Staffordshire and Stoke-on-Trent Integrated Care Board

System Quality Group (SQG) Terms of Reference

Overview of the SQG

1. Purpose

1.1. The purpose of the SQG is to provide a strategic forum at which all 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 and safety of care and services across the ICS.

2. Aims and Responsibilities

2.1. 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 (e.g. Safeguarding Boards) and regional NHS England 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 (e.g. AHSN, Provider Collaboratives, Clinical Senate / Clinical Networks)
- Test new ideas, share learning and celebrate best practice

2.2. 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 (which is also integrated in the ICP Strategy)
- Ensuring that the ICS objective of reducing inequalities is 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 for 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
- Developing and overseeing mechanisms to ensure that early warnings of system quality failings are identified, acted upon and monitored to ensure improvement
- Supporting Place-based and Provider Collaborative engagement, intelligence and improvement for quality

2.3. The SQG does not have executive powers and **will not**:

- Directly intervene in performance management, contractual or regulatory functions, though where necessary and appropriate it can advise on necessary changes and improvements
- Substitute the need for individual organisations to act promptly when emerging concerns become apparent
- Have 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. This is the role of the System Quality and Safety Committee. 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

3. Scope

3.1. The SQG is concerned with all services:

- Commissioned by the NHS (either the ICB, partners including Provider Collaboratives, Place-Based Partnerships or NHS England
- 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 or not 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, e.g. across pathways / settings with particular emphasis on reducing inequities in access, experience and outcomes.

4. Reporting Responsibility and Accountability

4.1. The SQG is a sub-group of and will report to the ICB Quality & Safety Committee (QSC) and Local Authority assurance. The SQG will also report to the regional NHS England teams on risks and issues via the Regional Quality Group.

4.2. Close working with wider partners (including regulators) will be required.

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

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

4.5. Key points from meetings will be formally recorded in the form of minutes and these will be made publicly available.

4.6. The Chair and relevant Local Authority lead member shall draw to the attention of the ICB (via the SQSC) and local authority assurance (respectively) any issues that require its consideration or executive action.

4.7. Reporting arrangements may change as the ICS emerges and will be updated to reflect the changes.

5. Sub-Groups

5.1. The initial list of sub-groups which shall report into the SQG is as follows:

- Continuous Quality Improvement (CQI)
- Patient Safety Specialists (PSS)
- Health Safeguarding Forum
- System Infection Prevention and Control Forum

5.2. Sub-group chairs shall provide written reports on the previous period's activity.

6. Membership

6.1. In line with National Guidance, the meeting shall be chaired by the ICB Chief Nursing and Therapies Officer. In the event of the chair being unable to attend, a nominated deputy will chair the meeting.

6.2. 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.

7. Additional Membership

7.1. Membership shall initially include:

- ICB to include Chief Nurse and Chief Medical Officer and their nominated deputies, Local Authority senior representatives, regional NHS England teams, Place quality leads, CQC, Health Education England (HEE), public health, primary care, Local Maternity and Neonatal Board representative, patient safety specialist(s), Provider Collaboratives, chairs of all sub-groups of the SQG and at least two lay members with lived experience (including Healthwatch)

- Members may nominate suitably informed deputies to attend and who must have decision-making authority if the member is unable to attend the meeting. Where necessary, this should be limited to maintain a trusting group dynamic and consistent understanding of the current quality position.

8. Quoracy

8.1. To be fully quorate:

- At least 50% of members must be present
- There must be representatives from the ICB, Local Authority, Provider Collaboratives, Place, lay representatives and regional NHS England teams; sub-group chairs are also required to attend all meetings
- 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

9. Frequency

9.1. The SQG will meet on a monthly basis initially. Once established it will move to meeting at least quarterly. Frequency will be subject to annual review.

9.2. Extraordinary meetings may be called at the discretion of the Chair.

10. Meeting Management

10.1. The ICB will provide business support to the SQG, including producing agendas and minutes, compiling and distributing meeting packs and monitoring actions.

10.2. A business cycle will be agreed by the SQG, approved by ICB QSC and reviewed annually or more frequently as required.

10.3. Additional sub-groups / task and finish groups may be convened as required.

10.4. Formal records are required to be kept in line with the ICB retention schedule.

11. Review

11.1. These Terms of Reference shall be reviewed at least annually, so one year from the date of initial approval. Additional reviews may be undertaken if deemed necessary as a result of changes to the emerging ICS arrangements.

12. Conflicts of Interest

12.1. Members will be required to declare any interests that may conflict with the SQG's business prior to or at the meeting.

12.2. 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 NHS Guidance 2017: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the- nhs-guidance-for-staff-and-organisations/.

13. Sharing of Information (including confidential materials)

13.1. 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.

13.2. Group members will give due regard to their responsibilities to comply with GDPR and DPA legislation.

Model TORs for a Place Quality Group

1. Purpose

1.1. 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.

1.2. 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

3.1. Meetings shall be held monthly.

4. Membership

4.1. Chair – Place-based quality lead (subject to final confirmation)

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

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

5. Quorum

5.1. 50% of members are required for the meeting to be quorate.

6. Attendance

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

7. Reporting

7.1. The Place-based quality group will report to the SQG and feed into the ICS established assurance structures (ICB and Local Authorities.