



National Guidance on System Quality Groups

National Quality Board

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1. Introduction

- 1.1. The quality of health and care matters because we should all expect care that is consistently safe, effective and provides a personalised experience. This care should also be delivered in a way that is well-led, sustainable and addresses inequalities. This means that it enables equality of access, experiences and outcomes across health and care services.¹
- 1.2. This definition of quality forms the National Quality Board's (NQB) [Shared Commitment](#) and [Position Statement for Integrated Care Systems \(ICSs\)](#), published in April 2021. These documents emphasise how important it is to ensure that quality is the organising principle of ICSs and set out consistent requirements for quality management and improvement. This includes:
- a designated executive clinical lead for quality (eg medical director, director of nursing) and clinical and care professional leadership embedded at all levels
 - a credible and focused strategy to improve quality across the ICS.
 - a defined governance, risk and response process, linked to regional NHS England and NHS Improvement quality governance² and wider forums (eg safeguarding assurance boards)
 - a defined way to engage and share intelligence and improvement for quality – at least quarterly through a System Quality Group (SQG), which all ICSs must have.³
- 1.3. This guidance provides further clarity to guide the development of quality governance arrangements in ICSs, particularly SQGs. It:
- sets out the NQB's requirements for quality governance in ICSs
 - provides model terms of reference for SQGs and place-based meetings
 - outlines suggested relationships with the integrated care boards (ICBs) and local authority assurance in relation to wider quality governance

¹ The concept of high quality health and social care must take due account of requirements in relation to the Equality Act 2010 and the Public Sector Equality Duty and relevant requirements in relation to reducing health inequalities introduced by the Health and Social Care Act 2012 and/or in the current Health and Care Bill. This aligns with the CQC's 2021 strategy.

² For example regional joint strategic oversight groups/quality groups.

³ Previously termed 'quality surveillance groups' (QSGs).

- provides advice on administrating SQGs, including conflicts of interest
 - sets out key principles for the approach to risk management within SQGs.
- This will be supplemented by further NHS England and NHS Improvement guidance on risk response and escalation, due in early 2022.

How should this guidance be used?

- 1.4. This guidance is for ICS leaders as they develop their approach to quality management and improvement. The includes those responsible for overseeing and delivering services:
 - commissioned by the NHS (either the ICB or NHSE)
 - jointly commissioned by the NHS and local authorities
 - commissioned by local authorities from NHS providers and non-NHS providers (eg under public health grant).
- 1.5. The guidance focuses on the purpose and functions of SQGs within ICSs. These groups will provide an important strategic forum within ICSs at which partners from across health, social care and wider can:
 - a) routinely and systematically share and triangulate intelligence, insight and learning on quality matters across the ICS
 - b) identify ICS quality concerns/risks and opportunities for improvement and learning, including addressing inequalities. This includes escalating to the ICB, local authority assurance (eg safeguarding assurance boards) and regional NHS England and NHS Improvement teams as appropriate
 - c) Develop ICS responses and actions to enable improvement, mitigate risks (respecting statutory responsibilities) and demonstrate evidence that these plans have had the desired effect. This includes commissioning other agencies, and using ICS resources, to deliver improvement programmes/solutions to the intelligence identified above (eg academic health science networks (AHSNs)/provider collaboratives/clinical networks)
 - d) test new ideas, sharing learning and celebrating best practice.

- 1.6. SQGs are not statutory bodies and will NOT serve as the ICB's formal assurance committee for quality. This will be undertaken by the ICB board itself or by a committee of the board to which it designates responsibility. However, SQG discussions and scheduled reports will inform the process of assurance for the ICB.
- 1.7. This guidance builds on and replaces the principles outlined in the [NQB's Guidance on Quality Surveillance Groups \(QSGs\)](#) in relation to the benefits of ICS-wide intelligence of, and solutions for care quality. It serves as the updated NQB Guidance on QSGs and should be read alongside the other ICS Guidance, including the [ICS Implementation Guidance on Effective Clinical and Care Professional Leadership](#) and the [Preparing for Handover Note for Quality](#).
- 1.8. The guidance will be updated as the new operating model evolves. Associated work is underway to refresh quality escalation processes, with refreshed NHS England guidance on escalation of quality risks in development for early 2022.

