Agenda Item No: 15

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 26 May 2015

Subject	Quality Assurance Committee Annual Report and Terms of Reference
Prepared by	Jane French, Clinical Governance Facilitator
Approved by	Ruth James, Director of Quality
Presented by	Maureen Rutter, non-Executive Director/Chair of Quality Assurance Committee
Name of meeting considered/approved by	Quality Assurance Committee

Purpose: To provide assurance that the committee has discharged its duties and delivered its annual business plan for 2014/15.		
	Decision	
	Approval	
	Information	
	Assurance	●

Executive Summary

The report demonstrates that the Committee has met its terms of reference in 2014/15.

Next Steps

The Board is asked to support the findings of the report.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below

Annual report on the delivery of the Integrated Governance Committee/Quality Assurance Committee
2014/15 Annual Business Plan.

1. Introduction

The purpose of the Quality Assurance Committee (QAC) is:

"To assist the Board and organisation in ensuring it fully discharges its duties in relation to the delivery of high quality services and patient outcomes, having regard to patient safety, clinical effectiveness and patient experience.,

In the progress of its work, the Committee will draw to the Board's attention any areas of concern that places the Trust at risk of non-compliance with regulatory, legal and code of conduct requirements, or threatens delivery of its strategic objectives

In achieving these ends the Committee will provide assurance to the Board that there are appropriate systems, processes and behaviours within the Trust to manage risks to quality and to deliver improvements to support the achievement of the Trust's strategic objectives and compliance with regulatory obligations."

To support the committee in discharging these duties an annual business plan sets out the actions required to meet each of the terms of reference.

2. Review of Terms of Reference (ToR), attendance and membership

The 2013/14 annual report of the work of the Quality Assurance Committee was presented in May 2014 and it was concluded that the group had fulfilled its terms of reference in the previous year.

The ToR for the committee and annual business plan were reviewed at the meeting in May 2014.

Attendance at QAC over the year is attached at appendix 1. Average attendance was 62% which is an increase on the previous year (when it was 56%), 12 members have not achieved 50% minimum attendance as specified in the Terms of Reference, however 8 of these have either joined the committee in the year or left.

Proposed revised terms of reference are attached as appendix 2 which includes an updated membership.

3. Duties of the Committee

3.1 Governance Reporting

The Committee supported the Quarterly Declaration of Compliance with Monitor's Quarterly Governance Framework in April 2014 and July 2014 it was agreed that there were no areas of concern which required escalation to the Board of Directors from this report. The report due in November 2014 was deferred until the external governance review by Deloittes had been completed and the report received and briefed. The recommendations from the governance review and the action plan were reported to QAC in March 2015. It was subsequently agreed by the Board the on-going monitoring of the action plan would be at the Board of Directors meeting.

The Committee also considered other reports as identified in the annual business plan including:

- The Trust-Wide Governance and Quality Report was reviewed by the Committee in May, September, November 2014 and in February 2015 and the Committee agreed issues for onward reporting to the Board and those where further analysis was required.
- In May 2014 the committee received the Annual Review of Compliance with NHS constitution and agreed that the organisation was compliant with the pledges and commitments.
- In April 2014 the committee reviewed the final draft of the 2013/14 Quality Account (QA). A mid-year update on the QA was brought in November 2014 demonstrating that progress had been made against all the priorities identified. The priorities for the 2015/16 Quality Account were presented to the committee in February 2015 and all 9 were agreed to be put forward for consideration to the Board.
- In June 2014 the Clinical Audit Annual Report 2013/14 was presented and the committee received assurance that the Clinical Audit plan for 13/14 had been delivered. The forward plan for 2015/16 was also received in May 2014; a mid-year review of progress with the 2015/16 plan was presented in December 2014. This review showed that 6 audits were off track and the committee discussed the actions required to address this, this will be followed up in the end of year report. No significant issues with quality of care identified by audits were escalated.
- In June 2014 the committee accepted the NICE guidance annual review report and the committee were satisfied that actions to obtain compliance were being addressed on outstanding guidance.
- In July 2014 the Information Governance (IG) Strategy was accepted by the Committee which noted the trust's position. An update on progress with the IG toolkit was presented in April 2014 and November 2014 and measures were being taken to deliver the required level of IG training by July 2014. The IG Annual report was presented to the committee in March 2015 and the Committee agreed the rationale to reduce the training threshold to 90% to allow for 10% staff turnover.
- In September 2014 Professor Mark Wilcox's report from the second C.Difficile Assurance Visit was presented to the Committee. The action plan was reported to be on target and had been set by Monitor. A further update was provided in February 2015 when the C.diff report was presented to the Committee
- In December 2014 a review of progress of the Annual Governance statement (formerly SIC) was presented. The committee supported the statement and agreed no significant control issues had emerged.
- In May 2014 the committee accepted a briefing on the PHSO report which informed of the decision to partly uphold a complaint and which highlighted findings from the PHSO.
- Connectivity – groups reporting to the QAC were asked in February 2015 to escalate issues using a standardised chair's log to improve connectivity. QAC started to use the chairs log in February 2015; this was well received by the Board.
- The recommendations from the governance review and the action plan were reported to QAC in March 2015. The Committee considered the recommendation from the review that the Trust establish a separate risk committee, it was agreed that the risk review and escalation process had been made much more efficient with the new risk escalation framework. The committee would therefore continue to have the responsibility for assurance of the effectiveness of the risk management process and the review and escalation of risk to the Board.

