BSW, Dorset and Somerset ICBs Cluster

Joint Quality and Population Engagement Committee – Terms of Reference (ToR)

Contents

1. Introduction

1.1 The Joint Quality and Population Engagement Committee (the Committee) is established by the BSW, Dorset and Somerset Integrated Care Boards (ICBs), as a Committee of their respective Boards in accordance with each ICB's Constitution.

1.2 The Committee applies the dimensions of quality set out in the National Quality Board's Shared Commitment to Quality, and is concerned with all services that:

- Are commissioned by the NHS (either the ICBs or NHS England)
- Are jointly commissioned by the NHS and local authorities, regardless of whether the ICB acts as principal, lead or co-commissioner
- Are commissioned by local authorities from NHS and non-NHS providers.
- Provide Health related care and support to the population served by the Cluster

1.3 The Committee is an assurance committee and has no executive powers. The Committee has the powers and authorities as delegated in the SoRD and specified in these terms of reference.

1.4 These Terms of Reference

- set out the membership, remit, responsibilities and reporting arrangements of the Committee
- are defined and agreed, and may be amended by, the respective ICB Boards in accordance with each ICB's Constitution and Scheme of Reservations and Delegations (SoRD)
- are published on the BSW, Dorset, and Somerset ICBs websites, as part of each ICB's Governance Handbook.

2. Responsibilities and duties

2.1 The Committee will

a. gain, and provide to the ICBs and the Cluster Board, assurance that the ICBs are delivering their functions in a way that secures the continuous discharge of the ICBs' statutory duties:
   - as to improvement in quality of services
   - as to reducing inequalities
   - to promote involvement of patients

b. gain, and provide to the ICBs and the Cluster Board, assurance that the ICBs meet and comply with the statutory requirements to make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives (if any), are involved (whether by being consulted or provided with information or in other ways)—
   i. in the planning of the commissioning arrangements by the ICBs,

ii. in the development and consideration of proposals by the ICBs for changes in the commissioning arrangements where the implementation of the proposals would have an impact on—
   - the manner in which the services are delivered to the individuals (at the point when the service is received by them), or
   - the range of health services available to them, and

iii. in decisions of the integrated care board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

2.2 In order to do so, the Committee will:

a. Gain, and provide to the ICBs and the Cluster Board, assurance that there is an effective system of quality governance and internal control that supports the ICBs and the cluster to effectively deliver their strategic objectives and provide sustainable, effective, safe high-quality care.

b. Agree and put forward the key quality priorities that are included within the ICBs and / or the cluster's strategy and annual plan/s, including priorities to address variations and inequalities in access to, and in provision and outcomes of, health and care services.

c. Gain, and provide to the ICBs, assurance that there are robust processes in place for the effective surveillance and management of the quality of services that are planned, commissioned and delivered by the B/D/S ICBs.

d. Regularly review strategic and principal operational risks (as held on the Board Assurance Framework/s (BAF) and Corporate Risk Register/s) which relate to quality and population engagement.

e. Obtain assurance that these risks are appropriately managed, and assure the Cluster Board, and where required: the ICB Boards, thereof. If the Committee cannot assure the Cluster Board / the ICB Boards, it will make the Cluster Board / the ICB Boards aware of the fact and the reasons for it.

f. Regularly consider reports and intelligence from all relevant sources on patient experience of commissioned services, recommend to the ICBs remedial actions to address concerns as may be required, and take assurance that learning is identified, shared and embedded.
   Reports and intelligence may include reports from the System Quality Group; reports on incidents, never events, complaints and claims; Serious Case Reviews; Adult Learning Reviews; Domestic Homicide reviews; reports from Local Safeguarding Partnerships, Safeguarding Adult Boards and Safer Community Partnerships, Prevention of Future Deaths reports; mortality report/s.

g. Oversee and scrutinise the ICBs' response to all relevant (as applicable to quality) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care

(DHSC), NHS England (NHSE) and other regulatory bodies/external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence). Gain, and provide to the ICBs and the Cluster Board, assurance that relevant action is taken to disseminate, implement and embed these both within the ICBs where ICB statutory functions and duties are concerned, and across all relevant stakeholder sites.