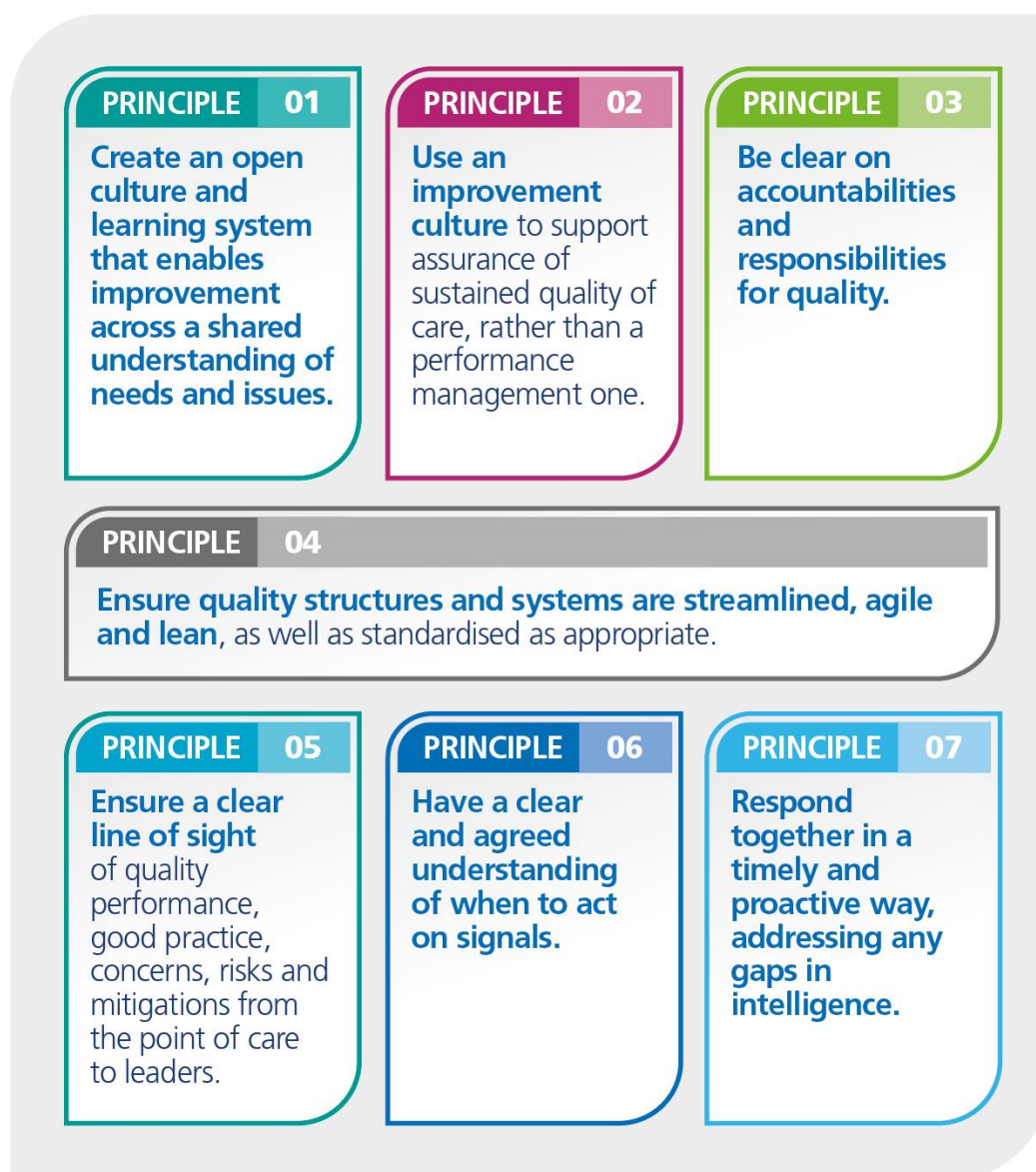
2. Key principles and structures

- 2.1. In ICSs, effective quality systems must serve three main aims for the ICB, local authorities and partners:
- a) timely insight and intelligence sharing into opportunities for learning and improvement, and issues that need to be addressed and escalated
 - b) positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect.
 - c) confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight and learning. This includes confidence that inequalities and unwarranted variation are being addressed.
- 2.2. To meet these three aims, a broad range of learning, insight and intelligence must be considered, including feedback from staff and people drawing on services (eg compliments, complaints, concerns), safeguarding, incident recording, safety culture measures, audits and risk management. This intelligence must be triangulated, shared, embedded and its impact reviewed to gain comprehensive insight and allow for robust assurance of care quality. SQGs will be crucial to achieving these aims.
- 2.3. While the remit of SQGs will be focused on engagement and intelligence-sharing for improvement, the discussions and decisions from SQGs will feed into the designated assurance functions of both the ICB and local authorities; shaping assurance around relevant matters (eg safeguarding, pathways). SQGs will also escalate any risks or concerns to the ICB, local authority assurance and regional NHS England and NHS Improvement teams where response and support is required, as clarified in regional-ICB memorandums of understanding. Further detail on quality structures is below, but beforehand we set out key principles.

Key principles

- 2.4. The NQB expects the following good practice principles to be followed by ICSs as they set up their quality management structures (Figure 1):

Figure 1: Good practice principles for quality management



- 2.5. Taking the first principle – the need for an open culture and learning system to enable sustainable improvements – both the [Institute for Healthcare Improvement’s Framework for Safe, Effective and Reliable Care](#) and the Care Quality Commission’s (CQC) [‘Closed Cultures’ Guidance](#) summarise the key ingredients to support this. These frameworks highlight the importance of quality leads in ICSs being able to answer questions such as:
- how will we develop a shared vision for quality improvement across the ICS, including the SQG, and ensure this is delivered and sustained?
 - how will we ensure that membership of the SQG is diverse and that all partners, including people with lived experience, have an equal voice?

- how will we build relationships based on shared values and behaviours, avoiding performance management approaches that drive closed cultures?

Regional NHS England and NHS Improvement teams will support this process by helping to ensure that SQGs have effective cultures and leadership in place.

- 2.6. Taking the need to ensure a clear line of sight and streamlined quality structures and systems, ICSs must be able to articulate where decision-making responsibility and accountability for quality sits within the ICS. They must also use this opportunity to improve current quality structures and reduce duplication. Already, progress towards smarter working is being made. Historical Clinical Quality Review Meetings between providers and commissioners are being transitioned to integrated, place-based meetings. Integrated quality meetings with care home providers, set up during the pandemic, are continuing. Quality improvement methodology and behavioural science is being embedded into new ways of working and opportunities for joint committees/committees in common are being explored.
- 2.7. The NQB supports progressive change to existing quality structures. New integrated structures, as well as a quality assurance and improvement focus, must be enabled and working effectively to enhance the positive behaviour and culture requirements needed to sustain high quality care.

Quality structures

- 2.8. Figure 2 summarises indicative relationships between quality structures within an ICS, recognising the need for flexibility. Figure 3 sets these out in the wider quality landscape from provider to national level. These figures are based on the premise that:

Provider and place	<ul style="list-style-type: none"> • Business as usual quality structures within providers (eg quality committees) and places largely remain, but dovetail in and feed up to the ICB and local authority structures • Routine quality monitoring and management is primarily done at place level
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	<ul style="list-style-type: none"> • Place-based structures enable the majority of quality improvement, strengthening the depth and timeliness of quality insight and helping to unblock barriers across pathways • ICSs may wish to include place quality leads in SQG membership and to develop equivalent groups at place level.
ICS	<ul style="list-style-type: none"> • As outlined in the introduction (1.5), SQGs provide a strategic forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the ICS. They support collective solutions to address quality concerns/risks within the ICS and also ensure these have the desired effect • SQGs are NOT the formal committee that provides assurance to the ICB that it is fulfilling its statutory NHS duties for quality (and should not be set up as statutory assurance committees). This is undertaken by the ICB board or a committee of the board to which it designates responsibility. However, the SQG discussions and scheduled reports inform the process of ICB assurance • ICSs should consider holding SQGs and quality assurance meetings on the same day – in common with the local authority – to reduce burden, support alignment and also enhance timely feedback into both the ICB's and local authority's relevant formal assurance structures.
Regions	<ul style="list-style-type: none"> • Clear reporting links are in place between SQGs and regional NHS England and NHS Improvement teams. Regional clinical quality leads are members of SQGs and ICB exec quality leads sit on Regional Quality Groups (RQGs). ICB exec quality leads have responsibility for escalating issues to regional teams • Regional teams facilitate quality improvement and get involved as needed to address serious/recurrent risks; working with the ICB and partners (eg CQC) • Regional teams also support the linkages with wider partners, including regulators (eg CQC, the Health and Care Professions Council [HPC], Health Education England [HEE], the General Medical Council [GMC], the Nursing and Midwifery Council [NMC]) and organisations such as NICE and Healthwatch to support improvement and risk management.

