



Clinical Effectiveness Group (CEG)

Terms of Reference

Date ToR Approved:	
Approved by:	Executive Management Board (EMB)
Review Date:	

1. Constitution

- 1.1. The Executive Management Board (EMB) hereby resolves to establish a formal management group forming a part of the system of internal control at SECAMB, to be known as the Clinical Effectiveness Group (CEG) referred to in this document as 'the group'.
- 1.2. The Group will report to the EMB, whose role is to underwrite the decisions made by the group and provide challenge for any decisions where additional assurance is needed.

2. Purpose

- 2.1. The purpose of the group is to ensure the continuous improvement of clinical care quality and outcomes across South East Coast Ambulance NHS Foundation Trust services. The group takes oversight of professional standards, clinical effectiveness initiatives, evidence-based practice implementation and associated clinical governance frameworks, education, training and development and trust wide learning.



3. Objectives

3.1. The objectives of the group are detailed below aligned to the four pillars of a Quality Management System (QMS):



3.2. The Group aims to:

3.2.1. Quality Control

- Ensure compliance with national clinical standards, NICE guidance, regulatory requirements and relevant JRCALC guidance
- Ensure the safe and clinically appropriate use of medications including medical gases.
- Ensure the safe and clinically appropriate use of management plans and patient specific instructions for frequent callers.
- Receive details of all national clinical audits. This will include, but is not limited to, mortality outlier alerts.
- Receive the National Clinical Outcome Indicator data.
- Receive the NHS Pathways audit data and learnings.
- Receive reports on matters relating to professional practice, colleague welfare/ wellbeing and clinical leadership & supervision
- Monitor and evaluate clinical performance indicators and patient outcomes across all services. Identify trends, hotspots, and emerging risks
- Monitor and evaluate professional standards
- Monitor and evaluate education, training and development

3.2.2. Quality Planning

- Review and approve the annual clinical audit programme and monitor its delivery.
- Support clinical and EOC audit programmes and research initiatives
- Ensure effective learning from all relevant sources
- Monitor and evaluate trust wide learning ensuring it is disseminated and adopted in a meaningful way

- Review, approve and monitor clinical guidelines, protocols, and care pathways
- Identify opportunities for improvement and innovation
- Oversee the development of appropriate scope of practice for clinical staff and volunteers
- Ensure partnership working with clinical and other relevant networks
- Oversee the development and implementation of clinical effectiveness strategies
- Review and approve recommendations in relation to learning, education, training and development, including recommendations for quality account priorities, patient safety incident response plan priorities and quality improvement priorities.
- Receive and review national ambulance related 'Preventing Future Death' reports to ensure relevant recommendations are implemented

3.2.3. Quality Improvement

- Facilitate knowledge sharing and best practice dissemination
- Monitor delivery of the Trust's Strategy through the development and delivery of the models of Care
- Oversee the critical analysis of research findings and implementation into Trust policy/procedures.
- Promote the adoption of evidence-based clinical practice

3.2.4. Quality Assurance

- Review reports on matters relating to the organisational strategy, clinical strategies and models of care
- Ensure effective clinical risk management
- Review and approve the annual research and development report
- Review and approve the annual supervision report
- Review and approve the annual cardiac arrest outcome report
- Review and approve the annual Controlled Drugs Accountable Officer report
- Review and approve the annual Health Informatics (Clinical Audit) report.
- Review and approve the annual EOC Practice Development (NHS Pathways) report

4. Membership

4.1. The membership of the Group will seek to ensure representation enables all clinical services to be engaged across field operations, resilience and specialist operations, 111 and 999 operational services.

4.1.1. Chief Paramedic Officer (Co-Chair)

4.1.2. Chief Medical Officer (Co-Chair)

4.1.3. Chief Nursing Officer

4.1.4. Deputy Chief Paramedic Officer

4.1.5. Deputy Chief Medical Officer

4.1.6. Deputy Chief Nursing Officer

4.1.7. Deputy Chief People Officer

4.1.8. Divisional Clinical Directors/ Clinical Leads or equivalent for Kent, Surrey, Sussex, Integrated Urgent Care and Resilience and Specialist Operations

