Trust Board Meeting in Public: Wednesday 9 May 2018
TB2018. 42

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<tr>
<th>Title</th>
<th>Quality Committee Chairman's Report Including Annual Report 2017/18</th>
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<th>History</th>
<th>The Quality Committee provides a regular report to the Board.</th>
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<td>The Annual Report summarises the activities of the Trust’s Quality Committee for the financial year 2017/18, setting out how it has met its Terms of Reference.</td>
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<th>Board Lead(s)</th>
<th>Professor David Mant, Committee Chairman</th>
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<th>Key purpose</th>
<th>Strategy</th>
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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.

2. Under its terms of reference, the 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.
   The regular report provided in Section 1 aims to contribute to the fulfilment of that purpose.

3. 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 2017/18 setting out how it met its Terms of Reference. This is provided in Section 2.

4. The Quality Committee’s Terms of Reference, Membership and objectives for 2018/19 are attached at Section 2, Appendix 1.

Recommendations

5. The Board is asked to:
   - Note the Quality Committee’s regular report to the Board from its meeting held on 11 April 2018 (Section 1); and
   - Review and approve the Quality Committee Annual Report 2017/18, the Terms of Reference (including minor amendments) and objectives for 2018/19 (Section 2).
SECTION 1

Introduction

Since the Board last met in public in March 2018, the Quality Committee [“the Committee”] held its most recent meeting on 11 April 2018.

Under its terms of reference, the 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. This report aims to contribute to the fulfilment of that purpose.

Background

At the meeting of the Board held in public in March, the Board reviewed the Quality Report which in the main reported on data relating to the reporting period up to the end of January 2018. Key points noted in relation to all aspects of quality included the following:

- The length of stay in the Emergency Assessment Unit [EAU] was noted to have increased, reflecting very high levels of bed occupancy. This was in turn recognised to be caused in part by a significant number of beds occupied by patients with influenza (the ‘tail’ of which was taking a long time to be cleared this year), and by the very high number of ‘stranded’ patients (patients in hospital for 7 days or more), which was currently running at over 170 each week. The Chief Nurse reported on work that she was leading across Oxfordshire to reduce the number of stranded patients.

- Following the necessary closure of the Trauma Centre at the John Radcliffe [JR] Hospital (the decision on which was made on the basis of an assessment of fire safety, in the wake of the Grenfell Tower tragedy), bed capacity at the JR for general and major trauma was reported to be insufficient, and the Board heard that proposals were being developed which would increase the utilisation of capacity at HGH;

- Action was being taken in 3 of the 5 clinical Divisions to deliver improved compliance with the World Health Organisation [WHO] checklist, but this had not yet demonstrated sufficient impact on the data reported;

- There had been little movement to improve the timeliness of test result endorsement and issue of discharge summaries. Performance on both measures continued to fall short of the targets set by Oxfordshire Clinical Commissioning Group [OCCG]. The Board heard of work being led by the Chief Information and Digital Officer to provide enhanced digital solutions. However, it was recognised that the matter would not be resolved through these alone, and would require behavioural changes as well;

- The Board heard that work was being undertaken to develop more sophisticated reporting on nursing and midwifery staffing levels, which would be focused on monitoring whether care hours provided met patient need, with increased advantage to be taken of the role of the nursing associate as appropriate;

- As part of the Trust’s commitment to Learning from Deaths it was reported that, from the December 2017 structured judgement reviews of mortality, there had been no deaths judged more likely than not to have been due to problems in care.
• Infection Control metrics showed a stable position up to the end of January 2018, but the Medical Director confirmed that there had subsequently been further sporadic C.difficile outbreaks, which would result in the Trust exceeding the ceiling for the year 2017/18;

• One Never Event had been declared on 30 January 2018 when a patient had a wrong site nerve block which was recognised prior to surgery, and the Medical Director reported to the Board on three more Never Events declared in February 2018 (two wrong site blocks and one wrong site surgery).

The main issues raised and discussed at the meeting of the Quality Committee in April are set out below.

Quality issues reviewed by the Committee in April 2018

a) The Committee began with a reflection on feedback given via email by patients and visitors to the Oxford University Hospitals NHS Foundation Trust in the month of February 2018.

It was noted that the majority of feedback provided via the email address publicised was positive, and this could provide a boost to staff morale.

