Quality governance
Good practice guide

This publication is part of Hospice UK’s Governance Support Programme for hospice boards and trustees
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The need for good hospice governance is greater than ever. We know from our members that the challenges faced by hospice boards and leadership teams right across the UK are increasing in number and complexity. Alongside this, the complexity of the strategic decision making required of them is increasing too, along with the risk of negative impact if they make poor decisions.

In 2013, the Commission into the Future of Hospice Care identified rapid demographic change, changes in patterns of illness, increasing financial constraints, and uncertainty about future funding as just some of the challenges that are causing hospices to become more vulnerable.

The Commission said that such pressures are only likely to increase, and in the three years since its final report was published, this prediction has proved entirely accurate. Added to this, in recent years we have seen rising public concern and media scrutiny of charitable fundraising and the quality of charity governance.

The Commission gave a clear message that hospices must adapt now to become fit for the future. It urged hospices to make positive, informed decisions about how they operate and to find new ways of ensuring that hospice care can match future needs. Good governance and effective leadership are central to hospices' ability to respond to these many and varied challenges. Yet it can be hard for hospice trustees to know who to turn to for support and how to tell whether they are getting it right.

This good practice guide is one in a series produced by Hospice UK as part of our Governance Support Programme for hospice boards and trustees. The series covers:

- Appraisal of hospice boards and trustees
- Board involvement in hospice strategy and planning
- Board reports that add value to your hospice
- Developing a balanced scorecard for your hospice
- Developing a dashboard for your hospice
- Effective board meetings in your hospice
- Hospice board recruitment and selection
- Quality governance for your hospice

We are confident that, taken together, these good practice guides will be an extremely useful resource for all hospice trustees and senior staff.

Antonia Bunnin
Director of Hospice Support and Development
Hospice UK
1. What is this publication about and what is its relevance to board members?

No hospice can afford to be complacent about the quality of its services. While hospices have long enjoyed a strong reputation for high quality care, no hospice should assume that its care is always of high quality, or will be so in future. Importantly, the context for hospice care is rapidly changing, demanding new perspectives on quality and increased attention to some aspects previously considered unimportant. Patient and user requirements are also changing.

The hospice board of trustees is responsible for the quality of care delivered across all services that its organisation provides. For this reason, its members must assure themselves that the hospice for which they are responsible is providing care that is of a high quality, and where this is not the case must ensure that the right efforts are being made to improve it. They must attend to issues relating to the quality of their services in a regular, consistent and rigorous way.

According to the National Quality Board, the board’s responsibilities for quality are threefold:

- To ensure that the essential standards of quality and safety, as determined by the regulator are at a minimum being met by every service that the organisation delivers.
- To ensure that the organisation is striving for continuous quality improvement and outcomes in every service.
- To ensure that every member of staff who has contact with patients, or whose actions directly impact on patient care, is motivated and enabled to deliver effective, safe and person-centred care. (In hospices, this principle should apply to all volunteers that have contact with patients too.)
2. What is quality governance?

Quality governance has been defined as ‘the combination of structures and processes at and below board level to lead on [organisation] wide quality performance’\(^1\).

Quality governance builds on early work undertaken by healthcare providers in the NHS on clinical governance, established as an important component of organisational governance in the early 1990s. Over recent years the NHS has been required to strengthen governance of quality in response to government reviews such as the Francis Report\(^3\). To that end, provider organisations are required to ensure that ultimate responsibility for quality is placed with their boards and that their perspective is broad – spanning the quality of all services provided to a range of stakeholders. While most hospices are independent organisations outside the NHS, they may wish to consider and mirror changes initiated within statutory services to improve the quality of care and people’s confidence in these services, given hospices’ important role within the health and social care economy and their relationship with statutory commissioners and funders.

Quality governance is more than attention to regulatory compliance. It also drives the improvement of care and services, and the considered management of risk. It demands an organisation wide perspective on the part of the board, with attention to related structure, process and outcomes. Importantly it draws on systematic and critical review of the care and services provided, as a basis for investment and development.

