NHS
Thurrock
Clinical Commissioning Group

Quality & Governance Committee

Annual Report and Self-Assessment

June 2015

Period of Assessment:	**2014/15**
Date of Report:	**7th June 2015**
Name of originator/author:	**Nicola Meeks, Head of Corporate Governance**
Governing Body Sponsor	**Jane Foster-Taylor, Chief Nurse**
Name of responsible committee/individual:	**Quality & Governance Committee**
Date Presented to Committee:	**12th June 2015**
Review date:	**April 2016**

CONTENTS

1 INTRODUCTION

1.1 As a formal sub-committee of the Governing Body, the Quality & Governance Committee presents its Annual Report to the Governing Body. This report will be considered at the Quality & Governance Committee on the 12th June 2015 and then will be submitted to the Governing Body to provide assurance that the Committee has been operating effectively and in accordance with its terms of reference.

1.2 In accordance with good governance practice, the Committee has carried out a self-assessment of its performance and effectiveness during 2014/15, giving consideration to the following over-arching key measures of success, for example:

- What difference has the committee made to the organisation's governance, risk and control environment?
- Did the committee encounter any surprises during the year, e.g. Unexpected adverse inspection reports?
- Did the committee have to re-focus its planned activities during the year – if so was this a proactive decision or reactive reason?

1.3 This report sets out the findings of committee business during the year and that of the self-assessment and establishes the programme of work to address any gap in effectiveness during 2015/16.

2 Scope and Methodology of the Self-Assessment

2.1 The CCG standard assessment of sub-committee effectiveness proforma was used to inform the self-assessment (included in Appendix A). The Head of Corporate Governance and the Chief Nurse reviewed how the committee had discharged its business throughout the year checking that the terms of reference and annual work plan of the Committee has been delivered. Six questions were also graded (1 – 4, with 1 being never and 4 being all of the time) to assess whether: the Committee worked purposefully and methodically to achieve its objectives; reported regularly in a way that furthered the work of the Board; was effectively chaired; had good attendance; had appropriate members / attendees and received timely, accurate and helpful information. Finally, the assessment also provided suggestions for improving the Committee's work, recommendations resulting from the assessment and any required amendments to the committee terms of reference (see 2.2 below)

2.2 The terms of reference for the committee has been reviewed in detail as part of the self-assessment process and has been updated (see Appendix B), however some consideration is being given to the role of the Quality & Governance Committee and the Audit Committee going forward and consequently a further update to the terms of reference will be carried out during the year.

2.3 In determining whether the Committee had discharged its responsibilities in line with the Committee terms of reference, a comprehensive assessment has also been made of Committee business during the year (see para 4.1).

3 Committee Governance 2014/15

3.1 The Quality & Governance Committee is a formal sub-committee of the Governing Body with defined Terms of Reference. The Terms of Reference were reviewed and ratified at the Governing Body in September 2014.

3.2 There were 12 regular meetings in the period covered by this report (April 2014 – March 2015) all of which were quorate.

3.3 The membership of the committee has been as follows:

Member	Title	Attendance
Dr Lakhvir Grewal	GP Board Member (Quality & CEG Lead)	8/12
Ms L Buckland	Audit Chair & Lay Member	11/12
Mr L Green	PPI Lay Member	11/12
Jane Foster-Taylor	Chief Nurse	9/12
Russell Vine	Practice Manager Board Member	11/12
Dr N Raj	GP Board Member (Safeguarding)	8/12

3.4 To support the committee the following officers of the CCG attended the committee during the year:

- Head of Quality & Patient Safety Team, Hosted Quality Team (LS)
- Quality & Patient Safety Manager, Hosted Quality Team (LT)
- Quality & Patient Safety Manager, Thurrock CCG (LD)
- Quality & Patient Safety Manager, Hosted Quality Team (SC)
- Head of Corporate Governance
- Commissioning Manager
- Complaints Manager

3.5 Attendance of committee members and other invited attendees has been assessed in more detail as part of the self-assessment below.

