South Central Ambulance Service
NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

Date issued:	**June 2025 V.3**
Next Review date:	**Annual review due June 2026**
Review dates:	**Approved by the Quality & Safety Committee July 2025**
Person Responsible:	**Non-Executive Director, Chair of Quality and Safety Committee**

1. Authority

1.1 The Quality and Safety Committee ("the committee") is constituted as a standing committee of the Trust's Board of Directors ("the trust board"). Its constitution and Terms of Reference shall be as set out below and any changes will be subject to trust board approval.

1.2 The Committee is authorised by the Board 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 to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience (e.g. external auditors and expertise if it considers this necessary for, or expedient to, the exercise of its functions). Any external advice that is commissioned must comply with the trust's Standing Financial Instructions.

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

2. Role

To provide scrutiny and challenge and assure the trust board that high standards of care that meet statutory duties and regulatory requirements are provided by the Trust and that there are robust quality governance structures, processes and controls in place from point of care delivery to the trust board.

3. Duties

3.1 In respect of general governance arrangements:

3.1.1 Seek assurance that there are processes in place to monitor patient safety, patient experience and clinical effectiveness performance across the organisation and identify risks to delivery

3.1.2 Approve the Quality Account and annual Quality Priorities prior to submission to the trust board and monitor progress against deliver of the quality priorities

3.1.3 Approve the annual clinical audit programme ensuring that it is sufficiently risk based

3.1.4 Approve the Patient Safety Plan prior to submission to the trust board and ensure that the safety programmes are driven by data and aligned to areas of known risk

3.1.5 Approve the Infection Prevention & Control Annual Report and Plan and the Safeguarding Annual Report before submission to the trust board

3.1.6 Approve policies that fall within the remit of the committee

3.1.7 Make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

3.2 In respect of the provision of high quality, sustainable services the committee will:

3.2.1 Monitor the Trust's compliance with the required standards of quality and safety, in order to provide relevant assurance to the Board that supports the signing of Annual Governance Statement. This will be done by ensuring that relevant standards are set and monitored, including (without limitation):

- Care Quality Commission registration criteria to continue to be met and that any

identified improvement actions are completed
- NHS Provider licence requirements relevant to quality and patient safety.

3.2.2 Monitor progress against the Tier 1 programmes under the Clinical Effectiveness strategic theme

3.2.3 Seek assurance that the trust is responding appropriately to patient safety incidents through receipt of regular reports relating to themes/trends, learning and improvement activity

3.2.4 Monitor Quality Improvement Programmes and activity relating to Patient Safety and Patient Experience and seek assurance that actions are driving improvement and reducing risk

3.2.5 Monitor progress against the Board Assurance Risks assigned to the committee and the significant risk register to ensure that risk is being effectively managed and mitigated

3.2.6 Ensure that the trust is meeting statutory duties in relation to Safeguarding through receipt of regular reports relating to Safeguarding activity across the trust and any lessons learned

3.2.7 Ensuring that the trust is meeting statutory duties in relation to health and safety through regular reports in relation to health and safety incidents and the plans in place to manage and mitigate risks

3.2.8 Ensure that the trust is responding adequately to any recommendations arising out of external accreditation or Peer Reviews and that any risks are escalated to the board as appropriate

3.2.9 Ensure that the trust is responding to any National Confidential Inquiry or national reports that are issued relevant to ambulance services and monitor progress against any actions arising

3.2.10 Monitor progress against delivery of the annual Infection Prevention and Control plan and ensure that risks are being managed and mitigated

3.2.11 Ensure that the trust is managing medicines safety and governance effectively and is compliant with statutory and regulatory requirements through receipt of regular reports

3.2.12 Monitor progress against the trusts Annual Clinical Audit plan and ensure that actions identified as a result of audits are being followed up

3.2.13 Receive all internal audit reports relating to the committee's terms of reference and ensure that actions are followed up in a timely way

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

3.3.1 Monitor the impact on the Trust's quality of care of cost improvement programmes and

service changes/developments and seek assurance that QIAs are monitored on an on-going basis to mitigate the risk of quality impact

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3.3.2 To ensure that care is based on evidence of best practice/national guidance.

3.3.3 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.

3.3.4 Ensure that the trust has robust processes in place to ensure that the implementation of all new procedures and technologies are managed safely and risks mitigated

3.3.5 To ensure the research programme and governance framework is implemented and monitored.

3.4 In respect of the trust's Digital services the committee will:

- Oversee the development of the trust's Digital Strategy and the associated delivery plan and receive exception reports, as appropriate
- Receive assurance on the delivery of the Trust's digital services including:

  i) Data quality and infrastructure
  ii) Data management
  iii) Digital Service responsiveness
  iv) Cyber preparedness
- Receive updates on work being undertaken with partner organisations across the ICS in relation to digital solutions

4. Membership

4.1 Membership of the Quality and Safety Committee shall consist of[1]:three Non-Executive Directors plus the Chief Nursing Officer, Chief Medical Officer and Chief Paramedic Officer.

4.2 The following executive directors will be in regular attendance:

4.2.1 Executive Director of Operations

4.2.2 Chief Governance Officer

Other executive directors may be invited to attend the committee where there are agenda items that are pertinent to their portfolios

4.3 The Committee will be deemed quorate to the extent that 2 Non-Executive Directors and one of the Executive director members are present

4.4 Trust employees who serve as members of the Quality and Safety Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

5. Attendance

[1]

5.1 List of those required at each meeting:

- Assistant Directors of Quality and Patient Safety
- Corporate Risk Manager
- Compliance and Quality Lead
- Patient representatives (e.g. Patient Safety Partner)
- Any nominated deputy attending in place of a member or essential attendee of Committee
- Any other person who has been invited to attend a meeting by the Committee to assist in deliberations.

5.2 Members listed at paragraph 4.1 are required to attend at least two thirds of the meetings held annually.

5.3 The Corporate Governance team will act as secretary to the Committee.

6. Frequency of meetings

6.1 Meetings shall be held bi-monthly.

6.2 Additional meetings may be held on an exceptional basis at the request of the Chairman of the Committee.

7. Minutes and reporting

7.1 The minutes of all meetings of the Committee may be formally recorded to aid in the production of written minutes and the recording will be deleted in line with Trust guidance.

7.2 The Committee will report to the Board after each meeting by way of an upward report.

7.3 The following sub-committees shall report using the standard upward reporting mechanism to the Executive Management Team as the primary reporting line and will for information purposes send a copy of the upward report to the Committee:

- Patient Safety and Experience Committee
- Clinical Review Group
- Safeguarding Committee
- Infection Prevention and Control Committee
- Medicines Optimisation and Governance Group
- Health & Safety Group
- Infection Prevention and Control Committee

7.4 Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.

8. Review

8.1 The Committee shall review its Terms of Reference annually as part of its overall review of committee effectiveness and will recommend any changes to the trust board as part of the Committee Annual Report.