Activities of quality governance include:
- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice
- identifying and managing risks to quality of care\(^1\).
3. What does quality governance cover?

Much of the literature in recent years has encouraged a focus on the areas of effectiveness, safety and experience as components in considering the quality of care. Appendix 1 provides some useful questions in relation to each of these areas.

In addition boards may wish to attend to additional dimensions of quality, such as those identified by the Health Foundation – which include timeliness, efficiency and equity of services⁴. See below for a definition of these dimensions.

**The dimensions of quality**

- **Safe**
  Avoiding harm to patients from care that is intended to help them.

- **Effective**
  Providing services based on evidence and which produce a clear benefit.

- **Person-centred**
  Establishing a partnership between practitioners and patients to ensure care respects patients’ needs and preferences.

- **Timely**
  Reducing waits and sometimes harmful delays.

- **Efficient**
  Avoiding waste

- **Equitable**
  Providing care that does not vary in quality because of a person’s characteristics.

A review of the literature regarding the quality of hospice care highlights an additional domain around the familiarity and comfort of the care environment⁵.

According to the Health Foundation, patient experience is best addressed by adopting person-centred care⁶. Its components are described in the figure on page 7.
Person centred care

In the context of hospice care, the board must accept that concern for the quality of care for the ‘patient’ as described above extends to the many other users of hospice services, including carers and families. In addition the board will want to consider the quality of experience of others with a stake in the hospice, including staff, volunteers and supporters from the local community and beyond.

Guidance regarding healthy NHS boards recommends that the arrangements for quality governance should complement and be fully integrated with the governance arrangements for other aspects of the board’s responsibilities, for example finance and research governance. Appendix 3 provides an example of how this can be achieved.
4. What does the board focus on to ensure effective governance of quality?

The King’s Fund proposed that quality governance has four component parts: strategy, capabilities and culture, processes and structures, and measurement.

The quality governance framework

Questions that the board may wish to ask itself in relation to these components are identified at the end of the descriptions of each part below.

1. Strategy

- Quality should drive the organisation’s strategy
- The board should be sufficiently aware of potential risks to quality
- The board should have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda
- The board should promote a quality focused culture throughout the organisation
- There should be clear roles and accountabilities in relation to quality governance
- There should be clearly defined, well understood processes for escalating and resolving issues and managing quality performance
- The board should actively engage with patients, staff and other key stakeholders on quality
- The appropriate quality information should be analysed and challenged
- The board should be assured of the robustness of the quality information
- Quality information must be used effectively
Quality care must be at the heart of the hospice’s strategy and the board takes responsibility for setting and monitoring standards of care. This should be made apparent by quality care being a core part of all board meetings as a standing item, as well as intrinsic to all major discussions.

2. Capability and culture

The board must ensure it has both the capability and the appropriate capacity to carry out its governance of quality care responsibilities, with a special focus on building the capability of members who do not have a clinical background.

Devising trustee induction and development programmes which offer and require all trustees to experience care provision first hand will be beneficial, as will techniques such as presentations about patient experience and utilisation of services and ward visits. Ensuring that board meetings regularly ‘spotlight’ particular aspects of care provision, opportunities and challenges will develop all trustees’ knowledge and capability around the governance of care. The board must also ensure that clinical leaders in the staff group are skilled and empowered to lead on quality care.

The board has a critical leadership role in shaping the culture of the hospice, ensuring that the patient is at the heart of all activities, with a focus on continuous learning and improvement, openness and transparency. The board must foster, model and promote these values, and make sure it has direct channels to hear the patient and carer voice first hand and use this intelligence in decision making.

King’s Fund research into the impact a board has on clinical effectiveness shows a direct correlation between governance behaviours (discussing and debating ways of improving quality) and the levels of performance achieved by the staff teams directly delivering care.

