

Trust Board Meeting: Wednesday 13 July 2016

TB2016.60

Title	Quality Committee Chairman's Report Including Annual Report 2015/16
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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 2015/16, 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. The regular report is provided at Section 1.
2. In line with best practice in other sectors, the Quality Committee also produces an Annual Report to the Board summarising the activities of the Trust's Quality Committee (the Committee) for the financial year 2015/16 setting out how it met its Terms of Reference and key priorities. This is provided in Section 2.
3. The Quality Committee's Terms of Reference, Membership and objectives for 2015/16 are attached at Section 2, Appendix 1.

Recommendations

4. The Board is asked to:
 - Note the regular report to the Board from its meeting held on 8 June 2016 (Section 1); and
 - Review and approve the Quality Committee Annual Report 2015/16 and the revised Terms of Reference (Section 2).

SECTION 1

1. Introduction

The Quality Committee met on 8 June 2016. 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 welcomed a prototype report of key data analytics produced through Orbit+ software, linked to the metrics in the Quality Report. The aim is to identify whether pressures in the system are having an adverse impact upon quality of care.
- b) The Committee was informed that, pending the outcome of the national ballot relating to the junior doctors contract (expected on or around 6 July 2016), conditional letters of offer had been issued to the cohort Foundation Year 1 junior doctors due to take up post in August 2016.
- c) New care pathways in the Paediatric Spinal Surgery services have now been reviewed, and the Committee heard that the draft report on the findings of that review is generally encouraging. Once finalised, the report will be considered in full, and shared with the Care Quality Commission [CQC].
- d) The Committee heard the experience of a patient who had dementia and was admitted for a cataract operation in December 2015. The Patient had since died, however the story had been anonymised and consent was obtained from the patient's family. The family described concerns around pre admission arrangements, theatre booking times, and the physiological and psychological impact of the distress caused by cancellation. An investigation had been undertaken into the complaints raised, and the Trust was provided with an opportunity to reflect on the current processes. The patient's perspective also illustrated the importance of staff training in dementia care to better understand their needs.
- e) The Committee received updates on the relevant developments in key themes of the Trust's strategic review:

➤ **Home Sweet Home (local health integration)**

The Trust is now undertaking further work to move from a dependency on bed-based care, through the development of an ambulatory model of care which provides care/treatment for patients in their own home. This could be achieved by either assessing the patient in their home, using point of care testing or transferring to the hospital for assessment only (but continuing to provide care /treatment in the patient home where feasible).

The ambulatory care pathway will be further supported by the expansion of staff within the Supported Hospital Discharge Service (SHDS), which is in the process of recruiting an additional 50 WTE staff to support discharging Oxfordshire patients directly from the Emergency Departments, Emergency Assessment Units, and Ambulatory care in addition to supporting this function across all clinical areas within the Trust.

➤ **Focus on Excellence (prioritising investment in services; developing world class excellence)**

All clinical services have now completed their submissions, and Parts One and Two of the questionnaires were being assessed by the Clinical Reference Group [CRG]. The Committee heard that the outcome of the CRG's assessment of submissions would be fed back initially to the Trust Management Committee, before it is disseminated through the Clinical Divisions and Clinical Directorates.

Part Three submissions will then be assessed, to identify which specific element(s) of a specialty/service are (currently, or potentially) capable of being recognised as a world class centre of excellence.

➤ **The Master Plan (long term estates planning)**

The Committee noted that, in the 'first wave' of this initiative, it is planned that approximately 120 staff that have non-patient facing roles will be moved to what will become the Trust's 'fifth site', at a new facility in Cowley. The Trust is establishing a Staff Council, and has invited feedback from staff on how the new facility can best be set up and supported.

The initiative will provide the opportunity to vacate the poorer parts of the estate, and ensure patients can best benefit from the space that is best suited to clinical use. It is anticipated that there will be subsequent "waves" to move more staff and services, the ultimate aim being to demolish the poorest parts of the estate.

➤ **Building Capabilities: Champions for Change Programme**

The Committee heard that the Champions for Change programme will be fully aligned to the comprehensive project plan, related to the five key themes and to the Sustainability and Transformation Plan (STP) for Oxfordshire, Buckinghamshire and West Berkshire.

A workshop is planned for Wednesday 7 September 2016 at St Hugh's College, the aim of which will be to define the role of the Champions in developing and implementing a comprehensive *Programme for Change*.

f) The Committee received its regular report from the Clinical Governance Committee [CGC], noting in particular specific issues discussed which included:

- Strategies for improving test results endorsement for every division.