4.1.9. Consultant Clinicians

4.1.10. Divisional Director of Operations representative

4.1.11. Head of Research and Development

4.1.12. Chief Pharmacist

4.1.13. Associate Director for Quality and Compliance

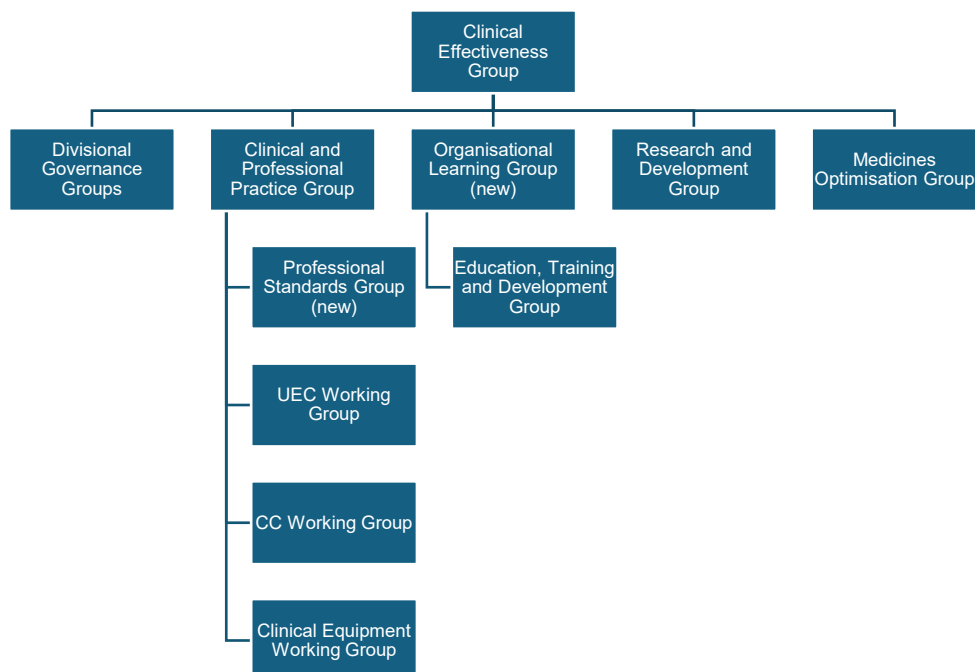
4.1.14. Divisional Operations Director representative

4.1.15. Head of Professional Standards

4.1.16. Frequent Caller Lead

4.1.17. Business Support Manager (BSM)

5. Sub Groups



6. Quorum

6.1. The quorum necessary for formal transaction of business by the group shall be 10 members, the following must be represented:

6.1.1. At least one of the co-chairs

6.1.2. Deputy Chief Officers as required to complete representation of the clinical triumvirate of paramedicine, medicine and nursing, taking the above into account.

6.1.3. Representatives from each divisional service area.

6.2. In the event of a quorum not being attainable the meeting can still take place, but no binding decisions can be made by the participants.

7. Frequency of Meetings

7.1. The Group shall meet bi-monthly and extraordinary meetings may be called by the Chair between regular meetings to discuss and resolve any critical issues arising.

7.2. The duration of each meeting will be three hours.

7.3. Meetings of the group will be diarised on a yearly basis.

7.4. All meetings are in person, only under exceptional conditions will the meeting be moved to Teams.

7.5. Any Microsoft Teams meetings will be recorded and stored in accordance with Trust policy.

8. Authority

8.1. The Group has no executive powers other than those specified in these Terms of Reference or by the Trust Board or its Sub-Committees in its scheme of delegation.

8.2. The Group is authorised to:

8.2.1. Request clinical performance data and reports from all service areas

8.2.2. Commission clinical audits and effectiveness reviews

8.2.3. Approve changes to clinical policies, guidelines and procedures

8.2.4. Escalate significant clinical effectiveness concerns to EMB

8.2.5. Approve clinical research proposals within defined parameters

8.2.6. Commission reviews and investigations within approved budgets

9. Information Management

9.1. All learning documentation to be managed in accordance with Trust information governance policies

9.2. Maintain a central learning repository accessible to relevant staff

9.3. Ensure appropriate sharing of learning while maintaining confidentiality where required

9.4. Regular communication of learning outcomes through established channels

10. Risk and Issue Management

10.1. Risk & issues will be managed as per Trust policy.

11. Reporting

11.1. Reporting schedule:

11.1.1. The Group shall report to the Trust's Executive Management Board.

11.1.2. The group receives reports from the sub groups in section five.

11.1.3. At the end of each substantive item during the meeting, the chair will summarise the consensus reached on the point discussed to enable the secretary to record a concise note with any decisions and actions.

