University Hospitals Sussex
NHS Foundation Trust

University Hospital Sussex NHS Foundation Trust

PATIENT AND QUALITY COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Patient & Quality Committee ("the Committee") is to support the Trust in achieving its quality strategic objective; "We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards."

1.02 The Committee will do this through;

- Providing input and recommendations to the Board for the development of the Quality Strategy and Clinical Framework and Strategy, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services and in line with national, regional and commissioning requirements;
- Driving a culture of learning and continuous improvement across the organisation;
- Obtaining assurance that the quality strategy is being implemented; and
- Review of soft intelligence, narrative and data relating to the NHS Quality Assurance Framework and Darzi principles of quality (patient and family experience, patient safety and clinical effectiveness) to enable integrated quality performance reporting to the Board.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Medical Officer (Lead Executive for the Committee)
- Chief Nurse (Alternate Lead Executive for the Committee)
- Chief Governance Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Deputy Chief Medical Officer (Quality)
- Director of Clinical Effectiveness
- Director of Patient Safety and Learning
- Director of Patient Experience, Involvement and Engagement
- Associate Director of Infection Prevention and Control
- Deputy Chief Nurse (Quality and Safety)
- Director of Midwifery

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.09 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 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. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Quality domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board on an annual basis of the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board on an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board on an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Statutory requirements

3.14 Review the annual Quality Account.

External reviews

3.15 The Quality Committee shall receive assurance from other significant assurance functions, both internal and external to the organisation, on its review of the findings and consider the implications to the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors.

3.16 To monitor the Trust's responses to all relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission (CQC).

3.17 To receive exception reporting from sub-groups regarding the CQC's insight report in respect of any potential changes to the Trust's quality risk profile.

Safe

3.18 To obtain assurance that there are effective systems and processes in place which embed learning from incidents and near misses in a way that reduces risk thereby improving outcome measures and quality of care.

3.19 To receive a summary report, using a standard template, which includes identification of areas of concern and escalations from the Committee's determined sub-groups.

3.20 To receive triangulated reports and review the themes, trends, management, and improvements relating to serious incidents, 'never' events, post-mortem reports, medico-legal cases and to seek assurance that remedial action plans are being implemented and learning is embedded and shared across the organisation. Assurance to be obtained through incident reports, Learning from Deaths reports, HSMR Action Plan, Duty of Candour audits and Patient Safety reports.

3.21 Review and monitor Equality and Quality Impact Assessments (EIA) (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.22 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

3.23 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults.

3.24 To consider reports from the Committee's reporting groups, e.g. Safeguarding, in the context of quality risks and assurances over the Trust's system of internal control as reflected within the BAF.

3.25 Review the annual Infection Prevention and Control report.

3.26 Obtain assurance over the Trust's maternity services including receipt of reports from the Executive Maternity Champion and the relevant maternity safety and performance dashboards

3.27 Obtain assurance over the safe delivery of the Trust's Dementia strategy.

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

3.29 To receive reporting from the Committees established reporting groups and ensure that the patient voice is being used to influence, change and shape practice.

3.30 To approve the Trust's patient and public engagement plans and the patient experience plans/strategy and ensure that these plans are incorporated into the quality and clinical governance teams across the Trust.

3.31 To consider reports from the Customer Relations Team, the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider action in respect of matters of concern.

3.32 To consider the results and the issues raised and the trends in all patient surveys (including real-time patient feedback systems), of in-patients and out-patients activities (e.g. Inpatient, Cancer, Maternity and ED) and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of robust improvement plans and the subsequent completion of action taken to address issues raised.

Effective

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

3.34 In response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action/improvement plans in respect of quality of care, particularly in relation to incidents and similar issues.

Well-led

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

3.36 To monitor and obtain assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

3.37 To consider reports from Service Governance Reviews, to ensure that the reviews are effective and that actions arising from them are addressed in a timely and appropriate manner.

3.38 To ensure that the Board Assurance Framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

Responsive

3.39 To obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

3.40 To review the Complaints Procedure in conjunction with the periodic review of the Complaints Policy.

3.41 To seek assurance that complaints are managed in a way that promotes a culture of openness, learning and continuous improvement across all divisions.

3.42 To review the themes and trends in complaints and the learning and improvements made relating to complaints raised and trends identified.

Integrated Care System (ICS) and system collaborations

3.43 To receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Sub-Groups

3.44 To oversee and scrutinise the performance of relevant sub-groups through a range of formal and informal activities.

3.45 The Committee shall approve all sub-groups' terms of reference annually or as recommended otherwise by the Trust Company Secretary.

Risk

3.46 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote continuous quality improvement with regard to the management of quality risk and the control environment throughout the Trust.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Finance & Performance Committee, People & Culture Committee, Research, Innovation & Digital Committee Quality & Safety Improvement Programme Committee or Charitable Funds Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups, which set out any matters requiring escalation to the Committee and provide assurance of effective standards and performance in their respective Departments.

4.05 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 Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee, the Chief Medical Officer or Chief Nurse. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 10 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee February 2024.

6.04 Next full review: by March 2026

Appendix - Mandated reports considered by the Committee

In addition to the reports referenced in the Committee's Cycle of Business, below is a list of the mandated reports the Committee would receive over the year

- Annual Quality Account
- Annual Mental Health Act Compliance Report
- Adult Safeguarding Annual Report and Quarterly Reports
- Child Safeguarding Annual Report and Quarterly Reports
- Infection Prevention and Control Annual Report and Quarterly report
- Learning from Deaths quarterly and annual report
- Annual Incident Report
- Duty of Candour Compliance Report
- Annual Complaints Report
- Quality Dashboards, covering Maternity and Key Indicators
- Dementia Strategy
- Patient Survey Reports
- PLACE Reports
- Parliamentary and Health Service Ombudsman Reports
- HealthWatch Reports
- Patient Experience and Engagement Annual Report