NHS Gloucestershire Integrated Care Board

Quality Committee Terms of Reference

v1.0

1st July 2022

1. Introduction

1.1 The Quality Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. Purpose of the committee

2.1 The Quality Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

2.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

2.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. Delegated authority

3.1 The Quality Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

3.2 The Quality Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.3 The Quality Committee is authorised by the Integrated Care Board to:

3.3.1 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.3.2 Commission any reports it deems necessary to help fulfil its obligations;

3.3.3 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.3.4 The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be.

- Independent Non-Executive Director of the ICB with the remit and responsibility for Quality (Chair);
- Independent Non-Executive Director of the ICB (Vice-chair);
- ICB Chief Nursing Officer or their nominated Deputy;
- ICB Chief Medical Officer;
- One main Acute Partner executive representative;
- One main Community and Mental Health Partner executive representative;
- One Primary Care representative who shall not be the ICB Chief Medical Officer;
- One or more Local Authority representatives (Director of Public Health, Director for Adult Social Services).

4.3 Members will possess between them knowledge, skills and experience in: clinical quality and governance and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5 Chair and vice chair

4.5.1 The Chair of the Committee shall be an Independent Non-Executive Member of the ICB.

4.5.2 Committee members may appoint a Vice Chair who shall be an Independent Non-Executive Member of the ICB.

4.5.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR in consultation with the Executive Lead - Chief Nursing Officer.

4.6 Attendees and other Participants

4.6.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- One Independent Non-Executive Director of each main system Provider partner (Community & Mental Health; Acute), who chairs their equivalent committee responsible for quality.
- ICB Deputy Director of Nursing;
- ICB Associate Director of Nursing (Commissioning);
- ICB Patient Safety Specialist;
- ICS Health and Care professional leads;
- ICS Designated Nurse Safeguarding Children and Safeguarding Adults Manager;
- ICB Quality Leads;
- ICB Quality and Nursing Business Manager;
- ICB Associate Director of Corporate Affairs.

4.6.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.6.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter

including representatives from the Primary Care, Secondary and Community Providers.

4.6.4 The Chief Executive should be invited to attend the meeting at least annually.

4.7 Attendance

4.7.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy, and the Chief Nursing Officer or Chief Medical Officer (or deputy).

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting.

5.3 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Voting and decision-making

6.1 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication

7. Frequency and notice of meetings

7.1 The Quality Committee shall meet six times a year (every other month). The Chair of the Committee may convene additional meetings as required.

7.2 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead – Chief Nursing Officer;

8.1.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report)

8.1.3 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

8.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5 The Chair is supported to prepare and deliver reports to the Board;

8.1.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

8.2 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of

members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the committee

9.1 The Quality Committee has been constituted in terms of its scope, responsibilities and membership to facilitate the ICB meeting its four fundamental purposes to

- **improve outcomes** in population health and healthcare;
- **tackle inequalities** in outcomes, experience, and access;
- **enhance productivity** and value for money;
- help the NHS support broader **social and economic development**.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 The committee will have a strong focus on the partnership agenda and will work with the System Quality Group to support the ICS to bring partners together on approaches that can't be achieved by a single organisation alone.

9.4 The responsibilities of the Quality Committee will be authorised by the ICB Board. It is expected that the Quality Committee will:

9.4.1 Be assured that there are robust processes in place for the effective management of quality;

9.4.2 Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern;

9.4.3 Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan;

9.4.4 Oversee and monitor delivery of the ICB key statutory requirements;

9.4.5 Review and monitor those risks on the Board Assurance F and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

9.4.6 Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

9.4.7 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites;

9.4.8 Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

9.4.9 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;

9.4.10 Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

9.4.11 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

9.4.12 To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

9.4.13 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

9.4.14 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

9.4.15 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;

9.4.16 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

9.4.17 Approval of policies and standard operating procedures (SOPs) as relevant to the committee's business.

10. Relationship with the ICB and other groups / committees / boards

10.1 The Quality Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

10.2 The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Infection Prevention and Control, Safeguarding Boards / Hubs etc).

10.3 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

11. Policy and best practice

11.1 The Committee shall have regard to current good practice, policies and guidance issued by the NHS England, NICE, Royal Colleges and other relevant bodies

12. Monitoring and Reporting Policy and best practice

12.1 The Chair of the Committee shall report the outcome and any recommendations of the committee to the Board of the ICB, and provide a report on assurances received, escalating any concerns where necessary.

12.2 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICB.

12.3 The Committee shall submit to the Board of the ICB an Annual Report of its work.

12.4 The Committee shall agree an annual schedule of reports and their frequency for the Quality Committee meetings.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending the Committee shall be have in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Conflicts of interests

13.4.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

13.4.2 All potential conflicts of interest must be declared and recorded at the start of each meeting.

13.4.3 A register of interests must be maintained by the Governance Team, submitted with the Quality Committee papers and annually to the Board.

13.5 If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

14.2 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.