CONSTITUTION
1. The Board of Directors approved the establishment of the Clinical Governance and Quality Committee (known as “the Committee” in these terms of reference) for the purpose of:
   a) providing a focus on clinical governance, quality and patient safety issues;
   b) overseeing clinical performance; and
   c) ensuring the organisation responds to the clinical issues raised in national / local reports, patient surveys, serious untoward incidents, clinical incidents and inquests.

2. The Committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

DUTIES
3. In particular the Committee will:

   Assurance to the Board of Directors
   a) provide strategic assurance to the Board of Directors in relation to:
      • clinical governance, quality, patient safety and clinical standards,
      • the effectiveness and robustness of the organisation’s system and processes for ensuring clinical governance, quality, patient safety and clinical standards,
      • the organisation meeting its obligations under the Patient Safety First initiative;
      • all required quality governance issues including Monitor’s Quality Governance Assurance Framework.

   Strategy
   b) develop and promote the vision, values and culture of clinical governance, quality, patient safety and clinical standards across the organisation;

   c) promote clinical leadership and engagement in the development and delivery of the organisation’s:
      • clinical strategy,
      • quality strategy;

   Improving quality
   d) review and ensure that lessons are learned and implemented across the organisation from patient feedback, including patient safety data and trends, compliments, complaints and patient surveys;
e) receive reports from the Trust Management Board and, where relevant, ensure implementation of the recommendations resulting from:
   - internal reports,
   - external reports,
   - clinical audit reports,
   - clinical accreditation visits,
   - service reviews,
   - legislation, regulations and guidance which address clinical governance, quality, patient safety and clinical standards;

f) drive the organisation the achieve, maintain and improve upon Care Quality Commission, NHS Litigation Authority and Clinical Negligence Scheme for Trusts (CNST) standards;

g) oversee the consideration and implementation of National Institute for Health and Clinical Excellence (NICE) guidance;

h) receive, consider and comment upon the Quality Report from the Trust Management Board and, taking account of comments from the Executive Directors’ Group, recommend its approval to the Board of Directors;

**Performance management**

i) work closely with the Trust Management Board:
   - oversee the clinical information which has been examined to review clinical performance,
   - develop and monitor key performance measures for clinical quality, patient safety and clinical standards,
   - review
   - oversee clinical incident reporting,
   - oversee the organisation’s response to serious untoward incidents and inquests;

j) consider the comments from the Trust Management Board on the clinical impact of delivering divisional performance against:
   - annual budgets, capital plans and the cost improvement programme,
   - quality, innovation, productivity and prevention plans,
   - commissioning for quality and innovation plans (CQUIN),
   - clinical activity and key performance indicators,
   - corporate governance activities and responsibilities,

highlighting issues and concerns in respect of clinical services (if appropriate) to the Board of Directors;

**Risk management and internal control**
k) receive the corporate risk register and take lead responsibility for identified risks in respect of clinical governance, patient safety quality and standards:
   • assess those risks brought to the attention of the Committee and identify those that are strategically significant for inclusion in the organisation’s Assurance Framework,
   • oversee the development of action plans to address the mitigation of strategically significant risks and gaps in controls and assurance,
   • liaise with the Risk Committee to consider the impact of these risks against all the risks facing the organisation;

l) work with the Audit Committee and the Risk Committee, advise on the clinical aspects of the Risk Management Strategy;

m) liaise with the Risk Committee to ensure compliance with the organisation’s risk management systems and processes and to identify those risks (and risk mitigation action plans) which need to be brought to the attention of the Board of Directors;

n) to meet bi-annually with, and review the performance of Divisional Clinical Governance and Quality Committees;

o) agree an annual programme of work as a basis for the Committee’s agenda.

Clinical trials and research studies
p) In line with the organisation’s policies, receive notification of the Trust Management Board’s actions in respect of applications for clinical trials and research studies.

MEMBERSHIP
4. The Committee will include the following members:

   a) a Non-Executive Director (Chair);
   b) an additional Non-Executive Director;
   c) the Medical Director;
   d) the Chief Nurse;
   e) the Chief Operating Officer.
   f) the Director of Governance

5. All members listed above have voting rights.

6. The Chair of the Committee is the Non-Executive Director appointed by the Chair of the University Hospitals of Morecambe Bay NHS Foundation Trust. The Deputy Chair of the Committee is the additional Non-Executive Director. If the Chair is not present, then the Deputy Chair shall chair the meeting.

ATTENDANCE
7. The following will be in attendance:
a) Associate Director of Quality Governance;
b) PA to Medical Director (as Secretary to the Committee).

8. In exceptional circumstances, and subject to the approval of the Chair in advance of the meeting:
   a) the Medical Director may nominate a Deputy Medical Director to attend on their behalf. A Deputy Medical Director attending in such circumstances will have the right to vote;
   b) the Chief Nurse may nominate a Deputy Chief Nurse to attend on their behalf. A Deputy Chief Nurse attending in such circumstances will have the right to vote;
   c) other members may also nominate a deputy. Such deputies will be in attendance and **will not** have voting rights.

9. The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendance and will have no voting rights.

10. Where an Internal Audit report is to be considered by the Committee then the Executive Sponsor of that report should invite the Head of Internal Audit to be present for that item only.