“Boards should set the tone in how they react to incidents and learn from their mistakes; they must be committed to transparency, demonstrate curiosity, and be open to challenge. They should be clear about how they account for quality to service users, the public and regulators. There should be a balance between internal and external focus and between strategy and operations.”

A candid approach to identifying areas of concern will need to be nurtured on the part of the board as this may well be quite different to the more traditional relationship between the executive team and the board which has focused on reassurance that all is well. Seeking regular information about aspects of care that could be done better, areas of greatest risk and opportunities for improvement against best practice on the part of board members may well prove valuable in this respect. Such information could be standing items on the agenda.

“A board that promotes the right culture of care can provide feedback and challenge to the senior clinicians, and is able to devolve to clinical teams within a strong governance framework.”

Questions for the board to ask itself:

- Are board members confident and competent in their ability to interrogate the data they are expected to use to inform their decision making?
- Is there a recognised expectation of, and support for, strong clinical leadership and clinician engagement both at board level and throughout the organisation to drive the quality agenda?
3.1 Structure

The board must have in place a chain of delegation that cascades accountability for delivering quality care through the hospice.

All trustees, whatever their area of expertise, have the same joint and several liabilities in relation to the governance of quality care. The board will want to consider whether they have a separate sub-committee, tasked with oversight of care service delivery and strategy, with clearly identified and limited delegated authority, terms of reference, responsibility for monitoring and reporting to the board, and a clear mandate for evaluation of performance and quality improvement. Such a committee will comprise a mix of trustees and executive staff who meet on a regular basis to interrogate data generated within and beyond the hospice that describe the context in which the hospice is operating, emerging intelligence and outcomes of engagement activities of the hospice. Together they will consider the degree to which the hospice is delivering high quality services against the standard agreed by the board and, where gaps exist, identify these and agree remedial action. Appendix 2 provides an example of the terms of reference for such a committee.

Hospice boards may choose to establish quality related working groups that work on behalf of the quality governance sub-committee. These can be important as a means of ensuring input on the part of a wide variety of staff from across the organisation to the processes related to quality governance. Appendix 3 provides an example of such a structure.

At executive level, many hospices choose to appoint a manager or a quality lead who can influence decisions and actions across the hospice as required, and manage processes related to quality and risk. These roles have historically focused on care and its regulation; more recently hospices are extending these roles to incorporate other aspects of governance and risk management. When this happens, management of the role may move from the traditional support offered by a director of nursing/registered manager to a director with a broader corporate portfolio. Some hospices share such a role, particularly when they are small.

Questions for the board to ask itself:

- Is there a dedicated sub-committee to oversee quality assessment, quality improvement and quality assurance, and to assure the board that these tasks are being fulfilled effectively?
- Are there sufficient resources (including IT) allocated to enable the organisation to input and access necessary data to contribute to quality governance intelligence in a sufficiently timely way?

3.2 Processes

Boards may wish to begin by defining quality care in the context of their own organisation.

Importantly, boards will want to ensure that processes exist to measure the quality of care and services drawing on robust intelligence. Hospices in the UK have historically done well in assessing structure and measuring processes related to care but have struggled with measuring and monitoring outcomes.

Work is currently underway to develop validated outcome measures for use in palliative care which hospices can adopt and use. Notably, Hospice UK has been working with the Cicely Saunders Institute to promote the understanding and use of the OACC suite of outcome measures amongst hospices.
Leadership on the part of hospice staff in relation to quality governance is often a skill and discipline that needs to be fostered. Quality governance as distinct to management can serve as a new approach for many managers, however experienced in other aspects of their work. Where managers are overseeing the work of groups reporting to the board, some leadership development may be required to ensure that their approach is rigorous and systematic.

Where quality governance focuses on service improvement alongside regulatory compliance, there will be a requirement for innovation in response to emerging needs and preferences. Boards will want to support staff and volunteers to identify and implement innovative approaches to their work so that the hospice is fit for the future. This may include working with other hospices or other organisations to adopt new ways of delivering care.