Negative feedback had been received on issues ranging from parking and access to the various hospital sites, to delayed appointment times and the general hospital environment. When relaying this back to the services involved, staff were encouraged to identify any improvements that could be made.

b) Points highlighted in the Quality Report, which in the main reported on data up to the end of February 2018, included the following:

i. WHO checklist compliance audits showed that all five clinical divisions had demonstrated 100% compliance rate for the month of February.

ii. A new validation process had been introduced for Safety Thermometer data, and in February 98.76% of patients were reported to have received care free of any newly acquired harm (exceeding the target of 95%).

iii. Information reported in relation to Infection Prevention and Control [IPC] included:

• Confirmation that there had been 12 cases of OUH apportioned C.difficile in February, against a monthly cumulative limit of 5;

• There had been no new cases of colonisation with Candida auris on Neuro Intensive Care Unit in February;

• An action plan to improve compliance with hand hygiene standards was presented, and the Chief Nurse confirmed that she would be overseeing its implementation to ensure that the measures had the impact required to deliver improved compliance.

iv. There continued to be little movement in the reported timeliness of test result endorsement and issue of discharge summaries. Performance on both measures continued to fall short of the targets set by Oxfordshire Clinical Commissioning Group [OCCG].

v. There was noted to have been an increase in reported incidents of moderate or greater harm across all divisions. There had also been an increase in the number of incidents declared as SIRI [serious incidents requiring investigation], and the
Committee received further report on four Never Events that had been declared in January and February, as first reported to the Board in March. The Medical Director advised that it was too soon to know if this represented the beginning of a trend, and whether it was reflective of increased pressures across the organisation, but this would be kept under review.

vi. There had been a decrease in the number of new complaints received, and the Chief Nurse reported that recurrent themes in complaints made tended to relate to dissatisfaction with process and communication, and did not indicate grounds for concern about deterioration in the quality of care.

c) In the regular report from the Clinical Governance Committee [CGC] (covering its meetings held in January and February 2018) key areas highlighted included the following:

- The fractured neck of femur (#NOF) time to theatre had improved from 70% to 87% as reported to CGC in February. This exceeded the target of 80%, and was noted to be the first month in which the target had been met across the Trust since April 2017.
- The Horton Hip Fracture Service was to be congratulated on having been shortlisted for an award in the Patient Safety category of the British Medical Journal [BMJ] Awards.
- CGC had also received a presentation on the relatively new concept of reporting positive incidents, to ensure that the opportunity was taken to learn from success, as well as from adverse events and near misses.
- At its meeting in February, CGC had heard that risks associated with an anticipated shortfall of Paediatric Registrars from March 2018 were under active review, and notwithstanding the subsequent report of mitigation measures being advanced, this was highlighted to remain as an acute problem for the service.
- Reported delay in the implementation of some technology appraisal guidance [TAs] issued by the National Institute for Health and Care Excellence [NICE] was noted, and the Committee asked for further information to be provided on the extent of delay, and the underlying reasons for it.

c) The Committee received the draft action plans being developed in response to the publication of reports issued by the Care Quality Commission [CQC] in relation to its:

- Well-led inspection of the Trust, conducted on 20 and 21 November 2017;
- Inspection of Maternity Services at the John Radcliffe, conducted on 7 and 8 November 2017; and
- Follow-up inspection of in-patient ward at the Oxford Centre for Enablement [OCE] at the Nuffield Orthopaedic Centre [NOC], conducted on 8 November 2017.

d) The Committee also received and noted the action plan developed in relation to CQC’s report on its review of the Oxfordshire Local System Review, undertaken in November 2017. It was noted that Oxfordshire County Council had been asked to take the lead in developing this action plan, and that the Oxfordshire Health and Wellbeing Board would be responsible for assuring its delivery.

e) The Committee reviewed the latest draft of the OUH Quality Account 2017/18, noting progress made against the Quality Priorities over the past year, and commenting on the proposed Quality Priorities for 2018/19;
f) The Committee undertook its regular review of the risks associated with the temporary suspension of Maternity and Neonatal Services at Horton General Hospital [HGH], and the contingency plan by which a Midwifery-Led Unit [MLU] had been temporarily established at HGH.

It was noted that the Independent Reconfiguration Panel’s [IRP’s] report to the Secretary of State for Health required Oxfordshire Clinical Commissioning Group [OCCG] to undertake a broader engagement exercise before a final decision could be taken about the future of maternity services in Oxfordshire.

