TERMS OF REFERENCE

Title of group / committee	HMP Birmingham Local Clinical Governance Committee
Date terms of reference signed-off at the LCGC	3rd March 2025
Date terms of reference approved at TCGC	March 2025
Date of next review of terms of reference	March 2026

1. Purpose and Aims of the Committee

Values
The Committee will role model the Trust values:

Compassionate:
- Supporting recovery for all and maintaining hope for the future.
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive:
- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed:
- Striving to deliver the best work and keeping patients at the heart
- Taking responsibility for my work and doing what I say I will,
- Courage to question to help us learn, improve, and grow together.

The purpose of the Integrated Community Clinical Governance Committee is to support and co-ordinate effective clinical governance arrangements across the Service Area, ensuring it can demonstrate high standards and a commitment to service improvement. It is a forum to share ideas, good practices and learning, clinical governance issues and ensure a consistent approach across the Service Area.

Specifically, this will include ensuring:
- That there is a systematic and co-ordinated approach to the provision of good quality clinical care across all areas of the Trust.
- Continuous improvement of clinical services.
- Patient safety and risks are effectively assessed, revised, and managed.
- Compliance with regulatory requirements

The Local Clinical Governance Committee reports to the Trust Clinical governance Committee.

2. Core Delegated Responsibilities and Accountabilities

The Committee provides assurance to the Trust Clinical Governance Committee on service quality, practice effectiveness and the application of controls, assurance in relation to clinical services and

ensures the service is discharging its responsibilities regarding clinical governance and clinical safety. This includes the approval of relevant strategies and policies, and monitoring of implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as the implementation of care management processes and clinical information management, providing assurance that these are appropriately managed and resourced.
The Committee is a forum for constructive challenge and to provide management assurance that related services are delivering high quality patient-centred care to expected standards and in line with relevant policies, guidelines, and best practice.

The committee will undertake the following roles.

- Provide assurance to Trust Clinical Governance Committee that appropriate and effective clinical governance arrangements are in place.
- Ensure that appropriate and effective clinical governance arrangements are in place within all local teams in the Directorate.
- Ensuring the use of a systematic and planned approach to the management and reduction of risk and awareness of the Trust Board Assurance Framework (BAF).
- Ensure that all aspects of the service are risk assessed and that if there are any partners, we manage risks through agreed processes.
- Ensure that all services and staff groups actively report incidents, are risk aware and receive feedback when risks are reported.
- Monitor and review all incidents reported by respective teams in relation to area, type, timing, severity and ensure that actions identified for learning are identified and responded to.
- Ensure recommendations identified from Patient Safety Incident Response Framework (PSIRF) investigations are reported and the actions are addressed.
- Drive the Health Inequalities Agenda including clear reporting and action on disparities in outcomes or access to services.
- Drive quality improvement across all clinical teams.
- Ensure that nationally identified / agreed best practice is taken into account relating to the programme's services when planning, reviewing, and delivering care.
- Identify priorities for clinical audit and ensure that local assurance audits are monitored and kept under review and improvement actions taken.
- Consider regular audits on all aspects of Mental Health Legislation practise within the service. Agree and implement relevant action plans where needed to provide regular assurance to the Trust Mental Health Legislation Committee.
- Agree and implement relevant action plans where needed to provide regular assurance on Care Quality Commission (CQC) inspections and actions.
- Ensure that Reducing Restrictive Practice plan overview including blanket restrictions are appropriate and reviewed regularly.
- Provide assurance that robust arrangements are in place for the proactive management of complaints.
- Ensure that appropriate mechanisms are in place and working across the Service Area for the appropriate engagement of service users, carers, and members of the public in the development and monitoring of services.
- To monitor, scrutinise and provide assurance on compliance with national standards such as NICE (National Institute of Clinical Excellence) guidance.
- To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, and the safety elements covered by the Health and Safety and regulatory compliance.
- To provide assurance through committee structures that environmental risks, including those identified because of PLACE (patient led assessments of the care environment) inspections or environmental audit, are addressed, and monitor appropriate action plans to mitigate these risks.

The committee will bring core agenda items to the meeting according to the Agenda Forward Planner shown in Appendix 1

3. Membership

Membership will be from all clinical areas within the programme and the meetings will be chaired by the Clinical Director. The Associate Director (AD), Head of Nursing and AHP's or Clinical leads can be nominated as co-chair.

Core Representation from the multi-disciplinary team or nominated deputy.

- Chair/deputy chair
- Nursing
- Medical staff
- Psychology
- AHP rep
- Pharmacy

Representation from the multi-disciplinary team or nominated deputy.

- User Voice
- Clinical Governance Facilitator
- Clinical leads
- Admin / minute taker
- Co-opted members will be invited dependant on the issues to be discussed.