Figure 2: Illustrative overview of quality governance in an ICS

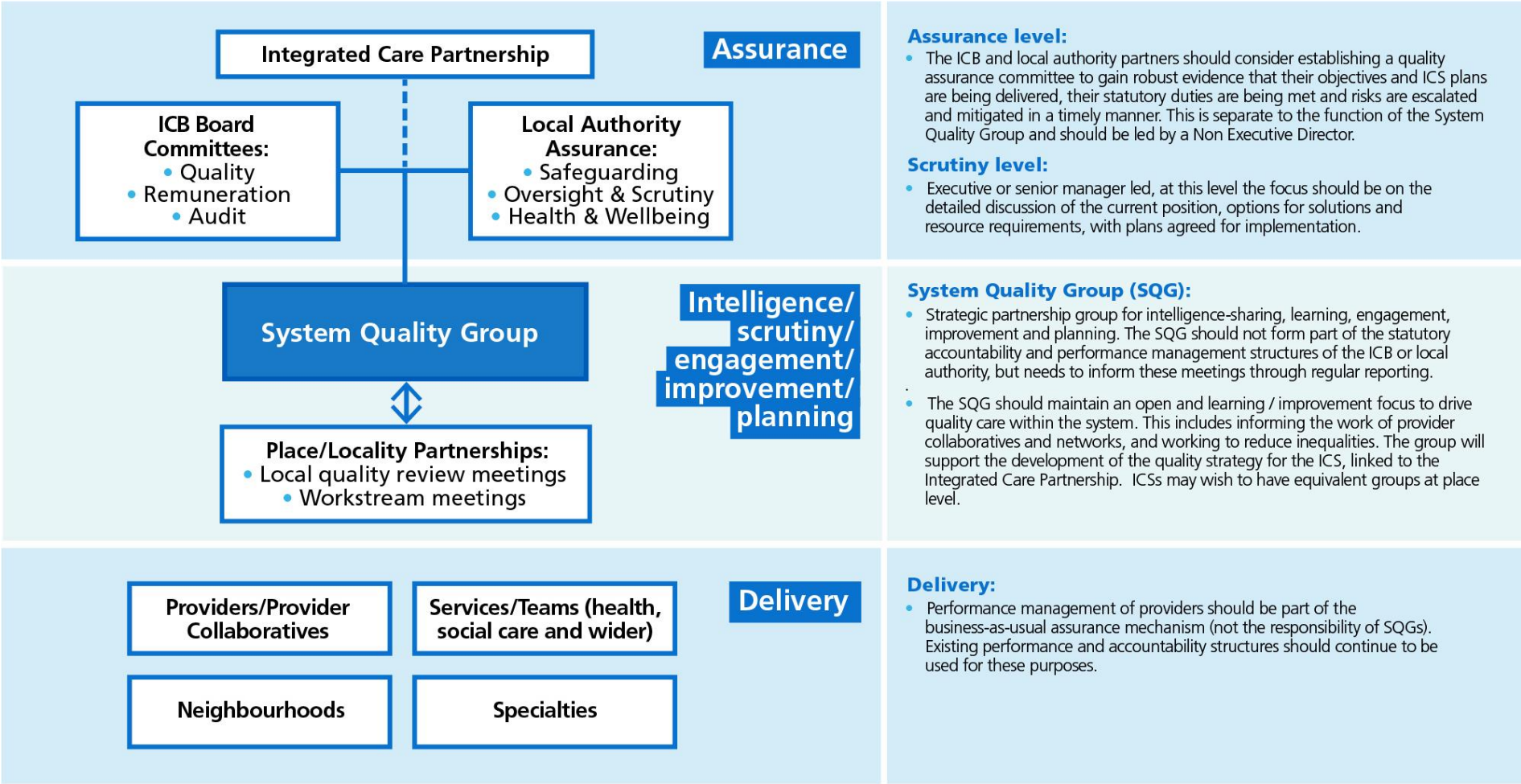
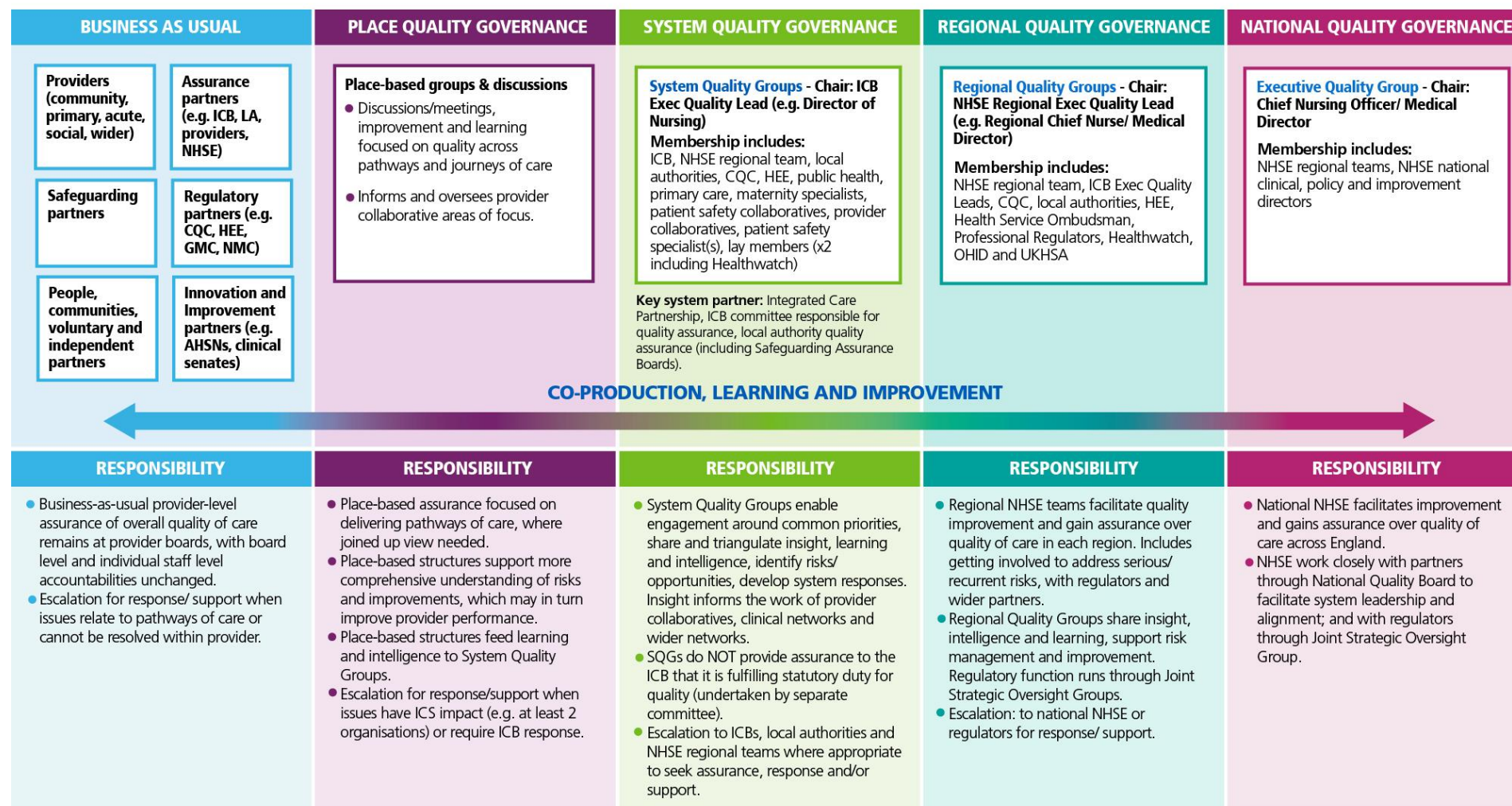