4 Achieving our Role and Compliance with our Terms of Reference

4.1 A detailed mapping exercise was carried out from Committee business to its terms of reference to ensure that the Committee has been achieving its terms of reference. The following items of business were taken to the committee during the year:

Key Responsibility:	Reports through which it was discharged:
Seek assurance that the commissioning strategy for the clinical commissioning group fully reflects all elements of quality (patient, experience, effectiveness and patient safety) keeping in mind that the strategy and response may need to adapt and change.	All work of the Committee underpins this principle, however during 2015/16 an additional item has been added to the work programme 'Commissioning Intentions', whereby the commissioning team will present for discussion the commissioning intentions document that informs contract negotiations with providers. • Patient Experience (monthly report) • QIPP and Quality Impact Assessments (quarterly) • PPI Engagement Plan (quarterly)
Provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does. This could be extended to include jointly commissioned services.	• Safeguarding Children (quarterly report) • Safeguarding Adults (quarterly report) • Health Care Acquired Infections (quarterly report) • Clinical Audit (six monthly report) • NHS 111 (quarterly report) • SEEDS (annual report) • Children's, Maternity and CAMHS (quarterly report) • Quality Accounts (annually)
Oversee and be assured that effective management of risk is in place to manage and address clinical governance issues. This includes scrutiny of the BAF and CRR on a quarterly basis.	• Board Assurance Framework (quarterly report) • Corporate Risk Register (quarterly report) In addition, any area discussed at QGC meetings that change or give risk to newly identified risks are fed back for amendment / inclusion in the risk register as appropriate (i.e. this action is not restricted to quarterly)
Review and endorse all corporate, information governance and human resources policies prior to their consideration by the CCG Board.	• PAG / Policy Assurance (monthly as required) • Information Governance (quarterly report) • Health & Safety Action Plan (six monthly) • Risk Management Strategy (annually) • Emergency Planning (annually) • Fire Code Compliance (annually) • Equality & Diversity (six monthly)
Have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRI); being informed of all Never Events and informing the governing body of any escalation or sensitive issues in good time.	• Serious Incidents (monthly)
Have oversight of the CCGs systems and processes for meeting its obligations around corporate social responsibility (CSR) and sustainability, including the development, implementation and review of the CCG's sustainable development management plan.	• Sustainability & Good Citizenship Plan (annually) • Sustainability & Good Citizenship (update) (annually)
Have oversight of the CCGs systems and processes for managing complaints and	• Complaints (quarterly)

Key Responsibility:	Reports through which it was discharged:
concerns. This will include receipt of quarterly report on the cases handled by the CCG.	
Seek assurance on the performance of providers of NHS care against targets and standards set by the CQC, Monitor and any other relevant regulatory bodies.	• Performance & Quality Indicators Report (monthly) • CQRG minutes – NELFT • CQRG minutes – BTUH • CQRG minutes – BHR • Primary Care Quality Support • Arden GEM / PHB & CHC Contract Monitoring Committee minutes • Adult Safeguarding Board minutes • Children Safeguarding Board minutes
Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.	• Serious Incidents (monthly) • Complaints (quarterly)
Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.	• Serious Incidents (monthly)

4.2 A number of additional items were presented at the Committee that weren't sufficiently covered by the responsibilities set out within the Terms of Reference and so three additional key responsibilities have been added as follows:

New Key Responsibility:	Reports through which it was discharged:
Seek assurance that CIP and QIPP projects are adequately assessed so as not to impact adversely (in an unmanageable way) on the quality of services delivered.	• QIPP and Quality Impact Assessments (quarterly) • Provider CIPs (six monthly)
Seek assurance that adequate controls and governance exist over Medicines Management processes.	• Medicines Management (quarterly) • Minutes of Medicines Management Committee (monthly)
Ensure that 'lessons are learnt' from National enquiries / reports relating to good practice and that where appropriate National guidance is incorporated in CCG processes (and those of providers) to strengthen clinical practice (such as NICE guidance / Francis recommendations).	• Research & Development (six monthly) • NICE (six monthly) • Francis / Berwick report (monthly) • Winterbourne (quarterly)

4.3 The purpose of the reports that are submitted to the Quality & Governance Committee is to advise on the quality of service provision for the population of NHS Thurrock CCG. The data is reviewed and triangulated to develop intelligence on the quality of the services which is used to inform an identify areas of concern which require further scrutiny.

