The Christie NHS
NHS Foundation Trust

Quality assurance committee annual report
April 2016 - March 2017

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1. Introduction

The purpose of the quality assurance committee annual report is to review the work of the committee undertaken in the period 1st April 2016 to 31st March 2017 and to set out how it has performed against its responsibilities as defined in its terms of reference.

2. Terms of reference & committee membership

The quality assurance committee terms of reference (ToR) were reviewed and approved at its 24th June 2016 meeting.

The quality assurance committee was chaired throughout the year by Professor Kieran Walshe, non-executive director.

3. Meetings

During 2016/17 five meetings were held: 24th June, 29th September, 30th November 2016, 26th January and 30th March 2017. In addition a joint meeting of the audit and quality assurance committees was held on 25th May 2016.

4. Quality assurance committee members: table of attendance

Name	Quality assurance committee (out of 5 possible meetings)	Joint audit & quality assurance committee (out of 1 meeting)
Kieran Walshe (Chair)	5	1
Christine Outram	5	1
Jane Maher	3	0
Tarun Kapur	5	n/a

5. Relationship to other Committees

The Committee has shared responsibility with the audit committee to provide assurances to the board of directors that The Christie is properly governed and well managed across the full range of its activities.

In broad terms the quality assurance committee is responsible for ensuring that assurance is provided for clinical & research governance and risk management. The quality assurance committee informs the board of directors of the outcomes of its reviews.

6. Achievement of the identified priorities

The list below forms the basis of the committee's programme during 2016/17:

1. Maintain registration with the CQC and full compliance with CQC key lines of enquiry, along with all other regulatory requirements.
2. Ensure that the Trust meets all quality related requirements of the Risk Assessment Framework for 2016/17 (superseded by the Single Oversight Framework from October 2016) and to bi-annually review the risk against the NHSI Quality Framework.
3. Ensure continuing audit and evidence of high standards of patient care and patient experience, monitor patient safety information and patient harm rates.
4. Monitor and support the ongoing development and presentation of clinical effectiveness data to ensure The Christie is delivering the best possible cancer care to its patients.

5. Ensure that the clinical audit programme is appropriate, adequately resourced and aligned with the strategic objectives of the Trust. Clinical Audit to attend every meeting of this committee to ensure clinical effectiveness.
6. Continue to provide high standards of cleanliness and effective HCAI management and compliance with the Hygiene Code.
7. Oversee the publication of the annual Quality Accounts.
8. To agree quality priorities for internal audit with a focus on complaints management which have been agreed with the Quality Assurance Committee.
9. To monitor the changes in the NHSLA requirements from Risk Management Standards to learning from claims.
10. To receive the annual monitoring report of the raising concerns policy.
11. To address issues raised through the committee effectiveness review.

All were achieved. The Board is invited to identify any additional subjects on which assurance may be required in response to changes in the healthcare environment.

7. Governance and risk management

The committee maintains an annual reporting cycle. Actions arising from meetings are recorded on an action-plan rolling programme. These two documents are used to plan, record and monitor the work of the committee. Following each of its meetings a key issues report and full minutes are submitted to the board of directors.

Throughout the year the committee has received a range of information in accordance with the annual reporting cycle.

7.1 Care Quality Commission (CQC)

On 18th November 2016 the CQC published their assessment of our services following a comprehensive inspection which took place between 10th and 13th May 2016. The CQC issued an **Outstanding** rating which is the best possible outcome. The CQC described us as 'exceptional' and 'a leader in its field'. The report also praised the 'friendly and open culture' and the 'commitment to excellence that filters through every area of the trust'.

The Trust was judged to be fully compliant in all regulated activity and did not receive any 'must do' improvement actions. The CQC did note some actions that the Trust could take to further improve services so an action plan was developed in partnership with clinical and management teams.

We are delighted with this outcome which demonstrates the excellent care and treatment we deliver to our patients.

The CQC full inspection report can be found at http://www.cqc.org.uk/provider/RBV

7.2 NHS Improvement

From 1 April 2016 NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority.

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers of NHS-funded care. Their role is to offer support to providers to ensure they give patients consistently safe, high quality and compassionate care within local health systems that are financially sustainable.

On 1st October 2016 a Single Oversight Framework, designed to help NHS providers attain and maintain Care Quality Commission (CQC) ratings of 'good' or 'outstanding', was launched and replaces the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority's 'Accountability Framework'.

The Framework will help identify NHS providers' potential support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Individual trusts will be segmented according to the level of support they need. There are 4 segments:

Segment	Description
1	**Providers with maximum autonomy** − no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** − the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Our current performance is rated as 1.