A project carried out by the maternity team as 'endorsing = signing for safety' was discussed and it was noted that the materials had been circulated to CGC.

Progress made in surgery and oncology with respect to discharge summary timeliness and test result endorsement was noted;

- Consideration of initiatives to address vacancies and staffing levels in the Surgery and Oncology Division;

- Review of an update on the progress of the Medicines Safety Action Plan;
- Notable practice indicated by high resection rates in the National Lung cancer audit;
- Confirmation that a report on the Coronary Artery Bypass Graft [CABG] (other) outlier concluded that there was no cause for concern.

The Committee also noted the report made to CGC regarding the long working hours undertaken by Consultant Anaesthetists during head and neck cases.

The Committee heard that CGC had given consideration to what constituted the safest model of practice for cases that were anticipated to be of over 12 hours' duration, balancing the advantages of providing continuity of care from a single anaesthetist, with the need to avoid lapses in concentration caused by fatigue.

It had been proposed that, whilst other models of practice were reviewed, there should be designated slots for cases which were anticipated to be of over 12 hours' duration, and provision made for replacement by an on-call anaesthetist if signs of fatigue were evident to any member of the team in theatre. CGC had heard that no other unit in the UK currently rostered two anaesthetists to each case, or placed any limit on the number of hours in head and neck surgery, and so this would represent better practice than anywhere else in the UK.

The Committee supported the submission of this proposal for consideration by the Trust Management Executive.

- g) The Committee received the Quality Report. Particular points drawn to the Committee's attention, and raised in discussion, included:
- Against the annual upper ceiling for OUHFT apportioned cases of C.diff, and a monthly limit set at 5, there were noted to have been 3 cases reported for April 2016, against a monthly limit set at five. Upon review at the April Health Economy meeting with the OUHFT, OCCG, Oxford Health and Public Health England in attendance, it had been determined that 2 were unavoidable and 1 case was avoidable, and the lapses of care identified had been highlighted to the respective Division and Directorate.
 - A review of nursing vacancies in Paediatrics (including Paediatric Intensive Care, Neonatal Intensive Care, and Adult Intensive Care) is being undertaken, the findings of which will be reported to the Board.
 - First reports on Care Hours per Patient Day (CHPPD) would be due in mid-June and the Operations and Safe Staffing Team were reported to be working with the wards to achieve accuracy on the real time bed board, as the accuracy of CHPPD would be dependent upon the accuracy of that data.
 - Some concern was expressed over the apparent deterioration in compliance with antimicrobial guidelines for antibiotic prescribing, and it was noted that EPR should be able to identify prescriptions made in contravention of these guidelines, requiring further investigation.

- The metric used for hospital acquired thrombosis identified and judged avoidable showed an increase to a total of 7 cases reported in March (with a subsequent decrease to 4 cases in April). Specific performance management measures were being taken in the Neurosciences Orthopaedics Trauma Specialist Surgery [NOTSS] division.
 - A survey of patients' and carers' experience was being undertaken in order to develop a patient's perspective of the initiative to reduce Delayed Transfers of Care [DToCs], due to be completed by the end of July.
 - The Director of Clinical Services confirmed that key Quality Metrics had been continued to be monitored since the DToC initiative commenced in December 2015. Analysis is being undertaken in relation to key indicators identified by the Royal College of Emergency Medicine, to gauge whether delays in A&E, and delayed discharge of transfers of care, were having an adverse impact on the quality of care. The conclusion of this data analysis is due to be reported to the Committee at its meeting in August 2016.
 - Concerns were expressed at the number of newly acquired pressure ulcers reported via Datix, which had numbered 97 in March 2016, compared to 69 in February and 75 in January. Improvement had been reported inasmuch as the severity of pressure ulcers had decreased, with no category 4 pressure ulcers reported in 2015/16. An update on Tissue Viability is due to be submitted for the Committee's consideration in October 2016.
- h) The Quality Report also highlighted quality items raised by Oxfordshire Clinical Commissioning Group, notably in relation to the timeliness of endorsing test results and issuing discharge summaries.

The Medical Director pointed out that the reporting period for the Quality Report was April 2016, since when there had been some improvement in May, reported as follows:

- 76.44% of discharge summaries had been sent before or within 24 hours of discharge (compared to 73.3% reported in April); and
 - 74.68% of results had been endorsed on EPR within 7 days (compared to 69.1% reported in April).
- i) The Committee endorsed the strategic aims for end of life care, stated to be:
- *Recognising* that the patient may be approaching the end of life
 - *Communicating* with the dying person and their family
 - *Involving* the dying person and their family
 - *Supporting* the individual and their family in accordance with their wishes and needs
 - *Planning and doing* to enact a personalised plan of care

It is intended that these priorities should be implemented at the level of staff, organisation and system, bearing in mind also that one of the local Commissioning for Quality and Innovation [CQUIN] goals relates to end of life care.

