

PENNINE LANCASHIRE QUALITY COMMITTEE

TERMS OF REFERENCE

1.0 Purpose of the Committee

The Quality Committee will be established as a sub-committee of both BwDCCG and ELCCG Governing Bodies, and be accountable to the Governing Bodies for all quality and safety issues, specifically to:

- 1.1 Receive and review assurance on quality and performance for the CCG and all commissioned services;
- 1.2 Provide an assurance to the Governing Bodies that there are robust structures, processes and accountabilities in place for identifying and managing significant risks facing the organisation (ie strategic, operational, clinical and organisational);
- 1.3 Approve policies and procedures for the management of risk and quality;
- 1.4 Approve the measuring and monitoring of quality standards and outcomes;
- 1.5 Receive regular assurance reports in relation to Safeguarding.

The Committee will seek to achieve this through close partnership working with other agencies and key stakeholders, whose role will be crucial in developing and enabling a culture of continuous quality improvement.

2.0 Principle Roles and Responsibilities

2.1 Quality and Performance

- 2.1.1 Implement and monitor progress against both CCG Quality Strategies.
- 2.1.2 To ensure the care commissioned on behalf of the East Lancashire and Blackburn with Darwen population is consistently applied, based on sound evidence, clinically effective and meeting agreed standards and delivers the best use of financial resources for its population.
- 2.1.3 To ensure commissioning decisions are based upon valid, accurate, complete and timely data and information. This will include a variety of quality schedules / metrics / indicators appropriate to each, contracts and commissioned services that are monitored regularly.
- 2.1.4 To be responsible for monitoring and managing performance in relation to quality.
- 2.1.5 To receive the Integrated Business Report and monitor and manage exceptions against trajectories.
- 2.1.6 Recommend significant changes and deviation to operational plan delivery associated with identified quality requirements and advise on variations in planned programmes of delivery, investment or disinvestment where the quality and effectiveness of commissioned and contracted services are compromised.
- 2.1.7 To ensure that both CCGs comply with and monitor commissioned providers with the Care Quality Commission standards for commissioned services.
- 2.1.8 To contribute to CCG understanding and action on the role of Quality, Innovation, Productivity and Prevention (QIPP) in driving and embedding improvement opportunities and initiatives in the commissioning of services.
- 2.1.9 To ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services.
- 2.1.10 Monitor quality and CQUIN performance in line with agreed timescales and oversee the delivery of improvement plans where quality measures are not achieving expected levels.

- 2.1.11 To ensure reports from Patient Experience are given priority to ensure improvement in the patient experience in line with local, regional and national priorities and measurements
- 2.1.12 To approve CCG arrangements for handling complaints
- 2.1.13 To approve the arrangements for handling FOI requests.
- 2.1.14 To approve arrangements for safeguarding children and vulnerable adults.
- 2.1.15 Receive, as a minimum, quarterly reports from the Safeguarding Lead in order to provide assurance to both CCG Governing Bodies that the health economy has robust systems and processes in place to fulfil their statutory duties for adults and children's safeguarding in Pennine Lancashire and that the CCGs fulfil their obligations in this regard.
- 2.1.16 To receive assurance updates from the Lancashire Medicines Management Forum in respect of quality and safety.
- 2.1.17 Provide monthly reports to both CCG Governing Bodies around the quality of commissioned services which give assurance that appropriate interventions are being taken where quality is below expected levels.

2.2 Risk Management

- 2.2.1 The Pennine Lancashire Quality Committee is responsible for providing regular assurance to the individual Governing Bodies that there are robust structures, processes and accountabilities in place for identifying and managing significant risks facing the organisation (i.e. strategic, operational, clinical and organisational)
- 2.2.2 The Pennine Lancashire Quality Committee is responsible for approving and maintaining dynamic risk management arrangements, including a robust risk register covering strategic, operational, clinical and organisational risks.
- 2.2.3 The Committee will ensure effective risk management of clinical and corporate governance areas arising from the CCG's performance management function, including incidents, information governance, clinical quality, medicines management, complaints, claims and the safeguarding of vulnerable adults and children.
- 2.2.4 The Pennine Lancashire Quality Committee is responsible for ensuring that an appropriate sub group infrastructure is established and maintained with clear lines of accountability and responsibility to carry through the integrated governance agenda, e.g. Risk Management and Compliance Group (RMCG) & others and to receive reports from these groups.
- 2.2.5 Receive a detailed report, bi-monthly to enable the committee to review the risks on the Corporate Risk Register (scored 8 or above) and Governing Body Assurance Framework and the progress being made to mitigate risks.
- 2.2.6 The Pennine Lancashire Quality Committee will direct any further action deemed necessary to ensure effective management of the risks and will provide expertise in determining whether the management of risks is satisfactory.
- 2.2.7 The Pennine Lancashire Quality Committee is the Committee responsible for approving policies and procedures for the management of risk.