3.2 Care Quality Commission (CQC)

The Committee has a duty to seek assurance of compliance with regulatory requirements and has received the following reports in relation to the registration requirements of the Care Quality Commission:

- In April 2014 the committee accepted an update on the CQC Intelligence Monitoring report (IMR) and the CQC assessment of standard 16 and agreed to monitor through the committee and in July 2014 the committee was presented with the latest draft and were satisfied that the risks identified in the draft report were being addressed.
- In April 14 the committee accepted a report regarding CQC notifications relating to Safeguarding Adults. The report showed an increase in reported incidents and the committee agreed this was due to increased awareness and reporting via the safeguarding team. The committee acknowledged the increased pressures in the team and supported a business case to invest in further staff.
- In October 2014 the committee received an update after the CQC mock inspections had taken place. A number of key issues were highlighted from the mock inspections and the committee was satisfied that steps were being taken to address these.
- In December 2014 the CQC made an announced visit to the Trust and all of its sites. An update was given to the committee following the visit and shared initial feedback from the clinical teams. Local feedback from the areas visited by the CQC were summarised for the committee in March 2015 and the committee was informed of the Quality Summit which has been organised for June 2015.
- Changes to the CQC regulations were highlighted to the committee in March 2015, the committee noted the changes and the measures planned to ensure compliance.

3.3 Quality of Care and Patient Safety

A range of issues are considered in this section of the agenda to ensure that the Committee discharges its duty to assure itself that:

'The Trust delivers high quality patient centred care, particularly with regard to patient safety, clinical effectiveness and patient experience.'

- The Annual Report from the Clinical Standards Sub Group (CSSG) which reports into the QAC was received in April 2015 and the Committee agreed that CSSG had delivered on the Terms of Reference and that systems were in place to address any gaps.
- The Annual Report of the Patient Safety Programme Board was received in April 2015; due to two of the six planned meetings being cancelled during 2014/15 the Committee felt that the Sub Group had only partially met its terms of reference. The Director of Quality advised the Committee that the format and membership of the group was being revised and there is a new Chair. A review of the Committee Structure will be presented to QAC in June 2015.
- The Annual Claims Report was presented in June 2014 and the committee informed that damages paid out were significantly less than the previous year. The NHSLA portal was also demonstrated in June 2014 and it was agreed that this will make benchmarking against similar trusts helpful in the future.
- The Annual Complaints Report was presented in July 2014 and the Committee noted that 102 formal complaints were received in Q4 which was an increase on the previous year. The PHSO upheld 2 complaints. PALs enquiries had reduced however it was noted that this may be related to changes in the processes in PRD after the RPIW.
- The Deprivation of Liberty Safeguards report was presented in October 2014 and the committee agreed that Board of Directors should be asked to decide on proposals in the report with the endorsement of the committee.
- Due to the concern about rising levels of C Difficile infection the Committee agreed to have a brief C.Diff update on a monthly basis until improvement is made. A report on C.Difficile – cleaning and other issues was presented to the committee in February 2015. A number of initiatives were being introduced and more were in development.
- The annual review of NICE guidance was presented to the committee in March 2015 and the changes in the process for distributing and monitoring compliance with the guidance outlined. The committee was assured that there are no safety concerns relating to NICE guidance.