4.4 The two Directorates feeding into the Committee are Corporate Governance and the Quality Team.

4.5 The Role of the Quality Team

4.5.1 The quality team is responsible for many of the reports presented to the Committee, is led by and is accountable to the CCG Chief Nurse. The decision was made to appoint a nurse with clinical knowledge and skills to support the community agendas for NHS Thurrock and this has proved to be most beneficial in the monitoring of provider services. The following areas are included in the portfolio of the team:

- End of Life Care
- COPD
- Review of Serious Incident Reports to inform improved performance and lessons learnt
- Supporting the education and training sessions at the Time to Learn
- Lead on quality visit agendas
- Monitoring of action plans following events and visits
- Clinical support to Local Authority for Care homes
- Investigation of patient experience concerns
- Pathway redesign and procurement
- Support commissioners with a clinical understanding of proposed service models, including on-going performance management and investigations where appropriate

4.5.2 The work of the team has grown over the last year and a review of the establishment of the department had indicated the need for a further team members. This will enable the team to be centralised at Thurrock, the organisational structure is yet to be confirmed.

4.6 The Role of Corporate Governance

4.6.1 The Head of Corporate Governance, supported by the Business Support Team is responsible for ensuring that the CCG operates within its defined remit and in accordance with legislation and good governance practice. This is largely delivered through risk management processes (the Board Assurance Framework), the development and updating of CCG policy and ensuring that mechanisms exist to monitor compliance with those policies. In addition, work streams are undertaken to provide assurance in other compliance areas (such as health & safety, equality etc).

4.7 Governing the Committee

4.7.1 The way in which the Committee conducts its business was assessed to ensure good governance practices were followed.

4.7.2 The Committee terms of reference is reviewed and updated annually and a comprehensive work plan is prepared and used to define the items of business for each meeting. Any items that are postponed or require further updates are automatically added to the work plan by the Committee secretary to ensure that there are no gaps in business items discussed.

4.7.3 Each meeting is minuted in detail and all minutes are ratified at the following Committee meeting. It was noted however that conflicts of interest declarations (where there is a nil return) are not always minuted as such within the minutes (recommendation QGC4 refers).

4.7.4 All meetings of the QGC have complied with quoracy as per the Committee terms of reference. However, it was noted that the committee membership and quoracy requirements stated within the terms of reference could be better defined. As part of the review of the terms of reference it was made clear which individuals / post holders were actually 'members' of the committee and which individuals / post holders attended to support the Committee. In addition, quoracy was simplified to four 'members', which removed the risk of the Committee not being quorate if the Chief Nurse was absent.

4.7.5 The meetings throughout the year, although effective in the conduct of business and completed on-time, often resulted in some items being 'rushed' due to the time constraints of the Committee. This could result in governance aspects not receiving the due attention of the Committee, as the focus of the agenda items were on quality as the priority of Committee business. A recommendation has therefore been made to review the remit of the Committee and understand if some aspects of business could be better served by another Committee (recommendation QGC2 refers).

4.7.6 As inferred in 4.7.5 above, the Committee was Chaired well, however, it was often Chaired (in effect) by the Chief Nurse rather than the nominated Chair GP Board Member (recommendation QGC1 refers).

4.7.7 The Committee was well attended by Officer and Lay Members, however GP Board Member attendance could be improved (recommendation QGC5 refers). This could ultimately affect the performance of the Committee as its intention is to be clinician led so that it is truly knowledgeable and experienced.

4.7.8 The submission of Committee papers to be circulated one week in advance was adequate with timely information being received 'most of the time'.

5 Delivery throughout the year

5.1 Patient Experience

5.1.1 The Quality & Governance Committee receive a monthly report on areas of patient experience relating to commissioned and other services for the population of Thurrock.

5.1.2 The standard of the Patient Experience reports to both the Quality and Governance committee meetings and the Governing Body has evolved throughout the year. These reports provide extensive in depth information on themes and trends from provider services based on intelligence from Friends and Family testing, NHS Choices, Patient Safety Thermometer, complaints feedback from the area teams and details of Care Quality Commission reports. This in depth information is used to determine areas for monitoring and assessment during quality visits. Other reports provide data relating to serious incidents and infection control concerns and performance against the trajectories.

