Sheffield Children's NHS
NHS Foundation Trust

TERMS OF REFERENCE

QUALITY COMMITTEE

Version	Status	Date	Issued / Amended	Summary of Changes
V3	Approved	July 2023	Corporate Affairs	Minor changes.

Review Date	July 2024

1. AUTHORITY

1.1. The Quality Committee (The Committee) is constituted as a standing committee of the Sheffield Children's NHS Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

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

2. ROLE

2.1. On behalf of the Board of Directors to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust to:

2.1.1. promote continuous improvement and safety, effectiveness and excellence in patient care;

2.1.2. identify, prioritise and manage risk arising from clinical care;

2.1.3. ensure the effective and efficient use of resources through evidence-based clinical practice; and

2.1.4. ensure compliance with legal, regulatory and other obligations, including national quality standards, eg as set out by the Care Quality Commission, National Institute for Clinical Excellence, the national Patient Safety Framework and NHS Long Term Plan.

3. DUTIES

3.1 In particular, in respect of general governance arrangements:

3.1.1. To ensure that all statutory elements of clinical governance are adhered to within the Trust.

3.1.2. To develop and recommend for approval by the Trust Board, Trust-wide quality priorities to form the basis of a Trust Quality Promise and give direction to the clinical governance activities of the Trust's services and divisions through routine consideration of the Trust's Annual Integrated Governance Report;

3.1.3. To approve the Trust's Annual Integrated Governance Report on behalf of the Board of Directors.

3.1.4. To approve the Terms of Reference and membership of its reporting committees (as may be varied from time to time at the discretion of the Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the Committee in the sub-committee's terms of reference for consideration and action as necessary;

3.1.5. To consider matters referred to the Committee by the Board of Directors or other committees thereof, the Executive Team and Management Board, the performance review process or divisional concerns that require urgent attention;

3.1.6. To consider matters escalated to the Committee by its own sub-committees;

3.1.7. To approve the annual Clinical Audit Programme on behalf of the Board of Directors and ensure it is consistent with the audit needs of the Trust;

3.1.8. To make recommendations to the Risk and Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;

3.1.9. To review and approve on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference, elsewise receive assurance from the Executive Risk Management Committee around the implementation of a robust process for the review and approval of relevant policies; and

3.1.10. To foster links with primary care and other stakeholders including the Public Involvement Groups and commissioners in matters relating to clinical governance/quality.

3.2 In particular, in respect of safety and excellence in patient care:

3.2.1 To commission the setting of quality standards by the Board and ensure that a mechanism exists for these standards to be monitored;

3.2.2 To ensure the Trust complies with NHS Resolution Authority standards;

3.2.3 To ensure the registration criteria of the Care Quality Commission continue to be met;

3.2.4 To review Trust compliance with the national standards of quality and safety of the Care Quality Commission, and foundation trust licence conditions that are relevant to the Committee's area of responsibility; to receive advice regarding remedial action being taken as necessary by the Executive Team and provide assurance to the Board of Directors;

3.2.5 To assure that there are processes in place that safeguard children and adults within the Trust;

3.2.6 To oversee the system within the Trust for obtaining and maintaining licences or accreditation relevant to clinical activity in the Trust (eg licences granted by the Human Tissue Authority or any successor organisation) receiving such reports as the Committee considers necessary;

3.2.7 To seek assurance through review of the routine Legal and Governance report that the Trust incorporates the recommendations from external bodies, eg the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission, as well as those made internally, eg in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery;

3.2.8 To ensure that robust arrangements are in place for the review of patient safety incidents (including never events, complaints, claims reports from HM Coroner) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;

3.2.9 To ensure that actions for improvement identified in incident reports, reports from HM Coroner, Learning from Deaths and other similar documents are addressed;

3.2.10 To identify areas for improvement in respect of incident themes and complaint themes from the results of National Patient Survey / PALS / Friends and Family Test and ensure appropriate action is taken;

3.2.11 To assure that the Trust has reliable, real time, up to date information about what it is like being a patient experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected;

3.2.12 To support the Board to promote within the trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern and monitoring the implementation of that policy;

3.2.13 To ensure implementation of the National Patient Safety Agency reporting system;

3.2.14 To escalate to the Risk and Audit Committee any identified unresolved risks arising with the scope of these terms of reference that require Executive action or that pose significant threat to the operation, resources or reputation of the Trust;

3.2.15 To ensure that any areas of concern identified from the Committee's review of clinical quality are entered onto the Trust risk register, as appropriate and any identified gaps in controls in relation to delivery of relevant Trust strategic objectives are reflected on the Board Assurance Framework.

