck stops within their organisations).

Useful question

Are we satisfied that all local agencies have clear internal lines of accountability, as well as protocols and channels for escalating any serious concerns to the appropriate regulator or regional or national bodies where this is indicated? (Are there recent local examples of where this has happened)?

Workforce development

Health and care systems need a workforce comprising considerate, competent and highly-motivated people – whose behaviours and practices reflect a primary focus on supporting and empowering people to have the best possible quality of life. This implies a need for well-designed education and training programmes, as well as continuous professional development, support and supervision and appraisal. All staff should also be very clear about how to raise their own concerns (including safeguarding concerns) and feel encouraged to do so.

Questions to consider

Does this area have a high quality, well-trained health and social care workforce? Are there exceptions to this, and what are the reasons?

Are local agencies collaborating well to address their workforce challenges – for example through joint recruitment campaigns and joint education and training initiatives?

Annex A

Figure 1: The 'Fundamental Standards' expected by CQC

Person-centred care: You must have care or treatment that is tailored to you and meets your needs and preferences.

Dignity and respect: You must be treated with dignity and respect at all times while you're receiving care and treatment. This includes making sure: you have privacy when you need and want it; everybody is treated as equals; you're given any support you need to help you remain independent and involved in your local community.

Consent: You (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.

Safety: You must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills and experience to keep you safe.

Safeguarding from abuse: You must not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint, inappropriate limits on your freedom.

Food and drink: You must have enough to eat and drink to keep you in good health while you receive care and treatment.

Premises and equipment: The places where you receive care and treatment and the equipment used in it must be clean, suitable and looked after properly. The equipment used in your care and treatment must also be secure and used properly.

Complaints: You must be able to complain about your care and treatment. The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.

Good governance: The provider of your care must have plans that ensure they can meet these standards. They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare.

Staffing: The provider of your care must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards. Their staff must be given the support, training and supervision they need to help them do their job.

Fit and proper staff: The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.

Duty of candour: The provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provide support and apologise.

Display of ratings: The provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.

Annex B

The key players in the local quality system: roles and responsibilities

Providers

Health and social care are provided by an increasingly diverse range of providers - including NHS acute and community Trusts, local authorities, private and voluntary sector providers, and other types of organisation such as social enterprises. These organisations vary enormously in how they are financed and constituted, and in how their internal accountability structures work. They also vary in their scale, the types and breadth of services offered, and in who their customers are.

Whatever their circumstances, providers have a fundamental responsibility to understand what high quality care and support looks like in their own context, and should strive always to deliver and assure this. They must have proper governance arrangements, including systems to ensure the quality and safety of those in their care. In the case of NHS providers, there is a requirement to publish an annual **quality account** that is available to the public.¹²

Most health and care providers are commissioned by at least one statutory agency – with many having contracts with several commissioning organisations. (An exception is some social care providers such as care homes that restrict their business to individuals who arrange and pay for their own care). All providers are subject to various forms of legislation (such as health and safety, and environmental legislation) designed to offer a safety net to the public. Almost all are also regulated by one or more of the main health and care regulators; most types of health and care service – however they are commissioned – are legally required to be registered with CQC (for adults) or Ofsted (for children).¹³

Primary Care

General Practitioners are independent contractors to the NHS; they are self-employed or draw salaries from their practices, which may include one or several GPs. Their services are commissioned by NHS England. Their services are regulated by CQC with GPs themselves being regulated by the General Medical Council (covering all types of doctor). GPs have a range of statutory duties including a “duty of care” for their patients. Like other parts of the NHS, GPs must exercise good clinical governance, and should work with patient advisory and liaison services and other patient groups to ensure that the ‘patient voice’ is listened to within their practices.

Commissioners

Commissioning agencies are responsible for planning, arranging and funding services at regional and local levels. In health, commissioning responsibilities are held both by NHS England (for some regional and specialist provision) and by 209 GP-led Clinical Commissioning Groups (CCGs). In social care, local authorities have statutory responsibilities in this area. An increasing range of partnership arrangements (especially between the NHS and local authorities) are in place, with many services being jointly commissioned.

Recent legislation confirms the role of commissioners in ensuring that local care and support services are of good quality. For example, the Health and Social Care Act 2012 requires CCGs to 'exercise their functions with a view to securing continuous improvement in the quality of services'. Similarly, the Care Act 2014 requires local authorities to develop markets that deliver a range of 'sustainable, high quality care and support services'.