5.2 Monitoring Quality, Safety and Suitability of Provider Services

5.2.1 There is robust monitoring of Provider services through quality visits by the team and the Clinical Quality Review Group Meetings which includes compliance with trajectories, key performance indicators and CQUINS.

5.2.2 The Quality Team review national reports for themes and trends and use this soft intelligence as background information as part of the quality visit agenda.

5.2.3 It is key that there is learning from investigations which could arise from complaints, incidents or infection control concerns. The Quality Team continue to seek assurances that this learning is embedded and practices amended should this be identified as part of the recommendations.

5.3 North East London Foundation Trust (NELFT) Community Services

5.3.1 There is a Quality & Patient Safety Manager aligned to the CCG to support the Executive Nurse in the monitoring of the commissioned community services through NELFT.

5.3.2 This was undertaken through a series of scheduled quality visits across all services and patient pathways. There was additional monitoring of quality and performance through the CQRG Meetings.

5.3.3 The Quality & Governance Committee was provided with outcomes from the visits and latterly with the full reports and action plans to optimise the quality of service delivery.

5.3.4 The Executive Nurse was proactively involved in the contract negotiations including the establishment of Clinical Quality Indicators (CQUINS) and Key Performance Indicators (KPIs).

5.4 Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)

5.4.1 It has been a turbulent year for service provision at BTUH with the Trust being put into special measures by MONITOR in ?? 2014, which were subsequently lifted in ?? 2014. The CCG worked closely with the lead CCG NHS Basildon & Brentwood CCG to monitor service delivery within the Trust and ensure that adequate steps were being taken to address concerns. The increased resources and good work within the

Trust to improve delivery led to a reduction in the CCG risk assessment for BTUH, however, this changed towards the end of the year when the Trust was again put into special measures, but this time in relation to financial stability.

5.5 South Essex Partnership NHS Foundation Trust (SEPT) Mental Health Services

5.5.1 In general there have been no significant concerns reported in relation to the service provision. There have been positive quality visits undertaken by the Quality Team.

5.6 Safeguarding Children and Children and Adolescent Mental Health Services (CAMHS)

5.6.1 There is continued monitoring of the CAMHS Service provision. This is to ensure improving standards are achieved and maintained. This monitoring is undertaken through the CQRG Meetings, quality visits which is led by NHS Castle Point & Rochford CCG.

5.6.2 Concerns were raised during the year that there was a lack of service provision to manage ADHD for children over the age of 11. Consequently a risk was included on the Board Assurance Framework and actions put in place to address the gaps in service provision.

5.7 Out of Hours Services

5.7.1 These services are commissioned through CPR CCG, the roll out of the NHS 111 service, managed through the IC24 contract, has been positive and continue to perform well when compared to other service providers nationally.

5.7.2 South Essex Emergency Doctors Service also provide the out of hours service for a number of NHS Thurrock CCG GPs, this is commissioned via NHS England. Although service users are satisfied with the service, concerns were raised in relation to the governance arrangements within SEEDS, which is being pro-actively managed by NHS England.

5.8 East of England Ambulance Service (EEAST)

5.8.1 The EEAST contract remains a high risk on the CCG Board Assurance Framework in relation to delivery of services and meeting KPIs. This is actively monitored at the Quality & Governance Committee and there continues to be a good relationship for contract management of the service.

5.9 Safeguarding Adults

5.9.1 A regular report is presented to the Quality & Governance Committee to provide updates on the work being undertaken in relation to Safeguarding Adults, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). It seeks to provide assurance that the organisation is compliant with requirements and standard expectations.

5.9.2 The Safeguarding Adults agenda is not always clear cut due to the differences in the legal status of the process and issues of capacity and consent. The introduction of the Care Act 2014 has provided some challenge to the CCG to ensure that existing processes continue to meet National requirements.

5.9.3 The CCG Adult Safeguarding lead has regular meetings to discuss current Adult Safeguarding concerns with the local authority. There is also CCG representation at the Adult Safeguarding Board Meetings.