Opportunities exist for hospices to assess their performance compared with other similar organisations through peer review. While this can be time consuming, the process can be highly valuable, particularly when the standards guiding review are considered to be accurate in relation to the work of the hospice. In England, there are NICE standards relating to the delivery of supportive and palliative care.

Hospices will want to ensure that they are evidence based in their approach to their work. For this reason boards will want to reassure themselves that their hospice is aware and adopting new guidance related to end of life care and similar (eg Review of Choice in End of Life Care 2015, Ambitions for Palliative and End of Life Care 2015).

Importantly, hospices must provide evidence that they are listening to current and potential users – including those who fail to access their services or choose to stop using them. Opportunities exist to draw on national initiatives including surveys of patients’ and carers’ views regarding the care they received. Real time reporting of the experience of care undertaken by patients as well as their families and carers has also been demonstrated to be acceptable and useful in end of life care contexts. User forums, consultation events and comment boxes serve as means of hearing how users and visitors to hospices experienced the hospice too.

Boards will want to receive regular reports that confirm the processes and impact of quality governance in their organisation. Many boards will require dashboards that offer high level data confirming the performance of the organisation in relation to quality governance. For some boards, use of a balanced score card offers a more comprehensive picture, moving beyond care to other aspects of a well managed organisation. Some boards chose to hear a patient story at the start of each meeting as a means of centring attention and focus on the main business of the organisation.

Hospices are encouraged to report on quality issues beyond the board. In England, for example, hospices are required to produce an annual quality account – available to the public and other stakeholders describing efforts to ensure high quality care. These are valuable documents and can be useful internally as well as externally. Hospices are advised to invest in the production and distribution of such reports.

4. Measurement

Quality reports, performance indicators and dashboards are required by a board and its sub-committee to ensure that a strong focus is maintained through the provision of consistent, robust information and a fully rounded picture, supported by in-depth discussion at sub-committee, developed further at the main board meeting.

Board members will want to ensure that:

- variances are clearly highlighted and explained
- key trends and findings are outlined and commented on
- implications for the future are explored and taken into account when considering future strategy and plans
• risks and associated mitigators are considered and debated
• performance is benchmarked against the performance of other hospices to ensure learning is developed and shared.

They will also want to ensure provision of data and information that is broad in nature.

Where hospices collect data that describes the quality of care, opportunities often exist to benchmark their performance against the performance of other similar organisations including other hospices. Hospice UK runs an inpatient safety metrics benchmarking programme, focused on the incidence of falls, medication errors and pressure ulcers. The process of benchmarking is valuable as a means of confirming the performance of one’s own hospice against others, as importantly it enables further discussion between hospices about practical ways in which performance can be improved.

The King’s Fund recommends quantitative and qualitative data which attends to the subjective experience of users, along with objective data related to performance.

In order to get a fully rounded picture, be sure to get reports from each of the four quadrants in the figure below:

Questions for the board to ask itself:
• Is the sub-committee confident that the data presented to the board are sufficiently robust, relevant and comprehensible?
• Can the board demonstrate, by using a mix of both qualitative and quantitative data, a rich picture of the quality of care being provided by the organisation?
5. Summary

Quality governance is an important role that hospice boards must embrace. We recommend boards take the following steps to strengthen and sustain quality governance. These steps are drawn from work done by the King’s Fund, and have been adapted for hospice use.

1. Set the context for engaging in quality – be clear about what quality means for the hospice, define its relevance to different aspects of the work, and be prepared for the fact that engaging with quality may at times be an uncomfortable experience.

2. Shape the culture and tone so that quality becomes the top priority – the board needs to adopt the right behaviours and leadership style, and communicate the value it places on quality to managers and staff, patients and families, and the general public.

3. Develop a strategy for quality improvement or, at the very least, make explicit commitments in relation to quality, linking clinical issues with others aspects of the business, such as financial efficiency.