- j) The regular report on Serious Incidents Requiring Investigation [SIRI] was reviewed, highlighting the outcome of investigations into two Never Events relating to wrong site nerve block, which had first been reported by exception to the Quality Committee in April 2016.

A human factors analysis had prompted the implementation of further measures, including:

- A requirement for anaesthetists to make a skin mark at the site of a nerve block; and
 - Institution of a rule that there should be “no chat at the start of a procedure”, analogous to the airline industry’s rule of “no chat below 10,000 feet”.
- k) The Committee received a verbal update on the systems which were being established to monitor the delivery of CQUINS, noting that this would be overseen by a group that will be meeting on a monthly basis.
- l) The Committee received an update on progress in the Peer Review Programme, the overarching aim which is to improve the quality of care for patients. It was confirmed that the review of all 18 clinical directorates was scheduled for completion by the end of 2016.
- m) Appointment of a “Freedom to Speak Up Guardian” was reported to be proceeding, notwithstanding continued delay in the issue of national guidance.

3. Key Risks Discussed

The following risks were discussed:

- i. The Committee received a summary of the Infection Control related audit data that had been reported by the OUH NHS FT during 2015/16, and reviewed compliance with National Policy and the Hygiene Code (2010).

It was suggested that lessons could be learned from implementation and embedding of the requirement to complete the WHO surgical safety checklists, to achieve improvement in the level of compliance with standards relating to:

- Hand hygiene
- MRSA screening
- Cleaning audits

It should be noted that subsequent to the submission of data for consideration by the Quality Committee, it has been suggested that some further validation of this data is required; however the need to prioritise quality improvement in some areas is acknowledged.

4. Key Actions Agreed

The Committee agreed actions as follows:

- The Deputy Medical Director will continue to develop key data analytics through Orbit+ software.

- A review of nursing vacancies in Paediatrics (including Paediatric Intensive Care, Neonatal Intensive Care, and Adult Intensive Care) will be undertaken, and the outcome reported to the Board.
- The Quality Committee will receive an update on Tissue Viability at its meeting in October 2016.
- The summary report of audits presented at the Clinical Effectiveness Committee will indicate whether improvements have been delivered or are required.
- The Medical Director will provide an update report on infection control related audit data 2015/16 and proposed strategies for compliance in 2016/17 to the Board in September 2016.

5. Future Business

Areas on which the Committee will be focusing at its meeting to be held on 10 August 2016 will include:

- Update on the Commissioning for Quality and Innovation Scheme [CQUINS]
- A report on whether delays in A&E, and delayed discharge of transfers of care, are having an adverse impact on the quality of care.
- A patient's perspective of the initiative to reduce delayed transfers of care.

5. Recommendation

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

Mr Geoff Salt
Chairman Quality Committee
July 2016

SECTION 2

Quality Committee Annual Report

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 2015/16 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. Since Dr Bruno Holthof took up post as Chief Executive in October 2015, the way in which the Committee conducts its business has been reviewed, to ensure that it meets its key objectives. In particular, the structure, composition and overall length of the agenda has been reformed, with the aim of ensuring that the opportunity is provided for genuine debate in relation to key strategic themes. Careful consideration is given to whether an item should be designated for discussion, decision or information.
- 2.2. In streamlining the agenda, the Committee remains focused on probing into the level of assurance provided on all aspects of the quality of care.
- 2.3. The review undertaken by the Deputy Director of Assurance 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;

Responsibilities

- 2.4. During 2015/16, 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

- 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 where these were available;
 - The Committee has considered the Quality Governance Framework, Quality Account and Quality Strategy during the course of the year;
 - The Peer Review Programme updates were also reported to the Committee in line with the cycle of business.
 - The Annual Complaints and PALS report;
 - 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.
- 2.5. The only responsibility which the Committee had not directly discharged, insofar as reports were made directly to the Trust Board, related to its responsibility to *'Monitor and review the system for ... Information Governance ... [and] Research & Development Governance, ensuring that the Board is assured of continued compliance through its annual report, reporting by exception where required'*.
- 2.6. The Quality Committee discussed how best assurance could be gained and given to the Board in relation to both of these matters, and concluded the following:
- That the views of the newly appointed Chief Information and Digital Officer should be sought in relation to Information Governance, once he came into post; and
 - That there could be scope within the 2016/17 Internal Audit Plan to assess the level of assurance relating to Research & Development governance.