5.10 Care Homes

5.10.1 The quality of services in Care Homes was monitored in collaboration with the local authority and CQC when concerns or other soft intelligence had been received.

5.10.2 A series of quality visits have been conducted during 2014/15 by the Quality Team and some joint local authority visits, which are detailed in Appendix C.

5.11 Commissioning Intentions

5.11.1 The CCG has actively included the quality team in procurement processes. In addition, commissioning intentions has now been included within the work plan for 2015/16.

5.11.2 A Quality Impact Assessments (QIAs) has been presented to the Committee to ensure that the quality of care in areas where commissioning decisions are being made remains appropriate and of an appropriate standard.

5.11.3 The Quality Support Team is ensuring that QIPP plans are being baseline assessed for assurance that essential quality elements are evidenced within them using the agreed tool.

5.12 Serious Incidents

5.12.1 A full annual report of serious incidents reported is available. The serious incident lead meets with provider services on a monthly basis to monitor compliance with reporting and to share the outcomes from investigations and provide assurance to the Chief Nurse.

5.12.2 A Serious Incidents report is presented to the Committee on a monthly basis.

5.13 Healthcare Acquired Infections

5.13.1 A full annual report for the Infection, Prevention and Control agenda has been produced detailing incident rates and outcome of investigations for the locality. The report is collated from the information presented to the Committee during the year.

5.14 NICE

5.14.1 Bi-annual reports were presented to the Committee for information and monitoring of

new guidance and quality standards. Aspects of this were also included within the Medicines Management Report.

5.15 Recommendations from National Reports

5.15.1 The Committee has reviewed the CCG response to each of the National enquiry reports (i.e. Francis, Berwick and Winterbourne) to ensure that appropriate actions are being taken, both internally and within Provider organisations to address potential areas of weakness highlighted in the reports.

5.15.2 The provider organisations are monitored against these recommendations through the CQRGs.

5.16 Information Governance

5.16.1 The Committee has been responsible for overseeing the work of the Essex IG Team (hosted by NHS Basildon & Brentwood CCG) and approving IG related policies and work streams.

5.16.2 Through the work of the Essex IG Team, the CCG has maintained its level 2 status against all Information Governance Toolkit requirements and so has maintained its Accredited Safe Haven Status.

5.16.3 The annual Senior Information Governance Risk Owner report to the Board has been prepared to summarise the work of the IG Team and the CCG compliance levels.

5.17 Sustainability

5.17.1 Work has been carried out during the year to further the sustainability agenda of the CCG in line with the Sustainability Development Management Plan. An annual sustainability report was included within the CCG Annual Report.

5.18 Equality & Diversity

5.18.1 Six monthly equality and diversity reports have been provided to the committee along with other measures of equality such as reporting the completion of equality impact assessments.

5.19 Good Governance

5.19.1 The Committee has been responsible for reviewing CCG key policies, setting out the framework of controls and governance both corporately and in terms of quality of service (clinical related policy).

5.19.2 Other work streams have also been reported to the Committee, who have provided oversight of CCG compliance with Health & Safety and Fire Safety Legislation (for example).

6 Findings and Conclusions of the Self-Assessment

6.1 Sections 4.7 and 5 of this report sets out the findings of the self-assessment and where improvements can be made recommendations have been proposed in section 7 below.

6.2 In conclusion, the Quality & Governance Committee has successfully delivered its duties as set out within the Committee terms of reference and highlighted in this report.

7 Recommendations

Ref	Recommendation	Implementation Date
QGC1	The Chief Nurse provides a more supportive role to the Committee rather than leading as a chair.	
QGC2	Consideration be given to how the committee could be more effective given the volume of business that needs to be conducted at each meeting by reviewing the remit of the committee.	
QGC3	A representative from Medicines Management attend and provide reports to the committee rather than the committee just receiving minutes of the Medicines Management Group.	
QGC4	Conflicts of Interest are formally minuted by a nil return.	
QGC5	The Committee establish the reasons why GP Member attendance was poor in some cases.	
QGC6	Review Meeting Template	

Appendix A – CCG Self-Assessment Proforma

NHS
Thurrock
Clinical Commissioning Group

Assessment of Sub-Committee Effectiveness – 2014/15

Name:	Jane Foster-Taylor
Sub-Committee:	Quality and Governance Committee

1. Referring to the attached Terms of Reference, please detail whether the committee has achieved all of its stated objectives this year to date.

