NHS
The Christie
NHS Foundation Trust

Agenda item 10/20d

Quality Assurance Committee Annual Report
April 2019 – March 2020

1. Introduction

The role of the quality assurance committee is to provide assurance to the board that The Christie is properly governed and well managed across a full range of activities and to provide assurance relating to quality by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control.

The purpose of the quality assurance committee annual report is to review the work of the committee in the period from 1st April 2019 to 31st March 2020 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 at its 27th June 2019 meeting. There were no suggested updates so the committee terms of reference were approved.

The quality assurance committee was chaired throughout the year by Professor Kieran Walshe, non-executive director. The other members of the committee are Christine Outram, Jane Maher and Tarun Kapur. The committee is also attended by the chief nurse & executive director of quality and one of the executive medical directors. Other directors and other officers are also invited to attend, particularly when the committee is discussing an issue that is the responsibility of that director or officer. During the year Jackie Bird, chief nurse & executive director of quality, left the organisation to take up a post elsewhere; Julie Gray took over as chief nurse on an interim basis.

3. Meetings

During 2019/20 five meetings were held: 27th June, 26th September, 28th November 2019, 30th January and 26th March 2020. In addition a joint meeting of the audit and quality assurance committees was held on 23rd May 2019.

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	5	1
Tarun Kapur	5	1

5. Relationship to other Committees

The quality assurance 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. In broad terms the quality assurance committee is responsible for ensuring that assurance is provided for clinical & research governance and risk management.

6. Achievement of the identified priorities

The list below forms the basis of the committee's programme during 2019/20:

1. Maintain registration with the CQC and full compliance with CQC fundamental standards along with all other regulatory requirements
2. Be prepared for the unannounced and Well led CQC inspections

3. Ensure that the Trust meets all quality related requirements of the Single Oversight Framework for 2019/20 and to bi-annually review the risk against the Quality Framework.
4. Ensure continuing quality audits and evidence of high standards of patient care and patient experience, monitor patient safety information and patient harm rates
5. 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
6. Ensure that the clinical audit programme is appropriate, adequately resourced and aligned with the strategic objectives of the Trust.
7. Continue to provide high standards of cleanliness and effective HCAI management and compliance with the Hygiene Code
8. Oversee the publication of the annual Quality Accounts
9. To agree quality priorities for internal audit
10. To be the lead committee for overseeing and reviewing the Trust's outcomes of the new national mortality process
11. To monitor the learning from claims
12. To receive the annual monitoring report of the raising concerns policy
13. To address issues raised through the committee effectiveness review

All the identified priorities 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 action plan rolling programme. Any actions arising from meetings are recorded on the rolling programme. This document is used to plan, record and monitor the work of the committee.

Throughout the year the committee has received a range of information in accordance with the rolling programme.

7.1 Care Quality Commission (CQC)

An Outstanding rating was first awarded to the Trust by the CQC following their inspection in 2016. The CQC again rated us as outstanding in 2018 when we became the first specialist trust in the country to be given their highest accolade twice. The CQC singled out the positive culture within the Trust with the CQC finding it to be 'extremely positive' with 'compassionate and effective' leadership, together with 'high levels of engagement with staff and service users.'

It should be noted that, notwithstanding these fantastic results, it is the culture of the organisation to pursue innovations that deliver even better outcomes for patients. The quality assurance committee continues to monitor any areas which could be improved.

7.2 NHS Improvement (NHSI)

NHSI 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.

The Single Oversight Framework, designed to help NHS providers attain and maintain Care Quality Commission (CQC) ratings of 'good' or 'outstanding', helps to identify potential support needs across five themes:

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

- leadership and improvement capability

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

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 segment 1.

7.3 Internal audit reports

In November 2018 MIAA advised the committee that they had changed the way in which they report their audit opinion. Significant assurance has now been broken down into two categories to ensure consistency:

- Substantial (there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently).
- Moderate (there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk).

The following internal audit reports, conducted on behalf of the quality assurance committee, were received during the year:

Internal audit report	Meeting issued	Audit assurance	Recommendations
Quality spot checks	26.9.19	Limited	2 high, 3 medium and 1 low

There was one limited assurance report assigned to the Quality Assurance Committee during 2019/20. This related to a quality spot check which encompassed 3 wards. There were many areas of good practice noted across all 3 areas which included being effective in creating a good patient culture and the ability of staff to speak up. The limited assurance outcome was due to 2 high level recommendations on the IPU. These were addressed quickly and all recommendations have now been actioned.

