TERMS OF REFERENCE
QUALITY COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Quality Committee ("the Committee"). The committee is a Non-Executive committee of the Board and has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the committee. The committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the committee in the conduct of its inquiries.

The committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Quality Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the committee is to maintain oversight of the clinical strategies; scrutinising delivery of quality care and strategy outcomes in order to provide assurance to the Risk and Audit Committee and to the Board that risks to delivery of the clinical strategies are being managed appropriately. This would support the signing of the Annual Governance Statement and Quality Accounts. The committee will ensure that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

Additionally, the committee has responsibility for scrutinising and assuring delivery of relevant aspects of the Trust's 'Place' objective and ensuring that associated risks are adequately mitigated; supporting the identification and promotion of shared learning, best practice and outstanding care.

Membership

Membership of the committee will be appointed by the Board and shall consist of three Non-Executive members; one of which will be a clinical Non-Executive who will be appointed as Chair and the following:

Director of Strategy, Transformation and Partnerships
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer

Deputies

Executive members are expected to nominate suitable deputies to attend committee meetings in their place, should circumstances prevent members' own attendance.

In Attendance

Senior clinical divisional representatives will be required to attend the committee in order to provide an Escalation Report of key issues arising from divisional leadership / governance meetings. Other members of Trust staff, including other Directors and Non-Executive Directors, may be invited to attend to present and/or discuss particular items on the agenda, and up to three Governors will be invited to observe the meeting. Patients and/or carers may be invited to attend meetings of the committee to discuss particular items.

The Head of Corporate Governance or his/her nominee shall act as secretary to the committee.

Quorum

The committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Chief Medical Officer). A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the committee.

Frequency of Meetings

The committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The committee has the following primary duties and functions:

1. To approve the trust's clinical strategies and Quality Priorities; scrutinising performance against Quality Account priorities.
2. To provide assurance to the Board of adherence to all of the areas of CQC work within the 5 domains reflecting the Key Lines of Enquiry;
3. To receive key regulatory and other inspection reports and scrutinise delivery of any associated action plans.
4. To provide a forum for scrutiny of any of the trust's clinical quality indicators;
5. To provide assurance to the Board that clinical quality risk is being managed and to ensure that risks are escalated to the Board as appropriate.
6. To guide and instruct the direction of clinical audit on behalf of the Board where performance, incidents or strategic clinical risks are identified in order to provide assurance of improvement and effectiveness of mitigations to the Board.
7. To consider any national and/or strategic drivers that may impact on the quality agenda at the trust.
8. To review the learning from complaints, incidents (serious incidents and Never Events) and claims and ensure all associated action plans are delivered and completed.
9. To monitor the development and implementation of the trust's Quality Improvement Strategy

General

The committee will:

1. Review the adequacy of the trust's clinical strategies and monitor delivery of outcomes;
2. Monitor strategic risks within the Board Assurance Framework and the Corporate Risk Register to ensure that risks are being managed and mitigated sufficiently, and that risks are escalated appropriately.
3. Receive details of all Serious Incidents, escalating to the Board where appropriate and receive assurance around the actions taken to prevent recurrence.
4. Monitor on-going compliance with contractual, National and Care Quality Commission standards and seek assurance that any areas of weakness are being addressed.
5. Monitor on-going compliance with the Well Led element of the CQC standards as they relate to the Board to ensure maintenance/improvement of the trust's governance risk rating.
6. Monitor compliance in relation to safeguarding children and adults.

7. Ensure procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and Nursing and Midwifery Council) are in place and are complied with to a satisfactory standard.
8. Monitor the impact of Cash Releasing Efficiency Programmes and significant service changes on quality.
9. Receive updates on an exception basis against key strategies that are approved by the committee and those that are approved by the Board where deemed appropriate, escalating to the Board as necessary

Clinical Governance:

1. Undertake in-depth reviews of the Clinical Quality Indicators reported to the Board.
2. Undertake scrutiny of the Quality Accounts to provide assurance to the Board and Risk and Audit Committee of their accuracy prior to approval.
3. Oversee the implementation and monitoring of the research programme and that the governance framework is implemented and monitored.
4. Approve and monitor the outcomes and learning arising from the Clinical Audit Plan and review the findings of all audits and the adequacy of the management responses. The committee will seek assurances as to quality improvements and how clinical risks have been identified and informed the Clinical Audit Plan.
5. Monitor the patient experience through receipt of information relating to patient surveys, complaints, claims, PALS contacts and incidents.

In consideration of reports, the committee will review the improvement required, availability of resources and outcomes.

Policy Approval

1. Approve strategies that are within the remit of the committee and are deemed appropriate for committee approval by the Board, as provided for in the trust's Standing Orders.
2. Ratify policies approved by the sub-committees that report to this committee on behalf of the Board, ensuring that due process has been followed.

Maintaining Board Oversight

In line with recommendations outlined in the NHSE/I review of Board Non-Executive Director Board Champion roles undertaken in 2021 and the subsequent guidance published in December 2021 *Enhancing Board Oversight: A new approach to NED champion roles,* the following responsibilities were remitted by the Board in January 2022 to be discharged by the Quality Committee:

- Hip fractures, falls and dementia
- Palliative and end of life care
- Resuscitation
- Learning from Deaths
- Safeguarding
- Safety and Risk

- Lead for children and young people

Reporting

The Chair of the committee will report in writing to the Board at the Board meeting that follows the committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive team for action.

The Chair of the committee will also attend the Risk and Audit Committee to provide assurance on the committee's processes and the work that it has undertaken.

The committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The committee has established the following sub-Committees:

- Clinical Outcomes and Effectiveness Committee
- Mental Health Steering Group
- Medicines Committee
- Infection Prevention and Control Committee
- Safeguarding Committee
- Patient Safety Committee
- End of Life Committee
- Patient Experience and Public Engagement Committee
- Research and Development Steering Group
- Health Inequalities Group
- Reproductive Health Clinical Governance Committee

The committee will also receive Escalation Reports from divisional leadership / governance meetings and divisional representation at committee will be required.

Administration

The Quality Committee will be serviced by the Corporate Governance Team who will agree the agenda and committee Work Plan with the Chair of the committee.

Review

These Terms of Reference will be reviewed in 12 months unless there is a requirement to do so earlier.

Appraisal

The committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors

Approved by Quality Committee – 21st March 2023
Ratified by the Board – 29th March 2023