Acute Quality and Operational Excellence Committee
Terms of Reference
Draft V1.0

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 work together effectively and efficiently towards our vision of "excellent health and care for everyone, everywhere, every time."

The Acute Quality and Operations Excellence Committee is a venue for shared leadership to continuously improve the quality of services, to promote a seamless experience for patients as they transition between health services, and to promote improved health and reduced health inequities for the population served. It is intended to guide both the development of site-focused quality initiatives, and support site-based implementation of region-wide quality improvements.

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 statements about Cultural Safety and DRIPA, Decision Making Framework, Patient Engagement, Diversity Equity Inclusion, Ethics, et al).

Accountability

The Acute Quality and Operational Excellence Committee is accountable to the local area's Quality and Operational Excellence Council, as well as to the Program Leadership Structure to fulfil the following clinical governance functions for the acute services at a local level, in the ways specified and guided by the established decision-making practices and processes. This includes consulting with and receiving advice from other local structures and Point of Care teams.

- Performance Improvement and Quality:
    - Monitor and analyze approved site-wide quality and safety measures. Measures will align to standard regional measures and be supplemented by appropriate local measures.

- Develop and then update annually a three-year site Quality Improvement Plan based on local population needs, local service priorities and regional improvement initiatives'
- Provide input to regional Quality Improvement Plans through relevant CARE Network.
- Define the sequence for implementing quality improvement for the site and oversee the implementation of local improvement activities.

- Clinical Standards and Policies:
  - Provide input into the design and implementation plans for regional clinical standards and policies.
  - Develop detailed implementation plans and schedules and coordinate activities for local site implementation.
  - Monitor compliance/adherence to standards and policies that are implemented within the site and take corrective action when needed.
  - Escalate issues with existing policy and procedures to relevant CARE Network.

- Clinical Risk and Patient Safety:
  - Review aggregated patient safety data to inform corrective actions.
  - Receive escalated patient safety event reports to determine if escalation to a regional level is required (e.g., C.A.R.E. Networks).
  - Oversee implementation of recommendations as a result of safety reviews, or as a result of never events within the community.

- Clinical Innovation:
  - Identify innovative opportunities within the site and raise them to appropriate C.A.R.E. Networks or trial local changes within approved budget and scope of authority.
  - Support the spread of regional innovations, within the acute site.
  - Monitor progress and benefits realized in local innovation trials; make recommendations for scale and spread.

- Clinical Audit:
  - Identify site audit priorities and recommend regional priorities as appropriate.
  - Conduct compliance audit activities for implementation of a change (e.g., new clinical standards and policies, clinical innovations, etc.).
  - Monitor audit results and implement follow-up actions.

- Clinical Services Planning:
  - Contribute to regional planning and priority setting based on the review of outcomes/data and the understanding of community health needs.
  - Provide input and feedback to regional service models to address current and future health care needs of the community,

- Operational Excellence:
  - Review the operational trends and themes across the site that impact the quality, efficiency and experience of care.
  - Monitor agreed-upon operational performance metrics for the site and develop mitigations where necessary.

Scope

In scope are the mechanisms (i.e. established tools, processes) for shared decision-making that define, monitor and enable quality of care for the specific services within the site and within approved resource allocations.

Out of scope are corporate governance, (i.e. operating budget process) human resources policies including occupational health and safety policy and performance, and staff performance. Issues of Medical Staff Governance are out of scope, Island Health respects and values the unique accountabilities the Local Medical Advisory Committees have to the Health Authority Medical Advisory Committee and the Board.

Decision Rights

- Approves the following within the scope of approved resources:
  - Sequence for implementing site-wide quality improvements identified by local structures, C.A.R.E. Networks and ICGC.
  - Site annual quality plan, including audit priorities.
  - Local implementation plan for acute clinical standards or policies defined by C.A.R.E. Networks or ICGC.
  - Local site implementation plan for clinical risk and patient safety recommendations.
  - Implementation plan for approved clinical innovations locally within the site and within scope of policies, standards, regulations, and approved resource allocation.

- Recommends:
  - Quality improvement priorities beyond scope of the site to area Quality and Operations Excellence Councils, C.A.R.E. Networks or ICGC, including need for policies, standards and risk mitigation measures.
  - Acute clinical innovations sponsored at the local level to spread regionally.

Membership

Voting committee members are selected to ensure diversity and inclusion, with the following being represented:

- Diversity from across departments within the site.
- Diversity across professional disciplines, including medical staff.

- Representation of chairs/members from other related local level structures (e.g., other local clinical governance structures within the community).
- Patient partner representatives.

Members of the Committee should also have:

- Credibility, and positional responsibility within the acute site.
- Ability to work in the abstract and be flexible.
- Experience with continuous quality improvement.
- Demonstrated active communications skills.
- Experience designing, planning and/or implementing change initiatives.
- Experience reviewing performance and quality data.

Committee Chair

The Committee Chair(s) are composed of Designated Site Leaders, Chiefs of Staff, and/or delegates. Chairs were appointed by Executive Sponsors following a transparent process. The Chair will nominate a delegate member of the committee for instances when a Chair is not available to fulfill their duties, if required.

Committee Resources

The Committee is supported in its work by a team of experts with diverse skillsets (e.g. quality improvement, clinical analytics, patient safety). This “Resource Team” will be comprised of regularly assigned members by ICGC responsible for facilitating the committee to achieve specific deliverables noted under “Accountabilities’ or the Director(s) responsible for clinical governance staffing. Points of contact are also provided to other supports such as finance, human resources, project and change management to complete specific phases of work. These Resource Team members are non-voting members of the Committee but may escalate issues to their leader if organizational policy is not followed.

Meeting Frequency

At minimum the Committee will meet every month, on a regular schedule. Meetings can only be canceled in consultation with the Clinical Governance Secretariat if there are insufficient agenda items or a quorum is not able to be reached. Extraordinary meetings will be held at the call of the Chair(s).

Attendance and Delegates

Clinical members of the Committee are required to attend all scheduled meetings, except when on leave, and will make their best effort to attend ad-hoc meetings.

Quorum

Quorum will be determined to be a minimum of 50% +1 of the voting members of the Committee.

Committee Administration

The maintenance of the minutes, agenda and documentation related to the Committee is the responsibility of the Committee Secretariat.

The Secretariat is responsible for the management of committee information, communications, agenda management/scheduling and monitoring adherence to clinical governance processes.

Substructures

The Committee may establish time limited working groups as required without approval. They are subject to confidentiality privileges and responsibilities as noted in the following section.

Confidentiality and Disclosure of S.51 Information

As mandated by ICGC on behalf of the Island Health Board of Directors, in alignment with the *Evidence Act*, the Committee 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.

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 Chair provides Committee reports to the Board, or the Board Mandated Committee that created the sub-committee.

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

The Chair ensures 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

The Committee will make all efforts to resolve disputes internally through respectful dialogue. When needed Chairs can call on voting members of the committees to vote on a specific issue to be resolved. When the committee cannot resolve an issue the Chair may escalate to the appropriate committee as per their mandate (e.g. CARE Network) or the Chair can consult with the Clinical Governance Secretariat for guidance on escalation pathways.

Review of Terms of Reference

This ToR for Acute Quality and Operational Excellence Committees is standard across all communities, and any changes to the document text must be approved by ICGC. Each committee will review the ToR annually and propose any needed changes to the Clinical Governance Secretariat for consideration.

Committee and Chair Evaluation

The function of the committee and chair will be evaluated regularly as part of the scheduled evaluation process for Clinical Governance.

Document Control

Version	Approved By	Date
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