THE IPSWICH HOSPITAL NHS TRUST

Healthcare Governance Committee

TERMS OF REFERENCE
Version 10.0

| **Purpose:** | To provide Terms of Reference for the effective working of the Healthcare Governance Committee; for use by Healthcare Governance Committee Members and for Governance processes within the Trust. |
| **For use by:** | Healthcare Governance Committee Members and Members of the Trust Board |
| **This document is compliant with/supports compliance with:** | This document supports compliance with: |
| | 1. National Health Service Litigation Authority Risk Standard 1: Governance |
| | 2. Care Quality Commission 5 Questions |
| | 3. The NHS Constitution |
| | 4. The NHS Foundation Trust Code of Governance |
| **This document supersedes:** | Healthcare Governance Committee Terms of Reference v8.0 August 2012 |
| **Approved by:** | Approval by Healthcare Governance Committee (via Trust Board) |
| **Approval date:** | 5 November 2013 |
| **Ratified by** | Trust Board |
| **Date Ratified** | 28 November 2013 |
| **Implementation date:** | 1 December 2014 |
| **Review date** | 1 November 2014 |
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| **Responsible Officer** | Division 4 Executive Support, Trust Secretariat |
| **Division and Department** |
| **Archive Date ie date document no longer in force** | To be inserted by Information Governance Department when this document is superseded. This will be the same date as the implementation date of the new document. |
| **Date document to be destroyed: ie 10 years after archive date** | To be inserted by Information Governance Department when this document is superseded |
### Version and document control:

<table>
<thead>
<tr>
<th>Version number</th>
<th>Date of issue</th>
<th>Change Description*</th>
<th>Author</th>
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| 3.1            | 15/06/09      | 1. Page 1: inclusion of Version Control Information.  
2. Section 9: change of Section title to 'Monitoring Compliance and Effectiveness.  
| 4.1            | 26/11/09      | 1. Inclusion of Audit Committee Chair into the membership. | Linda Storey, Trust Secretary. |
| 5.1            | 20/07/10      | 1. Page 1 compliancy information updated to reflect Foundation Trust Code of Governance, NHS Constitution and Care Quality Commission  
2. 1.1 amended to remove reference to responsibility for setting strategic direction.  
3. 1.3 and 1.4 new paragraphs to highlight responsibility for quality committees.  
4. 2.1 included: reference to establishment of annual work plan.  
5. Reference to 'providing' external assurance removed.  
6. 3.5, 3.6 and 3.7 outlines the committee's delegated responsibility from the Board in connection with the three Quality Groups and the Risk Committee.  
7. 4.2.1 attendee section amended to reflect change in associate director posts in Quality and Nursing Directorate.  
8. 7.3 added to reflect the terms of reference of the Trust Board.  
9. 7.4 added to reflect the terms of reference of the Patient Safety Group, Clinical Effectiveness Group and Risk Management Committee.  
10. Communication/reporting diagram removed.  
11. Appendix 1 removed (names of Committee members and reference to deputy). | Linda Storey, Trust Secretary following Healthcare Governance Committee discussion. |
| 6.1            | 28/03/11      | 1. Updated membership and job titles  
2. Update SUI terminology to reflect change to SIRI  
3. Addition of a process to follow for Chairman’s actions (Section 5.2 updated) | Sharon Hnatiw, Committee administrator, following Healthcare Governance Committee discussion |
| 7.1 | June 2012 | 1. Section 1 inclusion of a reference to improvement in quality of care and reformatting of sentences for clarity of purpose.  
2. Inclusion of 2.3.14: responsibility of review of Quality Account prior to Trust Board submission.  
3. 3.6 amendment to make reference to the Trust’s Scheme of Delegation.  
4. 4.1 change to membership to remove Director of HR and Director of Finance and Performance. Clarity regarding other attendees.  
5. Section 6 – revised process for minute circulation.  
6. 8.1.2 self assessment paragraph rewritten. | Linda Storey, Trust Secretary |
| 8.1 | Dec 2012 | 1. 4.1 numbers of Non-executive Director members changed from five to three. Chair of Audit Committee no longer a member.  
2. 6.6 minutes and highlight report no longer to be submitted to the Confidential Board meeting and instead to the next Board meeting in public. | Linda Storey, Trust Secretary |
| 9.1 | June 2013 | 1. Membership changes to include divisional clinical leaders.  
2. Rewrite of role, duties and responsibilities. | Linda Storey, Trust Secretary |
| 9.2 | Nov 2013 | 1. Complete re-write  
2. 2.1.1 emphasis on clinical engagement and compassion.  
3. Membership to include a wider group of regular attendees. | |

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1. Authority

1.1 The Healthcare Governance Committee (the Committee) is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment at future Trust Board meetings.

