

Trust Board Meeting: Wednesday 8 July 2015
TB2015.78

Title	Quality Committee Chairman's Report Including Annual Report 2014/15
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Status	For Information, and approval of the Annual Report
History	<p>The Quality Committee provides a regular report to the Board.</p> <p>The Annual Report summarises the activities of the Trust's Quality Committee for the financial year 2014/15, setting out how it has met its Terms of Reference and key priorities.</p>

Board Lead(s)	Mr Geoff Salt, Committee Chairman			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

1. The Quality Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings. This regular report is provided at Section 1.
2. A summary of the key messages from the meeting held on 10 June 2015 for communication throughout the Trust is attached at Section 1, Appendix 1.
3. In line with best practice in other sectors, the Quality Committee also produces an Annual Report to the Board that sets out how the Committee has met its Terms of Reference, and this is provided at Section 2.
4. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2014/15 setting out how it has met its Terms of Reference and key priorities.

Recommendations

5. The Board is asked to:
 - Note the regular report to the Board from its meeting held on 10 June 2015 (Section 1); and
 - Review and approve the Quality Committee Annual Report 2014/15 and the revised Terms of Reference (Section 2).

SECTION 1

1. Introduction

The Quality Committee met on 10 June 2015. The main issues raised and discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- a) The Committee heard a patient's story about a male patient, and the care he received at the end of his life, following his emergency admission to the John Radcliffe in March 2014. The patient's story highlighted the importance of clear and full communication with patients and relatives, within the profoundly complex arena of acute healthcare, where there could not always be certainty about condition and prognosis. The patient's story also illustrated the importance of 'stepping back', to observe the total interaction, and to gain an appreciation of the difficulties and stress being experienced by the family and the clinicians involved.
- b) The Committee received an update on national and local work being undertaken to ensure that high quality end of life care is available to all patients, in this context focusing in particular on the provision of care by the Trust. Areas for improvement have been identified, and the Committee noted that these are addressed through the Quality Priorities for 2015/16, on-going progress against which will be reported to the Committee. It was also noted that discussions are being held with the Oxfordshire Clinical Commissioning Group [OCCG], in an effort to secure funding for a business case for increased resources in the Palliative Care team, and a full Strategy for End of Life Care is being developed. The Committee supported the Trust's commitment to maintaining its current Care Quality Commission [CQC] rating of 'Good' for End of Life Care, and aspires towards a CQC rating of 'Outstanding'.
- c) The OUH Quality Account 2014/15 was approved for publication on NHS Choices by 30 June 2015. Feedback was received from the *Quality Conversation* event, held at the Trust on 4 June 2015, which had provided a further opportunity for public engagement, ahead of publication of the Quality Account. This had also demonstrated a good level of confidence in the Trust's quality priorities for 2015/16.
- d) The Committee considered a review of Never Events 2012-2015, which highlighted the need for adherence to safety processes, by every member of staff, for every patient, every day. The Trust has now commissioned an external, independent review by a specialist in the investigation of adverse events, Professor Brian Toft, the terms of reference for which will be reported to the Quality Committee at its meeting in August 2015. In the meantime, the Committee welcomed the establishment of a weekly forum for the review of all potential Serious Incidents Requiring Investigation [SIRI].