3.2.16 To approve the Trust's seven day assurance framework.

3.2.17 To approve, on behalf of the Board, the quarterly report on Learning from Deaths for publication on the Trust's website.

3.2.18 To approve, on behalf of the Board, the annual medical revalidation.

3.3 In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

3.3.1 To receive and review the Trust's annual Quality Accounts and make recommendations as appropriate for Trust Board approval;

3.3.2 To ensure that the Trust has a robust process in place to proposals for improvement programmes and other significant service changes and to monitor the impact of proposals for improvement programmes and other significant service changes on the Trust's quality of care (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the Committee) and report any concern relating to an adverse impact on quality to the Trust Board;

3.3.3 To ensure that care is based on evidence of best practice/national guidance;

3.3.4 To assure that procedures stipulated by professional regulations or chartered practice (ie General Medical Council), are in place and performed to a satisfactory standard;

3.3.5 To ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R);

3.3.6 To assure the implementation of all new procedures and technologies according to Trust policies;

3.3.7 To review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them;

3.3.8 To monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate;

3.3.9 Through the Trust's Annual Quality Accounts, monitor the development of quality indicators, particularly CQUINS or best practice tariffs, throughout the Trust; to advise the Board of Directors on appropriate quality and safety indicators and benchmarks for inclusion in reports to the Trust Board and keep these under regular review;

3.3.10 To generally monitor the extent to which the Trust meets the requirements of commissioners and external regulators;

3.3.11 To identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties;

3.3.12 To ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);

3.3.13 To ensure that where practice is of high quality, that practice is recognised and propagated across the Trust; and

3.3.14 To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

4. MEMBERSHIP

4.1. The membership of the Quality Committee shall consist of:

- At least three Non-executive Directors, one whom should be appointed Chair of the Committee by the Board of Directors
- Up to three other executive directors including the Chief Nurse and Executive Medical Director.

Members listed above are required to attend at least two-thirds of the meetings held annually.

4.2. Meetings of the Quality Committee may be attended by:

- Chief Executive
- Associate Non-executive Director
- Associate Director of Corporate Affairs / Corporate Affairs Officer (minutes)
- Any nominated deputy attending in place of a member of the Committee; and/or
- A Governor may be in attendance to observe the meeting

- The Trust's Legal Services Director
- Any other person who has been invited to attend a meeting by the Quality Committee so as to assist in deliberations or present reports.

The Trust Chairman has a standing invitation to all meetings but is not designated as a member of the Committee.

4.3. The Committee will be deemed quorate to the extent that the following members are present:

- Either the Chief Nurse or the Executive Medical Director.
- At least one Non-executive Director, whom shall Chair the Committee.

4.4. Wherever possible, membership of the Committee should include at least one common non-executive member with the Risk and Audit Committee. This member should act as a conduit of information and assurance across the two Committees in support of the Trust's integrated governance approach.

4.5. For the avoidance of doubt, Trust employees who serve as members of Quality Committee do so to act in the interest of the Trust as a whole and as part of the Trust-wide governance structure.

5. FREQUENCY OF MEETINGS

5.1. The Committee should meet at a frequency to be determined by the Committee Chair but should meet at least eight times a year.

5.2. Additional meetings may be held on an exceptional basis at the request of the Committee Chair or any two members of the Quality Committee.

6. MINUTES AND ASSURANCE

6.1. The minutes of all meetings of the Quality Committee shall be formally recorded by a member of the Corporate Affairs Office or their nominee.

6.2. The Committee will provide assurance to the full Board of Directors after each meeting. The Chairman of the Committee will bring to the attention of the Board of Directors any items that the Committee feels that the Board should be aware of.

6.3. The Committee will consider matters referred to it for action by the other committees and provide assurance back in writing.

6.4. The Committee will provide an annual report to the Risk and Audit Committee and Board of Directors on the effectiveness of its work and its findings. This will assist the Risk and Audit Committee in discharging its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control. In addition, the minutes of the latest Committee meeting will be included on the Board Agenda.

7. REPORTING/PROVIDING ASSURANCE

A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. In doing so they shall provide assurance to the Quality Committee on at least an annual basis. The list of such committees will be held by the Corporate Affairs Office.

8. REVIEW

8.1. The terms of reference of the Committee shall be reviewed annually by the Risk and Audit Committee and approved by the Board of Directors.

APPROVED BY THE BOARD OF DIRECTORS ON: 25 July 2023