1.2 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Healthcare Governance Committee.

1.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This authority does not extend, other than in exceptional circumstances, to confidential patient information. The Committee must have due regard to the Trust’s confidentiality policies and the Trust’s duty of care to its employees when exercising this authority.

2. Role

2.1 To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

2.1.1 promote safety and excellence in patient care through focus on clinical engagement and compassion;

2.1.2 identify, prioritise and manage risk arising from clinical care;

2.1.3 ensure the effective and efficient use of resources through evidence-based clinical practice; and

2.1.4 protect the health and safety of Trust employees.

2.2 The Committee will deliver its specific duties and responsibilities by focussing on the following priorities in conducting its business:

2.2.1 Quality Account priorities:
   1. Minimise in-hospital harm to patients
   2. Reduce the numbers of patients readmitted within 30 days
   3. Reduce amenable mortality
   4. Develop organisational values understood and owned by the staff
   5. Improve the net promoter score (friends & family test)
2.2.2 Development of the safety culture.
2.2.3 Excellent customer service and clinical outcomes.
2.2.4 Establishing candour at all levels.
2.2.5 Marrying quality and financial challenge.
2.2.6 Ward to Board assurance.
2.2.7 Higher visibility of the Committee within the organisation.
2.2.8 Support, guide and monitor Divisions in effective implementation of their responsibilities.
2.2.9 Ensure high levels of assurance are maintained.
2.2.10 Ensure staffing numbers and skills are maintained at appropriate levels.
2.2.11 Ensure systems and processes in place to enable staff to raise concerns in a positive and supportive environment.

3. Specific Duties and Responsibilities

3.1 In respect of general governance arrangements:

3.1.1 ensure that all statutory elements of clinical governance are adhered to within the Trust;
3.1.2 to agree trust-wide clinical governance priorities and give direction to the clinical governance activities of the Trust’s services and divisions;
3.1.3 to establish an annual work plan, reviewed annually to support the delivery of the trust-wide clinical governance priorities;
3.1.4 propose priority areas for the Annual Quality Account and review the draft Annual Quality Account prior to its submission to the Trust Board for approval;
3.1.5 to approve the terms of reference and membership of its reporting sub-committees (as may be varied from time to time at the discretion of the Healthcare Governance Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the Healthcare Governance Committee in the sub-committee’s terms of reference for consideration and action as necessary;
3.1.6 to consider matters referred to the Committee by the Trust Board;
3.1.7 to consider matters referred to the Committee by its sub-committees;
3.1.8 to receive and approve the annual clinical audit programme ensuring that it is approved by the Trust Board consistent with the audit needs of the Trust;
3.1.9 to oversee the Trust’s policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998;
3.1.10 to 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, ensuring the right focus of quality audits to financial audits;

3.1.11 to review and approve relevant policies and procedures as set out in the Trust's Scheme of Delegation;

3.1.12 to foster links with primary care and other stakeholders including Ipswich Hospital User Group members.

3.2 In respect of safety and excellence in patient care, in particular:

3.2.1 have overview responsibility for the Care Quality Commission 5 Questions:

1. - is it safe?
2. - is it effective?
3. -is it caring?
4. - is it responsive to people’s needs?
5. - is it well led?

3.2.2 to agree an annual safety plan and monitor progress;

3.2.3 to ensure that internal standards are set and monitored, including (without limitation):

- to commission the setting of standards by the Trust Board (e.g. in trust policies), and ensure that a mechanism exists for these standards to be monitored;
- to ensure the standards outlined in national service frameworks are implemented and monitored;
- to ensure the trust complies with NHSLA standards and monitor the level of compliance and actions to be taken to maintain and/or improve the trust's level of accreditation (as determined by the Board); and
- to ensure the registration criteria for the Care Quality Commission continue to be met;

3.2.4 to implement an engagement programme with the leaders of clinical divisions to ensure regular and constructive scrutiny of activities;

3.2.5 to promote within the trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with trust policy on reporting issues of concern;

3.2.6 receive assurance on staff welfare issues;

3.2.7 receive assurance on staffing levels

3.2.8 to oversee the processes to ensure the review of patient safety incidents (including near-misses, complaints, claims and Rule 43 coroner reports) from within the trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;