- e) The regular report on SIRS was reviewed, noting the key organisation-wide learning and themes from concluded root cause analyses, including:
- i. Human factors were recognised to have been a key aspect in one consultant's error in outpatients when the details of teeth to be removed in a planned procedure were wrongly transcribed onto the operative plan. The consultant's offer to see the patient in a non-standard clinic, whilst he was on call, in an attempt to help the patient's family, to shorten their waiting time, had unwittingly created a situation of time pressure, which contributed to the transcription error. Working within standard procedures is essential to avoid these situations. The consultant has since attended human factors training, and other team members will be attending.
 - ii. Careful consideration should be given to nursing patients who are at high risk of falls in side rooms where they cannot readily be observed, recognising that this may sometimes be appropriate where it reduces confusion which can occur in disoriented patients in open bays.
 - iii. X-rays should always be reviewed by a senior member of staff especially in high throughput areas such as EAU and SAU.
 - iv. Lessons from the occurrence of pressure ulcers will be analysed on a trust wide basis by the tissue viability team and the Deputy Chief Nurse to optimise learning of lessons.
 - v. There should be consistent and regular changes of position and associated documentation of actions for those patients identified at a higher risk of hospital acquired pressure ulcers
 - vi. Timely access and request of pressure relieving equipment is essential
 - vii. The importance of correct identification and grading of pressure ulcers as opposed to other types of wounds or injury.
 - viii. Focus on improved communications across whole health care team.
- f) An update on implementation of the Quality Strategy was provided, outlining plans for the delivery of the quality priorities, as well as the quality enablers, to ensure that a clear link is maintained between the Quality Strategy and the Quality Account.
- g) The Committee received the Quality Report, providing information on performance against a suite of fifty three quality metrics. Particular points highlighted included improved performance in some areas:
- over 95% compliance with antimicrobial guidelines in antibiotic prescribing
 - 81.6% fractured neck of femur patients receiving surgery within 36 hours which reversed the deterioration in performance reported in these areas in April 2015, but performance was noted to have deteriorated in other areas, including:
 - % of patients receiving stage 2 medicines reconciliation within 24 hours of admission
- f) The Quality Report also highlighted quality items raised by Oxfordshire Clinical Commissioning Group, notably in relation to:

- Timeliness, receipt and quality of discharge summaries
Performance, though improved, remains unsatisfactory, and further urgent work is on-going
 - Endorsing and communication of test results
Improvement is being tracked, and further interventions are being targeted as necessary
 - Responsiveness and quality of urology services
A plan is now in place to resolve current problems, following a meeting held between senior executives of the Trust and the Chairman, Chief Executive and Quality leads of the OCCG
- h) The Committee received the results of the National Inpatient Survey 2014, published on 21 May 2015. These showed that 87% of the Trust's inpatients rated their care overall at 7 or above on a scale of 0-10, with an average score of 8.2 (which was the same as last year). The Trust's priority will be to improve call bell response times, which have declined over the past 10 years, with the Trust's decline having been worse than the national average.
- i) The Committee received its regular report from the Clinical Governance Committee [CGC], welcoming evidence of increased engagement by senior clinicians, and noting in particular specific issues discussed which included:
- Report on actions arising from the Cancer Peer Review: including report on the continued development of plans to provide dedicated Teenage and Young Adult [TYA] cancer facilities on the Churchill site. TYA nursing provision was reported to have increased with the appointment of a TYA Lead Nurse funded by Teenage Cancer Trust, and a youth support worker has been appointed and psychology support time has increased to 1 whole time equivalent [WTE].
 - CQC report on maternity outlier for puerperal sepsis: The increase in the number of patients diagnosed with 'puerperal sepsis' was reported to have been due in part to incorrect diagnoses by junior medical staff (which was not in accordance with Trust guidance), and in part to incorrect clinical coding.
 - Update on the Action Plan for incorrect intra-ocular lens (IOL) implants at time of cataract surgery: Procedures have been tightened, and Standard Operating Procedures (SOPs) for special IOL ordering, and for IOL selection, are in place. Staff are attending Human Factors training, and there is a revised WHO check list incorporating the improved practices.

3. Key Risks Discussed

The following risks were discussed:

- a. The Committee considered updated extracts of the Corporate Risk Register [CRR] relating to the risks assigned to it, and noted that the information recorded on the Oxfordshire Clinical Commissioning Group's [OCCG's] BAF and CRR had been reviewed by the Trust Management Executive [TME] at its meeting on 4 June 2015.

- b. The Committee specifically discussed the risk of failure to reduce delayed transfers of care, and agreed that demonstrable progress made through and since the *Perfect Week* could support reduction in the scoring of the consequence of the risk (from 4 to 3), resulting in the risk being re-scored at 15 (Likelihood 5 x Consequence 3).

4. Key Actions Agreed

The Committee agreed actions as follows:

- The Executive team will pursue efforts to secure funding from OCCG for a business case for increased resources in the Palliative Care team
- The Terms of Reference for the external, independent review of *Never Events* by Professor Brian Toft will be reported to the next meeting of the Committee in August 2015
- The Trust will respond formally to the statement received from Healthwatch Oxfordshire in relation to the OUH Quality Account 2014/15, to register the further amendments made to the draft Quality Account, subsequent to receipt of Healthwatch comments made by letter dated 8 May 2015
- The Director of Development and the Estate will be invited to attend the next meeting of the Committee in August 2015, to consider estates issues raised in the Quality Report, and on Quality Walk Rounds.

