Quality Committee Terms of Reference

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1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below. A summary of the Committee's key assurance responsibilities, expected assurance outputs, inter-committee relationships, and risk oversight expectations can be found in Appendix B. In case of any conflict between Appendix B and the main body of these terms of reference, the main body of the terms of reference shall prevail.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and the other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Deputy Chief Nursing Officer;

3.4.2 Clinical Director for Patient Safety;

3.4.3 Associate Director of Patient Experience;

3.4.4 Director of Midwifery;

3.4.5 Head of Clinical Quality Assurance;

3.4.6 Head of Patient Safety;

3.4.7 Head of Medical Directorate; and

3.4.8 Associate Director of Corporate Affairs (**Company Secretary**).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the year) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Nursing Officer and the Chief Medical Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The Company Secretary (or a nominated deputy) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by

the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 *Patient Safety*

7.1.1 The Committee will review the aggregated analysis of adverse events (including patient safety incident investigations (PSII) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 *Patient Experience*

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 *Patient Outcomes*

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 *Quality Improvement*

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 *Performance Monitoring*

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

Risk

7.5.6 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

7.5.7 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.5.8 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

7.5.9 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.6 ***Reporting***

7.6.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.6.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality accounts/quality report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

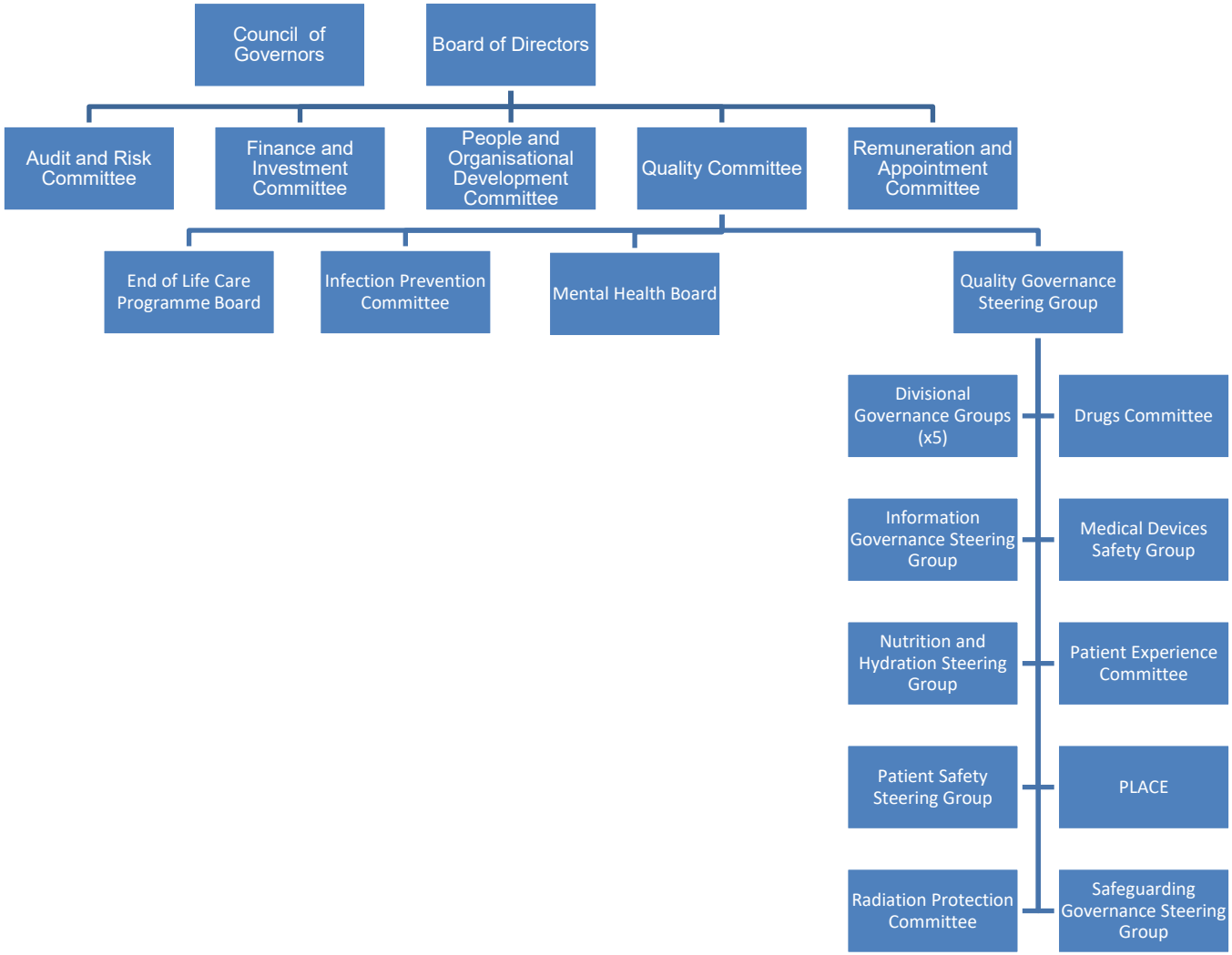
9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