Figure 3: Overview of NHS quality governance



3. Terms of Reference for SQGs

Background – QSGs

3.1. QSGs were set up by the NQB in 2013 in response to the Francis Inquiry⁴ to provide a forum in which quality concerns could be raised and dealt with collectively in a timely, co-ordinated way.⁵ They have two principal objectives:

- a) maintaining and safeguarding quality
- b) supporting and enabling improvement.

QSGs have since operated locally, regionally and nationally, and been supplemented by enhanced assurance activity (including Risk Summits) when recurrent or serious risks have required focussed attention. The [NQB's Guidance on QSGs and Risk Summits](#) has provided a clear framework for quality governance, but needs updating to reflect ICS development, particularly the role of providers within governance structures⁶ and previous feedback that the effectiveness of QSGs could be strengthened.⁷

3.2. The NQB's April 2021 [Position Statement](#) set out key changes to the terms of reference (TORs) of QSGs, renaming them System Quality Groups in reflection of the shift to greater engagement, collaboration and learning. Regional QSGs have since also been renamed Regional Quality Groups.

3.3. Key changes to SQGs are summarised in the table and clarified in more detail below. Further information is provided in Annexes A and B (Model TORs for SQGs and place-based meetings).

⁴ The Francis Inquiry, published in 2013, examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. This included the need for openness, transparency and candour throughout the health care system:

<https://researchbriefings.files.parliament.uk/documents/SN06690/SN06690.pdf>

⁵ <https://www.england.nhs.uk/publication/quality-surveillance-groups-national-guidance>

⁶ When QSGs were established, providers were not included.

⁷ The feedback has highlighted that QSGs would benefit from clearer accountability, a stronger focus on improvement at system level (moving from provider level oversight to look at pathways and journeys of care, including reducing inequalities), and more evidence-informed and actionable decision-making

Existing Quality Surveillance Groups	New System Quality Groups
Geography: NHS England and NHS Improvement Area Team footprints.	ICS footprints. ICSs may have sub-groups at place, which report into SQG.
Purpose: Forum to share intelligence and enable identification and management of quality concerns.	Forum to share intelligence, identify and support management of concerns. Focus on diagnosis, planning, improvement and learning, including reducing health inequalities through wider determinants (eg housing).
Membership: Chaired by regional NHS England and NHS Improvement team. Set membership.	Chaired by ICB exec quality lead (with regional NHS England and NHS Improvement as member). More permissive membership, representing health, social care and wider (with minimum requirements that includes provider collaboratives).
Scope: Quality within providers (often acute providers).	Quality in ICS (eg across pathways, provider collaboratives) and related to wider partnership priorities (eg sustainability, inequalities).
Reporting: To regional quality governance (Quality Surveillance Groups).	To established ICB and local authority assurance mechanisms, and to regional quality groups on risks, issues and examples of best practice.

Purpose of SQGs

- 3.4. As outlined in the introduction (1.5), SQGs provide a strategic forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the ICS. SQGs are not statutory bodies, but members will be accountable to their own statutory body and SQGs will help to ensure that quality as a statutory function is supported and delivered in an integrated way. As a consequence of the insight shared within meetings, SQG members are expected to take forward a range of actions, reflecting their individual statutory responsibilities (eg improvement support, performance management, contractual action, regulatory/enforcement action).

Scope

3.5. SQGs will be concerned with the full range of health and care services and providers within the ICS. This includes services commissioned by the NHS, jointly with local authorities or by local authorities.⁸ Given the breadth of the quality agenda, SQGs should focus on:

- **Appropriate depth of discussion** to enable decision-making, with escalation by exception and advisory or task and finish groups set up to take forward priority work. Examples of such groups include:
 - infection prevention and control (IPC)
 - patient safety
 - ICS safeguarding themes
 - children and young people's services (e.g. mental health, Special Educational Needs and Disabilities))
 - frailty and older people.
- **Improving people's experience of care, co-design and co-production.** This includes involving people with relevant lived experience as equal partners in the full range of SQG activities, including co-designing improvements.⁹
- **Population health and ICS quality issues.** This includes defining improvement projects for pathways, joining up with public health colleagues to address wider determinants, identifying and addressing emerging place-based concerns, variation and inequalities, and delivering areas of mutual interest across health and social care (eg safeguarding and safety).
- **SMART objectives and priorities** – with clarity upfront on how partners will work together to address these and what 'success' will look like. Theories of change may be a helpful tool to use in tracking how outcomes will be delivered.