h. Gain, and provide assurance to the ICBs and the Cluster Board, regarding the robustness and effectiveness of the ICBs' arrangements for discharging their statutory responsibilities for
   i. safeguarding adults and children.
   ii. infection prevention and control.
   iii. equality, diversity and inclusion as it applies to people accessing and using commissioned health and care services that are.
   iv. medicines optimisation and safety.
   v. Continuing Health Care (CHC), Funded Nursing Care (FNC), and mental health aftercare (s117, deprivation of liberties)

   To do so, the Committee will consider, and approve for publication where required, relevant regular and annual reports.

i. The Committee will highlight to the ICBs and the Cluster Board any areas of concern or unsatisfactory redress, and recommend the implementation of remedial action by the ICB Chief Nurse Officer.

3. Authority

3.1 The Committee is authorised to

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee of the ICBs or any member of each ICB Board;
- Commission reports required to help fulfil its obligations;
- Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the respective ICB for obtaining professional advice;
- The committee is invested with the delegated authority to act on behalf of each ICB Board. The limit of such delegated authority is restricted to the areas outlined in the Responsibilities of the Committee;
- Create sub-groups of the Committee and determine the terms of reference of such sub-groups in accordance with each Board's Constitution, Standing Orders and SoRD. The Committee may not delegate any decision-making powers to such groups.
- Meet with the Population Health and Commissioning Committee and the Strategic Finance and Resources Committee as required.

4. Accountability and Reporting

4.1 The Committee is formally accountable to the BSW ICB, Dorset ICB and Somerset ICB Boards. It will regularly report to the Custer Board.

4.2 After each meeting of the Committee, the Committee Chair reports to the Cluster Board about decisions taken, assurances received, and any concerns that the Committee wishes to escalate.

4.3 Reporting will be in the form as agreed with the Cluster Board, and may take the form of the Committee's minutes, of exception or highlight reports, or dedicated reports produced by the Committee.

4.4 On behalf of the Committee, the Chair may also report about other issues and matters within the Committee's remit that in the Committee's view require the attention or decision-making of the Cluster Board, the ICBs' boards, or accountable officers.

4.5 The Committee receives scheduled reports from any sub-groups that it establishes, and from the ICBs' / the Cluster's quality function, in a format that is determined by the Committee and enables it to obtain the assurances that it seeks.

5. Membership

5.1 The following are members of the Committee who have voting rights and decision-making powers:

- 4 Non-Executive Directors, one of who will chair the committee
- The B/D/S ICBs Joint Chief Nursing Officer (CNO)
- The B/D/S ICBs Joint Chief Medical Officer (CMO)
- The B/D/S ICBs Joint Chief Officer for Commissioning and Place

Members are expected to make every effort to attend all committee meetings.

5.2 The Committee Chair may determine one of the other Non-Executive members of the Committee as deputy chair.

5.3 The following receive a standing invitation to attend Committee meetings. They may inform and advise the Committee, but have no voting rights or decision-making powers:

- The CEO
- The Chief Officer Population Health and Improvement
- The Deputy Chief Nursing Officer
- The Deputy Director Safeguarding, SEND and LeDeR
- The Deputy Director All Age Continuing Care

- The Director of Communications, Engagement and Population Insight
- The Chief Pharmacist
- The Chief Clinical Information Officer
- One Patient Safety Partner

5.4 Only the above members and regular attendees of the Committee have the right to attend Committee meetings.

5.5 The Chair on behalf of the Committee may invite ad-hoc and in view of agenda items such individuals to Committee meetings as are considered necessary to enable the Committee's effective conduct of its business. Such additional attendees will only attend as requested and will not become regular attendees. They will not have a right to receive committee papers, and they will not have voting rights or decision-making powers.

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

5.7 In the case of absences:

a. Where a Committee member is unable to attend, they should ensure that a named and briefed deputy attends the meeting in their place. Such deputies will count towards the quorum.
b. Where a regular attendee of the Committee is unable to attend a meeting, a suitable representative may be agreed with the Committee Chair.

6. Quorum

6.1 A quorum shall be 4 members, including one Non-Executive Director and either the Chief Medical Officer or the Chief Nurse Officer.

