Clinical Governance Committee

Terms of Reference

1. Purpose of the Committee

1.1 The Clinical Governance Committee is a standing committee of the Board, which together with the Audit and Risk Committee, Staff Governance Committee and Finance and Performance Committee forms the full governance framework for NHS Boards.

1.2 The Clinical Governance Committee is established by the Board to provide assurance to the Board that appropriately robust clinical governance processes are in place and effective throughout the organisation.

2. Composition of the Committee

2.1 Membership

2.1.1 The Clinical Governance Committee members will be appointed by the Board. As a minimum, full Membership of the committee should include a minimum of 3 Non-Executive Board members plus 1 substitute. Note: one of the Members must be the Area Clinical Forum Chair and one must be the Non-Executive Whistleblowing Champion.

2.1.2 The Chair will be appointed by the Board. The appointment of the Chair will be reviewed biennially in line with current legislation.

2.1.3 Current membership comprises:

- Non-Executive Director as Chair (who also holds the Whistleblowing Champion role)
- Three other Non-Executive Directors
- Chair, Area Clinical Forum
- Chair, Area Partnership Forum

2.2 Executive Leads

2.2.1 The joint executive lead officers for the Clinical Governance Committee shall be the Medical Director and the Director of Nursing and Acute Services.
Generally the designated Executive Leads will support the Chair of the Committee in

ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. Specifically they will:

- Support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation, and the Board's Best Value framework;
- Liaise with the Chair/Corporate Services Manager in agreeing a programme of meetings for the business year, as required by its remit;
- Oversee the development of an Annual Work plan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year end, for endorsement by the Committee and approval by the Board;
- Agree with the Chair an agenda for each meeting, having regard to the Committee's remit and work plan;
- Lead a midyear review of the Committee Terms of Reference and progress against the annual work plan, as part of the process to ensure that the work plan is fulfilled;
- Oversee the production of a Committee Annual Report, informed by self-assessment of performance on the delivery of the Committee's remit, work plan and key performance indicators for endorsement by the Committee and submission to the Board.

2.3 Attendees

2.3.1 Attendees may be invited to the Clinical Governance Committee as required but regular attendance of the following is expected:

Core attendees (expected at every meeting):

- Medical Director (Joint Executive Lead)
- Director of Nursing and Acute Services (Joint Executive Lead)
- Director of Public Health
- Director of Finance
- Chief Officer, Integration Joint Board
- Chief Executive
- Clinical Governance and Risk Team Leader
- Chief Nurse (Corporate)

Ad hoc attendees (required to contribute to key items on the CGC agenda)

- Director of Pharmacy
- Director of Dental Services
- Associate Medical Director for Acute Services
- Associate Medical Director for Primary Care
- Chief Midwife
- Chief Nurse Acute
- Chief Nurse Community
- Primary Care Service Manager
- Health and Safety Manager
- Head of Information and Digital Technology

2.3.2 Where an officer is unable to attend a particular meeting, a named representative shall attend in their place.

3. Functions

3.1 Remit

3.1.1 Provide assurance to the Board on Clinical Governance in NHS Shetland, with the following focus:

3.1.2 Person-Centred – to provide assurance regarding participation, patient and service users' rights and feedback:

- To provide assurance that there are effective systems and processes in place across NHS Shetland to support participation with patients, service users, carers and communications, to comply with participation standards and the Patient Rights (Scotland) Act 2011 generally and specifically within the context of service redesign.
- To monitor complaints response performance on behalf of the Board of NHS Shetland, and promote positive complaints handling including learning from feedback and complaints.

3.1.3 Safe (Clinical Governance and Risk Management) – to provide assurance in respect of clinical governance and risk management arrangements by seeking assurance that there are adequate systems and processes in place to ensure that:

- Robust clinical control frameworks are in place for the effective management of clinical governance and risk management and that they are working effectively across the whole of NHS Shetland.
- Performance is reviewed in the management of clinical and professional risks, including emergency planning and service/business continuity planning.
- Effective public protection arrangements are in place.
- Incident management and reporting is in place and lessons are learned from adverse events and near misses.
- Complaints and Duty of Candour events are handled in accordance with national guidance and organisational procedures and lessons are learned from their investigation.
- A culture of continuous improvement in service quality is in place, within the context of the annual efficiency programme.
- Whistleblowing concerns are handled in accordance with the national Whistleblowing Standards and that lessons are learned from their investigations.
- Recommendations are made to the Shetland NHS Board Audit Committee on requirements for internal audit activity.

3.1.4 Effective (Clinical Performance and Public Health Performance and Evaluation) – to provide assurance that clinical effectiveness and quality improvement arrangements are in place:

- To ensure that recommendations from any inspections have appropriate action plans developed and are monitored and reported on.
- Where performance improvement is necessary, to seek assurance regarding the reliability of the improvement intervention.
- To ensure that clinical dashboards and other data and measurement systems underpin the delivery of care.
- To ensure that the healthcare provided is informed by evidence based clinical and professional practice guidelines.
- To ensure that staff governance issues which impact on service delivery and quality of services are appropriately managed through clinical governance mechanisms and effective training and development is in place for all staff.