In practice, commissioners exercise these responsibilities via contracts with service providers, and must have robust **contract monitoring** processes to ensure that services are delivered to the required specification (including specified standards of care).

Many local authorities also operate local **accreditation** schemes, to provide assurance for local citizens about the quality of care and support services (including those that are not formally regulated). This may be especially useful for those people who fund their own care or obtain it using a Personal Budget and/or a Personal Health Budget, and therefore need to make their own informed choices about which providers they can trust.

Regulators

The **Care Quality Commission** (CQC) is the agency responsible for assessing, inspecting and judging the quality and safety of most health and care services in England.

It is responsible for registering providers – by first ensuring that the provider meets fundamental standards (see Annex A). It then inspects these services (having first engaged with patients, users and other stakeholders) and publishes its findings and ratings about their quality.

In practice, the frequency and scope of inspections depends on the nature of the service. (For example, CQC's target is that the core services in acute hospitals are all inspected in a planned way at least once in three years. Care homes and home care agencies are inspected at least every two years. However, more frequent or focussed inspections may be carried out if there are issues or concerns). Services must always develop action plans to address the findings of their inspections. Where a service fails to meet regulatory requirements, CQC has powers to enforce standards; in serious cases, it may monitor the service very intensively until the problem is addressed. Ultimately, the CQC has the power to withdraw registration and so enforce service closure.

Acting in a complementary role to CQC, **Monitor** acts as the main economic regulator of Foundation NHS Trusts – ensuring these Trusts are well-led, and having regard to whether their services are effective, efficient and economic, and of good quality. The **Trust Development Authority** (TDA) continues to have oversight of non-Foundation NHS Trusts (of which there are currently around 90 across England). These two agencies share their findings with the CQC, and work together with the CQC if there are areas of concern.

For **children's social care** services (including childminding, Early Years services, family centres and children's homes) **Ofsted** plays a similar role to the CQC. It registers individuals and services that are paid to look after children and carries out planned inspections of these services. Unlike CQC, Ofsted also inspects local authorities' own processes for arranging education and support for children; these inspections check how well local authorities are supporting school improvement, whilst also covering child protection, and arrangements for children who are looked after by the council and those leaving care.

Professional regulators

Qualified health and care professionals are also required to register with their own professional body (such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC), or Health and Care Professions Council (HCPC). They must comply with the professional codes established by these regulators; this includes demonstrating that they are continuously updating their knowledge and skills. The professional regulators can investigate individuals who fall short of their standards and, in extremis, remove them from the relevant professional register, thereby banning them from working in their profession.

Planning and Advisory Bodies

Healthwatch

Healthwatch is the national body that champions people who use health and social care and has a key focus on the design of integrated care.

Each of the 152 local authority areas has a **local Healthwatch**; these organisations are separately commissioned by local authorities, but they feed into the national network. Each local Healthwatch is concerned with local engagement – collecting and channelling the views of patients, users and the public to decision-makers. They have powers to scrutinise local services (including local authority, NHS and independent sector services) including visiting and observing their operations. Each also has responsibilities for supporting people in communities by giving them information or signposting them to the support they need. Local Healthwatch is required by law to be represented on health and wellbeing boards.

Local authorities, health services and regulators have a duty in law to respond to issues raised by Healthwatch.

Health and wellbeing boards

The Health and Social care Act 2012 established **health and wellbeing boards** as a forum where leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. These boards are formally constituted as committees of local authorities – although in practice they have unique legal status, in recognition of their extended membership and distinctive function.

These boards are coterminous with local authority boundaries. They are designed to strengthen democratic legitimacy, by involving democratically elected representatives and patient representatives in commissioning decisions, alongside commissioners across health and social care. They have a statutory duty to involve local people in the preparation of Joint Strategic Needs Assessments and the development of joint health and wellbeing strategies. They have powers to scrutinise and comment on local health and social care commissioning plans, and must be consulted about these.

Overview and scrutiny committees

Local authority overview and scrutiny committees were established under the Local Government Act 2000. They comprise local elected councillors who are not part of the Executive or Cabinet of their councils. They are able to investigate any issue which affects the local area, or the area's inhabitants, whether or not it is the direct responsibility of the council's cabinet. They have powers to require officers (including NHS commissioners) to attend meetings, to answer questions and to comply with requests for information. They hold decision-makers to account, and can make recommendations both to their council's executive or to other bodies, including NHS England.