⁸ Including: public, independent, not for profit and third sector providers; primary care (including general practice, dental, optometry and pharmacy); community services; secondary and tertiary services; mental health; military health and veterans services; directly commissioned services, including specialised commissioning and health and justice.

⁹ See: [Understanding integration: how to listen to and learn from people and communities | The King's Fund \(kingsfund.org.uk\)](https://www.kingsfund.org.uk/publications/understanding-integration-how-to-listen-to-and-learn-from-people-and-communities)

3.6. The types of issues and actions that could reasonably come through an SQG are:

- **Place-based quality** – eg triangulating quality performance, safeguarding and safety reporting to identify patterns and trends in the data, gaps, and support improvement, access and patient flow.
- **Pathways and journeys of care** – eg children's mental health, urgent and emergency care, frailty, autism and learning disability (eg embedding key system learning from a LeDeR Review).
- **Inequalities and variation** – including full consideration of how the ICS can reduce inequalities and address wider determinants of health (eg housing, fuel poverty) to improve the quality of care.
- **Quality within multiple providers and provider chains** (eg provider collaboratives, independent chains) – eg triangulation of learning from deaths information (eg Regulation 28 Prevention of Future Deaths reports, patient safety incidents and investigations, national clinical audit), with learning shared and embedded across the ICS.
- **Safeguarding concerns** – eg within a learning disability or autism unit.

Reporting responsibility and accountability

3.7. SQGs are expected to report to the ICB either directly or via a designated assurance committee (eg quality committee) and local authority assurance. There will also be close working with Regional NHS England and NHS Improvement clinical quality teams – given they are members of SQGs and ICB executive quality leads sit on Regional Quality Groups.

3.8. In terms of local authority engagement, SQGs must consider:

- How they will ensure effective engagement with local authority representatives (directors of children's services and directors of adult social care) on the group – eg a local authority representative may be designated as co-chair.
- How they will ensure that issues, risks, learning and trends from local authorities (eg emerging safeguarding concerns, annual reports) are

brought to the SQG, triangulated with wider intelligence and inform priorities and actions.

- How they will inform local authority areas of priority and plans.
- How they will partner with local authority partners on areas and concerns of mutual interest.

3.9. Close partnership working with professional and system regulators will also be required by the SQG and a key responsibility of ICB executive quality leads. This includes sharing and considering intelligence gathered through the [Emerging Concerns Protocol](#),¹⁰ which may be used by partners within the ICS to gather information when a statutory quality concern has been identified.

3.10. To ensure effective governance and transparency, SQGs must ensure that key points from meetings (including task and finish groups) are recorded and publicly available. The SQG must also maintain an active action log. Actions must be SMART, with clear information on timelines, the action holder etc. Action logs should be reviewed at each meeting and the impact captured and shared for future learning.

3.11. In terms of reporting, the SQG Chair (eg ICB executive quality lead) shall draw to the attention of the ICB, or its designated board committee for quality assurance, any issues that require its consideration or executive action. The same reporting function of the outputs of the SQG should be fed back by the key local authority members to the local authority designated committee for quality assurance. Reports should be balanced, including positive and negative perspectives to give a realistic picture of the state of care.

Identifying and managing risks

3.12. In terms of managing risk, the ICB will be accountable for the effective oversight and management of healthcare risks (where they do not fall under local authority assurance, eg safeguarding), including risks within independent healthcare providers. They will need to work closely with regional NHS England and NHS Improvement teams and wider partners (eg CQC, HEE, NMC, GMC) as part of this. As for oversight more broadly, the

¹⁰ A process for regulators to connect and share intelligence, however small, to ensure all quality concerns are raised.

level of ownership and accountability of the ICB in managing risks, and hence involvement of Regional teams, will be tailored to the ICS, as set out in regional NHS England and NHS Improvement-ICB memorandums of understanding.

3.13. That said, the SQG will play a key role in quality risk management within the ICS; helping to identify concerns and risks, diagnosing and developing actions/improvement plans to mitigate and respond to risks, and overseeing implementation. To support this, ICSs should:

- Ensure that risk management structures and focus within the SQG sit within and compliment the normal risk management processes of partners within the ICS. Commonality of language and scoring should be considered as a starting point if this does not already exist. Relevant risks should be managed as close to the point of care as possible.
- Develop an agreed SQG statement in relation to the appetite to quality risks within the ICS that sits within and supports the wider appetite to risk. Health and care delivery is not a risk free environment. Not all risk can be fully mitigated and so the development, agreement and implementation of common risk appetite is key. This will allow a collective understanding of acceptable risks and assist in the prioritisation of work and the defined level to which any risk needs to be mitigated.
- Take a system perspective to risk management – looking across pathways to understand wider issues/implications and how partners within the ICS can help mitigate them. Risks should only be escalated from place level when an ICS solution is required. A broad range of insight and intelligence should be triangulated to support this (see section 4).

3.14. NHS England and NHS Improvement's guidance on risk response and escalation is currently being updated and will provide further clarity on the approach to risk management by ICBs, notably the processes and arrangements required to address serious/recurrent risks, conflicts of interest, or issues that require a regional/national response and oversight (linked to the system oversight framework [SOF]). This will include the use of Risk Summits, which are organised to address very serious risks, and will be run by regional NHS England and NHS Improvement teams or an external

partner (eg CQC), following discussion with the ICB and relevant partners. This guidance will be shared in early 2022.

Membership

3.15. Minimum requirements for SQG members are included in the model TORs in Annex A. This includes:

- the ICB
- local authorities
- provider collaboratives
- regional NHS England and NHS Improvement teams
- regulators (CQC and HEE)
- primary care
- local maternity systems
- patient safety specialist(s)
- at least two lay members with lived experience (including Healthwatch)

Providers spanning multiple ICSs (eg ambulance trusts) are expected to be on each SQG, plus place-based quality leads as appropriate locally.