11.1.4. At the end of the meeting, the group chair shall seek a consensus from group members as to those items that shall be escalated to the parent group.

11.2. Key Performance Indicators:

11.2.1. Clinical quality indicators and benchmarking data

11.2.2. Patient outcome measures and mortality reviews

11.2.3. Compliance rates with clinical guidelines

11.2.4. Clinical audit completion rates and recommendations implementation

11.2.5. Staff clinical competency assessments

11.2.6. Research and innovation metrics

11.2.7. Education, training and development (ETD) metrics

12. Annual Work Programme

12.1. The group operates an annual work programme including:

12.1.1. Clinical effectiveness strategy review and update

12.1.2. Supervision annual report review

12.1.3. Annual clinical audit programme approval

12.1.4. Clinical guideline and protocol reviews

12.1.5. Patient outcome analysis and benchmarking

12.1.6. Clinical education effectiveness evaluation

12.1.7. Research, improvement and audit priorities identification

12.1.8. Clinical and ETD risk review

12.1.9. Annual quality planning

13. Secretariat

- 13.1. The group shall be supported by an appointed administrator from the Paramedic Directorate to ensure the timely distribution of the agenda and papers prior to meetings by the Team Administrator.
- 13.2. The group appointed administrator will ensure the minutes of each meeting are taken and distributed to members. This will include the updating of the group's Action Log which will be shared with the membership.
- 13.3. Papers will be shared no later than five working days before the meeting.
- 13.4. Minutes and actions will be distributed within 10 working days.
- 13.5. Any other business by advance arrangements with the Chair.

14. Chair's Action

- 14.1. Where a matter falling within the authority of the group requires an urgent decision, the chair/Deputy Chair can act on behalf of the group.
- 14.2. All decisions made under such Chair's Action must be submitted to the next scheduled meeting for ratification and formal.

15. Review

- 15.1. These Terms of Reference will be reviewed annually or following significant organisational changes.
- 15.2. The effectiveness of the group will be evaluated through:
 - 15.2.1. Annual self-assessment against objectives
 - 15.2.2. Stakeholder feedback surveys
 - 15.2.3. External validation through inspection outcomes
 - 15.2.4. Measurable improvements in organisational performance
- 15.3. These Terms of Reference shall be approved by the Executive Management Board and formally every year.

Equality Impact Assessment (EIA) template (refer to guidance)

What piece of work does this relate to: Click or tap here to enter text.

Role: Click or tap here to enter text.

1. Is this a:

- Change to an existing strategy (long term plan of action), policy or procedure ☐
- Change to a service or function (actions or activities) ☐
- A new strategy or policy/procedure/business case/ ops bulletin etc. ☐
- A new service or function ☐
- Project which requires approval at Board or Working group ☐

2. Who will be impacted by this work? Tick all that apply.

Patients ☐	Student/learners ☐	Volunteers ☐	External Partners (please specify below) ☐ Click or tap here to enter text.
Carers ☐	Trade unions ☐		Other (including a particular geographical area, describe below) ☐ Click or tap here to enter text.
Staff ☐	Suppliers ☐		

3. Summarise the work being assessed. Describe current status followed by any changes that stakeholders would experience.

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4. Checklist

All the Trust's policies, programmes, strategies, services and major developments affect patients, carers, service users, employees and the wider community. These will have a greater or lesser relevance to equality, diversity and inclusion.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation, pregnancy and maternity and any other relevant characteristics (for example socio-economic status, social class, income, unemployment, residential location or family background and education or skills levels).

Make notes to assist with the completion of the EIA.

Questions	Yes	No
Is there potential for/ indication of or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	☐	☐
<i>If yes, please add information:</i>		
Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the change?	☐	☐
<i>If yes, please add information:</i>		
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☐
<i>If yes, please add information:</i>		
Could the proposal affect our workforce or employment practices?	☐	☐
<i>If yes, please add information:</i>		
Is there potential for or evidence that the proposed change will not promote equality of opportunity or promote good relations between different groups?	☐	☐
<i>If yes, please add information:</i>		

5. Equality Impact Assessment

5.1. Key stakeholders

A key principle for completing Equality impact assessment is that they should not be done in isolation. Consultation with affected groups and stakeholders needs to be built in from the start, to enrich the assessment and develop relevant mitigation. Detail here who you have involved with completing this EIA.