Membership and Attendance Record

- 2.7. During 2015/16, 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	15-Apr-15	10-Jun-15	12-Aug-15	7-Oct-15	9-Dec-15	10-Feb-16
Chair – Non-Executive Director (GS)	☐	✓	✓	✓	✓	✓
Vice Chair - Non-Executive Director (PW)	✓	✓	X	✓	✓	✓
Chairman of the Trust Board (FC)	✓	✓	X	X	✓	✓
Non-Executive Director (CG)	✓	✓	✓	✓	✓	✓
Non-Executive Director (DM)	✓	X	X	X	✓	✓
Chief Executive	✓	✓	✓	✓	✓	✓
Medical Director	✓	✓	✓	✓	✓	✓
Chief Nurse	✓	✓	✓	☐	☐	✓
Director of Clinical Services	✓	✓	☐	✓	✓	✓
Director of Assurance	✓	✓	✓	✓	✓	✓
Director of Organisational Development & Workforce	✓	✓	✓	✓	✓	✓
Deputy Medical Director	✓	✓	✓	✓	X	✓

Key: ✓ = In attendance ☐ = represented by deputy X = Absent

- 2.8. The Committee has also welcomed visitors to observe many of its meetings, including members of staff, and governors.

Reporting Requirements

- 2.9. 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 discussed by the Committee and reported to the Trust Board for information included:

- Issues arising from discussions in relation to patient stories.
- Issues arising from discussions in relation to the Quality Reports.
- Discussions in relation to Never Events and the conclusion of the Toft Report
- The safe and secure storage of medicine.
- The risks associated with the temporary suspension of aspects of elective paediatric spinal surgery.

- 2.10. The reports consistently identified areas to be raised to the Trust Board or referred to other sub-committees of the Trust Board.

Terms of Reference

- 2.11. The Terms of Reference were last reviewed and revised in July 2015, and the review of the effectiveness of the Committee for 2015/16 has confirmed that no further changes are required to the Terms of Reference, beyond updating Committee membership.
- 2.12. The updated Terms of Reference are presented in Appendix 1.

Cycle of Business

- 2.13. The items on the cycle of business were largely delivered as planned with the exception of Information Governance. However Research Governance had not been included in the Cycle of Business for the year.

2.14. A number of additional items was considered by the Committee during the year including papers on:

- Annual Report on Pressure Ulcers and Tissue Viability
- Nurse Staffing levels and the Acuity and Dependency reviews
- Annual Review of Prevention of Future Death Reports
- Diabetes Care
- End of Life Care
- Diagnostic testing
- The mortality review process
- Vascular Surgery
- Patient and Public Engagement Strategy
- Rebalancing Health & Social Care in Oxfordshire
- Plans to improve theatres performance
- Agency Staffing Price Cap

3. Key Outcomes

3.1. In discharging the Terms of Reference as described in the preceding paragraphs the Committee has also achieved the following:

- Continued to monitor the quality of the patient experience during the course of the year.
- 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.
- Provided oversight to the self-assessment against the Monitor Quality Governance Framework and has over seen the implementation of a range of improvements in the Trust's quality governance processes.

4. Conclusion

4.1. The review has identified that the Committee has delivered the responsibilities as set out in the Terms of Reference with just the noted exception as outlined in paragraph 2.5. Attendance at meetings has been good, and the cycle of business has been completed, subject only to the items noted.

4.2. Areas for action during 2016/17 will include development of clearer guidance on the role and remit of the Committee to ensure that papers are more effectively tailored to meet the Committee's needs.

5. Recommendations

5.1. The Committee is asked to:

- Note the contents of the Annual Report; and
- Review and approve the updated Terms of Reference.

Mr Geoffrey Salt
Chairman, Quality Committee
July 2016

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**

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Quality Committee Membership 2016/17

Non-Executive Director (Chair)	Mr Geoffrey Salt
Non-Executive Director (Vice Chair)	Mr Peter Ward Professor David Mant
Non-Executive Director	Dame Fiona Caldicott
Non-Executive Director	Mr Christopher Goard
Non-Executive Director	Mr Peter Ward
Non-Executive Director	Professor David Mant
Chief Executive	Dr Bruno Holthof
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

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Quality Committee Objectives 2016/17

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 and CQUINs during the course of the year.

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