Integrated Clinical Governance Council
Terms of Reference
Draft V2.0

Context

Clinical governance is a systematic approach used by organizations to oversee, shape, manage and continuously improve the quality of care (HSO Standard 1003:2021(E)). To strengthen the foundations for clinical governance at Island Health a single organizational governance structure for clinical planning, policies and standards aligned to best practices was adopted in 2022 to ensure culturally-safe, high-quality care. This structure, as one element of a refreshed clinical governance model, reflects the provincial/governmental, organizational, regional and local point of care levels of the system; each with its own responsibilities and accountabilities to clearly define how we can each work together effectively and efficiently towards our vision of "excellent health and care for everyone, everywhere, every time."

The senior clinical committee at the organizational level is the Integrated Clinical Governance Council (ICGC) accountable to the Executive Leadership Team (ELT) to direct and evaluate defined clinical governance functions and cross-continuum quality improvement activities, in alignment with provincial programs/Provincial Health Services Authority and other key external partners. The ICGC is guided in its work by the organizational strategic goals modelled after the Institute for Health Improvement Quadruple Aim, and annual organizational priorities approved by ELT.

The success of the ICGC is determined by how well:

- The services of Island Health are proactively planned, and integrated in support of a person centred seamless service to those served and health equity;
- Shared clinical decision making is enabled amongst all members of the care team, including the person, family and community in alignment with good governance practices with a particular focus on cultural safety and meeting obligations under the Declaration on the Rights of Indigenous People's Act;
- Continuous quality improvement is embedded into day to day operations, and
- Evidence and data are used in decision making.

All Clinical Governance Terms of Reference are supported by additional reference documents which specify expectations for all committees to align to: organizational priorities for improvement, governance principles and frameworks, definitions, process maps, tools and templates (examples of links that will be included are Decision Making Framework, Patient Engagement, GBA+ Assessment, Ethics, et al).

Accountability

The ICGC is accountable to the ELT for the design, implementation and evaluation of clinical governance functions within the approved clinical governance structure. These functions are currently defined as:

- Clinical Standards and Policies

- Clinical Risk and Patient Safety
- Clinical Audit
- Performance Improvement and Quality
- Clinical Innovation
- Clinical Services Planning

To fulfil this mandate, the ICGC establishes committees with the appropriate experts as required, assigns decision rights and assigns support resources to these committees, within ELT approved organizational resources.

The ICGC is also accountable for:

- Continuous improvement of the clinical governance model and functioning including changes to committees and C.A.R.E. Networks (additions and removals) and terms of reference;
- Addressing cross-continuum clinical matters in relation to policy, standards and plans that cannot be delegated to the regional and local structures;
- Setting expectations for all clinical governance committees including the process by which work is conducted and decisions are made in alignment with good governance (e.g. open and transparent decision making, inclusion of diverse voices, use of quality evidence, etc.);
- Modelling the practices of good governance expected of the committees;
- Internal and external scanning for emerging issues that may impact quality and safety broadly;
- Prioritizing quality improvements and directing the overall change schedule across all clinical governance initiatives to mitigate risks and achieve outcomes based on emerging issues;
- Transparent reporting out on decisions;
- Enabling committees to meet expectations through the provision of committee resource teams and secretariat support,
- Ensuring an objective and transparent evaluation of the effectiveness of the clinical governance model (structures, processes, outcomes) is conducted every three years, and
- Assessing, monitoring and managing escalated clinical risks and deescalating risks to the appropriate committee.
- Escalating to the Enterprise Risk Management Executive Committee trends in clinical risks that may inform the enterprise risk register[i]
- Contributing to and/or participating in any human resource or corporate investigations as required.

Scope

In scope are the mechanisms (i.e. established tools, processes) by which the organization sets and holds itself accountable for decisions to define, monitor and enable quality of care and services at the organizational, regional and local levels to populations of need across the Island Health region, within approved resource allocations. Services include those delivered by Island Health and all its staff, medical staff, volunteers, and third parties.

Out of scope are corporate governance (i.e. operating budget process), human resources policies, including occupational health and safety policy and performance, staff and medical staff

performance and day-to-day clinical operations working within approved standards, policies, budgets and service plans.

Decision Rights

- Approves:
  - All cross-service clinical policies and standards except when determined there is sufficient enterprise-level clinical, financial and human resource risks or requirements to warrant escalation to ELT;
  - The Three-Year Quality Improvement Plans, updated annually within approved resource allocations and submitted by the C.A.R.E. Networks;
  - The change implementation schedule, as required, to direct committees to manage changes and capacity within approved allocations; and
  - The allocation and re-allocation of existing clinical governance support resources (i.e. financial and human resources) across committees.