5. Future Business

Areas upon which the Committee will be focusing at its August meeting will include:

- Annual Complaints Report and Update on Complaints Policy
- Quality Impact Assessments of Cost Improvement Programme schemes
- Annual Claims Report
- Update on Peer Review Programme

6. Recommendation

The Trust Board is asked to note the contents of this paper.

Mr Geoff Salt
Chairman Quality Committee
July 2015

Quality Committee

met on Wednesday 10 June 2015

KEY MESSAGES from the meeting include:

The Trust is committed to the provision of high quality **End of Life Care**.

Areas for improvement have been identified, and these are addressed through the **Quality Priorities for 2015/16**, progress against which will be reported to the Committee. Renewed discussions are on-going with the Oxfordshire Clinical Commissioning Group [OCCG], to secure funding for a business case for increased resources in the Palliative Care team, and a full Strategy for End of Life Care is being developed. The Trust is committed to maintaining its current Care Quality Commission [CQC] rating of '**Good**' for End of Life Care, and aspires towards a CQC rating of '*outstanding*'.

The OUH **Quality Account 2014/15** has been formally approved for publication by 30 June 2015.

The Committee also received an update on the **Quality Conversation** event, held on 4 June. This had provided a further opportunity for public engagement, ahead of publication of the Quality Account, and demonstrated a good level of confidence in the Trust's quality priorities for 2015/16.

Implementation of the **Quality Strategy** is progressing, with plans for delivery of the quality priorities, as well as the quality enablers, to ensure that a clear link is maintained between the *Quality Strategy* and the *Quality Account*.

The monthly **Quality Report** showed **improved** performance in some areas, including:

- over 95% compliance with antimicrobial guidelines in antibiotic prescribing
- 81.6% fractured neck of femur patients receiving surgery within 36 hours

This reversed the deterioration in performance reported in these areas in April 2015, but performance was noted to have **deteriorated** in other areas, including:

- % of patients receiving stage 2 medicines reconciliation within 24 hours of admission

The **Quality Report** also highlighted **quality items raised by OCCG**, notably in relation to:

- Timeliness, receipt and quality of **discharge summaries**
Performance, though improved, remains unsatisfactory, and further urgent work is on-going
- Endorsing and communication of **test results**
Improvement is being tracked, and further interventions are being targeted as necessary
- Responsiveness and quality of **urology services**
A plan is now in place to resolve current problems, following a meeting held between senior executives of the Trust and the Chairman, Chief Executive and Quality leads of the OCCG

Quality Committee

A review of **Never Events 2012-2015** has highlighted the need for adherence to safety processes, by every member of staff, for every patient, every day. The Trust has now commissioned an external, independent review by a specialist in the investigation of adverse events, Professor Brian Toft, the terms of reference for which will be reported to the Committee at its meeting in August 2015. In the meantime, the Trust has established a weekly forum for the review of all potential Serious Incidents requiring Investigation [SIRI].

The National Inpatient Survey 2014 showed that 87% of the Trust's inpatients rated their care overall at 7 or above on a scale of 0-10, with an average score of 8.2 (the same as last year). The Trust's priority will be **to improve call bell response times**, which have declined over the past 10 years, with the Trust's decline having been worse than the national average.

The report from the **Clinical Governance Committee** reflected increased engagement by senior clinicians, and the Committee noted key points raised, including:

- report on puerperal sepsis
- action to reduce the risk of incorrect intra-ocular lens implant
- development of teenage and young adult cancer facilities at the Churchill site

Other documents noted/reviewed by the Quality Committee included:

- CQC Intelligent Monitoring Report, banding the Trust at '3' [lowest risk 6, and highest 1]
- Changes to the Corporate Risk Register, following transition into 2015/16
- Annual Review of the Committee's Effectiveness and Annual Report

For further information please contact Susan Polywka, Head of Corporate Governance xt 72474

SECTION 2

Quality Committee Annual Report 2014/15

1. Background

- 1.1. Good practice states that the Trust Board should review the performance of its Committees annually to determine if they have been effective, and whether further development work is required.
- 1.2. This Annual Report summarises the activities of the Trust's Quality Committee (the Committee) for the financial year 2014/15 setting out how it has met its Terms of Reference and key priorities.
- 1.3. The purpose of the Committee is laid down in its Terms of Reference. In summary it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety.