- The committee received an update in March 2015 on the Quality Impact Assessments undertaken on Trust cost improvement plans (CIP) for 2015/16. The committee was assured that the CIP scheme for 15/16 had been reviewed and evaluated effectively. The committee agrees that it would receive quarterly updates on monitoring of the QIAs and approval of the QIAs on any new CIPs
- The Pressure Ulcer Prevention Assurance Framework was presented to the Committee in March 2015. The policy has also been reviewed and implemented. Pressure ulcers remain a challenge and a priority for 2015/16 and the committee accepted the framework update and was assured that actions were being undertaken to promote prevention of pressure ulcers.
- An update on the progress of the South Tees Accreditation for Quality of Care (STAQC) was presented to the committee in March 2015. The committee supports the STAQC process and a section will be included on this in the Quarterly Quality and Governance report.

- Other items reviewed in this category include:
    - PHSO final report ST 299-11 was received by the committee in July 2014
    - Clinical benchmarking exception report was received in July 2014
    - PHSO report ST414-12 was presented in September 2014
    - Update on Never Event and Action Plan – Ophthalmic Theatres was received in October 2014.
    - Annual report and outcome of peer review process for cancer MDTs was received in November 2014.
    - Dementia Strategy update was received in December 2014.
    - An update on falls was received in February 2015
    - Update on Major Trauma Centre Peer Review Measures was presented in March 2015.
    - A new process for safety alerts issued from the NPSA was approved by the committee in December 2014.

3.4 Risk and Assurance

There are two specific duties of the Committee covered in this section of the agenda:

'Appropriate systems of risk management and internal control are in place. '

'Action plans, risk alerts, and lessons learned are disseminated and implemented throughout the Trust, and actively monitored.'

The following agenda items considered by the Committee during the year in relation to this part of its remit:

- The Annual Report on implementation of the Risk Management Strategy was accepted in July 2014.
- A review of the risk management process by internal audit was received in July 2014, this was a limited assurance report. An update on progress with actions was received in September 2014 in response to the recommendations high scoring and longstanding risks were presented in December 2014. It was agreed that further work was needed including training of staff managing risk registers. Further review to take place after the training.
- The corporate risk register is reviewed at every meeting to identify any significant risks which require escalation to the Board of Directors. Risks escalated during 2014/15 were as follows in the table below:

ID	Title	Escalated
1290	Risk of patient safety/litigation issues due to on-going failure to meet mandatory training compliance rate of 80%	April 14
1350	Risk that trust is unable to maintain compliance with 62 days cancer target	April 14
1356	Employment tribunal case number 2500526	May 14
1367	Inadequate Radiologist support for Urology from DMH	June 14
1381	Employment tribunal no. 2500830	Sept 14
1383	Risk of failure to maintain a quality system for transfusion that meets the requirements of Blood Safety and Quality Regulations	Sept 14
1395	Risk of Patients being ventilated outside of Level 3 care due to increased demand versus capacity	Oct 14
1411	Risk of not being prepared for an Ebola patient(s)	Nov 14
1307	Risk of compromise in care delivered to neonates due to non-compliance with BAPM staffing standard	Nov 14
1396	Delay in histology reporting	Dec 14
1397	risk of delay in reporting histopathology	Dec 14
1421	Risk of inability to provide right care, right time, right place, right professional on current outlier configuration	Dec 14
1451	Risk of Missed Diagnosis	Jan 15
1462	Risk of inability to provide the present OMFS service	March 15

- The Emergency Preparedness (EP) annual report was received in December 2014 and the committee was assured that EP plans are in place.
- The Assurance Framework was presented to the committee on a quarterly basis up until July when this was changed to monthly reporting.
- A new process for safety alerts issued from the NPSA was approved by the committee in December 2014.
- The quality report was presented on a quarterly basis and identifies lessons learned and actions taken as a result of incidents and complaints.

3.5 Organisational Capability

The Committee has a duty to assure itself that:

> *'The Trust has the organisational capability with regard to its workforce and IM&T systems to deliver its objectives.'*

The following reports were received in the year:

- Annual Report from the Workforce sub group was received in May 2014.
- A review of Organisational Development report was accepted by the committee in June 2014.
- A Revalidation (Medical staff) report was accepted by the group in July 2014. The organisation has 120 trained appraisers and the majority of doctors comply.
- Annual update on Management and outcome of HR processes was accepted in October 2014.
- The Nurse Staffing Review report was presented to the Committee in November 2014.
- A report on the outcomes of the RPIW programme of work was accepted by the Committee in December 2014.