6.2 If any member of the Committee is disqualified from participating in an item on the agenda due to a declared conflict of interest, that individual no longer counts towards the quorum.

6.3 In the event of difficulty in relation to achievement of the quorum, independent Non-Executive Members who are not members of the committee may be co-opted as members for individual meetings. The Chair of the Audit Committee cannot be co-opted.

6.4 If the meeting becomes inquorate, and if members agree, the meeting may continue but cannot take decisions. Any decisions in principle must be ratified at the next quorate meeting of the Committee.

7. Meeting frequency and conduct

7.1 The Committee will normally meet bi-monthly. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

The Cluster Board, Cluster Chair or Cluster Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.2 A meeting is constituted when members attend face-to-face, via telephone or video conferencing, any other electronic means, or through a combination of the above. Quoracy rules apply in any case. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

7.3 The Committee normally holds its meetings in private.

7.4 The Committee conducts its business in accordance with relevant codes of conduct, good governance practice, including the Nolan principles of public life, the ICBs' Standards of Business Conduct Policies, Standing Financial Instructions, SoRD and other relevant policies / guidance on good and proper meeting conduct for NHS organisations.

7.5 All Committee members are bound by the Standing Orders and other relevant policies of each ICB. All members and those in attendance must declare any actual or potential conflicts of interest. This is recorded in the meeting minutes.

7.6 The Committee will apply each ICB's Standards of Business Conduct Policy with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.

8. Decision making

8.1 Decisions are normally arrived at by consensus.

8.2 Where consensus cannot be reached, the Chair will move to a formal vote. The quoracy rules apply. Only members of the Committee may vote. Each member is allowed one vote, and a simple majority is conclusive on any matter.
The Chair may have a casting vote if members are equally divided on an issue.

8.3 If a decision is urgent and cannot wait for the next scheduled meeting, and an extraordinary meeting is not appropriate or possible, the Chair may conduct business via email ('out-of-meeting decision'). The Secretariat will undertake the process on behalf of the Chair. The quoracy rules as set out in these Terms of Reference will apply. All out-of-meeting decisions will be formally reported to the Committee.

9. Equality, Diversity and Inclusion

9.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and administration

10.1 The Secretariat for the Committee is provided by the Governance Team. The Secretariat will ensure that:

a. The Committee's forward plan is maintained and kept current with the Chair and the relevant executive lead.
b. Meeting agendas are agreed by the Chair with the support of the relevant executive lead, and meeting papers and materials are prepared and distributed in accordance with each ICBs Standing Orders.
c. Members' and regular attendees' attendance at meetings is monitored, and the Chair is informed if members do not meet the minimum expectations re attendance.
d. Records of members' appointments and renewal dates are up-to-date, and the Chair and the Board are prompted to renew membership and identify new members where necessary.
e. Management of conflicts of interest including ensuring correct handling of declarations.
f. Good quality minutes are taken in accordance with each ICBs Standing Orders and agreed with the Chair, and a record is kept of matters arising, action points and issues to be carried forward.
g. The Chair is supported to prepare and deliver reports to each Board.
h. The Committee is updated on pertinent issues/ areas of interest/ policy developments.
i. Action points are taken forward between meetings, and progress against those actions is monitored.
j. Governance advice is available and easily accessible for Committee members.

11. Review

11.1 The Committee will regularly review its performance, its membership and these terms of reference, and recommend to each ICB Board any amendments it considers necessary to ensure it continues to discharge its business effectively

Effective date: 11 May 2026
Review date: within 12 months of approval or earlier as required
Contact: bswicb.clustergovernance@nhs.net

Appendix 1: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Approval of ToR, formal establishment of the committee

Document control
The controlled copy of this document is maintained by the governance function for the BSW, Dorset and Somerset ICB cluster BSW ICB. Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Appendix 2: Members

Members
4 Non-Executive Directors:

- Caroline Gamlin, Chair
- Ade Williams
- Suzannah Power
- Christopher Foster

Chief Nurse Officer: Shelagh Meldrum
Chief Medical Officer: Bernie Marden
Chief Officer for Commissioning and Place: David Freeman

Observers
Place NED (Somerset): Grahame Paine
Place NED (BaNES): Paul Fox
Place NED (BCP): Karl Hoods