3.16. To date, SQGs have also invited the following as routine members:

- improvement and innovation partners (eg NICE field teams, AHSNs, allied health professions, clinical networks)
- wider regulators (eg HCPC, GMC, NMC)
- freedom to speak up (FTSU) guardians

Plus individual providers to join as per local need. Additional members may be invited for focused discussions and updates (eg patient safety partners to discuss Patient Safety Strategy implementation; community, voluntary and third sector organisations to discuss care in the community).

3.17. The membership of SQGs should reflect the principles set out in the [Functions and Governance Guidance](#) for ICBs (eg adhering to Nolan principles, sufficiently senior and skilled to participate) and those described

from the previous NQB Guidance.¹¹ This includes ensuring that all voices are enabled¹² and that members have an equal voice.

- 3.18. Key to the success of SQGs and an important benefit of their establishment is the relationships built, allowing partners within the ICS 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, and partners within the ICS should identify one individual of appropriate seniority who can consistently attend the SQG to maintain a trusting group dynamic – one in which SQG representatives feel able to share emerging intelligence and discuss concerns.¹³

Meeting frequency

- 3.19. SQGs must meet at least quarterly, but as they establish will likely need to meet more regularly (eg monthly or bi-monthly). Effective monitoring and management of dynamic quality risks requires frequent communications and there must be consideration of how this will be achieved. Risk management is part of business as usual activity and existing arrangements should be used where possible. As is common practice, virtual communication can be beneficial in supplementing the scheduled SQG meetings to allow timely, proactive response to emerging concerns and risks.

Quoracy

- 3.20. It is important that SQGs have defined quoracy arrangements in place. It is recommended that no business is transacted unless at least 50% of members are present at meetings, and that this includes ICB, provider collaboratives, local authority, regional NHS England and NHS Improvement representatives, and lay members with lived experience.
- 3.21. Given that meetings may be quarterly, it is essential that quoracy is maintained to ensure timely oversight and resolution of concerns.

¹¹ 1) Care quality centred; 2) Inclusive; 3) High Trust; 4) Challenge; 5) Improvement focused, not performance management focused.

¹² In accordance with the Equality Act 2010, including the Public Sector Equality Duty and where appropriate the health inequalities duties introduced by the Health and Social Care Act 2012 and the proposed new provisions in the draft Health and Care Bill.

¹³ When this is not possible, a deputy who is well briefed on previous discussions and issues may join.

Consideration should be given to how quoracy is set to support regular meetings and how virtual meetings can support the consistent sitting of quorate meetings.

Managing conflicts of interest

3.22. SQGs need to consider how they will manage conflicts of interest (Cols) relating to quality. The ICB [Functions and Governance Guidance](#) provides advice and principles to support this. Regarding SQGs specifically, examples of Col include:

- Quality concerns about a provider/provider collaborative represented on the SQG
- Failure of leadership within a provider
- Access to quality information about a provider that may be contractually advantageous
- Legacy competitive relationships impacting on the effectiveness of meetings.

3.23. Clarification of how SQGs will manage Cols needs to be included in the TORs (see Annex A). SQGs may wish to develop a code of conduct for this purpose. A template code of conduct is attached in Annex C.

4. Intelligence-led decision-making within SQGs

- 4.1. SQGs provide an important opportunity for ICSs to use quantitative and qualitative data, intelligence and insights effectively to understand and improve care quality. The use of data over time, shared transparently, is key to supporting learning and adaptation. This includes recognising signals and early warning signs, understanding variation and inequalities that exist and learning together from this by developing improvement plans. To effectively monitor, measure and develop learning, SQGs must draw on a wide range of different sources of data, intelligence and insights (see figure below and Annex D). Many key indicators are included in the [Quality Toolkit](#) available on Viewpoint.

Figure 4: Example sources of quantitative and qualitative data

Internal data		External data	
Quantitative		Quantitative	
<ul style="list-style-type: none"> • Staff survey and workforce data • Hospital mortality data • Infection prevent and control data • Local Authority data (e.g. ASCOF) • Integration Index (from 2022/23) 		<ul style="list-style-type: none"> • CQC inspection ratings • Quality data in Oversight Frameworks (SOF, QOF) • NICE evidence • Clinical audit data • National surveys data i.e. patient surveys 	
Qualitative		Qualitative	
<ul style="list-style-type: none"> • Freedom To Speak Up • Professional insights /intelligence • Internal reviews/reports and action plans • Staff training and development records • Complaints, PALS and concerns data 		<ul style="list-style-type: none"> • Safeguarding serious case reviews • Emerging Concerns Protocol • Patient / service user websites and groups • Traditional and social media • Coroner's regulation 28 reports 	

- 4.2. How this data will be translated into actionable knowledge by the SQG should be considered at the offset. In quality management systems, it is crucial to keep the burden of data collection minimal and shared data sets should be standard practice. Thematic analysis should be used to understand quality across pathways and journeys of care, as well as common themes (eg learning from deaths). ICSs may wish to draw on the

expertise of their system intelligence function to develop innovative analyses and presentations of data to support the SQG in delivering its duties as accurately, efficiently and effectively as possible.

- 4.3. When recurrent/serious risks are suspected or occur, ICS may use the Quality Risk Profiling Tool (QRPT) to gain a more in-depth view of the risks presented. The QRPT is an interactive tool and, as it evolves, will have integrated statistical process control (SPC) capability to support understanding of trends and trajectories. It will also build on risk management good practice.

5. Summary

5.1. This guidance seeks to support ICS leaders as they establish their quality governance arrangements, and specifically SQGs. To summarise:

- Quality must be the organising principle of ICSs – the core question for ICS leaders right now is ‘how can we ensure that we are a quality-led ICS?’
- All ICSs are expected to have an SQG in place to enable quality improvement across the ICS. This should be chaired by the ICB executive quality lead (eg director of nursing, medical director). The group will bring together partners from across health, social care, public health and wider. ICSs may also wish to consider whether they need equivalent groups at place level.
- The SQG will not perform the statutory quality assurance function for the ICB. This will be delivered through the ICB itself or a committee with designated responsibility (eg quality committee). The SQG will also not be statutorily responsible for managing risks in the ICS, but will be key in supporting identification of concerns/risks, developing and overseeing improvement plans and escalating accordingly (to ICB, local authority assurance, regional NHS England and NHS Improvement team).
- This guidance sets out requirements and principles to inform the development of SQGs, including model TORs. Regional NHS England and NHS Improvement teams will work closely with ICSs as they set up these arrangements. Further learning and guidance will be shared, including updated versions of this guidance as ICSs evolve.

