NHS
South East London

NHS South East London Integrated Care Board
System Quality Group

Terms of Reference

Final - 10 June 2022

1. Introduction

1.1. The System Quality Group (SQG) of the ICS will support and recognise the Triple Aim[1] duty (improved population health, quality of care and cost control) to put quality, safety, patient experience and safeguarding at the forefront of planning and decision-making.

1.2. The National Quality Group (NQB) provides a common definition and vision of quality for those working in health and care systems. This follows the Darzi-based definition of high-quality care as being safe, effective, and providing a positive experience. Added further to this are responsibilities for care systems to place greater emphasis on population health and health inequalities[2].

1.3. The System Quality Group will develop shared ambitions and priorities to ensure inequalities and variation in the quality of care and outcomes are addressed, serious quality and safeguarding concerns are managed effectively, and that learning, intelligence and improvement are shared across the system and beyond to inform ongoing improvement.

2. Purpose

2.1. 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

[1] The Triple aim: better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed
[2] www.england.nhs.uk/ourwork/part-rel/nqb/

improvement and concerns/risks to quality and safeguarding, and develop system responses to enable ongoing improvement in the quality of care and services across the ICS.

3. Scope

3.1. The SQG is concerned with all services:

a. Commissioned by the NHS (either the ICB or NHS England / Improvement).

b. Jointly commissioned by the NHS and local authorities.

c. Commissioned by local authorities from NHS and non-NHS providers.

3.2. 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.

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

3.4. The SQG does not have executive powers and will not substitute the following activities:

- Performance management of ICS partner organisations
- Involvement in or duplication of organisational regulatory processes
- Responsibility for ensuring the ICB is fulfilling its statutory duties and system leadership role regarding quality (e.g., 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.

4. Duties

4.1. The SQG will provide assurance to the ICS Body (via the Quality & Performance committee), the SEL Local Authorities and wider partners within the ICS with a strategic mechanism to:

a. Routinely and systematically share and triangulate intelligence, insight and learning on quality matters across the ICS.

b. Routinely and systematically triangulate themes and learning from safeguarding reviews across the ICS.

c. Identify ICS safeguarding & quality concerns/risks and opportunities for improvement and learning, including addressing inequalities. This includes escalating to the ICB Quality & Performance committee, local authority assurance (e.g., safeguarding assurance boards) and regional NHS England and NHS Improvement teams as appropriate.

d. 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 identifying improvement solutions and working with ICS partners and other relevant agencies to ensure delivery.

e. Test new ideas, sharing learning and celebrating best practice.

4.2. The SQG will support the strategic priorities of the system regarding safeguarding & quality, including:

a. Ensuring that the quality & safeguarding 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).

b. Ensuring that inequalities are embedded in all discussions to improve quality and safeguarding.

c. Supporting a psychologically safe and healthy culture for quality and safeguarding management within the ICS, which is based on transparency, open sharing of information and learning, collective ownership of actions and issues.

d. Informing/defining the ICS appetite to quality and safeguarding risks.

e. Ensuring a shared view of risks to quality and safeguarding and a shared approach to measurement, learning and improvement. This includes supporting alignment and resolving system barriers to improvement.

f. Supporting place-based and provider collaborative engagement, intelligence and improvement for quality and safeguarding.

5. Accountabilities, authority and delegation

5.1. The SQG reports to the ICB Quality & Performance committee and local authority assurance groups. The SQG will also report to the regional NHS England and NHS Improvement teams on risks and issues.

5.2. Individual members and advisory/task and finish group leads are responsible for reporting back on activities.

5.3. The SQG will consider reports from place-based meetings, provider collaboratives, clinical senates, safeguarding partnership and adult boards, thematic work (e.g. advisory/task and finish group), national policy work and other sources.

5.4. Key points from meetings will be formally recorded and made available to the Quality & Performance committee.

5.5. 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.

5.6. The SQG may establish a working group or task and finish group to lead work under a defined term of reference / engagement. The SQG must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

6. Membership and attendance

6.1. The SQG will be constituted of members from ICS partner organisations, non-ICS partners and the wider regulatory system. SQG members will include the following, with some specific postholders to be confirmed:

- ICB Chief Nurse
- ICB Chief Medical Officer
- 2 x ICB Director of Quality
- 6 x ICS providers representatives e.g. directors of quality or equivalent
- HEE Postgraduate Dean South London
- HEE Deputy Postgraduate Dean South London
- NHSEI Director of Nursing Leadership and Quality
- CQC Head of Inspection, London – Adult Social Care Inspection Directorate
- 2 x Chair of SEL LMS
- 1 x Patient Safety Network representative
- 1 x ICS Patient Safety Specialist (postholder to be confirmed)
- 2 x ICB Lay Members - including SEL Healthwatch Director, with second postholder to be confirmed.
- 6 x Place Based Clinical Leads for Quality
- 3 x provider collaboratives representatives and network chairs
- 1 x Director of Public Health representative (postholder to be confirmed)
- 1 x Primary Care representative (postholder to be confirmed)
- 1 x lead Local authority representative (postholder to be confirmed)
- 1 x Chair of the safeguarding partnership for adults representative
- 1 x Chair of the safeguarding partnership for children and young people representative

6.2. Officers of the ICB will be invited to join the meeting as members in attendance. This membership will be agreed by the SQG Chair.

6.3. The CNO and CMO will assume responsibility for linking the work of the SQG with that undertaken by the Care and Clinical Professional Leadership Group.

6.4. The SQG is permitted with agreement of the chair and a majority of members, to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary. The Group may

additionally request subject matter experts attend on a one-off or *ad hoc* basis as required.

7. Chair of meeting

7.1. The meeting will be chaired by the ICB Chief Nurse, and the deputy chair will be appointed by the Group).

7.2. At any meeting of the Chair or Deputy Chair if present shall preside. If they are absent, ICB Director of Quality shall preside.

7.3. If the presiding Chair is temporarily absent on the grounds of conflict of interest, the ICB Director of Quality shall preside, or, in the case that they also may not, then a person chosen by the Group members shall preside.

8. Quorum and conflict of interest

8.1. The quorum of the Group is at least 50% of members of which the following must be present:

- One of ICB CNO and CMO
- 3 x Provider representatives
- 3 x Place clinical leads for quality
- 1 x Lay Member
- One of NHSE/I, CQC or HEE

8.2. In the event of quorum not being achieved, matters deemed by the chair to be 'urgent' can be considered outside of the meeting via email communication.

8.3. The SQG will operate with reference to NHS England guidance and national policy requirements and will abide by the ICS's standards of business conduct. Compliance will be overseen by the chair.

8.4. The Group agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

8.5. Members will be required to declare any interests they may have in accordance with the ICB Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

9. Decision-making

9.1. The SQG does not have formal decision-making authority relating to budgets or other organisational resources.

9.2. Any proposals arising from the Group (e.g. for use of resources) should be requested via the usual ICS governance process.

10. Frequency

10.1. The Group will meet at least quarterly, subject to annual review.

10.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

10.3. Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the SQG Chair and meeting secretariat.

10.4. Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

10.5. Members and staff members from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the Group.

11. Reporting

11.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

11.2. The System Quality Group will report on its activities to IBC Quality & Performance committee. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the SQG; and any actions agreed to be implemented.

11.3. The minutes of meetings shall be formally recorded and reported to the NHS ICB and made publicly available.

12. Group support

12.1. The ICB Quality team will provide business support to the SQG. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

13. Review of Arrangements

13.1. The Group shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the Group considers this appropriate or necessary.