National Health Service Act 2006
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission
Health Act 2009
National Health Service (Quality Accounts) Regulations 2010
Code of Governance for NHS Provider Trusts
NHS System Oversight Framework
NHS Foundation Trust Annual Reporting Manual
NHS England and NHS Improvement's requirements for quality accounts

Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

Appendix B

Key Assurance Responsibilities

The committee's key assurance responsibilities are:

Clinical governance	Overseeing the systems, controls and risk management arrangements supporting safe, high-quality, patient-centred care.
Relevant Reports/Papers:	• Messages from the Quality Governance Steering Group • Board Assurance Framework • Fundamentals of Care Reports • Mental Health Reports • NatSSIPS Reports • Infection Prevention and Control Annual Report • Consultant Job Planning Reports • Committee Chair's Report to Board • Committee Terms of Reference
Patient safety	Reviewing themes and trends from adverse incidents, never events, complaints, claims, and inquests.
	Obtaining assurance on safeguarding systems and considering internal audit findings relating to quality and safety.
Relevant Reports/Papers:	• Maternity and Neonatal Safety Reports • Maternity and Neonatal Workforce Reports • Patient Safety Reports • Safeguarding Annual Report • Medicines Safety Annual Report
Patient Experience	Reviewing reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service, and other sources of feedback on all formal and informal patient feedback.
Relevant Reports/Papers:	• Experience of Care Reports • Learning from Deaths Reports • Annual Complaints Report
Clinical outcomes and effectiveness	Reviewing the annual clinical audit programme and monitoring its delivery.
	Overseeing Trust-wide outcomes and national audit findings.
Relevant Reports/Papers:	• Annual Clinical Audit Programme • Audit Findings Reports • Clinical Effectiveness Outcomes Reports
Performance and data quality	Advising on quality and safety indicators, benchmarks and supporting data quality.
	Identifying potential evidence and areas of health inequalities and seeking assurance that these are being addressed.
	Seeking assurance that improvement targets are supported by achievable action plans.
Relevant Reports/Papers:	• Quality Indicators Updates • Quality Priorities
Regulatory and compliance	Reviewing the Quality Account and other key non-financial governance submissions before Board approval.
	Reviewing CQC reports, compliance with fundamental standards and delivery of actions arising from regulatory findings.
Relevant Reports/Papers:	• Quality Account • CQC Reports and Action Plans

Expected Assurance Outputs

The committee's expected assurance outputs are:

Clinical governance	Reporting concerns regarding the systems, controls and risk management arrangements supporting safe, high-quality, patient-centred care via the Committee Chair.
Patient safety	Reporting on themes and trends from adverse incidents, never events, complaints, claims, and inquests and escalating concerns to the Board as appropriate.
	Providing the Board with assurance on safeguarding systems and reporting internal audit findings relating to quality and safety as appropriate.
Patient Experience	Reporting feedback from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service, and other sources and escalating concerns as appropriate.
Clinical outcomes and effectiveness	Providing the Board with assurance regarding the annual clinical audit programme and reporting any concerns arising from clinical audits as appropriate.
Performance and data quality	Providing the Board with assurance in relation to reported quality and safety indicators, benchmarks and supporting data quality.
	Providing the Board with assurance in relation to the Trust's activities to identify and address health inequalities.
	Providing the Board with assurance that improvement targets are supported by achievable action plans.
Regulatory and compliance	Recommending that the Quality Account and other key non-financial governance submissions be approved.
	Reviewing CQC reports, compliance with fundamental standards and delivery of actions arising from regulatory findings and escalating matters to the Board as appropriate.

Inter-Committee Relationships

The Committee shall report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality account and the appropriateness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

Risk Oversight Expectations

Board Assurance Framework Risk	**Oversight**
Outstanding patient outcomes, safety and experience	
1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.	Y
1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.	Y
1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.	Y
Pioneering research and innovation	
2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.	N
World class people	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	N
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.	N

3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.	N
Integrated networks and collaboration	
4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.	Y
Foundations for the future	
5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.	N
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	N
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation,	N
5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.	N

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