It was confirmed that no adverse events associated with the suspension of obstetric and neonatal services at HGH had been reported during February 2018.

g) The Director of Improvement and Culture provided an update on workforce planning, outlining the measures that are being taken to ameliorate the potential impact of fragility in workforce capacity on the quality and safety of patient care.

Trust-wide initiatives were reported to include recruitment drives and events focused on improving retention rates, and a review of skill mix across nurses in Bands 4, 5 and 6. Creative local initiatives are also being developed to address some specific challenges faced in certain areas, though it was recognised that these needed to be pursued within a framework that ensured equity and fairness.

h) Following results of the Staff Survey 2017, as considered by the Board in March, the Committee received a report on Trust-wide Listening Events that had been held, including an outline of the principal ideas and suggestions raised which will inform the specific priorities to be pursued to ‘Change things for the better’.

i) The Committee reviewed latest developments in the Board Assurance Framework [BAF] and Corporate Risk Register [CRR], including a summary of the risks currently recorded on the divisional risk registers held by each of the five clinical divisions, and the process for the escalation of risk.

Key Risks:

i. The potential risk that on-going operational and financial pressures could have an adverse impact on patient safety and the quality of care was discussed. To guard against this, the Committee re-stated the need to remain vigilant in its scrutiny of key quality indicators, and specifically asked for an update on measures to ameliorate the potential impact of fragility in workforce capacity on the quality and safety of patient care;

ii. Clinical risks recorded on the corporate risk register were presented for review, and the Committee in particular noted the recognised risk that ability to deliver the Trust’s Quality Priorities could be affected if the Trust’s financial performance did not improve;

iii. A summary of the risks currently recorded on the divisional risk registers held by each of the five clinical divisions was reviewed. Subject to the calibration of risk scores to ensure more consistency across all divisions, the Committee will expect the Trust Management Executive [TME], through the Clinical Governance Committee [CGC] as appropriate, to ensure adherence to the process for escalation of risk, as outlined;

iv. Risks identified in the findings of the CQC’s reports on Maternity Services at the JR, OCE at the NOC, and the Well-Led Review were discussed, and the Committee reviewed the associated action plans to ensure that implementation should be effective in managing and mitigating those risks;
Risks associated with the temporary suspension of Obstetric and Neonatal services at HGH, and the contingency plan instituted, were reviewed and found to be unchanged.

Key Actions Agreed to address risks included:

i. The Committee has asked to receive an update at each of its meetings to report on the impact of measures being taken to ameliorate the potential impact of fragility in workforce capacity on the quality and safety of patient care;

ii. The Committee will expect TME to monitor adherence to the process for escalation of risks as appropriate from divisional risk registers to the corporate risk register [CRR], including through scrutiny undertaken by the Clinical Governance Committee as a sub-committee of TME, and will expect this to be reflected in the CRR regularly presented for review;

iii. The Committee will receive regular reports on progress in the implementation of action plans developed to address findings of the CQC.

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

Professor David Mant
Chairman, Quality Committee
May 2018
SECTION 2

Quality Committee Annual Report 2017/18

Executive Summary

1. The purpose of this Annual Report is to demonstrate to the Board the extent to which the Quality Committee has met its Terms of Reference during the financial year 2017/18.

2. The Deputy Director of Assurance has reviewed the activities of the Committee and has assessed that they are consistent with its terms of reference.

3. Attendance at the Committee was generally high with 8 of the 9 members in post for the entire year attending at least 5 of the 6 scheduled meetings. Professor David Mant took over as Chairman of the Quality Committee in December 2017.

4. The Committee acknowledges that the quality of the papers routinely presented to it has improved during the year, particularly the Quality Report, Reports on Serious Incidents Requiring Investigation [SIRI] and Never Events, and report from the Clinical Governance Committee, to provide better assurance that all aspects of quality are being appropriately managed.

5. The Committee routinely considers at the end of each meeting whether the issues which have been discussed have implications for the Board Assurance Framework, and Corporate Risk Register, commenting on levels of risk when appropriate. The Committee Chairman has now initiated a review of the way in which the Committee may better identify and assess risk, with the objective of ensuring that specific risks to quality recognised at clinical unit and divisional level (including those identified by the Care Quality Commission [CQC]) may be appropriately escalated to, and discussed by, the Quality Committee.