Name / Group (remove this before publishing)	Organisation	Role on assessment team e.g., service user, manager of service, specialist (which area)

5.2. Who may be positively or negatively affected by this activity?

Protected characteristics (Equality Act 2010)

- Age ☒
- Disability ☒
- Race ☒
- Gender reassignment ☒
- Marriage & civil partnership ☒
- Pregnancy & maternity ☒
- Religion & beliefs (including no belief) ☒
- Sex (male or female) ☒
- Sexual orientation ☒

In addition, consider the following vulnerable groups:

- Armed forces ☐
- Carers ☐
- Digital exclusion ☐
- Domestic abuse ☐
- Education (literacy) areas ☐
- Homeless ☐
- Looked after children ☐
- Rural areas ☐
- Urban areas ☐
- Socioeconomic disadvantage ☐
- People with addiction or substance misuse problems ☐
- People on probation ☐
- Prison population ☐
- Undocumented migrant, refugees, asylum seekers ☐
- Sex workers ☐
- Other (please specify below) ☐

5.3. **Assessment outcomes** – discussion undertaken between [Click or tap to enter a date.](#) and [Click or tap to enter a date.](#)

Protected equality characteristic	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Age		
Disability		
Race ¹		
Gender reassignment		
Marriage & civil partnership		
Pregnancy & maternity		
Religion & beliefs		
Sex		
Sexual orientation		

¹ An ethnic group or ethnicity is a named social category of people who identify with each other on the basis of shared attributes that distinguish them from other groups such as a common set of traditions, ancestry, language, history, society, culture, nation, religion, or social treatment within their residing area. A useful guide to terminology can be found here: <https://www.lawsociety.org.uk/topics/ethnic-minority-lawyers/a-guide-to-race-and-ethnicity-terminology-and-language>

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Armed forces		
Carers		
Digital exclusion ²		
Domestic abuse		
Education (literacy)		
Homeless		
Looked after children		
Rural/urban geographies		
Socioeconomic disadvantage		
People with addiction or substance misuse problems		

² **Digital Exclusion can be linked to the following key root causes:**

- Connectivity access to the internet – can include financial barriers as well as suitable broadband speeds/connectivity
- Digital Skills the ability to use digital tools such as email, online shopping, digital healthcare - also includes having confidence in online safety, and how to utilise particular services or apps
- Technology and Accessibility access to appropriate devices to suit their individual needs – includes access to devices suitable for use with a certain disability as well as financial and location barriers
- Not wanting to use digital platforms simply not wishing to utilise digital services – this could be due to distrust of providers, online security, privacy etc.

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
People on probation		
Prison population		
Undocumented migrants, refugees, asylum seekers		
Sex workers		
Other		

5.4 Impact on Human Rights

If a provision or feature of your policy or service potentially unlawfully interferes with a human right then it is negative . If something protects or promote a human right, then it is positive. Human rights and freedoms belong to everyone. They give the legal basis to basic values of fairness, respect, equality, dignity and autonomy. They provide a set of minimum legal standards for all public bodies, including the NHS. They protect an individual's rights whilst considering the rights of other people and wider society.

Human Rights	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
A2. Right to life (e.g. Pain relief, DNAR, competency, suicide prevention)		

Human Rights	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
A3. Prohibition of torture, inhuman or degrading treatment (e.g., Service Users unable to consent)		
A4. Prohibition of slavery and forced labour (e.g., Safeguarding vulnerable patients' policies)		
A5. Right to liberty and security (e.g., Deprivation of liberty protocols, security policy)		
A6&7. Rights to a fair trial; and no punishment without law (e.g., MHA Tribunals)		
A8. Right to respect for private and family life, home and correspondence (e.g., Confidentiality, access to family etc)		
A9. Freedom of thought, conscience and religion (e.g., Animal-derived medicines/sacred space)		
A10. Freedom of expression (e.g., Patient information or whistle-blowing policies)		
A11. Freedom of assembly and association (e.g., Trade union recognition)		
A12. Right to marry and found a family (e.g., fertility, pregnancy)		
P1.A1. Protection of property (e.g., Service User property and belongings)		

Human Rights	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
P1.A2. Right to education (e.g., accessible information)		
P1.A3. Right to free elections (e.g., Foundation Trust governors)		

6. Action plan and monitoring arrangements

Insert your action plan here (example layout provided). This should be based on mitigations recommended in 6.2. Involve your key stakeholders in monitoring progress against the actions above, and add more rows as required.