- The National Inpatient Survey Action Plan was received for information by the committee in December 2014.

3.6 Other duties

The Committee receives minutes from each of the sub-groups, and provided minutes of its meetings to the Board of Directors each month. The Committee received end of year reports for the Clinical Standards Sub Group, Patient Experience Sub Group and the Patient Safety Sub Group in April 2014. The Committee agreed that the Clinical Standards Sub Group and Patient Experience Sub Group had delivered their duties and met their terms of reference; the Patient Safety Sub Group has only partially met its terms of reference due to a number of meetings being cancelled.

The annual report from the Workforce sub group was not received in April and will be presented to QAC in May 2015. The committee will need to take a view at that point as to whether the Workforce sub group has met its terms of reference.

The governance review recommended a review of the committee structure and clarification of the action / working groups feeding into it so that reporting lines are clear and that committees are not over-burdened.

4 Looking Forward

A proposed business plan for 2015/16 is attached in appendix 3. This has been reviewed to ensure that the recommendations of the governance review have been addressed.

Recommendations from a recent review of the HR function is awaited which may propose an alternative mechanism for assurance relating to workforce development, capability, HR metrics and workforce strategy. In the interim the Workforce sub group will continue to report to QAC.

Changes for the Committee to note / approve:

- To monitor the effective management of Care Centres' risk registers, a mechanism needs to be agreed by which the Committee will do this. Centre governance structures are to be standardised and risks will be reviewed at monthly performance reviews. The terms of reference may need to be amended to reflect this connectivity.
- It is proposed that the Board Assurance Framework (BAF) is only reported to Board. QAC may identify risk to the delivery of strategic objectives through its work and these will be escalated to the Board. Effective development and maintenance of the BAF is monitored by the Audit Committee.
- Patient safety walkabouts are monitored at the Patients Safety Sub Group.

To response to the concerns relating to HCAI the trust commissioned an external review of the governance of the infection prevention and control (IPC) functions. This review recommends that the Infection Prevention Action Group (IPAG) reports directly into QAC rather than Clinical Standards sub group (CSSG) as currently. It is recommended that this approach is adopted for 15/16 given the level of enhanced scrutiny and focus on the HCAI agenda.

It is proposed that a report clarifying the lines of reporting from the action and working groups and the clinical centres through the committee structure is presented to the Committee in June 2015.

Ruth James
Director of Quality
May 2015.

Appendix 1

Quality Assurance Committee Attendance for April 14 – March 15

NAME	Apr-14	May-14	Jun-14	Jul-14	Sep-14	Oct-14	Nov-14	Dec-14	Feb 15	Mar 15	Total Out of 10	Total %
Wallace, Mrs H	P	P	P	P							4	40%
Rutter, Mrs M	P	A	P	P	P	P	P	P	P	P	9	90%
Holt, Miss R	P	A	A	P		A	D	P	P	D	6	60%
Headland, Mrs M	A	A									0	0%
Donoghue, Mrs S			A	A		P		D	D	P	4	40%
Cruickshank, Mr D	A	A	P	P		P	A	P	A	P	5	50%
Harrison, Mr C/HR	P	P	A	A	A	D	P	A	P	A	5	50%
James, Ms R	P	P	P	P	D	D	P	P	P	P	10	100%
Huntley Mrs N	P	P	D	P	P	P	P	A	P	D	9	90%
Irons Mrs L		P	A	A	P	P	A	A	A	A	3	30%
Carter, Mrs E							P	P	P	P	4	40%
Kenward, Lt Col G	P	A	P	A	D						4	40%
Penney, Col T						P	A	P	P	A	4	40%
Regan, Mrs Y					A	A		P	P	P	3	30%
Newton, Mr C/Finance	A	A		P	A	A	A	A	A	A	1	10%
Thompson Mrs B	P	A	P	P	P	P	P	P	P	A	8	80%
Wilson Prof R	P	A	A	P	P	P	A	P	A	P	6	60%
Elliott, Mrs K	P	P	A	P							3	30%
Watson, Mrs S		P	A	P							2	20%
	15	15	15	15	13	13	14	14	14	14		
Total Present	10	7	6	11	7	11	7	10	10	9		
% of Attendance at meetings 2014/15	67%	47%	40%	73%	54%	85%	50%	71%	71%	64%		