2.3 Integrated Governance

- 2.3.1 Ensure effective risk management of clinical and corporate governance areas arising from the CCG quality and performance management function for BwDCCG and ELCCG.
- 2.3.2 Ensure robust arrangements are in place for the management of all serious untoward incidents to be reported to both CCGs, make recommendations regarding the requirements for external enquiries and agree arrangements for the closure of incidents.
- 2.3.3 Ensure that policies exist and are implemented for the management of confidential information and compliance with Caldicott requirements within both CCGs.

3.0 Deliverables

- 3.1 Ensure that appropriate policies and procedures exist to address legal requirements, statutory requirements and minimise risk.
- 3.2 Receive copies of internal and external audit reports from the Audit Committee, relevant to Quality & Safety.

4.0 Membership

4.1 The Committee Membership

- Lay Advisor, Quality & Patient Experience (ELCCG) – Chair
- 1 Lay Member Secondary Care Doctor (BwDCCG) - Deputy Chair
- Chief Finance Officer (ELCCG)
- Clinical Director – Performance (ELCCG)
- Compliance and Resilience Manager (ELCCG)
- Director of Performance and Delivery
- Director of Quality (BwDCCG)
- Director of Quality and Chief Nurse (ELCCG)
- Heads of Commissioning x 5 (4 x ELCCG, 1 x BwDCCG)
- Head of Medicines Commissioning
- Head of Safeguarding
- Head of Quality
- ELCCG Locality GP representatives x 5 - one from each Locality
- BwDCCG GP representative
- Non-Executive Governing Body Member (ELCCG)
- Non-Executive Governing Body Member (BwDCCG)
- Secondary Care Clinician – Non-Executive Governing Body Member (ELCCG)

4.2 In Attendance

- CSU support staff for Quality and Performance (BwDCCG)
- CSU support staff for Quality and Performance (ELCCG)
- Governance Performance & Risk Manager (BwDCCG)
- Public Health representative
- Social Care representative – as required

Provider nominees will be invited to attend for specific agenda items if deemed appropriate

4.3 Conflict of Interest

Members must comply with the requirements of the CCG's Conflict of Interest Policy.

In the event that all clinical members are excluded from decisions due to conflicts of interest the decision will have to be referred to the Governing Body.

4.4 Quoracy

A quorum shall consist of 50% of the Committee and must include 1 Non-Executive Governing Body Member / Executive Governing Body Member for each CCG and 1 clinical representative, from either CCG.

5.0 Governance and Reporting Arrangements

5.1 Reporting arrangements

The Committee will receive and consider reports and intelligence, including minutes of meetings, concerning: clinical quality/contractual reviews; user experience of services; safety incorporating system-wide Safeguarding and Infection Control; and application of best practice including research, development, audit and guidelines.

5.2 Reporting arrangements

The Committee will report to each Governing Body meeting for each CCG, providing assurances in respect of all areas within its remit, key matters concerning performance and risk, including mitigating actions and decisions required by the Governing Bodies. The minutes will also be presented to the Audit Committee for each CCG.

5.3 Review

The Terms of Reference are to be reviewed when appropriate, but as a minimum, every 12 months at the first meeting in the financial year.

5.4 Establishment of Sub-Groups / Task and Finish Groups

The Committee shall establish sub-groups or Task and Finish Groups as and when necessary to support the delivery of the work required.

5.5 Items of a Confidential Nature

Agenda items of a confidential nature will be discussed by Committee members only with an inclusion as and when necessary of a Part 2 to the meeting.

6.0 Secretarial Arrangements

The Director of Corporate Business will provide the secretariat to the committee. The agenda for the meetings will be drawn up with the Chair of the Committee. The agenda and papers for meetings will be distributed five working days in advance of the meeting.

The Secretary will monitor the compliance of the Committee in terms of:

- Frequency of attendance by Members
- Receiving of reports from sub-committees
- Attendance records cross referred to quorum requirements
- Reporting to Audit Committee and Governing Body.
- An annual cycle of business that supports the committees role and responsibilities and the delivery of objectives/milestones outlined in the Quality Strategy