ACTIONS & DECISIONS TRACKER					
What is being assessed:					
What management group will have oversight of these actions (this should be the group which has oversight of the change):					
Item	Initiation Date	Action/Item	Person Actioning	Target Completion Date	Update/Notes
1					
2					
3					
4					

The above actions should be added to the action log for the named management group.

7. Version Control

Version Number	Purpose/Change	Author	Date

The above provides historical data about each update made to the EIA.

Please include the name of the author, date and notes about changes made – so that you are able to refer back to what changes have been made throughout this iterative process.

Please submit a completed version on the EIA section of Marval. The approval note from Marval can be used as evidence as approval. Once approved please send to polsandprocs@secamb.nhs.uk

Executive Management Board

Terms of Reference

1. Constitution

The Executive Management Board (EMB) is established by the Chief Executive.

2. Purpose

2.1. The purpose of EMB is to seek on-going assurance that South East Coast Ambulance Service maintains robust systems of governance, risk management and internal control that enables clinical and managerial leaders to ensure safe, high quality, patient-centred care.

2.2. Where gaps are identified, EMB will;

- ensure corrective action is taken
- monitor effectiveness
- report the matter to the Board of Directors, as required

3. Membership

3.1. EMB shall be comprised of each member of the executive management team¹. Directors may nominate a deputy to attend in their place, subject to the prior approval of the Chief Executive.

3.2. The Chair of EMB will be the Chief Executive. In his absence the Chief Executive will nominate a deputy.

4. Quorum

4.1. The Chair (or nominated Deputy) plus three members.

5. Attendance

5.1. With the approval of the Chair (or nominated Deputy) EMB may ask any member of staff to be in attendance for all or part of a meeting.

6. Frequency

6.1. EMB shall meet at least monthly. Extraordinary meetings may be called by the Chair, as required.

¹ Executive Directors, Company Secretary and Head of Communications

7. Authority

7.1. EMB is authorised by the Chief Executive to take management decisions on matters not reserved to the Board of Directors and / or investigate any action within these Terms of Reference.

8. Duties

8.1. To identify and ensure actions are taken to help deliver the trust's goals and objectives, assign responsibility for delivery and performance management, and ensure appropriate actions plans are in place to recover performance that is off plan.

8.2. To review business cases in advance of board approval, and to approve business cases which fall within the delegated financial limits approved by the Board.

8.3. To continuously monitor the quality of services provided by the trust and ensure that appropriate actions are in place to improve quality overall or address significant shortfalls against standards.

8.4. Bring together the sources of information it needs to ensure on-going assurance that the Trust has robust systems of governance, risk management and internal control, and where areas of concern are indicated, for taking the necessary corrective action. Specifically, it will review the adequacy and effectiveness of the assurance processes that support delivery of the Trust's objectives, the management of principal risks and compliance with legal and regulatory requirements.

8.5. EMB will have a standing agenda item at least monthly, on risk management, which will include the review of extreme risks, seeking assurance that high/extreme risks are being effectively managed by the relevant Operational Group(s). For example;

- All narrative is timely and appropriate
- Progress of action(s)
- Adequacy of controls (controls assurance) when identified
- Risk grading reviewed
- Key dates reviewed
- Status reviewed (Open or Proposed for Closure)

9. Reporting

9.1. The Chair shall report to the Board of Directors by exception any issue EMB considers the Board should be sighted on.

10. Support

10.1. The Company Secretary will be responsible for ensuring the provision of secretarial support to EMB, which will include;

10.1.1. Agreeing meeting agendas with the Chair

10.1.2. Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings

10.1.3. Recording and circulating formal minutes of meetings and keeping a record of matters arising and issues to be carried forward,

11. Review

11.1. EMB will review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness.

Step 1 of 1

Info

QIA Submission

Project Title

Project Title is required.

Executive Sponsor

Executive Sponsor is required.

Project Lead

Project Lead is required.

