Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC – JANUARY 2015 **Agenda Item Number: 12/15**
Enclosure Number: (6)

Subject:	Governance and Quality Committee Revised Terms of Reference
Prepared by: **Sponsored by:** **Presented by:**	Tracey Stenning, Acting Head of Governance Cathy Stone, Director of Nursing Cathy Stone, Director of Nursing
Purpose of paper	Requires Trust Board approval Discussion requested by Trust Board
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	The Governance and Quality Committee Terms of Reference (ToR) were reviewed in accordance with the requirements of the ToR at the Governance and Quality Committee in November 2014. There have been some minor changes to the ToR to reflect the changes to the Care Quality Commission standards and the removal of the NHSLA Risk Management Standards. The Committee is now only attended by one Non-Executive Director, the membership has been updated to reflect this and has assigned the Director of Nursing as the Vice Chair.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	For Board discussion and approval/ratification.
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	The proposed Terms of Reference will take effect immediately once approved.
Consideration of legal issues (including Equality Impact Assessment)?	Considered – none.
Consideration of Public and Patient Involvement and Communications Implications?	Considered – none.

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	Aim 1: Deliver safe and high quality patient centered care.
BAF/Corporate Risk Register	Assurance Framework: 1-1415, 2-1415

Reference (if applicable)	Risk Register ID:9-1415
Risk Description	Assurance Framework: • 1-1415: Inability to maintain ongoing compliance with all CQC standards. • 2-1415: Failure to comply with internally and externally set standards on quality and safety. Risk Register: • 9-1415: Failure to achieve internal and external set quality/patient safety improvements.
CQC Reference	

Committees/Meetings at which paper has been approved:	**Date**
Governance and Quality Committee	4 November 2014

GOVERNANCE AND QUALITY COMMITTEE
Terms of Reference

1. Constitution
The Trust Board hereby resolves to establish a Committee to be known as the Governance and Quality Committee. The Governance and Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose
The purpose of the Governance and Quality Committee is to provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided for patients and that the risks associated with its activities are managed appropriately.

The Committee is responsible for monitoring the implementation of the Trust's Quality Improvement Strategy and the implementation of the Quality Account, in addition to the ongoing monitoring of compliance with national standards and local requirements.

3. Objectives
The objectives of the Committee are to:

a) Establish an annual work plan which the Committee will review annually.
b) Receive assurance from the Committee sub-groups.
c) Ensure all aspects of risk are appropriately managed across the Trust through oversight of the work of the Risk Assurance Committee and that appropriate review and assurance mechanisms are in place.
d) Monitor the implementation of the Quality Improvement Strategy and have an overview of associated strategies, including those of Risk Management and Clinical Audit.
e) Promote a just and open culture in which risk management will continue to develop as an integral, seamless component in the delivery of safe and effective healthcare. Monitor risks on the Assurance Framework and Risk Register for which the Committee has responsibility, to ensure progress against plans to achieve the residual risk rating.
f) Review the Trust's compliance with the Care Quality Commission standards of quality and safety.
g) Monitor progress and compliance against defined quality priorities.
h) Oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication.
i) Receive, through the reporting schedule, assurance of high quality care provision and compliance with National and local guidelines, standards and requirements.
j) In accordance with the Committee reporting schedule review reports and any associated recommendations and action to gain assurance of compliance and quality improvement.
k) Gain assurance from Clinical Service Centres that they implement the activity required to achieve compliance with service and corporate governance standards.
l) Ensure any procedural documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural.
m) Establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

4. Authority
The Governance and Quality Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity 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 for such information.

5. Membership and Attendees

The Committee shall consist of the following members:

- Non – Executive Director (Chair)
- Director of Workforce and Organisational Development
- Chief Operating Officer
- Medical Director
- Director of Nursing (Vice Chair)
- Director of Finance
- Head of Governance
- Head of Patient Safety/Deputy Director of nursing
- Head of Patient Experience
- Chief of Service (representative) / Medical Governance Lead
- General Manager (representative)
- Head of Nursing (representative)
- Director of Education
- MDHU Representative

The Committee shall consist of the following attendees:

- Governor

Other members may be co-opted on to the committee as required, either for additional work or for the purpose of communication or presentation.

6. Attendance

Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

The Committee shall be supported by the Secretary, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee.
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.
- Taking the minutes and keeping a record of matters arising and issue to be carried forward.
- Advising the group on scheduled agenda items.
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting.
- Maintaining a record of attendance.

8. Meetings

- Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar.
- Items for the agenda must be sent to the Committee Secretary a minimum of 14 days prior to the meeting: urgent items may be raised under any other business.

- An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.
- The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

9. Reporting

The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board and Audit Committee when approved.

The Chair of the Governance and Quality Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention, including the non-submission of reports.

10. Quorum

A quorum is determined as being six of the members in attendance but must include the Chair or Vice-Chair and one Executive Director.

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

12. Monitoring Effectiveness

In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 48 hours, on 80% of occasions

ToRs agreed by:	**Governance & Quality Committee**	**Date of agreement:**	**November 2014**
ToRs ratified by:	**Trust Board**	**Date of ratification:**	
Review date:	**November 2015**		