2. Scope of Review of Effectiveness

- 2.1. The review undertaken by the Head of Corporate Governance has focused on a review of the papers presented to the Quality Committee in comparison to the agreed Terms of Reference and the Cycle of Business. The review has been broken down into the following subsections:
 - Responsibilities;
 - Membership and Attendance Record;
 - Reporting Arrangements;
 - Cycle of Business;
- 2.2. In addition to the above a questionnaire was also used as part of the review. Any specific points arising from the checklists, not covered elsewhere, have been highlighted in a separate section of the report.

Responsibilities

- 2.3. During 2014/15, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:
 - The routine presentation and consideration of the following:
 - Quality Reports, including Executive walk round results, safe staffing metrics, infection control metrics and clinical audit information.
 - Patient Story Reports, including an update on diabetes progress.
 - Clinical Governance Committee Reports and minutes.
 - SIRS Summary Reports but in addition the Committee specifically considered reports in relation to Breast Screening recall and an incident at the Horton General Hospital.
 - A review of the impact of delays (DTC) on the quality of care and an update on the metrics used to assess this risk regularly;
 - Updates were provided on the Quality Impact of the Cost Improvement Programme, including progress in improvements to the planning and monitoring processes;

- Updates have been provided in relation to progress against completion of the CQC Inspection Action Plans, and CQC Intelligent Monitoring Reports have been regularly provided to the Committee when received from the CQC;
- The Committee has considered the Quality Governance Framework, Quality Account and Quality Strategy during the course of the year;
- It has also considered a review of policies and practices for escalating issues relation to quality performance;
- The Peer Review Programme updates were also reported to the Committee in line with the cycle of business.
- The Board Assurance Framework and Corporate Risk Registers were regularly reviewed and discussed, to ensure that identified controls were appropriate to mitigate the risks to a level within the Trust's risk appetite. The Committee focused on the principal risks (PR) which were specifically assigned for oversight by the Committee, being:
 - PR1: Failure to maintain the quality of patient services;
 - PR6: Failure to sustain an engaged and effective workforce and
 - PR 7: Failure to deliver the required transformation of services.

Membership and Attendance Record

- 2.4. During 2014/15, the Committee met six times with attendance recorded in the table below. This demonstrates that every meeting of the Committee during the year was quorate.

Role	9-Apr-14	11-Jun-14	13-Aug-14	8-Oct-14	10-Dec-14	11-Feb-15
Chair – Non-Executive Director (GS)	✓	✓	✓	✓	✓	✓
Vice Chair - Non-Executive Director (PW)	✓	✓	✓	✓	✓	✓
Chairman of the Trust Board (FC)	✓	X	X	X	✓	✓
Non-Executive Director (CG)	✓	✓	✓	✓	✓	✓
Associate Non-Executive Director (DM)	✓	X	✓	✓	✓	✓
Chief Executive (JM)	✓	✓	X	✓	✓	✓
Medical Director (TB)	✓*	✓*	✓*	✓	✓	✓
Chief Nurse (CS)	✓	✓	✓	✓	✓♦	✓
Director of Clinical Services (PB)	✓	✓	✓	✓	✓	✓
Director of Assurance (EW)	✓	✓	✓	✓	✓	✓
Director of Workforce (MP)	✓	✓	✓	✓	✓	✓
Non- Executive Director (AT) nb in attendance	✓	✓	X	✓	✓	X

*(as Interim Medical Director)

Key: ✓ = In attendance X = Absent ✓ ♦ = Deputy in attendance

Reporting Requirements

- 2.5. The Committee reported to the Trust Board after each meeting during the year. Reports included a description of the business conducted, risks identified and key actions agreed. Key risks identified by the Committee and escalated to the Trust Board for information included:
- Issues arising from discussions in relation to patient stories.
 - Key themes emerging from the Staff Survey results.
 - Issues arising from discussions in relation to the Quality Reports.
 - Discussions in relation to Never Events.
- 2.6. The reports consistently identified areas to be raised to the Trust Board or referred to other sub-committees of the Trust Board. It has been recognised through the review of the referral process between committees that some improvement could be made to ensure actions passed between committees are more fully captured and appropriate actions taken are reported back to the referring committee. This is in the process of being addressed and a Standard Operating Procedure covering this process is being drafted.