3.2.9 to identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/patient advice and liaison service and ensure appropriate action is taken;
3.2.10 to oversee the system within the trust for obtaining and maintain any licences relevant to clinical activity in the trust (e.g. licences granted by the Human Tissue Authority or any successor organisation), receiving such reports as the Committee considers necessary;

3.2.11 to monitor the trust's compliance with the national standards of quality and safety of the Care Quality Commission, and Monitor’s licence conditions (once authorised as a Foundation Trust), that are relevant to the Committee’s area of responsibility, in order to provide relevant assurance to the Trust Board to that the Board may approve the Trust's annual declaration of compliance and corporate governance statement;

3.2.12 to ensure that risk to patients are minimised through the application of a comprehensive risk management system, including, without limitation:

- to review the trust’s risk management strategy prior to its presentation to the Trust Board for approval;
- to ensure that processes are in place to ensure the escalation of risks to the trust’s risk register;
- to ensure that processes are in place to ensure the escalation of risks to trust’s Board Assurance Framework;
- to monitor the management of the critical risks assigned to the Committee. Request further information to provide assurance where the Committee agrees necessary;
- to receive reports from the trust’s Deputy Director of Nursing on risk management;
- to ensure the trust incorporates the recommendations from external bodies (e.g. Care Quality Commission), as well as those made internally (e.g., in connection with serious incident reports) into practice and has mechanisms to monitor their delivery;
- to maintain and monitor the trust’s risk management policy;
- to ensure those areas of risk within the trust are regularly monitored and that effective disaster recovery plans are in place;
- to ensure implementation of the National Patient Safety Agency reporting system;
- to assure that there are processes in place that safeguard children and adults within the trust; and
- to escalate to the Combined Board and/or Audit Committee and/or Trust Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust;

3.2.13 to agree an annual patient experience plan and monitor its progress;

3.2.14 to assure that the trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, to identify areas for improvement and ensure that these improvements are effected.

3.2.15 to ensure that the trust has an education strategy, policy and plans in place, that education resources are allocated and reviewed to enable the delivery of educational initiatives and compliance and delivery of national, regional and local education standards.
3.3 **In respect of efficient and effective use of resources through evidence-based clinical practice:**

3.3.1 agree an annual quality plan and monitor progress;

3.3.2 monitor the impact on the trust’s quality of care of cost improvement programmes and any other significant reorganisation (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the Committee) and report any concern relation to an adverse impact on quality to the Trust Board;

3.3.3 to ensure that care is based on evidence of best practice/national guidance;

3.3.4 to assure that procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and the National Midwifery Council) are in place and performed to a satisfactory standard;

3.3.5 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 and guidelines and radiation use and protection regulations (IR(ME)R);

3.3.6 to assure the implementation of all new procedures and technologies according to trust policies;

3.3.7 to review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them;

3.3.8 to monitor trends in compliance received by the trust and commission actions in response to adverse trends where appropriate;

3.3.9 to monitor the development of quality indicators throughout the trust;

3.3.10 to generally monitor the extent to which the trust meets the requirements of commissioners and external regulators;

3.3.11 to identify any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas in all specialities;

3.3.12 to ensure the research programme and governance framework is implemented and monitored;

3.3.13 to ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);

3.3.14 to ensure that where practice is of high quality, that practice is recognised and propagated across the trust; and

3.3.15 to ensure that the trust is outward looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

4. **Membership and Quorum**

4.1 **Membership**

The membership of the Healthcare Governance Committee shall consist of:
Three Non-executive Directors of the Trust, one of which will be appointed Chair for a period of two years
Chief Executive
Director of Nursing and Quality
Medical Director
Chief Operating Officer
Director of Human Resources

4.2 Attendance

4.2.1 The following participants are required to attend meetings of the Healthcare Governance Committee:

Divisional Clinical Directors or their nominated Clinical Delivery Group Lead
Deputy Director of Nursing and Quality
Heads of Nursing/Clinical Services/Head of Midwifery
Chief Pharmacist
Clinical Tutor
Junior Doctor Representative
Patient Safety Lead
Patient Experience Lead
Trust Secretary
Head of Internal Audit

4.2.2 Other members of staff may be requested to attend meetings for specific items as requested by the Committee.

4.2.3 The Committee will have over-riding authority to restrict attendance under specific circumstances.

4.3 Quorum

4.3.1 The Committee will be deemed to be quorate to the extent that the following members are present:

At least one Non-executive Director
either the Medical Director or Director of Nursing and Quality or their deputies
A third Director.

4.3.2 In the absence of the Committee Chair, the meeting will be chaired by a Non-executive Director appointed by the other Non-executive Director members.