Yes, the objectives of the committee detailed in the terms of reference have been mapped to committee business and all objectives have been achieved.

2. Referring to the attached annual workplan, please detail whether the committee has completed its agreed workplan this year to date.

The work plan has been completed, however the area of Medicines Management has been weak as monthly reports have not been received.

How would you rate the following aspects of the committee's effectiveness?

		Never / rarely 1	Some of the time 2	Most of the time 3	All of the time 4
3.	The Committee has worked purposefully and methodically to achieve its objectives			✓	
4.	The Committee has reported regularly in a way that has furthered the work of the Board			✓	
5.	The Committee has been effectively Chaired		✓		
6.	The Committee has met sufficiently and with good attendance		✓		
7.	The Committee has the right number of appropriately knowledgeable and experienced members who have been able to contribute effectively		✓		
8.	The Committee has received timely, accurate and helpful information			✓	

If you have rated any of the above aspects as a 1 or a 2, please give your reasons below: 5 – JF-T has tended to take on the role of the Chair, this should revert back to Dr Grewal. Time for the committee is also an issue because of the large agenda that needs to be covered. 6 – GP attendance could be improved 7 – GP's need to attend more consistently		
Member Attendance:	Lay Members and Practice Manager Board Member - 92% Chief Nurse - 75% GP Members – 66%	Acceptable: GP attendance to be improved.
Submission of Papers:	Generally out a week prior to meeting	Acceptable: Yes
Do you have any other suggestions for improving any aspect of the committee's work? To consider how the work of the Committee could be re-distributed to ease time pressure. Improve Medicines Management Feedback / Accountability		
Recommendations resulting from this assessment: Request regular updates from Medicines Management. Discuss attendance with GP Members Review Remit / work of Committee		
Amendments required to Committee Terms of Reference: Some amendments required as a result of the mapping exercise i.e. small number of areas not covered in terms of reference, but are clearly the remit of the Committee. ToR needs to be reviewed in light of potential changes if work re-distributed.		

Please complete and return this questionnaire to Nicola Meeks either manually or by email to n.meeks@nhs.net, before XXX.

* delete as applicable

Appendix B – Proposed Revised Terms of Reference

NHS
Thurrock
Clinical Commissioning Group

Terms of Reference

Committee:	**Quality & Governance Committee**
Frequency Of Meetings:	Monthly
Committee Chair:	GP Board Member
Membership:	▪ GP Board Member (Adult Safeguarding, Quality & CEG Lead) - Committee Chair ▪ Chief Nurse ▪ Lay Member (PPI) - Deputy Committee Chair ▪ Lay Member (Governance) ▪ GP Board Member (Children Safeguarding Clinical Lead) ▪ Practice Manager Board Member
Attendance:	▪ CCG Chair shall not be a member of the committee, but will attend one meeting per year and is entitled to attend each meeting. ▪ (Acting) Interim Accountable Officer shall not be a member of the committee, but will attend one meeting per year and is entitled to attend each meeting. ▪ Deputy Chief Nurse ▪ Quality & Patient Safety Managers (3) Other representatives may be invited with the Committee Chair's approval
Lead Officer:	Chief Nurse
Secretary:	Administrator, Business Support
Quorum:	At least four committee members

Approval:	CCG Board
Date Approved:	
Version	v3.3
Review Date:	June 2016

DELEGATED AUTHORITY

The Board (CCG Governing Body) has established a Committee of the Board to be known as the Quality & Governance Committee (the Committee), in accordance with the CCG Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation. The Committee is not an executive Committee of the Board, although some delegated responsibilities for decision making have been defined within this Terms of Reference for the Committee with regard to setting CCG Policy.

The Committee will apply best practice in the decision-making process and in all areas of operation. Where possible, it will take the agreed practices of the CCG, as set out in the Constitution, as the model for functioning. The Committee will have full authority to commission any reports, research etc. as it deems necessary to ensure delivery of safe effective care.