The internal auditors also tested and reported on the findings of a review of the trust's quality account indicators. The three indicators tested were:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
- Complaints.

MIAA found that the data used to formulate the performance figures was accurate, valid, timely, reliable, relevant and complete.

Work in Progress
The following pieces of work are in progress and / or planned and will be reported to the Quality Assurance Committee following completion

- NatSSIPs & LocSSIPS
- Well Led / Committee Effectiveness
- CSSS Governance Arrangements
- Patient & Public Engagement
- Incident Management

7.4 Governance reports
During 2019-20 the committee received and reviewed the following annual reports:

- Health, safety & security annual report 2018/19
- Equality and diversity annual report 2018/19
- Infection prevention and control annual report 2018/19
- Clinical audit and improvement annual report 2018/19
- Safeguarding vulnerable people annual report 2018/19
- Learning from complaints annual report 2018/19

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 clinical and quality improvement presentations on the following topics:

- 7 day services
- Cancer waiting times (June & September 2019 and January 2020)
- Consent practice / audit
- Pharmacy waiting times

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, the 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 provided an Assurance Framework Opinion statement which confirmed the Assurance Framework is structured to meet NHS requirements, is visibly used by the Board of Directors and clearly reflects the risks discussed by the Board.

7.8 Review of committee effectiveness

During 2019/20 members of the Quality Assurance Committee were asked to complete a self-assessment questionnaire that asked 23 questions, each of which was given the status of:

1. Hardly ever / Poor	2. Occasionally / Below average	3. Some of the time / Average	4. Most of the time / Above average	5. All of the time / Fully satisfactory

There were 4 answers which indicated the committee was only effective 'some of the time / average'. These were:

1. Concise, relevant & timely information (1)
2. Meetings held sufficiently far in advance of board meetings (1)
3. Attendance & contribution at meetings (1)
4. On-going personal development to remain up to date (1)

With the exception of the above comments and the unanswered / not applicable questions, all other responses recorded the committee as being effective either 'most of the time / above average' or 'all of the time / fully satisfactory'.

The positive answers accounted for 93.7% of answers.

The overall results were extremely positive and showed a slight improvement on the previous year.

8. Annual Governance Statement

The Annual Governance Statement for 2019/20 will be considered at a joint meeting of the audit and quality assurance committees on 21st May 2020 and approved in June.

9. Quality Accounts

As a result of the COVID-19 pandemic, there is no requirement for foundation trusts to prepare a quality account and publish it as part of the annual report and accounts for 2019/20 or to commission external assurance on its quality report for 19/20. We have produced the quality report as usual and intend to submit the report without auditor opinion. This includes data covering patient satisfaction surveys, complaints, waiting times, clinical audits, 1 and 5 year survival rates, serious Incidents and infection rates, as well as performance against national targets and goals agreed locally with commissioners. Where data is missing from the last weeks of the financial year due to the outbreak, this has been noted.

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 2020/21

- Maintain registration with the CQC and full compliance with CQC fundamental standards along with all other regulatory requirements
- Be prepared for the unannounced and Well led CQC inspections should they take place
- Ensure that the Trust meets all quality related requirements of the Single Oversight Framework for 2020/21 and to bi-annually review the risk against the Quality Framework.

- Ensure continuing quality audits and evidence of high standards of patient care and patient experience, monitor patient safety information and patient harm rates
- 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
- Ensure that the clinical audit programme is appropriate, adequately resourced and aligned with the strategic objectives of the Trust.
- Continue to provide high standards of cleanliness and effective HCAI management and compliance with the Hygiene Code
- Oversee the publication of the annual Quality Accounts
- To agree quality priorities for internal audit
- To be the lead committee for overseeing and reviewing the Trust's outcomes of the new national mortality process
- To monitor the learning from claims
- To receive the annual monitoring report of the raising concerns policy
- To address issues raised through the committee effectiveness review

Professor Kieran Walshe
Chair of the Quality Assurance Committee
31st March 2020