4. Expect and support strong clinical leadership and clinician engagement both at board level and throughout the organisation to drive the quality agenda.

5. Develop the board’s capability to understand and promote continuous quality improvement and provide support to do this. This may require building knowledge and skills in quality improvement approaches, quality assurance systems and data analysis.

6. Nurture the ability of all trustees to constructively challenge their board colleagues – asking ‘why’ questions is the only way to really find out what is happening with quality issues.

7. Have a dedicated sub-committee to oversee quality assessment, quality improvement and quality assurance, and to assure the board that these tasks are being fulfilled effectively:
   - Pay attention to dynamic administration, including the length of meetings, the volume of papers, and appropriate breaks. If the basics are not right, the board will not be in a position to give its full attention to quality.
   - Review the use of sub-committees and ensure that the correct breadth and depth of information regularly reaches the board.

8. Put quality at the top of the agenda for board meetings and devote at least 25% of time to discussing quality.

9. Draw on a mix of both qualitative and quantitative data to form a rich picture of the quality of care being provided by the organisation, including using patient stories and information from hospice ‘walkabouts’ and/or other direct patient/family feedback.
6. Sources of information and further reading

The following materials are published for public healthcare bodies that have directors and non-executive directors and undertake a broad remit of care, but are also very relevant to hospices and hospice trustees:

The Monitor quality governance framework

Healthcare Quality Improvement Partnership – Good governance handbook
www.hqip.org.uk/provider-governance/

National Quality Board – Quality governance in the NHS: a guide for provider boards

The Health Foundation – Quality improvement made simple: what everyone should know about health care quality improvement
www.health.org.uk/publication/quality-improvement-made-simple

The King’s Fund report summarising the main findings of the Francis Inquiry into the failings of care at Mid Staffordshire in relation to NHS leadership and culture. It sets out what needs to be done to avoid similar failures in future. Importantly it holds that NHS boards must embrace a leadership style that is shared, distributed and adaptive. Board members in particular are responsible for setting the tone for their organisational culture, and should do more to actively seek and listen to the views of patients, governors, commissioners and staff.

The Monitor quality governance paper: How does a board know that its organisation is working effectively to improve patient care?
www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-foundation-trusts/mandatory-

Quality in the new health system, April 2013

The healthy NHS board

Board governance assurance framework

Putting quality first in the boardroom

Well-led framework for governance reviews: guidance for NHS foundation trusts.
Updated April 2015 page 14

Strategic framework for action on palliative and end of life care 2016-2021.
The Scottish Government, December 2015
Appendix 1: A framework of questions about the quality of care

These are drawn from work done by the King’s Fund and have been adapted for hospice use.