**RESPONSIBILITY OF MEMBERS AND ATTENDEES**

11. Members of the Committee have a responsibility to:

   a) attend at least 80% of meetings, having read all papers beforehand;
   b) act as ‘champions’, disseminating information and good practice as appropriate;
   c) identify agenda items, for consideration by the Chair, to the Lead Director / Secretary at least 12 days before the meeting;
   d) prepare and submit papers for a meeting, using the template in the Governance Strategy, at least 8 days before the meeting;
   e) if unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf;
   f) when matters are discussed in confidence at the meeting, to maintain such confidences;
   g) declare any conflicts of interest / potential conflicts of interest in accordance with the University Hospitals of Morecambe Bay NHS Foundation Trust’s policies and procedures;
   h) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the University Hospitals of Morecambe Bay NHS Foundation Trust’s policies and procedures).

**QUORUM**

12. A quorum will be three members, of whom there should be:
a) at least one should be a Non-Executive Director;
b) at least one should be an Executive Director.

13. When considering if the meeting is quorate, only those individuals who are members can be counted, deputies and attendees cannot be considered as contributing to the quorum. In those exceptional circumstances where the Chair of the Committee has approved the attendance of Deputy Medical Directors or Deputy Chief Nurses deputising for the Medical Director / Chief Nurse (as appropriate), then these clinicians can be considered as contributing to the quorum.

FREQUENCY
14. Meetings will normally take place monthly and at least two weeks before a Board of Directors meeting (so as to allow this Committee to report to the Board of Directors).

15. The business of each meeting will be transacted within a maximum of two and a half hours.

AUTHORITY
16. The Committee is authorised by the Board of Directors:
   a) to investigate any activity within its terms of reference and produce an annual work program;
   b) to approve or ratify (as appropriate) those policies and procedures for which it has responsibility as listed in the ‘Policy Schedule’ in the Corporate Governance Manual;
   c) to promote a learning organisation and culture, which is open and transparent;
   d) to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference; and

17. The Committee does not have the authority to commit the resources. Any matters requiring a decision on resources are to be referred to the Finance and Performance Committee and the Director of Finance.

DECISION MAKING
18. Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

19. Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, provided that nothing in the way of business is conducted is prohibited by the standing orders of the University Hospitals of Morecambe Bay NHS Foundation Trust.

20. In the event of a formal vote the chair will clarify what members are being asked to vote on – the ‘motion’. Subject to meeting being quorate a simple
majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

21. Only the members of the Committee present at the meeting will be eligible to vote. Members not present, deputies and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

REPORTING
22. The Committee will have the following reporting responsibilities:

a) to ensure that the minutes of its meetings are formally recorded and submitted to the Board of Directors. These minutes shall be accompanied by a summary prepared by the chair of the meeting outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of the Board of Directors;

b) to produce those assurance and performance management reports listed in the Committee’s annual work programme which has been agreed with, and are required by, the Board of Directors;

c) any items of specific concern, or which require the Board of Directors approval, will be subject to a separate report;

d) to provide exception reports to the Board of Directors highlighting key developments / achievements or potential issues;

e) to produce an annual report for the Board of Directors setting out:
   i. the role and the main responsibilities of the committee
   ii. membership of the committee
   iii. number of meetings and attendance
   iv. a description of the main activities during the year
   v. a completed annual self-assessment (the format to be approved by the Audit Committee) and the identification of any development needs for the Committee

REPORTING GROUPS
23. The groups identified below will be required to submit the following information to the Committee:

a) their terms or reference for formal approval and review;

b) the minutes of their meetings, together with a summary prepared by the chair of that group outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of this Committee;

c) to produce those assurance and performance management reports listed in the individual group’s annual work programmes which have been agreed with, and are required by, this Committee;

d) an annual report setting out the progress they have made and future development; and

e) any report or briefing requested by this Committee.

24. The groups are:
a) Medicines Management Sub-Committee
b) Infection Prevention and Control Committee
c) SIRI Group
d) Safeguarding Group
e) any Task and Finish Group set up by the Clinical Governance & Quality Committee to assist them in carrying out their duties.

25. In addition the Committee will also receive assurance in respect of minutes and / or reports from:
   a) Drugs and Therapeutics Group
   b) Medication Safety Group
   c) Anti-microbial Group

ADMINISTRATIVE ARRANGEMENTS
26. The Joint Lead Directors, the Medical Director and the Chief Nurse, are members of the Committee and have corporate responsibility for:

   a) liaising with the Chair on all aspects of the work of the Committee, including providing advice;
   b) ensuring the Committee acts in accordance with standing orders and the scheme of reservation and delegation;
   c) identifying an officer to undertake the role of Secretary;
   d) overseeing the delivery of the Secretary's duties.

27. The Secretary of the Committee will be responsible for:

   a) attending the meeting;
   b) ensuring correct and formal minutes are taken in the format prescribed in the Governance Strategy and, once agreed by the Chair, distributing minutes to the members and submitting a copy to the Assistant Chief Executive;
   c) keeping a record of matters arising and issues to be carried forward;
   d) producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete;
   e) producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these dates and booking appropriate rooms and facilities;
   f) providing appropriate support to the Chair, Lead Director and the Committee members;
   g) providing notice of each meeting and requesting agenda items no later than 14 days before a meeting;
   h) agreeing the agenda with the Chair and the Joint Lead Directors prior to sending the agenda and papers to members no later than 7 days before the meeting;
   i) ensuring the Annual Work Programme is up to date and distributed at each meeting;
j) ensuring the papers of the Committee are filed in accordance with the University Hospitals of Morecambe Bay NHS Foundation Trust’s policies and procedures.

REVIEW
28. Terms of Reference will normally be reviewed annually, with recommendations on changes submitted to the Board of Directors for approval.

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To be approved by: Board of Directors
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