Annex A: Model TORs for an SQG

Overview of the SQG

Purpose

The purpose of the SQG is to provide a strategic forum at which partners from across health, social care, public health and wider within the ICS can join up around common priorities (linked to the ICP strategy), routinely and systematically share insight and intelligence, identify opportunities for improvement and concerns/risks to quality, and develop system responses to enable ongoing improvement in the quality of care and services across the ICS.

Aims and responsibilities

The SQG will provide the ICB, local authority and wider partners within the ICS with a strategic mechanism to:

- Routinely and systematically share and triangulate intelligence, insight and learning on quality matters across the ICS.
- Identify ICS quality concerns/risks and opportunities for improvement and learning, including addressing inequalities. This includes escalating to the ICB, local authority assurance (eg safeguarding assurance boards) and regional NHS England and NHS Improvement teams as appropriate.
- Develop ICS responses and actions to enable improvement, mitigate risks (respecting statutory responsibilities) and demonstrate evidence that these plans have had the desired effect. This includes commissioning other agencies/using ICS resources to deliver improvement programmes/solutions to the intelligence identified above (eg AHSN/provider collaboratives/clinical networks).
- Test new ideas, sharing learning and celebrating best practice.

The SQG will support the strategic priorities of the system regarding quality, including:

- Ensuring that the quality is central to system planning, decision-making and delivery, and that there is a credible and focused strategy to improve quality across the ICS (integrated in the ICP strategy).
- Ensuring that inequalities are embedded in all discussions to improve quality

- Supporting a psychologically safe and healthy culture for quality management within the ICS, which is based on transparency, open sharing of information and learning, collective ownership of actions and issues.
- Informing/defining the ICS appetite to quality risks.
- Ensuring a shared view of risks to quality and a shared approach to measurement, learning and improvement. This includes supporting alignment and resolving system barriers to improvement.
- Supporting place-based and provider collaborative engagement, intelligence and improvement for quality.

The SQG does not have executive powers and will not:

- Directly intervene in performance management, contractual or regulatory functions, though it can advise on necessary changes and improvements.
- Substitute the need for individual organisations to act promptly when pressing concerns become apparent.
- Have responsibility for ensuring the ICB is fulfilling its statutory duties and system leadership role regarding quality (eg safeguarding, serious incidents, freedom to speak up), including monitoring and managing them effectively. However, the SQG will be responsible for ensuring the ICB is aware of the risk that it carries if it fails to fulfil these duties satisfactorily.

Scope

The SQG is concerned with all services:

- Commissioned by the NHS (either the ICB or NHS England and NHS Improvement).
- Jointly commissioned by the NHS and local authorities.
- Commissioned by local authorities from NHS and non-NHS providers.

It includes services within its population boundary regardless of whether the ICB commissions services from that provider, consideration of out of area placements and providers that cross ICS and regional boundaries. Independent providers are also included.

The focus will be on population health and ICS quality priorities, eg across pathways/settings with particular emphasis on reducing inequities in access, experience and outcomes.

Reporting responsibility and accountability

- The SQG reports to the ICB delegated committee responsible for quality assurance (or ICB Board) and local authority assurance. The SQG must also report to the regional NHS England and NHS Improvement teams on risks and issues.
- Close working with wider partners (including regulators) will be required.
- Individual members and advisory/task and finish group leads are responsible for reporting back on activities.
- The SQG will consider reports from place-based meetings, provider collaboratives, clinical senates, thematic work (eg advisory/task and finish group), national policy work and other sources.
- Key points from meetings will be formally recorded and made publicly available.
- The chair and relevant local authority lead member shall draw to the attention of the ICB and local authority assurance any issues that require its consideration or executive action.
- Reporting arrangements may change and will be updated to reflect the changes.

Membership

Chair

- The meeting shall be chaired by the ICB executive quality lead. In the event of the chair being unable to attend, a nominated deputy will chair the meeting.
- The chair will ensure full participation during meetings, that all relevant matters and agenda items are discussed, and that effective decisions are made and communicated to the partners within the ICS.

Members

- Members are: ICB, local authorities, regional NHS England and NHS Improvement teams, CQC, HEE, public health, primary care, maternity, patient safety collaboratives, patient safety specialist(s), provider collaboratives and at least two lay members with lived experience (including Healthwatch).
- Members may nominate suitably informed deputies to have decision-making authority if they are unable to attend the meeting. Where necessary, this should be limited to maintain a trusting group dynamic.

Quoracy

To be fully quorate:

- At least 50% of members must be present.
- There must be representatives from the ICB, local authority, provider collaboratives, lay representatives, and regional NHS England and NHS Improvement teams.

In the event of quorum not being achieved, decisions deemed by the chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

Procedural Arrangements

Frequency

- The SQG will meet at least quarterly, subject to annual review.
- Extraordinary meetings may be called at the discretion of the chair.

Meeting management

- The ICB will provide business support to the SQG, including drafting agendas and minutes, compiling meeting packs and monitoring actions.
- A business cycle will be agreed by the SQG and reviewed annually or more frequently if required.
- Sub-groups/task and finish groups may be convened as required.
- Formal records are required to be kept as per the retention schedule.

Conflicts of interest

- Members will be required to declare any interests that may conflict with the SQG's business prior to or at the meeting.
- The chair will be required to ensure that any interest is recorded in the minutes of the meeting and managed accordingly within the meeting in accordance with the following NHS Guidance issue 2017:
<https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/>.

Sharing of Information (including confidential materials)

- Unless confidential, all papers should be considered as subject to the Freedom of Information Act (FOI). Information sharing agreements between members will be agreed as a principle of working together
- Group members will give due regard to their responsibilities to comply with GDPR and DPA legislation.

Annex B: Model TORs for a place quality group

1. Purpose

To provide a forum at which place-based partners from across health, social care, public health and wider can routinely share insight and intelligence into local quality matters, identify opportunities for improvement and concerns/risks to quality, and develop place-based responses to support ongoing quality improvement for the local population.