Terms of Reference

- 2.7. The Terms of Reference were last reviewed and revised in July 2014, and the review of the effectiveness of the Committee for 2014/15 has confirmed that no further changes are required to the Terms of Reference, beyond ensuring that the Terms of Reference are now in line with the new Trust template.
- 2.8. The updated Terms of Reference are presented in Appendix 1, with the changes highlighted.

Cycle of Business

- 2.9. The items on the cycle of business were largely delivered as planned with the exception of a review in relation to Research Governance.
- 2.10. A number of additional items was considered by the Committee during the year including papers on:
- Pressure Ulcers and Tissue Viability
 - Nurse Staffing levels and the Acuity and Dependency reviews
 - The CQC Survey of Women's Experiences of Maternity Services
 - Annual Review of Prevention of Future Death Reports
 - Dementia Strategy
 - Healthcare for All
 - The implementation of the Patient Experience Strategy
 - The delivery of Theatre Safety Review Action Plan
 - Trust response to National Hip Fracture Database Annual Report
 - Mental Health Act
 - Duty of Candour

3. Issues raised by questionnaire results

- 3.1. The results of the responses from the questionnaire circulated to Committee members were considered by the Committee and no further actions were identified.

4. Key Outcomes

- 4.1. The following outcomes are proposed as a proxy for the effectiveness of the Committee:
- The Trust was inspected by the Care Quality Commission in February 2014, the result of which was an overall rating of Good. Of the 115 rating judgements issued in the four reports, 104 were rated as Good, with only 11 areas Requiring Improvement and the Committee has continued to monitor the completion of the resultant Action Plan;
 - The Committee has continued to monitor the quality of the patient experience during the course of the year.
 - The Committee has overseen the development of the Quality Strategy and the results of certain aspects of this have been reflected in the Quality Account, considered by the Committee.
 - The Committee provided oversight to the self-assessment against the Monitor Quality Governance Framework and has overseen the implementation of a range of improvements in the Trust's quality governance processes.

5. Conclusion

- 5.1. The review has identified that the Committee has delivered the majority of the responsibilities as set out in the Terms of Reference, attendance at meetings has been good, and the cycle of business has been mostly completed.
- 5.2. Areas for action during 2015/16 to ensure all responsibilities are delivered as set out in the Terms of Reference include the SOP mentioned in 2.6.

6. Recommendations

- 6.1. The Board is asked to:
- review and approve the Quality Committee Annual Report 2014/15, and
 - formally approve the proposed amendments to the Committee's Terms of Reference

Mr Geoff Salt
Chairman Quality Committee
July 2015

Appendix 1

Quality Committee Terms of Reference

1. Authority

- 1.1. The Quality Committee (the Committee) is constituted as a standing committee of the Trust Board. The Committee is a Non Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.
- 1.2. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.
- 1.3. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.

2. Purpose of Committee

- 2.1. The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety.

3. Membership

- 3.1. The membership of the committee shall be composed of the following core members:
 - 5 Non-Executive Directors (one of whom will be the Chair of the Committee)
 - Chief Executive
 - Medical Director
 - Chief Nurse
 - Director of Clinical Services
 - Director of Assurance
 - Director of Organisational Development and Workforce
 - Deputy Medical Director
- 3.2. All Board members outside the core membership have an open invitation to attend any meeting if he/she wishes to do so.

4. Attendance and Quorum

- 4.1. The quorum for any meeting of the Committee shall be attendance of a minimum of six members of which two will be Non-executive Directors and two Executive Directors.