4.3.3 The Trust Secretary will keep under review attendance at Committee meetings and take any necessary action to ensure that meetings are held in accordance with these terms of reference.

4.3.4 When members cannot attend it is expected a deputy will be nominated.

4.3.5 Members listed at paragraph 4.1 and attendees listed at paragraph 4.2.1 are, respectively, required to attend a minimum of 4 meetings within a twelve-month period.

4.3.6 For the avoidance of doubt, trust employees who serve as members of the 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. Frequency of Meetings

5.1 Meetings will be held bi-monthly.

5.2 Additional meetings may be convened on an exceptional basis at the request of the Chair or any three members of the Committee.

5.3 The Chairman has the authority to exercise an emergency or urgent decision where a particular issue requires a response that cannot be deferred to the next meeting. When this occurs, the Committee may take one of three actions:

1. Convene an urgent meeting, ensuring that the Committee is quorate.
2. Email Committee members requesting their input/view by a given date.
3. Take Chairman’s action for urgent decisions. When this option is taken, the decision must be made by the Chair in consultation and agreement with at least three other Committee members.

The exercise of actions under paragraphs 2. and 3. Above shall be reported to the Committee at its next meeting for formal ratification, and the Trust secretary informed.

6. Arrangements for meetings and minutes

6.1 The Clinical Governance Co-ordinator will be Secretary to the Committee. The duties in this respect will include:

6.1.1 Agreement of agenda with Chairman and Director of Nursing and Quality and collation of papers.

6.1.2 Taking the minutes and keeping a record of matters arising and issues to be carried forward.

6.1.3 Advising the Committee on pertinent areas in consultation with the Trust Secretary.

6.1.4 Working with the Trust Secretary to ensure that the committee works effectively and efficiently and co-ordinates its work with that of the Trust Board and other sub-committees of the Trust Board.

6.2 The Agenda will take account of key activities and deadlines. Any member can request an item to be included on the agenda, which should be made to the Committee Chair at least 10 days prior to a meeting. Any additional agenda items received after this date will be considered at the discretion of the Committee Chair.

6.3 Agendas and supporting papers will be sent to members so that they are received 5 working days prior to the meeting.

6.4 Unconfirmed minutes will be circulated to Committee Members following their compilation.

6.5 Unconfirmed minutes will be shared with the next Audit Committee Meeting.

6.6 Unconfirmed minutes and a highlight report will be submitted to the next Board meeting held in public and any subsequent changes to the minutes will be reported to the next board meeting held in public following the meeting at which the changes were agreed.

6.7 The Committee Chair and Trust Secretary will determine whether any part of the minutes require redaction in accordance with the Trust’s protocol for redaction of information prior to their release in the public domain.
6.8 Minutes of the Committee meeting with redactions will be placed on the Intranet and a copy sent to all Healthcare Governance Committee sub groups.

7. Reporting arrangements

7.1 A highlight report and minutes of each meeting will be submitted to the Trust Board as outlined in Section 6. above.

7.2 The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

7.3 The Committee shall submit an Annual Report to the Trust Board.

7.4 The following sub-committees shall report to the Committee to provide assurance that they are carrying out their duties and responsibilities:

- Patient Safety and Clinical Effectiveness Group
- Patient Experience Group
- Risk Management Committee
- Strategic Education Board

8. Monitoring Compliance and Effectiveness

8.1 The effectiveness of the Committee will be monitored through:

8.1.1 The Committee will review its performance and effectiveness and demonstrate that it is fulfilling its terms of reference through the publication of an Annual Report.

8.1.2 Completion by Committee Members of an annual self assessment of the Committee’s performance, the results of which will be collated and reported to the Committee by the Trust Secretary. The Committee will agree actions to make improvements to Committee performance which will be incorporated into the Committee’s Annual Report to the Trust Board.

8.1.3 Monitoring of compliance with all aspects of the Terms of Reference by the Trust Secretary on an ongoing basis, including attendance at, and frequency of, Committee meetings, together with compliance to reporting arrangements.

8.1.4 The Trust Secretary will take any necessary action to ensure that meetings are held in accordance with these terms of reference and will report to the Chairman of the Committee any identified gaps in order that action can be agreed and taken to resolve compliance issues.

8.1.5 An annual review of the Committee’s Terms of Reference by the Committee Members.

9. Approval of These Terms of Reference and Review Arrangements

9.1 Reviewed by the Healthcare Governance Committee on 5 November 2013.
9.2 Approval by the Trust Board:
9.3 To be reviewed annually: Next review November 2014