The Committee's ToR is available upon request and shall be published on the website of the CCG.

The Committee will report directly to the CCG Board, providing assurance on the quality of services commissioned on behalf of the patients to ensure quality, safety and a positive patient experience & that the CCG's statutory responsibilities in this respect are met.

It is acknowledged that the Board is ultimately accountable for the actions of the Committee and therefore the Committee will:

I. report on its work by presenting the minutes of its meetings to the Board.
II. report to the Board on an annual basis, the work undertaken in the previous year and the intended programme of work for the forthcoming year.
III. review the ToR annually and submit for Board approval.

PURPOSE OF COMMITTEE

The purpose is to develop a work plan based on:

- The remit or the Quality & Governance Committee is to provide oversight and give assurance to the Board of the quality of services commissioned, including joint commissioning, to promote continuous improvement, learning and innovation with respect to safety of services, clinical effectiveness and patient experience.

DEVOLVED FUNCTIONS

Section 9 of the CCG Constitution describes the CCG functions and duties delegated to the Board. The Board delegates to the Committee those functions relating to areas outlined in the remit and responsibilities of the Quality & Governance Committee stated below.

REMIT & RESPONSIBILITIES

The key responsibilities of the Committee are to:

1. Seek assurance that the commissioning strategy for the clinical commissioning group fully reflects all elements of quality (patient experience, effectiveness and patient safety) keeping in mind that the strategy and response may need to adapt and change

2. Provide assurance that commissioned services (identified by spend, lead and associate contracts) are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does. This could be extended to include jointly commissioned services

3. Oversee and be assured that effective management of risk is in place to manage and address clinical governance issues. This includes scrutiny of the relevant sections of the Board Assurance Framework and Corporate Risk Register on a quarterly basis

4. Have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of all Never Events and informing the governing body of any escalation or sensitive issues in good time;

5. Have oversight of the CCG's systems and processes for managing complaints and concerns. This will include receipt of a quarterly report on the cases handled by the CCG.

6. Seek assurance on the performance of providers of NHS care against targets and standards set by the Care Quality Commission, Monitor and any other relevant regulatory bodies

7. Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans

8. Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern

9. Seek assurance that Cost Improvement Programmes (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) projects are adequately assessed so as not to impact adversely (in an unmanageable way) on the quality of services delivered.

10. Seek assurance that adequate controls exist over Medicines Management processes.

11. Ensure that 'lessons are learnt' from National enquiries / reports relating to good practice and that where appropriate National guidance is incorporated in CCG processes (and those of providers) to strengthen clinical practice (such as NICE guidance / Francis recommendations).

12. Have oversight of the CCG's systems and processes for meeting its obligations around corporate social responsibility (CSR) and sustainability, including the development, implementation and review of the CCG's Sustainable Development Management Plan.

13. Review and endorse all corporate, information governance and human resources policies prior to their consideration by the CCG Board

14. This committee will receive reports from the Information Governance Team (hosted by the NHS Basildon & Brentwood CCG), and will have designated Serious Incident Reporting Officer as part of this committee.

MANAGING THE COMMITTEE

Members of the Committee are expected to comply with the same standards of conduct expected of all CCG and Governing Body members, as set out in the CCG Constitution and the national NHS Constitution.

This includes:

- Abiding by the CCG Conflict of Interest Policy, thereby declaring all interests honestly and fully and declaring any conflict of interests.
- Abiding by the Standards of Business Conduct articulated in the CCG Standing orders.
- Abiding by the Nolan Principles of public life when discharging duties. The seven principles are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.
- The TOR will be agreed by the Thurrock CCG Board and reviewed annually.
- The Committee will undertake an annual self-assessment effectiveness survey.

Committee Chair

In the event of the chair of the committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

Secretary

The nominated officer who shall act as secretary is stated at the outset of this Terms of Reference. The secretary will be responsible for supporting the Chair in management of committee business and for drawing the committee's attention to best practice, national guidance and other relevant documents as appropriate.

Frequency and notice of meetings

The meetings of the Committee will be held a minimum of monthly with extraordinary meetings should the Chair judge necessary to discharge the responsibilities of the Committee.

Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the chair or secretary at least 15 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for said items need to be submitted at least 10 working days before the meeting takes place to the Secretary.

The date, time and venue of all meetings will be notified to members at least 5 working days prior to the meeting.

Minutes and Committee Papers

All Committee papers must be accompanied by the standard cover sheet providing an executive summary of the salient points of the paper being presented.

The minutes of meetings shall be formally recorded within 5 days of the meeting by the designated secretary and checked by the Chair of the meeting 1 week following receipt and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

Decision Making / Policy and Best Practice

In making decisions the Committee will apply best practice in the decision making processes. This will ensure that all decisions are informed by relevant and reliable data that provides sufficient information upon which a decision can be made and in accordance with CCG procedures (for example those set out within Standing Financial Instructions).

RELATED COMMITTEES

The Committee shall present the minutes of their meetings (and where appropriate papers) relating to any matter of internal control or risks stated on the Board Assurance Framework to the Audit, Risk and Governance Committee so that it is fully informed of such matters to enable them to discharge their responsibilities.

Other working groups / committees that provide assurance to the Committee are:

- Medicines Management Committee
- Adult Safeguarding Board
- Children's Safeguarding Board
- CQRG – NELFT, BTUH, BHRT
- Arden GEM / PHB & CHC Contract Monitoring Committee

REPORTING & REVIEW

Reporting to the CCG Board

In addition to the CCG Board receiving the minutes, the Committee should assess its effectiveness annually against the "effective committee" checklist and report the outcome to the Board on an annual basis.

WORK PLAN

The Committee will develop a Work Plan based on the remit and responsibilities of the Committee to include the monitoring of systems and processes in place for quality, clinical effectiveness, patient safety and patient experience.

This Work Plan will detail the reports required and the frequency of reporting. This will be reflected in a rolling agenda of standing items and a programme of reports presented according to the Work Plan.

CONFLICTS OF INTEREST

The CCG's rules on conflicts of interest as set out in the CCG Constitution, SO and SFIs apply to the work of this Committee. Members, including those in attendance, must, at the outset of the meeting, declare any interest and, where there is a potential or actual conflict, withdraw from the discussion on that item.

Appendix C – Quality Visits Schedule 2014/ 15

Joint local authority and CCG visits

2014

Date	Care home
11.3.14	Grays Court
21.3.14	Ladyville Lodge
28.3.14	Grays Court
28.3.14	Grapecroft
3.4.14	Coach House
30.4.14	Grays Court
27.6.14	Coach House
3.7.14	Grapecroft
29.8.14	Coach House
1.9.14	Meeson's Lodge
3.10.14	Grapecroft
7.11.14	Coach House

2015

Date	Care home
20.1.15	Bluebell court
20.2.15	Cedar House
3.3.15	Bluebell Court
26.3.15	28 Medina Road
26.3.15	Gallimore Lodge
26.3.15	Coach house

NELFT Visits undertaken by the Quality Team

2014

Date	Care home
28.1.14	Mayflower Inpatient Unit
22.1.14	Tissue Viability Service
6.2.14	Diabetes
13.2.14	Physiotherapy Service based at Orsett
13.2.14	Speech and Language Therapy
14.3.14	DESMOND session
3.3.14	Macmillan Team
4.4.14	ICT based at Gifford House
25.4.15	John Tallack Centre
14.5.14	Admission Avoidance Team
5.6.14	Minor Injuries Unit
24.7.14	Day unit and PCAT
30.7.14	Falls Clinic
9.7.14	ICT based at Phoenix Court
29.8.14	AFC
5.9.14	ICT based at Mayflower
10.9.14	ICT based at Brentwood community Hospital
2.10.14	ICT based at Corringham
18.11.14	COPD service
6.11.14	End of Life care
10.12.14	ICT based at Gifford House
22.12.14	AFC

2015

Date	Care home
8.1.15	Mayflower Inpatient unit
14.1.15	Thorndon ward
12.2.15	AFC
9.3.15	ICT based at Phoenix Court
25.3.15	RRAS
30.4.15	Speech and Language Therapy
11.5.15	Tissue Viability Service
29.5.15	Mayflower Inpatient unit