- 4.2. It is expected that all members will attend **at least** 4 out of 6 committee meetings per financial year. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the committee to the Board.
- 4.3. If Executive or Non-executive Directors are unable to attend a meeting, they should nominate a deputy subject to agreement with the Chief Executive and consultation with the Committee Chairman. **Deputies will be counted for the purpose of the quorum.**
- 4.4. **The Chair may request attendance by relevant staff at any meeting.**

5. Frequency of meetings

- 5.1. Meetings of the Quality Committee shall be held six times per year, scheduled to support the business cycle of the Trust and at such other times as the Chairman of the Committee shall identify, subject to agreement with the Chairman of the Trust and the Chief Executive.
- 5.2. **The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.**
- 5.3. Meetings of the Quality Committee shall be set at the start of the calendar year.

6. Specific Duties

6.1 The Quality Committee shall:

- Oversee the effectiveness of the clinical systems developed and implemented by the Clinical Governance Committee to ensure they maintain compliance with the Care Quality Commission' Fundamental Standards of quality & safety.
- Oversee an effective system for safety within the Trust, with particular focus on; patient safety, including a consideration of the Quality Impact Assessment of Cost Improvement Programmes, staff safety and wider health & safety requirements.
- Oversee an effective system for delivering a high quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.
- Oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.
- Assure the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of quality and safety.
- Oversee and assure the Board on statutory and mandatory requirements, relating to quality of care.
- Oversee and assure on external assessment systems (, professional bodies' and regulatory bodies' requirements.

- Monitor and review the system for Quality Governance, Information Governance, Workforce Governance, Research & Development Governance, ensuring that the Board is assured of continued compliance through its annual report, reporting by exception where required.
- Identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee.
- Undertake any other responsibilities as delegated by the Trust Board.

7. Sub-Committees

- 7.1 The Quality Committee has no formal sub-committees but it will receive regular reports from the Clinical Governance Committee.

8. Administrative Support

- 8.1 The Quality Committee will be supported by the Medical Director, as the nominated lead Executive Director. The Committee will be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:
- Agreement of the agenda with the Medical Director and the Committee Chair, collation and distribution of papers at least five working days before each meeting.
 - Taking the minutes and keeping a record of matters arising and issues to be carried forward.
 - Providing support to the Chair and members as required.

9. Accountability and Reporting arrangements

- 9.1 The Committee shall be directly accountable to the Trust Board.
- 9.2 The Committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of quality. The Chair of the Committee shall prepare a summary report to the Board detailing items discussed, actions agreed and issues to be referred to the Board. The Chairman will report any specific issues on the risk register to the Audit Committee.
- 9.3 The minutes of the Committee meetings shall be formally recorded and submitted to the next meeting of the Board following the production of the minutes.

10. Monitoring Effectiveness and Compliance with Terms of Reference

- 10.1 The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

11. Review of Terms of Reference

11.1 The Terms of Reference of the Committee shall be reviewed at least annually by the Quality Committee and approved by the Trust Board.

Date approved: **Month Year**
Approved by: **[name of parent committee]**
Next review date: **Month Year**

Appendix 1

Quality Committee Membership 2015/16

Non-Executive Director (Chair)	Mr Geoff Salt
Non-Executive Director (Vice Chair)	Mr Peter Ward
Non-Executive Director	Dame Fiona Caldicott
Non-Executive Director	Mr Chris Goard
Non-Executive Director	Professor David Mant
Chief Executive	Sir Jonathan Michael
Medical Director	Dr Tony Berendt
Chief Nurse	Ms Catherine Stoddart
Director of Clinical Services	Mr Paul Brennan
Director of Assurance	Ms Eileen Walsh
Director of Organisational Development and Workforce	Mr Mark Power
Deputy Medical Director	Dr Clare Dollery

Quality Committee Objectives 2015/16

The Committee's overarching objective is to gain a sufficient understanding of the operation of control processes surrounding the quality of clinical care across the Trust to provide assurance to the Board. In particular it will:

- Review those processes in place to monitor and report on compliance with CQC regulations;
- Monitor of the development of a revised system for the update, review, signoff and implementation of clinical guidance across the Trust;
- Continue to review the implementation of the Trust's Quality Strategy with a focus on:
 - The development and use of indicators demonstrating safety;
 - The use of indicators in relation to outcomes (focusing on the monitoring of improvements in the clinical audit system and its impact on quality improvements in clinical care);
 - The development and use of indicators in relation to patient experience (focusing on the implementation of Friends & Family Test)