Planning and Advisory Bodies

Local safeguarding boards

Local safeguarding children boards were established under the Children Act 2004, whilst the role of safeguarding adults boards became statutory under the Care Act 2014. Both are responsible for co-ordinating and ensuring the effectiveness of their member organisations in relation to safeguarding. This includes working with local people to decide how best to protect children and adults in vulnerable situations; publishing their safeguarding plans; and reporting to the public annually on their progress.

Quality surveillance groups

Quality surveillance groups were established in 2013, and focus on those services that are funded by the NHS (including public health). They operate at two levels: locally (across the areas covered by the 27 NHS area teams) and regionally. The membership of the local groups includes NHS England, CCG leads, local authority representatives, local Healthwatch, the Public Health Centre, and all the statutory health and care regulators. The role of these groups is to bring together organisations and their respective information and intelligence, so there is a clear picture of quality at local level that is owned by all the member agencies. They are expected to work together to take coordinated action to mitigate any quality failures. In practice, these groups can be forums where issues are aired confidentially and in a safe setting, and plans developed to tackle problems.

Annex C¹⁴

Agency	Legal framework	Accountability to
NHS England	Health and Social Care Act 2012	Secretary of State
Local authority	Local Government Act 1999, 2000 – ‘duty of best value’ – and sundry	Locally elected politicians. (The Secretary of State has powers to intervene in serious cases of failure)
Clinical commissioning groups	Health and Social Care Act 2012	Performance-managed by NHS England
NHS foundation trust	Semi-autonomous organisational units	Accountable to Parliament, regulated by Monitor and CQC
NHS trust	NHS and Community Care Act 1990	Supported/managed by the TDA through an ‘accountability framework’
General Practitioners	NHS Act 2006 (“duty of care”) and sundry	Private businesses, commissioned by NHS England, regulated by the CCG and GMC
Independent sector provider of social care		Independent bodies, regulated by CQC
CQC	Established through Royal Assent, 2008	Executive non-departmental body (sponsored by the Department of Health)
Monitor	Health and Social Care Act 2012	Executive non-departmental public body (sponsored by the Department of Health)
Trust Development Authority	Health and Social Care Act 2012	A Special Health Authority of the Department of Health
Healthwatch	Health and Social Care Act 2012	Operationally independent committee of CQC
Health and wellbeing boards	Health and Social Care Act 2012	(Members have separate lines of accountability)
Overview and scrutiny committees	Local Government Act 2000	Local authorities
Safeguarding children boards	Children Act 2004	(Members have separate lines of accountability)
Safeguarding adult boards	Care Act 2014	(Members have separate lines of accountability)
Quality surveillance groups	Non-statutory	NHS England (run by local area teams)

References

1. "How to make your Quality Surveillance Group effective ". National Quality Board, 2nd Edition, March 2014
2. "Driving up quality in social care – What is quality?" Think Local Act Personal (TLAP), 2013
3. This list is adapted from "High Quality Care for all" (The "Darzi Report") 2008
4. See "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry" pub. Gov.UK 2013
5. TLAP's "Making it Real" benchmarks are another example of a tool that is widely used to check that people are experiencing personalised care.
6. These are listed in TLAP's "quality initiatives map": <http://www.thinklocalactpersonal.org.uk/Browse/Quality/Quality-Initiatives-Map/>. They include standard setters such as the Social Care Institute for Excellence (SCIE) and the Health and Care Professions Council which regulates social workers.
7. http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf
8. Formal lines of accountability are sketched out in Annex C. (Board Members may find it useful to familiarise themselves with how formal and informal reporting between agencies and their accountable bodies works in practice).
9. Some of these are listed in TLAP's publication, "Driving up quality in Adult Social Care - What is quality?" (ibid)
10. See: "Exploring CQC's well-led domain: how can Boards ensure a positive organisational culture", Kings Fund 2014
11. The national Dignity in Care campaign, and the "Dementia-friendly communities champions", are two examples of national initiatives that have helped significantly to raise awareness.
12. Local Authorities are encouraged to produce an equivalent public document – called a "Local Account" – and the majority do so annually.
13. There are currently fifteen categories of registrable activity in health and care. This includes health and care provided in hospital settings, care homes, and "extra care" housing schemes. It also includes care provided in people's own homes - such as community health, rehabilitation services and home care – and specialist services such as dentists, family planning clinics and ambulance services.
14. A useful summary (although slightly out of date) is set out in "Accountability in the NHS: implications of the government's reform programme", Kings Fund 2011



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