Place-based quality meetings will give place and local leaders:

- understanding of quality issues at place level, and the objectives and priorities needed to improve the quality of care for local people, devolved down to providers as appropriate.
- timely insight into quality concerns/issues that need to be addressed, responded to and escalated (including to the SQG).
- positive assurance that risks and issues have been effectively addressed
- confidence about maintaining and continually improving both the equity, delivery and quality of their services.

2. Specific duties

- Gain timely evidence of provider and place-based quality performance.
- ensure the delivery of quality objectives by providers and partners within the designated place, including ICS programmes that relate to the place portfolio.
- identify, manage and escalate where necessary, risks that materially threaten these and any local objectives.
- identify themes in local triangulated intelligence that require local improvement plans for immediate or future delivery.
- gain evidence that staff have the right skills and capacity to effectively deliver their role, creating succession plans for any key roles within the services.
- hold senior staff to account for performance and the creation and delivery of remedial action/improvement plans where necessary.

- share good practice and learning across providers and neighbourhoods.
- ensure key objectives and updates are shared consistently with the senior ICS leaders, SQG and ICB via the established governance structures.
- provide and monitor the effectiveness of quality management structures to oversee the management of the place.

3. Frequency

Meetings shall be held monthly.

4. Membership

Chair – place-based quality lead.

Representatives from ICB, local authorities, public health, voluntary and community sector, providers, primary care, maternity networks, lay members with lived experience.

In addition to the membership detailed above, any other individual may be invited to attend at the chair's discretion.

5. Quorum

50% of members are required for the meeting to be quorate.

6. Attendance

A representative (nominated deputy) must attend in the absence of members of the group.

7. Reporting

The place-based quality group will report to the SQG and feed into the ICS established assurance structures (ICB and local authorities).

Annex C: Model code of conduct for an SQG

Introduction

Our code of conduct and meeting rules set out what is expected of everyone attending the SQG meetings.

Coming to this meeting shows agreement to follow these rules and standards of behaviour so that everyone can be present without harassment, interruption, fear or intimidation.

Valuing equality, diversity and inclusion

All delegates attending the meeting, must undertake to:

- treat all people with respect and act in a way which does not unlawfully discriminate against or exclude anyone
- encourage and enable representation from under-represented groups
- ensure that the meeting is enabled for people with disabilities, eg availability of hearing hoops, use of virtual chat functions
- act in a fair and responsible way to any staff, fellow delegates or volunteers they encounter.
- communicate in advance to the chair, facilitator or nominated officer any information necessary to help them at the meeting or event.

Collective responsibility

All people coming to the meeting agree, by their presence, that they will:

- observe the authority of the chair or facilitator at all times if one is present, raising points and matters for discussion only through the chair at formal meetings.
- listen quietly to and respect the views and experiences of other people contributing.

Confidentiality

To enable the exchange of information between attendees at this meeting to be carried out in accordance with the Data Protection Act 2018, the Human Rights Act 1998, the Freedom of Information Act 2000 and the Common Law Duty of Confidentiality, all attendees must undertake to:

- ensure that all information that is shared and exchanged within the confines of this meeting is for the specific purpose of the meeting and members agree to:
 - not to reveal any confidential Information to any person outside of the meeting.
 - to store all confidential information securely.
 - not to make copies or duplicates of the confidential information except to the extent that it is reasonably necessary to carry out any follow up actions.
- information may be exchanged within this meeting for the purpose of identifying any action that can be taken by any of the agencies or departments attending this meeting to resolve the problem under discussion.
- a disclosure of information outside the meeting, beyond that agreed at the meeting, will be considered a breach of the subjects' confidentiality and a breach of the confidentiality of the agencies involved

Annex D: Relevant quality data and intelligence

Internal	External
Quantitative	Quantitative
<ul style="list-style-type: none"> • Serious Incidents data and National Patient Safety Alert data • Infection prevention and control data including HCAIs • Hospital mortality data • Freedom to Speak Up (FTSU) data • Integration Index (forthcoming 2022/23) • Staff Survey results data • Workforce data - absence rates and turnover rates • Quality Accounts data • Maternity reporting tool data on quality • Quality data in Model Health System and the Quality Toolkit • Adult and child safeguarding • Local Authority data (eg ASCOF) • Charity/voluntary organisation data • Quality data in the Commissioning for Quality and Innovation (CQUIN) Framework • Workforce Race Equality Standard (WRES) data 	<ul style="list-style-type: none"> • CQC inspection ratings data • Quality data in the System Oversight Framework (SOF) • Quality data in the GP Quality and Outcomes Framework (QOF) • External Audit data • External benchmarking data • Clinical Audits data • NHS Digital data/intelligence on quality • UK Health Security Agency (UKHSA) data/intelligence • External horizon scanning data • Homicides/unlawful killings – historic and ongoing including action plans • National surveys data - CQC patient surveys, HEE training surveys, GMC National Training Survey, GP patient survey (GPPS) • Public Health Outcomes Framework • Friends and Family Test
Qualitative	Qualitative
<ul style="list-style-type: none"> • Complaints, PALS and concerns data • Quality Accounts information • Speaking up reports from staff • Serious Incident investigations and action plans • Internal Audit reports and action plans • Internal reviews (lessons learned, peer reviews, thematic), recommendations and action plans • System Quality Groups/Quality Committees • Staff feedback/survey information • Mandatory and statutory training records • Staff professional development plans (PDPs) • Maintaining High Professional Standards (MHPS) • Risk and issues registers • Contractual and legal action • Quality impact assessments • Healthwatch reports library 	<ul style="list-style-type: none"> • CQC Inspection reports, warning notices, related notifications • HSCRF emerging concerns protocol • HEE intensive support framework and Deanery reports • Professional regulators intelligence • Oversight and Scrutiny Committees, Health and Wellbeing Boards • Central Alerting System (CAS) safety alerts • Patient/service user websites, groups and forums • Traditional media and social media • Getting It Right First Time (GIRFT) and RightCare reports • Regulation 28 Prevention of Future Death reports • Judicial review reports • Safeguarding serious case reviews • Charity Commission case reviews/reports • Use of NICE Quality Standards • Independent Reviews

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

This publication can be made available in a number of alternative formats on request.