3.1.4 Population Health – to provide assurance that all necessary systems and processes are in place that ensure staff engaging in population health related activities incorporate the key components of population health governance, namely:

- Quality and clinical/professional effectiveness
- Public information and involvement
- Population health research
- Risk management
- Realistic care and medicine
- Well informed e.g. health literacy and digital literacy

3.2 Standing Items

- Joint Governance Group (JGG) Update Report
- Operational Clinical Governance Group (OCGG) Update Report
- Clinical Effectiveness Quarterly Report as shared with Joint Governance Group (JGG) Quarterly Report
- Adverse Event Quarterly Report
- Quality Score Card incorporating the QMPLE Quarterly Report
- Whistleblowing Quarterly Report
- NHS Complaints and Feedback Monitoring Quarterly Report
- CGC Aligned Risk Register Quarterly Report
- Approval of the Approved Medical Practitioners (AMP) List Mental Health Act Quarterly Report
- Quality Report for Health Services delivered under the Partnership Health and Care Staffing (wef September 2023)
- Health and Care Staffing Programme Quarterly Report
- Leadership Walkaround Updates
- Topics of Emerging Concern (wef September 2023)
- Population Screening (wef March 2024)
- Control of Infection Committee Update (wef March 2024)
- Annual Workplan Quarterly Update (wef June 2024)
- Clinical Governance Assurance – progress updates from Whistleblowing Incidents action plans (wef Nov'24)

3.3 Ad-hoc Reports

March

- CGC Annual Work Plan, Year End Review
- CGC Annual Work Plan for Year Ahead
- Draft CGC Annual Report for Approval
- Draft CGC Annual Certificate of Assurance

June

- Half Yearly Review CGC Terms of Reference (ToR)
- Draft Whistleblowing Annual Report
- Medical Devices Committee Annual Report

Sept

- Medical Director's Annual Report to include DME and Realistic Medicine (Annual Duty of Candour Report to be attached as an appendix – moved from June**)**
- Child Death Reviews
- Director of Pharmacy Annual Report
- Mid-Year Review of CGC Annual Workplan
- Hospital Transfusion Committee Annual Report (moved from June)
- Draft Annual Feedback and Complaints Report (moved from June)

Dec

- Shetland Public Protection Annual Report
- CGC Draft Annual Report
- Control of Infection Committee Annual Report
- Population Screening Annual Report
- Mid-Year Review CGC Terms of Reference (ToR)

4. Meetings of the Committee

4.1 Frequency

4.1.1 The Committee shall meet four times per year.

4.1.2 The Chair of the Committee may at any time convene additional meetings of the Committee to consider business which may require urgent consideration.

4.2 Agenda and Papers

4.2.1 The Chair will set the agenda in conjunction with the Executive Leads.

4.2.2 The agenda and supporting papers will be sent out at least five working days in advance of the meetings. Notice of each meeting will confirm the venue, time and date together with an agenda and shall be made available to each member of the committee.

4.2.3 All papers will clearly state the agenda reference, the author, the purpose of the paper and the action the Committee is asked to consider.

4.3 Quorum

4.3.1 No business shall be transacted at a meeting of the Clinical Governance Committee unless at least three of the whole number of Members is present.
Meetings will be held either in-person, on Microsoft Teams or through a hybrid arrangement of in person attendance and on Teams.

4.4 Minutes

4.4.1 Formal minutes shall be taken of the proceedings of the Committee. Draft minutes shall be distributed for consideration and review to the Chair of the meeting within 10 working days of the meeting except in exceptional circumstances. The Chair must return any edits within a further five working days of receipt.

4.4.2 The draft minutes will be circulated electronically to Committee Members for approval within the following 10 working days. (Note: this is not current practice. Currently, Minutes are editing by Chair and distributed as part of the Pack for the following meeting).

4.4.3 Minutes will be included for noting in subsequent Board Meeting papers following approval by the Clinical Governance Committee.

4.4.4 The Committee Chair will provide a short decision note to all Board members following the meeting, and will escalate any pertinent issues to the next Board meeting regardless of the availability of the approved minutes. Escalation issues might include the Committee's inability to provide assurance about an area of delegated responsibility, or flag attendance concerns.

5. Authority

5.1 The Committee is authorised by the Board, within its Terms of Reference, to investigate any activity undertaken by NHS Shetland. It is authorised to seek and obtain any information it requires from any employee and all employees of NHS Shetland are directed to co-operate with any request made by the Committee.

5.2 The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the assistance of people from outside NHS Shetland or the wider NHS, with relevant expertise, if it is considered necessary.

5.3 The External and Internal Auditors shall have the right of direct access to the Chair of the Committee for audit purposes.

6. Reporting Arrangements

6.1 The Clinical Governance Committee reports to Shetland NHS Board for non-delegated matters.

The Clinical Governance Committee should develop an effective information sharing mechanism with all other Standing Committees of the NHS Board (Note: at time of writing, exact approach still to be agreed: to be considered at Board Development Session on dd/mm/25).

6.2 The Committee has a duty to review its own performance and effectiveness, including:

- A half yearly review of Terms of Reference, considering the need for any amendment/update to Terms of Reference, which in the event, will require to be approved by the Board;
- A midyear review of the Committee's established key performance indicators;
- A midyear review of Annual Work Plan, identifying any areas of slippage on timescales / tasks and put in place any additional actions to ensure full delivery of the Committee's remit and work plan by the business year end;
- In accordance with Best Value for Board and Committee Working, the submission of an Annual Report by 5 April each year encompassing: the name of the Committee, the Committee Chair, members, the Executive Leads and officer supports/attendees, frequency and dates of meetings, member attendance, the activities of the Committee during the year including confirmation of delivery of the Annual Work plan and review of the Committee Terms of Reference and key performance indicators, improvements overseen by the Committee and matters of concern to the Committee (in line with the Annual Report template).