7.3 Internal audit reports

Internal audit reports conducted on behalf of the quality assurance committee were received during the year as follows:

Internal audit report	Meeting issued	Audit assurance
Review of preparedness for nurse revalidation	24th June 2016	High
Friends & family test	24th June 2016	Significant
Medicines management (outreach) peripheral sites	24th June 2016	Significant
Medical devices	26th January 2017	Significant
Quality spot check - Radiology	30th March 2017	Significant
Quality spot check – Ward 11	30th March 2017	Significant
Duty of Candour	30th March 2017	Significant

Any recommendations are captured in an action plan and implemented as required. There were no limited assurance reports assigned to the Quality Assurance Committee during 2016/17.

7.4 Governance reports

During 2016 the committee received the following annual reports:

- Health, Safety and Security annual report 2015/16 (there is a legal requirement to present this report annually)
- Equality and Diversity annual report 2015/16
- Clinical audit annual report 2015/16
- Learning from complaints 2015/16
- Safeguarding vulnerable people annual report 2015/16

There were no issues of concern raised in any of the reports.

7.5 Risk management

In line with the risk management strategy the committee seeks to provide assurance that risk management processes are embedded and well managed. This is achieved via scrutiny of the key risks reports within the performance report provided to the board of directors and through an overview of the work of the risk and quality governance committee.

The information provided in these reports has enabled the committee to provide assurance to the board of directors that there are effective systems of internal control in place with regard to clinical and research governance and risk management.

7.6 Improvement

During the year the committee received presentations on the following:

- The Christie CODE accreditation process
- Clinical audit presentation: To allow a natural death / DNAR
- Review of inpatient deaths
- Review of management of pressure ulcers & patient falls
- Infection control
- Clinical Research effectiveness
- Educational Effectiveness (coming in March)
- Sepsis

7.7 Board assurance framework

The Board Assurance Framework (BAF) focuses on the key risks for the organisation. The BAF is a 'live' document which is continuously reviewed and updated.

The quality assurance committee reviewed the BAF at each of its meetings and received updates from the company secretary (document owner). The committee has assured itself that the process undertaken to populate the BAF is appropriate in that the necessary directors and managers have been involved and take responsibility for their entries and that there are no major omissions from the list of controls.

The quality assurance committee is satisfied that the system of risk management in the organisation is adequate in identifying risks. The committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the committee's attention) that have not been adequately resolved.

Internal audit has provided their opinion on the board assurance framework and have determined that the Trust is green in all aspects of their review and that the Assurance Framework is an integral part of the Trust's governance framework and clearly linked to the board agenda.

7.8 Review of committee effectiveness

In line with its terms of reference the committee undertook a self-assessment exercise during 2016.

The overall results were extremely positive and showed good progress for the committee although there were areas identified which were felt could be improved. It was therefore proposed that the agenda for the committee be redesigned to clarify the structure and purpose of the discussion which would help to give sufficient time to agenda items. A 6th non-executive director was appointed and he became a member of this committee. This will ensure better and consistent non-executive director presence at the meetings.

8. Annual Governance Statement

The Annual Governance Statement for 2016/17 was considered and approval at a joint meeting of the audit and quality assurance committees on 24th May 2017.

9. Quality Accounts

The Trust received an unqualified audit opinion (the best outcome) for its quality report, which was published as part of the annual report and accounts for 2016/17. This included data covering patient satisfaction surveys, complaints, waiting times, clinical audits, 1 and 5 year survival rates, SUIs and infection rates, as well as performance against national targets and goals agreed locally with commissioners.

10. Reviewing legality of actions

The committee has not received any reports of any enforcement activity by any relevant regulators in relation to the Trust's activities.

11. Priorities for 2017/18

1. Maintain registration with the CQC and full compliance with CQC essential standards of quality and safety, along with all other regulatory requirements.
2. Ensure that the Trust meets all quality related requirements of the Single Oversight Framework for 2017/18 and to bi-annually review the risk against the Quality Framework.
3. Ensure continuing audit and evidence of high standards of patient care and patient experience, monitor patient safety information and patient harm rates.
4. Monitor and support the ongoing development and presentation of clinical effectiveness data to ensure The Christie is delivering the best possible cancer care to its patients.
5. Ensure that the clinical audit programme is appropriate, adequately resourced and aligned with the strategic objectives of the Trust. Clinical Audit to attend every meeting of this committee to ensure clinical effectiveness.
6. Continue to provide high standards of cleanliness and effective HCAI management and compliance with the Hygiene Code.
7. Oversee the publication of the annual Quality Accounts.
8. To agree quality priorities for internal audit with a focus on complaints management which have been agreed with the quality assurance committee.
9. To be the lead committee for overseeing and reviewing the Trust's outcomes of the new national mortality process.
10. To monitor the changes in the NHSLA requirements from Risk Management Standards to learning from claims.
11. To receive the annual monitoring report of the raising concerns policy.
12. To address issues raised through the committee effectiveness review.

Professor Kieran Walshe
Chair of the Quality Assurance Committee
31st March 2017