P = present
A = Apologies given
Shading = leaving/joining committee
Dep = deputy attended
Blank = no apols and no attendance
No Aug or January meetings
Quorum=5

Appendix 3

Quality Assurance Committee Annual Business Plan 2015/16 - DRAFT				
	Objective	**Report**	**Lead**	**Date of Action**
13a	**That the Trust maintains an effective system of integrated governance, risk management and internal control that supports the achievement of the Trust's strategic objectives.**			
a.i	Review the management of risks on the corporate risk register, ensuring controls are adequate and that action plans are implemented. Identify risks for escalation to the Board	CRR and emerging high scoring risks report	K Davies	Monthly
a.ii	Review the annual governance statement to ensure that the report is consistent with the management of risk and the internal control processes reviewed by the committee during the year	Review AGS for year 14/15	R James	May 15
		Review progress of AGS for year 14/15	R James	Nov 15
a.iii	Receive outcomes of internal audit reviews (relevant to QAC) and be assured of implementation of recommendations	Internal audit reviews.	R James	Ad hoc
a.iv	Monitor progress on the implementation of the risk management strategy	Annual report on implementation of Risk Management Strategy	K Davies	July 15
a.v	To monitor the effective management of Care Centres and corporate departmental risk registers;	TBC – consider through minutes of monthly performance reviews or each centre to produce an annual report	TBC	TBC
a.vi	Review emergency planning and business continuity arrangements.	Annual report	E Harvey	Dec 15
a.vii	Assure the Board that the sub groups within the committee structure have delivered their term of reference	See 13i		
13b.	**The Trust delivers high quality patient centred care, particularly with regard to patient safety, clinical effectiveness and patient experience.**			
b.i	Provide assurance to the Board on the quality of care. Identify issues of escalation to the Board and commission further analysis and review where additional assurance is required. Monitor progress with the trust objective to reduce avoidable harm by 50% Monitor progress with the trust objective to improve mortality	Quarterly quality report	E Carter	May 15 Sept 15 Nov 15 Feb 16
		Receive minutes and chairs log from the Patient Safety Sub Group	R James	June 15 Sept 15 Oct 15 Dec 15 Feb 16
		Receive minutes and chairs log from the Clinical Standards Sub Group	R Wight	Monthly

		Receive the monthly HCAI action plan	R Holt	Monthly
		Receive progress reports on the pressure ulcer assurance framework	G Hunt	Sept 15 Mar 16
b.ii	Ensure that the quality priorities identified in the quality account reflect the issues reported to the Committee, monitor progress with the quality priorities.	Review selection of priorities for 14/15	E Carter	March 15
		Receive and review draft Quality Account for 204/15		May 15
		Monitor progress against the quality improvement priorities 15/16.		Nov 15
b.iii	Assure the board on progress with the organisations objective to improve patients experience. • Review results of national patient surveys and associated action plans • Receive and review Annual Complaints Report. • Review outcome of Ombudsman investigations. • Review progress with the patient and carer engagement strategy	Receive and review minutes of the Patient Experience Sub-Group	Ruth Holt	Bi-Monthly
		national patient surveys and associated action plans	Karen Harwood	Ad hoc
		Annual Complaints Report.	Kay Davies	June 15
		Ombudsman investigations and action plan	Kay Davies and relevant clinical centre	Ad hoc
		Patient and carer engagement strategy progress report	Caroline Parnell	TBC
b.iv	Provide assurance to the Board that the trust is meeting its obligations and meeting its statutory requirements in relation to safe-guarding children/adults	Annual report on safe-guarding to ensure our obligations re safe-guarding are met.	Helen Smithies	June 15
b.v	Provide assurance to the Board that the clinical audit programme is developed to support the delivery of organisations objectives, provide assurance and where opportunities for quality improvement are identified that these are actioned.	Review clinical audit annual report 14/15	E carter	May 2015
		Mid-year review of clinical audit		Dec 15
		Review clinical audit forward plan		June 15
b.vi	To undertake an annual review of compliance with NICE guidance and notification of any areas of non-compliance.	Annual report on NICE guidance	R Wight	March 16
b.vii	Assure the Board on the finding of peer reviews and monitor that necessary actions are implemented.	Annual cancer peer review report. Other ad hoc peer review reports	TBC	Nov 2015
13c.	**The Trust assesses and mitigates potential risks to quality from new initiatives including those arising from cost improvement workstreams or operational efficiency measures**.			
c.i	To review the Quality Impact Assessment of the Trusts CIPs undertaken and monitor progress with QIA metrics during implementation	Quarterly QIA report	R James	Feb 16
13d.	**The Trust complies with regulatory, legal and code of conduct requirements eg. those determined by Monitor, Care Quality Commission,**			
d.ii	Provide assurance to the Board that the trust is maintaining the	Review Intelligent Monitoring Report	E Carter	June 15