<table>
<thead>
<tr>
<th>Clinical effectiveness</th>
<th>How does the board assure itself that it has the right structures and processes in place?</th>
<th>How does the board assess ongoing improvement?</th>
<th>How does the board assess future work required?</th>
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<td></td>
<td>• Do we have the right standards/guidance in place to ensure we are effective in our care and are they up to date?</td>
<td>• What new national and local guidance/standards have been received, considered and incorporated into practice?</td>
<td>• How good is our performance in terms of outcomes of care compared to other similar organisations?</td>
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<td>• Are these standards multi-professional in nature and are they relevant across all our services?</td>
<td>• How have we performed against relevant targets set in the quality improvement plan?</td>
<td>• What new skills or services are required to improve our outcomes?</td>
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<td>• Are we collecting data on outcomes of care?</td>
<td>• What new national and local guidance/standards have been received, considered and incorporated into practice?</td>
<td>• How research active are we and how do we improve on this?</td>
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<td></td>
<td>• How do staff and volunteers update their professional or role knowledge regarding the changing evidence base?</td>
<td>• How have we performed against relevant targets set in the quality improvement plan?</td>
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<th>Patient safety</th>
<th>How does the board assure itself that it has the right structures and processes in place?</th>
<th>How does the board assess ongoing improvement?</th>
<th>How does the board assess future work required?</th>
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<td></td>
<td>• Do we have the right standards relating to patient safety in place?</td>
<td>• What activity to reinforce patient safety has taken place over the last quarter? To what degree have these activities improved our RAG rating or similar?</td>
<td>• What (more) can we do to improve patient safety?</td>
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<td>• Do we have a work plan in place to guide how we focus our efforts to maintain and improve patient safety?</td>
<td>• What critical incidents have taken place and what is being done to learn from them?</td>
<td>• What areas of patient safety do we need more information on?</td>
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<td>• How comprehensive is our risk register in relation to patient safety?</td>
<td>• How have our risk management strategies changed as a result of what has happened; how should the risk register change?</td>
<td>• What new risks or risk mitigators do we need in place?</td>
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<td>• How closely aligned are our strategies/plans for risk management with perceived risks facing the organisation?</td>
<td>• How have we performed against the targets set in the quality improvement plan?</td>
<td>• What new alerts or early warning triggers do we need to have in place?</td>
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<td>• Are we engaged in benchmarking our performance against other organisations?</td>
<td>• How can our escalation and decision making processes be improved?</td>
<td>• How can our escalation and decision making processes be improved?</td>
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<td>Patient experience</td>
<td>How does the board assure itself that it has the right structures and processes in place?</td>
<td>How does the board assess ongoing improvement?</td>
<td>How does the board assess future work required?</td>
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<td>• How do we define user satisfaction and how are we measuring it?</td>
<td>• What activity has taken place to understand and build satisfaction in users over the last quarter?</td>
<td>• What (more) can we do to improve user satisfaction with the hospice?</td>
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<td>• Are we collecting data that accurately confirms whether patient experience is truly of a high quality across all services?</td>
<td>• What do our key user groups think about the hospice: quality of care, the services offered, how informed they are, their level of involvement and participation?</td>
<td>• What unmet needs exist that we should meet?</td>
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<td>• Do we have mechanisms in place to hear from people who failed to access our services or who chose to leave them?</td>
<td>• How have we performed against relevant targets?</td>
<td>• What areas of user satisfaction do we need more information on in order to improve?</td>
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<td>• Are we considering complaints alongside compliments regarding the service?</td>
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<td>• How do we compare with other hospices/nationally?</td>
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<td></td>
<td>• Are we hearing from people who do not wish to make a formal complaint but could identify ways in which we could improve our services?</td>
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Appendix 2: Sample quality governance sub-committee terms of reference

The quality governance committee (QGC) is a sub-group of the board of trustees for the purpose of coordinating all aspects of the governance of quality care in the hospice. It advises the board of trustees on the adequacy and effectiveness of all mechanisms for ensuring clinical effectiveness, patient safety and patient satisfaction, along with advising the board about strategic development needs and opportunities on all aspects of care and care quality.

The focus of the group is to act on behalf of the board to deliver continuous improvement of the quality of services, safeguarding the high standards of care by creating an environment in which excellence in care will flourish.

1. Constitution and meetings

1.1 Membership

The QGC will have not less than seven members of whom at least three will be trustees. At least two of these trustees shall be suitably experienced and knowledgeable in relation to the clinical services the hospice delivers. Some individuals with specific skills that the committee considers necessary may be co-opted as appropriate.

Members will be appointed to the committee by the board, with due regard for the need for understanding of the organisation’s objectives, structure and culture, service specification and standards and other legislative, regulatory and accountability contexts within which the hospice operates. The QGC will corporately possess knowledge and skills in clinical risk management, clinical audit, and clinical/quality governance principles and technical issues relevant to the service delivery and strategic management of the hospice.

1.2 Quorum

A quorum for each meeting will be four members of which at least two must be trustee members and two must be executive team members. The Chair of the board of trustees may, if necessary, nominate alternate trustees if one of the member trustees cannot attend a meeting.