6. The Committee has agreed that it needs to see better data to ensure that risks to quality, particularly those resulting from staffing pressures in specific clinical areas, are identified at the earliest possible stage. The executive team is undertaking a number of initiatives to provide the enhanced data requested to the Committee.
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 OUH Trust Board’s Quality Committee (the Committee) for the financial year 2017/18 setting out how it has met its Terms of Reference.

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. Review by Assurance Team

2.1. 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 was broken down into responsibilities, reporting arrangements, and cycle of business, and membership and attendance record.

Responsibilities

2.2. Compliance with key responsibilities was evidenced by the routine presentation and consideration of: i) Quality reports, including updates and reflections from national reports, safe staffing and acuity metrics, infection control metrics and clinical audit information; ii) Patient, Carer and Staff Story reports; iii) Clinical Governance Committee reports and minutes; iv) SIRI Summary reports; v) Updates on the temporary suspension of obstetric and neonatal services and associated risks; vi) Updates on the CQUIN Programme; vii) Annual report on SIRI and Never Events; viii) Updates in relation to progress against completion of the CQC Inspection Action Plans.

2.3. The Committee also considered the Quality Priorities for the Trust and the Quality Account, reports on Workforce and Organisational Development Performance, key themes emerging from the Peer Review Programme, the Annual Complaints and Patient Advocacy and Liaison Service [PALS] report and the Annual Safeguarding Adults and Children report.

2.4. The Board Assurance Framework and Corporate Risk Register were reviewed and discussed at the end of each meeting to ensure that identified controls were appropriate to mitigate the risks to a level within the Trust’s risk appetite.

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 discussed by the Committee and reported to the Trust Board for information included: i) compliance with venous thromboembolism (VTE) risk assessments and quality indicators; ii) the effect of nurse staffing shortages and the impact upon patient care; iii) high risk cleaning scores; iv) issues arising from discussions in relation to the experiences noted from the presentation of patient stories; v) Issues arising from discussions in relation to the Quality Reports.
2.6. Specific issues arising from quality reports included tracking progress in the achievement of national and local CQUINs, compliance with dementia and cognitive screening, issues raised by the Oxfordshire Clinical Commissioning Group [OCCG], safety incident data, SHMI Mortality noting that indicators had decreased from 0.96 to 0.94; influenced by the decrease in observed deaths for secondary malignancies and cancer of the bronchus., infection control risks, safe staffing issues, and the need to maintain focus on the safety aspects of performance against NHS national targets.

2.7. The reports from the Committee consistently identified areas to be raised to the Trust Board or referred to other sub-committees of the Trust Board. They made reference to national reports (for example the CQC report: ‘Learning, candour and accountability’) and to specific Trust reports (for example, in relation to Never Events and Serious Incidents and to Workforce Retention).

Cycle of Business

2.8. The items on the cycle of business were largely delivered as planned with some minor adjustments to the timing of delivery of some papers. A number of additional items were considered by the Committee during the year including papers on:

- The Trust’s response to the implementation of national guidance on learning from deaths, following the CQC’s report commissioned by the Secretary of State for Health following the prior report into deaths in the Southern Health Trust;
- CQC Review of Learning, Candour and Accountability;
- Digital integrated heat map of quality, operational and financial performance standards;
- Lessons learned from the NHS Cyber-attack. XP devices in use was a major factor however the vulnerability occurred in all unpatched Windows versions. OUH completed the migration from Windows XP to Windows 7 several years ago and was unaffected by the outbreak due to a combination
- The impact on theatre capacity in the event of closing the Vanguard Theatre and the results of the Judicial Review in relation to the OCCG consultation process.
- Key themes emerging from the Peer Review Programme and updates on the completion of the directorate reviews.
- Clinical harm review of patients waiting 52 weeks, which provided additional assurance to NHS Improvement.
- An assessment of the comparative performance of free-standing Midwife Led Units (MLU) in Oxfordshire was considered by the Board in November 2017 and was reported to the Committee for consideration in relation to the on-going assessment of the risk of the temporary changes to the MLU in the Horton General Hospital.
- The human factors CQUIN: lessons learned and achievements report prompted an exploration by the workforce team for the development of the programme into the Trust-wide programme.