- Recommends to ELT approval of:
  - Any clinical policy, standard or improvement initiative with sufficient enterprise-level clinical, financial and human resource risks or net-new resource requirements;
  - Annual Quality Reports from the C.A.R.E. Networks for the Board of Directors;
  - Clinical Services Plan and amendments;
  - Annual organization-wide quality improvement priorities contributing to the organization wide priorities;
  - Report on the evaluation of clinical governance; and
  - Additional net new clinical governance support resources for committees.

Membership [Membership composition under discussion]

- All Vice-Presidents accountable for clinical services planning, delivery and infrastructure
- Person, Family and Community voice representatives (to be determined as per the Engagement Strategy)
- Chairs of the Operations Excellence Committee and Clinical Excellence Committee of each C.A.R.E. Network
- Chair of Health Authority Medical Advisory Committee
- Chair of Nursing and Allied Health Advisory Committee
- Chairs of the Population Planning Committees
- Others as required.

Council Co-Chairs

The Chief Medical Officer and Chief Nursing and Allied Health Officer will co-chair the ICGC.

Meeting Frequency

The Council will meet one time per month or more frequently at the call of the Co-Chairs based on a risk assessment of the issues for resolution or decision.

Attendance and Delegates

Members of the Council are required to attend all scheduled meetings, except where on leave, and will make their best effort to attend ad-hoc meetings. Delegates from the originating committee are permitted. Guests may request, or be requested by ICGC to attend meetings to present information to support the committee to fulfil its mandate, and in alignment with the broader organization.

Quorum

[New section to be co-created with ICGC]

Council Administration

A Clinical Governance Secretariat is responsible for the clinical governance information infrastructure, agenda management/scheduling and monitoring adherence to clinical governance processes. Chairs of clinical governance function sub-committees will recommend improvements to established clinical governance processes as needed or as part of a coordinated evaluation process.

Mandate, Confidentiality and Disclosure of S.51 Information

The ICGC is mandated by the Island Health Board of Directors to be a duly constituted committee pursuant to Section 51 of the *Evidence Act*.

As mandated by the Board of Directors, in alignment with the *Evidence Act*, the Council may carry out Section 51 activities where it is reviewing a quality of care or quality assurance matter. Section 51 prohibits the disclosure of information and documentation collected as part of a quality of care review. This applies to those activities for the purpose of studying, investigating or evaluating the provision of health care with a view to evaluating, controlling and reporting on clinical practice in order to continually maintain and improve safety and quality of care. This only applies to care that occurs in hospitals as defined by the *Hospital Act*, a provincial mental health facility defined by the *Mental Health Act*, and can include care that occurred during transportation to and from those facilities.

The Board of Directors has delegated authority to the ICGC to create and approve duly constituted Section 51 sub-committees that meet criteria under the *Evidence Act*. The ICGC may delegate quality of care review functions to a sub-committee or to an individual charged with quality of care investigative functions. The sub-committee can be set up on an ad-hoc basis if necessary or permanently established based on approvals. The sub-committee will report back to the committee that created them.

To support the Committee's ability to provide well-informed advice and approvals, members may receive confidential information. In such circumstances, all members must hold information confidential.

Information or records generated within the scope of a Section 51 investigation or prepared for submission to a Section 51 committee are prohibited from disclosure in accordance within the

Evidence Act. This includes information prepared by others at the request of the Section 51 committee or in anticipation of Section 51 review. The sub-committee can receive quality review reports, and act on those reports. The Co-Chairs provide Section 51 committee reports to the Board, or the Board-Mandated Committee that created the sub-committee.

Section 51 matters will be considered by the Council in camera, and shall be recorded separately in the minutes with a clear notation the Council is functioning as a Section 51 Committee for the purpose of that agenda item or items.

The Co-Chairs ensure everyone participating in the meeting, telephone discussion, email exchange or any other form of communication receives clear instructions regarding the confidentiality of the proceedings.

Dispute Resolution

[New section to be co-created by ICGC]

Review of Terms of Reference

The Terms of Reference will be reviewed at least annually, and as required. Changes are to be approved by the ELT before they are enacted.

Committee and Chair Evaluation

[New section to be co-created with ICGC]

Document Control

Version	Approved By	Date
Draft V2.0	Sandra Bjola	July 5, 2023

[i] *Risks that are complex and assessed as having a direct impact on the strategic objectives, or breadth of impact across the organization that requires are higher level authority to analyse, treat, and monitor or requires decisions or actions beyond ICGC authority.*