1.3 Chair

The QGC Chair will be a trustee and will be appointed by the Chair of the board and ratified by the board. In the absence of the Chair, the group will be chaired by a trustee nominated by the members present.

1.4 Meetings

The QGC will meet for a minimum of four times a year. Meetings should last no more than two hours. The QGC Chair may convene a meeting at any time on reasonable notice to consider any matter falling within these terms of reference.

1.5 Support

The QGC will include the following hospice staff members:

- the chief executive
- the clinical director
- the director of patient care
- the director of HR and volunteer services.

In addition the following staff will attend the QGC:

- the infection prevention practitioner
- the inpatient/hospice at home multidisciplinary team manager
- the community multidisciplinary team manager.

The QGC will be supported by the secretary to the Chair and chief executive, who will take formal minutes of the meetings.
1.6 Reporting
The QGC Chair will formally report back in writing to the board after each meeting with a one page summary report agreed by members at the meeting. The summary report will highlight any significant matters which the committee considers should be drawn to the board’s attention and will be attached to a copy of the minutes.

The QGC Chair will provide an annual report to the board timed to support the board’s consideration of the clinical quality strategy, and containing the QGCs recommendations on future clinical/quality governance strategy, focussed on improving clinical effectiveness, patient safety and user satisfaction.

2. Scope of authority
2.1 Delegated authority
The QGC is a sub-group of the board of trustees to which it will report. The QGC has no executive decision making powers and will act purely in an advisory and reporting capacity to the trustee board, ensuring all requirements around the governance of care, clinical risk management and audit are developed and met across all areas of the hospice.

2.2 Overview authority
The QGC will monitor, review and report outcomes concerning the following areas of the operation:

- strategic processes and arrangements for clinical risk
- new clinical policies and timely review of all clinical policies and procedures
- self assessment compliance returns to Care Quality Commission
- prepare the annual governance of quality care report to inform the board prior to completion of the annual quality account
- controlled drug accountable officer reporting
- the business plan in terms of care quality and improvement for recommendation to the board
- clinical audit results and the adequacy and effectiveness of the management response to issues identified by audit activity
- register of complaints, serious adverse incidents and other forms of feedback from service users, including patient and family experience
- satisfaction surveys
- health and safety statistics to include clinical and non clinical incident reporting
- assurances relating to the clinical/quality governance requirements of the hospice including those highlighted through the risk register
- initiatives in relation to: clinical supervision, professional development, performance review, research activity and learning
- an external perspective: the breadth and depth of care services in light of new external initiatives, new models of care, new national and local guidance, and research about palliative care and care quality, to ensure the hospice remains at the forefront of delivering high quality leading edge palliative care.

2.3 Information required
To achieve this, the QGC will be provided with:

For each meeting:

- a copy of the minutes from the last meeting with a note of work done on the action points
- a summary report detailing the most recent quarter’s patient feedback, audit activity, the statistics for health and safety, clinical and non clinical incident reporting and complaints.

Biannually:

- a copy of the risk register, stratified to highlight order of priority
- briefings on new initiatives in the world of palliative care with consideration for the implications for the hospice
- benchmarking data to enable comparison with other agencies.

Annually:

- CQC self assessment returns
- annual quality account
- statement of purpose.
Appendix 3: Example of working groups that may support a sub-committee of the board in the governance of quality

- Board
  - Quality governance sub-committee
    - Research committee
    - Clinical audit
    - Organisational safety
    - Patient and service user safety
    - Information governance
    - Service user experience
    - Activity and reach
      - Clinical ethics
      - Medicines management
      - Nutrition group
      - Infection prevention and control group
      - Skin and wound group
References


(2) The statutory regulators are: the Care Quality Commission (CQC) for hospices in England; the Care and Social Services Inspectorate Wales (CSSIW) and HealthCare Inspectorate Wales (HIW) for hospices in Wales; Healthcare Improvement Scotland for hospices in Scotland, and the Regulation and Quality Improvement Authority (RQIA) for hospices in Northern Ireland.