2.9. The Committee also reviewed and commented on the approach to reform and refresh the quality priorities for 2018/19 and the development of the Quality Strategy. It requested a review of the cleaning assurance standards data following areas of sub-optimal performance in areas designated as high risk. And it received information on improving services for people with mental health needs who present in A&E. CQC Regulatory Action updates and CQC activities were presented to the Committee as required.
3. Membership and Attendance Record

3.1. During 2017/18, the Committee met six times with attendance recorded in the table below. This demonstrates that every meeting of the Committee held during the year was quorate. The Committee is currently carrying a vacancy in respect of one of the Non-Executive Director members. All members are expected to attend at least four out of six meetings held in each financial year and all but one member was able to do so, with 8 out of the 9 members in post for the entire year attending at least 5 meetings.

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**KEY**

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3.2. After the annual review in June 2017, a number of changes to the Committee membership were agreed and approved by the Board.

3.3. Professor David Mant took over as Chairman of the Quality Committee in December 2017.

3.4. The Committee has on occasion also welcomed visitors to observe some meetings.

4. Self-assessment

4.1. The Committee acknowledges that the quality of the papers routinely presented to it has improved during the year, particularly the Quality Report, Reports on Serious Incidents Requiring Investigation [SIRI] and Never Events, and report from the Clinical Governance Committee, to provide better assurance that all aspects of quality are being appropriately managed.

4.2. The Committee routinely considers at the end of each meeting whether the issues which have been discussed have implications for the Board Assurance Framework, and Corporate Risk Register, commenting on levels of risk when appropriate. The
Committee Chairman has now initiated a review of the way in which the Committee may better identify and assess risk, with the objective of ensuring that specific risks to quality recognised at clinical unit and divisional level (including those identified by the Care Quality Commission [CQC]) may be appropriately escalated to, and discussed by, the Quality Committee.

4.3. The Committee has agreed that it needs to see better data to ensure that risks to quality, particularly those resulting from staffing pressures in specific clinical areas, are identified at the earliest possible stage. The executive team is undertaking a number of initiatives to provide the enhanced data requested to the Committee.

5. Terms of Reference

5.1. The Terms of Reference were last reviewed and revised in July 2017. The current review resulted in minor changes (presented in blue italics in Appendix 1). It is proposed that a workshop be held to seek to clarify the requirement of the papers to meet the Committee’s need, including the content of the executive summary. If the results of this workshop have implications for the Terms of Reference, any proposed changes will be submitted for approval by the Board.

6. Conclusion

6.1. The review has identified that the Committee has delivered the responsibilities as set out in the Terms of Reference. In particular it has continued to monitor the quality of the patient, public and staff experience during the course of the year, overseen the Quality Priorities as reflected in the Quality Account, and reviewed the results from the recent CQC visits during the year and monitored progress in relation to the completion of action plans.

6.2. Attendance at meetings has been good and the cycle of business has been completed.

6.3. Areas for action during 2018/19 include: i) the development of the Quality Strategy; ii) the continued development of quality data to improve the assurance information included in papers and ensure that the papers are tailored to meet the Committee’s needs; and iii) the continued promotion of the risk register as a tool for the development of related papers to be discussed at the Committee.

Professor David Mant
Chairman, Quality Committee
May 2018
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 Improvement and Culture
   - Chief Information and Digital Officer
   - 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’s 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 impacts of the financial improvement and EBITDA performance, 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
## Quality Committee Membership 2018/19

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Executive Director (Chair)</td>
<td>Professor David Mant</td>
</tr>
<tr>
<td>Non-Executive Director (Vice Chair)</td>
<td>Mr Geoffrey Salt</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Dame Fiona Caldicott</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Mr Christopher Goard</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Vacancy</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Dr Bruno Holthof</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Dr Tony Berendt</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>Ms Sam Foster</td>
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<tr>
<td>Director of Clinical Services</td>
<td>Mr Paul Brennan</td>
</tr>
<tr>
<td>Chief Information and Digital Officer</td>
<td>Professor Peter Knight</td>
</tr>
<tr>
<td>Director of Assurance</td>
<td>Ms Eileen Walsh</td>
</tr>
<tr>
<td>Deputy Medical Director</td>
<td>Dr Clare Dollery</td>
</tr>
</tbody>
</table>
Quality Committee Objectives 2018/19

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:

- Continue to review the development and implementation of the Trust’s Quality Strategy, Quality Priorities and CQUINs during the course of the year.
- Review those processes in place to monitor and report on compliance with CQC regulations;
- The continued development of quality data to improve the assurance information included in papers and ensure that the papers are tailored to meet the Committee’s needs; and
- The continued promotion of the risk register as a tool for the development of related papers to be discussed at the Committee.