Governance Oversight group

Governance Oversight group is required.

Select Directorate:

Select Directorate: is required.

Please select the type of QIA you would like to raise:

Please select the type of QIA you would like to raise: is required.

Clear

Raise Request

- Project Title is required.
- Executive Sponsor is required.
- Project Lead is required.
- Governance Oversight group is required.
- Select Directorate: is required.
- Please select the type of QIA you would like to raise: is required.

Patient Safety and Experience Group (PSEG)

Terms of Reference

Date ToR Approved:	
Approved by:	Executive Management Board (EMB)
Review Date:	

1. Constitution

The Executive Management Board (EMB) hereby resolves to establish a formal management group forming a part of the system of internal control at SECAMB, to be known as the Patient Safety and Experience Group (PSEG) referred to in this document as 'the group'.

PSEG sits parallel to the Clinical Effectiveness Group that provides strategic oversight of clinical standards and practice. Both groups constitute the control tool for the oversight of clinical governance across the organisation.

The Group will report to the EMB, whose role is to underwrite the decisions made by the group and provide challenge for any decisions where additional assurance is needed.

2. Purpose

The purpose of the group is to ensure continuous improvement and provide strategic oversight of quality, safety, patient experience & compliance enabling executive scrutiny, escalation, and assurance to the Board.

The group takes oversight for monitoring progress against the quality strategy and regulatory requirements, identifying risks, agreeing mitigations and facilitating learning and continuous Quality Improvement across the Trust.

3. Membership

The Group shall have no less than six members and shall represent the views of all relevant service areas (a rep from each directorate).

The membership of The Group should comprise, but is not limited to:

Chief Nursing Officer (Chair)
Chief Medical Officer (Co-Chair)



Chief Paramedic Officer
Deputy Chief Nursing Officer
Deputy Chief Paramedic Officer
Deputy Chief Medical Officer/ Assistant Chief Medical Officer
Associate Director of Quality & Compliance
Associate Director for Quality & Safeguarding
Head of Education
Safety Improvement Specialist
**Divisional Quality Leads x 4
**One Divisional Clinical Lead representative
**One Divisional Operations Director
Head of Compliance
Head of IPC
Head of Patient Engagement
Head of Quality Improvement
Frequent Caller Lead
Specialist Operations representative
Medicines Safety Officer
ICB representative

**EVERY Division must be represented by a member of the Divisional SLT
Other Subject matter experts or Managers will be invited to attend this meeting during the focus area deep dive part of the agenda as required.

Attendance is expected from all members except in case of annual leave or exceptional circumstances. Apologies should be sent to the group business manager. If unable to attend, a suitably nominated deputy must be briefed and a decision-maker.

The Chair of the group will follow up any unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the group, the chair will discuss the matter with the members and, if necessary, seek a substitute or replacement.

4. Objectives

The objectives of the group are detailed below aligned to the four pillars of a Quality Management System (QMS):

Quality Planning

(setting direction, strategy, and embedding culture)

- Plan and agree annual PSIRP, QI Priorities, Quality Accounts, annual campaigns (e.g. Safe in the Back) at a joint meeting to take place every six months with the Clinical Effectiveness Group (CEG).
- Champion a positive safety culture built on openness, transparency, and psychological safety. Support staff engagement initiatives that foster continuous improvement and compassionate accountability.



- Create the conditions where patients and the public can work with the Trust and their voices are heard and embedded in decision-making.
- Monitor delivery of the Trust's Strategy, quality objectives and statutory Quality Account requirements, providing assurance from a patient safety and quality perspective.

Quality Control

(measuring, monitoring, and assuring performance against standards)

- Provide executive oversight of all patient safety incidents, their responses, and their learning ensuring these are appropriately responded to in a timely manner.
- Scrutiny and challenge of the Incident Review Group (IRG) process ensuring a standardised approach/practices, staff advocacy, fairness and effective management of unwarranted variation
- Monitoring of patient safety and experience related risks on the risk register; oversight of Prevention of Future Death (Regulation 28) reports; approval of quality-checked PSIs; review of PSIRF training plans; monitor emerging themes.
- Review of PFD responses completed by the Clinical Effectiveness Group (CEG) to support quality improvement and compliance.
- Scrutiny and oversight of the frequent caller process and outcomes including the history marking process.
- Review key performance, quality, safety, and patient experience metrics (SPC charts, dashboards, benchmarking). Identify trends, hotspots, and emerging risks.
- Support ongoing monitoring of the quality of frontline operations (performance) to provide assurance to the Board.
- Monitor progress in implementing action plans to address shortcomings in quality of services.

