University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Quality Committee

January 2023

DOCUMENT DETAILS

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Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
October 2020	1	October 2021	July 2020	Company Secretary	New document
May 2021	1.1	October 2021	26 May 2021	Assistant Company Secretary	Removed CEO as member of the committee at section 2.1 Added the CEO's attendance at section 2.4 Added CEO's receipt of papers at section 5.4
October 2021	1.2	October 2022	November 2021	Company Secretary	Added the Care Group Quality & Risk Groups to the reporting groups in sections 1.4 and 9.1 Added Associate Director of AHP/HCS as an attendee in section 2.2

					Added that the Clinical Lead for Clinical Audit is to attend for the Annual Audit Plan and Annual Report in section 2.2.
January 2022	1.3	January 2023		Corporate Governance Assistant	Changed "Quality Governance Group" to "Clinical Governance Group" in sections 1.4 and 9.1.
January 2023	2.0	January 2024		Company Secretary	Full review and re-draft.

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INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A

BOARD OF DIRECTORS/COMMITTEE APPROVAL			
If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	
Print Name		Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Quality Committee is to support the Trust in achieving its strategic objective: "**To enhance emergency care and hospital flow and continually improve the quality so that services are safe, compassionate, timely and responsive, achieving consistently good outcomes and an excellent patient experience**".

1.3 The Quality Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Quality Strategy, Risk Management Strategy and Clinical Audit Strategy and the End of Life Care Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services;
- Promoting a culture of learning and continuous improvement;
- Obtaining assurance on the implementation of the quality strategy; and
- Receiving and reviewing information and data relating to quality performance reporting to the Board.

1.4 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (children and adults), infection prevention and control, medicines management, learning from deaths and end of life care.

1.5 The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

1.6 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

Quality Strategy and delivery of the Quality Agenda

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

Risk Management

2.3.1 To oversee that the Trust has robust management systems and processes in place for ensuring high standards for quality of care.

2.3.2 To oversee that the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience.

2.3.2 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.3 To be kept appraised of all new and current risks rated 12-25, clinical and non-clinical, identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

Assurance

2.4 Statutory requirements

2.4.1 To review the annual quality report.

2.4.2 To review the quarterly and annual mortality reports.

2.4.3 To review the annual adult and children safeguarding report and statement.

2.4.4 To review the annual reports on claims.

2.4.5 To review the annual infection prevention and control report and statement.

2.5 External reviews

2.5.1 To receive assurance from other significant assurance functions, both internal and external, on review of the findings of external reviews and consider the implications to the Trust. These will include, but not be limited to, regulators and inspectors.

2.5.2 To monitor the Trust's responses to relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

2.5.3 To receive and monitor the CQC Insight Model Report.

2.5.4 To receive and monitor the CQC in-patient survey reports and associated action plans.

2.6 Safe

2.6.1 To review reports on serious incidents, mortality, learning from deaths, never events, claims and inquests to receive assurance that appropriate thematic review, investigation and learning to reduce risk has been undertaken.

2.6.2 To receive reports including:

- identification of areas of concern and escalations; and
- in the context of quality risks and assurances over the Trust's system of internal control as reflected in the Board Assurance Framework;

from defined sub-groups of the Trust Management Group and/or Board Committees (including, as considered required, Safeguarding, Infection Prevention & Control, Radiation Protection, Medicines Governance, Health and Safety, Mortality Surveillance, Clinical Governance Group and Strategic Nursing Midwifery and Professions Group).

2.6.3 To review and monitor Quality Impact Assessments relating to cost improvement programmes and transformation programmes to obtain assurance that there will be no unforeseen detrimental impact on the quality of care for patients.

2.6.4 To obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and adults.

2.6.5 To obtain assurance over the Trust's maternity services including receipt of reports from the Maternity Safety Champion and relevant maternity safety and performance dashboards.

2.6.6 To obtain assurance over the safe delivery of the Trust's palliative and end of life care services including receipt of the annual End of Life Care Report and Care of the Dying Audit.

2.6.7 To obtain assurance in relation to the safe delivery of the Trust's resuscitation services.

2.6.8 To obtain assurance in relation to the safe delivery of the Trust's children's services.

2.6.9 To obtain assurance in relation to the delivery of the Trust's falls and dementia services.

2.6.10 To review reports in relation to Getting It Right First Time.

2.6.11 To receive relevant reports from national bodies in relation to standards or practice of clinical care.

2.7 Effective

2.7.1 To ensure a comprehensive clinical audit programme is in place to support and apply evidence-based practice, implement clinical standards and guidelines and drive quality improvement. This shall include through monitoring progress against the Clinical Audit Strategy.

2.7.2 When requested by the Board, or where determined by the Committee, to monitor the implementation of action or improvement plans in relation to quality of care, particularly in relation to incidents and similar issues.

2.8 Caring

2.8.1 To consider reports from the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on formal and informal patient feedback and to consider action in respect of matters of concern.

2.8.2 To consider the results of issues raised and the trends in patient surveys of in-patients and out-patients activities and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of suitable improvement and the completion of action to address the issues raised.

2.9 Well-Led

2.9.1 To receive and consider the Trust's clinical governance and risk management reports and review recommendations on actions for improvement.

2.9.2 To provide assurance reporting to the Board that the Care Quality Commission's fundamental standards for quality and safety are monitored and highlight any gaps in compliance, controls or assurance.

2.9.3 To review, make comment and provide assurance reporting to the Board on the care and safety issues which are subject to other regulatory scrutiny (for example, NICE).

2.9.4 To oversee, through receipt of periodic status reporting, the update of clinical policies.

2.10 Responsive

2.10.1 To identify key themes from complaints, PALS and patient engagement, good practice and learning and provide oversight on behalf of the Board.

2.10.2 To identify key themes from patient experience, quality indicators and provide oversight of action plans to attain assurance.

2.10.3 To receive, by exception, reports relating to patient experience following review at relevant groups.

2.11 ICS

To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Quality Committee comprises of three Non-Executive Directors, one of whom will be a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Nursing Officers;
- Deputy Chief Medical Officers;
- Director of Infection Prevention and Control;
- Care Group Medical Directors;
- Associate Director of Pharmacy;
- Associate Medical Director (Chair of CGG);
- Care Group Directors of Nursing;
- Associate Director of Quality Governance and Risk;
- Clinical Lead for Clinical Audit;
- IR(ME)R Lead/Chair of Radiation Group;

- Associate Director of Allied Health Professionals & Healthcare Scientists

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee or Finance and Performance Committee). A Non-Executive Deputy Chair (other than the Chair of the Audit Committee or Finance and Performance Committee) may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer will attend on an ad-hoc basis or as required.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 There may be up to two governors attending each meeting as observer(s). Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.2 The Committee is authorised to approve its governance cycle.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.5 The Committee is authorised to approve policies in accordance with the Document Control Policy.

5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation and Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least five members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors, one of whom must be the Chief Medical Officer or Chief Nursing Officer. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Nursing Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 The agenda and papers shall be made available upon request to members of the Board.

5.8 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee shall refer to the Audit Committee, Finance & Performance Committee, People & Culture Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.5 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Trust's Annual Report disclosures.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

APPENDIX A

ATTENDANCE AT QUALITY COMMITTEE MEETINGS

NAME OF COMMITTEE:	Quality Committee								
	Meeting Dates								
Present (*include names of members present at the meeting)*									
In Attendance									
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)									