	standards required for compliance with its CQC registration and Monitor's quality governance framework	(6-monthly and by exception when number of risks increase or change significantly).		Dec 15 By exception
		Receive and review outcome of CQC inspections. Monitor CQC action plan	E Carter	June 15 Sept 15 Feb 15
		Receive updates on the outcome or the ward accreditation process	J Connor	Sept 15 Mar 16
d.iii	Provide assurance to the Board that the trust maintains compliance with the NHS Constitution	Receive assurance on compliance with NHS Constitution (annually).	E Carter	Jan 16
d.iv	Provide assurance to the Board of compliance with the Information Governance Toolkit	Receive annual report	N Huntley	July 15
		Receive update on progress with Info Gov Toolkit		Nov 15
		Pre-submission update.		Mar 15
13e.	**The Trust has the organisational capability with regard to its workforce and IM&T systems to deliver its objectives. (TBC pending the outcome of the HR review)**			
e.i	Assurance require regarding: Workforce strategy Equality and Diversity Monitoring Workforce planning and management of risks Sickness, Appraisal and mandatory training HR processes – grievances	Receive 6 month updates on progress	TBC	TBC
e.ii	Receive assurance on progress of revalidation	Annual report	R Wight	TBC
e.iii	To assure the board on the data quality	Annual reports on data quality and data coding. Ad hoc reports on issues escalated by the data quality steering group via the patient safety sub group	A Davis	TBC And ad hoc
e.iv	Receive assurance that nursing establishment meets requirements for delivery of high quality nursing	Nursing establishment review reports	R Holt	TBC TBC
e.viii	Receive assurance that the education, learning and development activities within the trust meet the needs of staff	Annual report	Susy Cook	TBC
e.xi	Monitor the work of the workforce sub group and receive issues for escalation relating to organisation capability	Receive and review notes of meetings	TBC	Apr 15 July 15 Nov 15 Jan 15
13f.	**Action plans, risk alerts, and lessons learned are disseminated and implemented throughout the Trust, and actively monitored.**			

f.i	Receive assurance on implementation of risk alerts via the Patient Safety Sub Group.	Minutes of patients safety sub group	Ruth James	As in 13b
f.ii	Ensure that there is learning from: • complaints and PALS • incidents/SUIs, Never Events, Prevention of Future Deaths Reports and that this is shared throughout the trust.	Through the quarterly quality report	Emma Carter	As in 13b
f.iii	Ensure there is learning form clinical claims and that risk identified by claims are managed	Through the quality report and the annual claims report presented to the Patient Safety Sub Group	Emma carter and Nicky Huntley	As in 13b
13g.	**The Trust promotes a culture of openness as a prerequisite to improving patient safety and the quality of healthcare, ensuring that communication is open, honest and occurs as soon as possible following a patient safety event, or when a poor outcome has been experienced.**			
g.i	To assurance the board that the trust is compliant with the Duty of candour requirements and the principles of the Speak Out Safely report	Progress report	Kay Davies	Oct 15
13h.	**That organisational development and service improvement work contribute to quality improvement.**			
h.i	To review the programme of service improvement work to ensure that this supports and informs the Trust's objectives.	Receive the corporate improvement team annual report.	Andrew Moore	Jun 15
13i.	**Review of Terms of Reference and Effectiveness of Sub-groups**			
i.i	Receive assurance from the sub-groups that they have delivered their aims and objectives for the year:	Clinical Standards Sub-Group	R Wight	April 16
		Patient Experience Sub-Group	R Holt	April 16
		Patient Safety Sub-Group	R James	April 16
		Workforce Sub-Group	TBC	April 16
13j.	**The Chair of QAC will annually report to Board of Directors that the Terms of Reference, attendance and membership of QAC have been reviewed and that the Terms of Reference have been met.**			
j.i	Provide assurance to Board that QAC and sub-groups have reviewed their Terms of reference, membership and attendance, and delivered their aims and objectives for the year.	Annual report to the Board	M Rutter	May 15 May 16