Quality Improvement

(driving change, learning, and innovation)

- Ensure timely review, dissemination, and embedding of learning from incidents, investigations, audits, complaints, claims, and external reviews. Promote shared learning across services and systems.
- Oversight and commissioning of Harm Reviews in line with the Harm Review SOP.
- Apply evidence-based Human Factor and ergonomic methods and tools to improve the reliability and safety of healthcare systems and processes.
- Monitor patient safety, Learning from Deaths, patient feedback, staff feedback, complaints, and surveys to drive quality improvements.
- Oversight of processes in place to tackle Health Inequalities.
- Strategic oversight of patient safety and experience at a divisional level providing constructive challenge to Quality Leads.



- Promote adoption of QI methodology across the organisation.
- Oversee delivery of priority QI programmes and assess their impact on patient outcomes, staff wellbeing, and system performance.
- Identify, recognise, and share good practice.
- Identify learning and links into Education and Training

Quality Assurance

(meeting statutory, regulatory, and professional requirements)

- Oversee identification, assessment, and mitigation of risks to quality and patient safety. Ensure effective alignment with the Board Assurance Framework and risk register.
- Provide oversight and assurance of the complaints process, ensuring management in line with statutory requirements and national standards.
- Provide oversight and assurance of the IPC strategy, ensuring compliance with statutory and regulatory requirements, monitoring infection rates and trends.
- Monitor and review compliance with CQC, NHSE, statutory, and professional standards. Provide assurance to the Board on regulatory readiness.
- Provide oversight and assurance that safeguarding arrangements are robust, effective, and compliant with statutory and regulatory requirements.
- Provide assurance on the effectiveness and outcomes of both the processes and learning from patient safety incidents, safeguarding, and IPC.

5. Agenda

The following standing items will be included in the agenda in a three-hour meeting bi-monthly:

1. Welcome, introductions, minutes & action log

- Confirm previous minutes and review actions.

2. Review of Chair's reports

- Safeguarding subgroup
- IPC subgroup
- Divisional Governance Group's
- Frequent Caller subgroup

3. Patient Safety & Incident Oversight

- Overview of incidents and learning (including PSIs, Duty of Candour, harm reviews).
- Scrutiny of Incident Review Group (IRG) process.
- Prevention of Future Deaths reports.
- Claims and Inquest reports.
- Horizon scanning – PFDs / CQC

3. Risk & Compliance Update



Saving Lives,
Serving Our Communities

- Patient Safety and Experience risks (Board Assurance Framework / risk register alignment).
- Updates / escalations on regulatory compliance (CQC, NHSE, safeguarding, IPC, complaints).

4. Patient Experience & Engagement

- Themes from complaints.
- Themes from patient experience questionnaires and compliments.
- Patient/public stories, engagement activity or case studies.

5. Safety & Quality Metrics

- Review of KPIs, SPC charts, trends and hotspots.
- Benchmarking against peers and national data.
- Performance

6. Quality Improvement

- Progress on priority QI programmes.
- Highlights of good practice and innovation.

7. Focus area(s) deep dive as per cycle of business

8. Focus on Models of Care

9. Review of Patient Safety and Experience related Policies/Procedures

10. Closing summary, key risks and escalations to Board

The standing agenda will be supported by a cycle of business to support specific focus areas and rotate deep dive reviews, reducing overload whilst ensuring statutory reports, strategy reviews and thematic deep dives are undertaken.

Cycle of business to include but not limited to:

- PSIRP & PSIRF training plan
- Health Inequalities
- Complaint's annual themes and improvements
- Frequent Callers oversight
- Safeguarding children/adults report
- IPC report on strategy, trends, compliance
- Quality Account
- Quality objectives
- Patient engagement
- QI update – review of innovation and impact
- Deep dive into patient safety & learning themes update, Harm Reviews, and Prevention of Future Death reports
- Regulatory readiness (CQC/NHSE compliance check)