All members will be expected to:

- Ensure that clinical governance decision making, and process engages all staff.
- Ensure the appropriate professional input, leadership, and ownership of decisions from all clinical teams represent their clinical area/discipline.
- To communicate outcomes/information from their meeting to their team.
- Read the papers prior to the meeting.
- Participate fully in all discussions at the meeting.
- Ensure that, through all discussions, the focus is on the needs of service users and quality of care.
- Ensure that contributions are succinct and reflect the agenda item.
- Ensure that other members are supported to make their point and that queries raised are responded to.
- Ensure senior colleagues read to reports as presented to the committee.
- Ensure that mobile phones are kept silenced during the meeting.
- Ensure that electrical equipment used for access to the meeting papers (iPads and laptops) are not used for other purposes (i.e. monitoring email) during the meeting.

4. Quorum

The Local Clinical Governance Committee will have reached quorum when there are at least six members in attendance and covering three professional groups and the core members or representatives are in attendance.

5. Attendance Levels

Committee members will be expected to attend at least eight meetings each year. Every team must be represented at each meeting. The Clinical Director, AD, Head of Nursing or nominated deputy should

be present for each meeting. The senior leads should be represented by at least one clinical nurse manager or clinical service manager.

6. Frequency of Meetings

The Local Clinical Governance Committee will meet at least ten times each year and normally once a month. The Chair may wish to convene an extraordinary meeting should the need arise.

7. Accountability Arrangements

The Local Clinical Governance Committee is accountable to the Trust Clinical Governance Committee. The Chair is accountable for the success, effective and smooth operationalisation of the Local Clinical Governance Committee.

8. Sub-Group Accountabilities and Delegated Responsibilities

The Local Clinical Governance Committee will commission groups to undertake specific pieces of work as required to support the work of the committee.

The local Clinical Governance Committee will share information and work with their Clinical forums as and when appropriate.

Each representative is required to take feedback, relevant information, and the key messages back to their own team to discuss.

9. Effectiveness of the Committee Function

The Committee will monitor its compliance with the terms of reference by following an annual work plan. Exceptions to the work plan will be reported to Trust Clinical Governance Committee.

In addition, the following Key Performance Indicators will be used to evidence the effectiveness of the committee in overseeing its governance responsibilities;

1. **Action Completion Rate**
   - **Definition:** Percentage of actions identified in the committee meetings that are completed within the agreed timeframe.
   - **Target:** ≥ 80% of actions completed within the specified deadlines.
   - **Rationale:** Will ensures accountability and timely implementation of improvements.

2. **Incident Review and Learning Implementation Rate**
   - **Definition:** Percentage of reported incidents reviewed
   - **Target:** Reduction in closed incidents by manager to see a reduction in trajectory month on month to comply with Policy.
   - **Rationale:** Demonstrates a systematic approach to incident management

3. **Clinical Audit Compliance on AMaT and Improvement Rate:**
   - Definition: Percentage of clinical audits registered and marked as complete on AMaT platform. Where improvement is required ensure a re-audit is scheduled.
   - Target: 100% of planned audits completed. Where required reasonable actions logged.
   - Rationale: Ensures Clinical Audits are both conducted and lead to quality improvements.

4. Timeliness of Reporting and Escalation:

- **Definition:** Percentage of Local CGC Triple A Escalation Reports submitted to the Trust Clinical Governance Committee within agreed timelines
- **Target:** ≥ 95% of reports submitted on time
- **Rationale:** Measures the committee's efficiency and ability to meet governance requirements.

Appendix 1

CGC Core Agenda Plan

	Safety	Experience	Effectiveness	Safety	Experience	Effectiveness	Safety	Experience	Effectiveness	Safety	Experience	Effectiveness
Agenda item	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Minutes of previous meeting												
Meeting actions												
Team managers' report												
Peer Review/Internal Reviews and Associated Action Plans - as required												
CQC Action Plan Updates/Compliance Visits/Enquiries - as required												
Incident report												
PSIRF Investigation Reports – as available												
Risk register												
QI update Report												
RRP Plans including blanket restrictions (from Q3 report in 2025)	Six monthly											
Infection Control updates (Matrons quarterly report with area specific detail)												
Complaints report												
FFT & Patient experience												
Patient Safety Report to include learning from PSRIF and LFD's status reports (AAR, PSII, MDT, SJR's, homicide reviews reviews/actions)												

Clinical Audit and NICE guidance report												
Local Quality Audits (ward based) TBC from Q2 2025												
MHA Visits and Associated Action Plans (or post visit when received from MHL Management Team)												
Safeguarding update reports - as available from SG Team												
Chair to update on last Trust CGC												
Ad hoc items												
Terms of Reference												

Appendix 2

BSMHFT Board Assurance Framework Risks aligned to Local Clinical Governance Committee

2. Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve

SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.

4. Clinical Services: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care

SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.