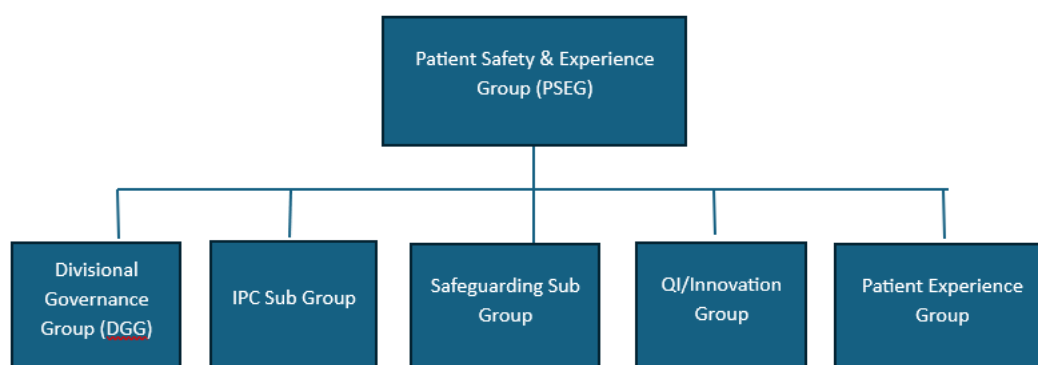


6. Quorum

The quorum necessary for formal transaction of business by the group shall be six members, the following must be represented ensuring there is a representative from all directorates involved.

- One of the Executive Director Chairs, CNO or CMO
- One of the Deputy Directors of Quality and Nursing, Paramedicine or Deputy/Assistant Chief Medical Officer
- A representative of EACH Divisional SLT
- One Divisional Quality Lead and one Divisional Clinical Lead
- A representative from Operations.

In the event of a quorum not being attainable the meeting can still take place, but no binding decisions can be made by the participants.



7. Attendance

Members are required to attend at least 75% of meetings. The Chair will follow up on any issues related to unexplained non-attendance.

8. Frequency of Meetings

The Group shall meet bi-monthly and extraordinary meetings may be called by the Chair between regular meetings to discuss and resolve any critical issues arising.

Meetings of the group will be diarised on a yearly basis.

All meetings are in person, only under exceptional conditions will the meeting be moved to Teams.

Any Microsoft Teams meetings will be recorded and stored in accordance with Trust policy.



9. Principles for effectiveness

- Papers circulated at least 5 working days before
- Use of Quality Dashboard / IQR for data led discussions
- Benchmarking data from other ambulance trusts to be available
- Robust reporting templates
- Focus on assurance AND improvement
- Action-focused, with learning culture emphasis.
- Minutes and action log to be distributed to all attendees within 10 working days of the meeting.

10. Authority

The Group has no executive powers other than those specified in these Terms of Reference or by the Trust Board or its Sub-Committees in its scheme of delegation.

The Group is authorised by EMB to investigate any actions within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the group.

The Group has the power to make decisions pertaining to quality and patient safety related issues, including informing changes to policies, procedures or working practices. The Group must, however, ensure any such decision is aligned to SECamb policy and will report such decisions via the recognised SECamb Governance channels.

11. Risk and Issue Management

Risk and Issues will be managed as per Trust policy.

12. Reporting

The Group shall report to the Trust's EMB.

At the end of each substantive item during the meeting, the chair will summarise the consensus reached on the point discussed to enable the secretary to record a concise note with any decisions and actions.

At the end of the meeting, the group chair shall seek a consensus from group members as to those items that shall be escalated to the parent group.

13. Chair's Action

Where a matter falling within the authority of the group requires an urgent decision, the chair/Deputy Chair can act on behalf of the group.

All decisions made under such Chair's Action must be submitted to the next scheduled meeting for ratification and formal.



14. Secretariat

Administrative support will be provided by the Business Support Manager (BSM) whose specific responsibilities include:

- Issuing meeting notices and papers in advance.
- Taking minutes of meetings.
- Advising on the Terms of Reference and quoracy.

15. Review

The group will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities and reflecting Trust values in our conduct and behaviours as set out in these Terms of Reference.

The group shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to Executive Management Board for approval.

These Terms of Reference shall be approved by the Executive Management Board and formally reviewed initially after six months, but in the future at intervals not exceeding two years.

16. Purview

The Group embodies and promotes the Trust's Learning Culture and will discharge its duties based on responding to opportunities to learn and continually improve.

