Quality & Risk Assurance Committee
SELF ASSESSMENT CHECKLIST – 2021/22

Ref	Issue	Yes/No	Supporting evidence
GENERAL GOVERNANCE			
1.	Does the Committee have recent written terms of reference that define the Committee's role?	Yes	
2.	Have the terms of reference been adopted by the Board?	Yes	Last adopted April 2021 and on agenda for March 2021.
3.	Are the terms of reference reviewed annually to take into account recent good practice developments and the remit of other committees within the Trust?	Yes	Reviewed and approved March 2021. Revisions agreed in year and on agenda Feb 2022.
4.	Has the Committee established a plan for the conduct of its own work across the year?	Yes	The Committee has agreed a forward plan for Committee meetings.
5.	Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively?	Yes	See Committee membership section of Terms of Reference (ToR).
6.	Are changes to the Committee's current and future workload discussed and approved at Board level?	Yes	Workload reviewed over the course of the year in the context of the operational response to COVID19. Approach agreed by the Board and Committee Chair/Lead ED (such as PIPR 'light'/Dec 21 stepped down). Papers amended to ensure that cover papers provided for reports with key issues/ highlights and use of supporting reference packs. This allows the committee to focus on key issues Management and timing of workforce matters considered at Committee and Board with amendments to ToR and agenda.
7.	Does the Committee report regularly to the Board?	Yes	Yes at each Board meeting through Chair's report and Minutes.
8.	Are members, particularly those new to the Committee, provided with training?	Yes	NED members have had familiarisation sessions with Trust leads. Governor induction covers core oversight/ duties.
9.	Does the Board ensure that members have sufficient knowledge of the organisation to identify key risk areas and to challenge both line management on critical and sensitive matters?	Yes	Selection process for NEDs includes assessment of appropriate experience/skills and NEDs are appointed to contribute to their individual portfolios. Three NED members have recent/ current clinical backgrounds and one has a background in the public understanding of risk. The Board learning together programme was established to ensure there is development of

			knowledge across a broad range of areas including IG & Cyber, BAF, safeguarding and whistleblowing however this has been largely suspended since 2020. The NED Buddy programme builds on knowledge of the organisation. Clinical Directors & other staff are invited to attend/present on particular areas. All NEDs invited to join divisional presentations at Performance Committee. *NEDs have accessed external training/development sessions attended: Risk Management; NED Induction (2020/21)*
10.	Does at least one Committee member have a recent and relevant clinical/medical background?	Yes	Three NED members have recent and relevant clinical backgrounds and one has a background in the public understanding of risk. See also Committee membership section of ToR.
11.	Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	Yes	Provided to Board through the annual Quality Accounts.
12.	Does the Committee receive the right information to enable it to undertake its role?	Yes	See agendas and papers – these have been developed in year to reduce the volume of reports in the main Committee pack, supported by reference packs.
13.	Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	Reports from QRMG and Committee members. Changes in NHSI Policy relating to Workforce and Patient Safety are brought to the Committee e.g. Safer Staffing We also self-assess against national guidance and principles.
14	Has the Committee reviewed whether the reports it receives from sub-groups and executives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes	The Committee receives regular & timely reports from subgroups. Format of reporting from QMRG updated in year. Forward plan sets out agreed reporting timelines for sub-groups & committees.
15.	Is the Committee's role in the review of the risk management policy and process clearly defined?	Yes	DN433 BAF Policy and DN139 Risk Management Strategy set out the role and process. DN139 was last reviewed by the Committee in December 2020 and is due for

			review in April 2022. DN433 reviewed in January 2022, and final revisions were agreed through the Board risk workshop in March 2022.
16.	Does the Committee annually review the relevant policies of the Trust?	Yes	Policies reviewed as required – this may not always be annual
17.	Does the committee have sufficient capacity and information to maintain a clear oversight of quality improvement?	Yes	See membership and reports received by Committee. However, QI has been on QA priorities for two years with limited progress. We need to consider a programme approach to ensure governance oversight.
18.	Are papers circulated in good time and are minutes received as soon as possible after the meetings?	Yes	
19.	Does the Committee meet the appropriate number of times to deal with planned matters?	Yes	The Committee meets on a monthly basis.
20.	Does the committee direct the work appropriately of and receive reports from its sub-groups?	Yes	Considered by the committee and confirmed that reporting was acceptable.
21.	Has the Committee considered the costs that it incurs: and are the costs appropriate to the perceived risks and the benefits?	No	Committee to confirm if there is a need for action. In general terms there is no direct cost associated with agenda items however the committee are aware of where resource may be required and action taken as a consequence e.g. M.Abscessus & CCU plans.
22.	Does the Committee assess its own effectiveness periodically?	Yes	Becoming more curious in questioning effectiveness for example in safer staffing reporting has been reviewed to ensure that we have a triangulated approach that assesses patient outcomes, adherence to policy and professional judgement. This would also be seen in workforce measures in relation to the annual staff survey (measurement in relation to EDI, FTSU).
23.	Does the Annual Report and Accounts of the Trust include a description of the Committee's establishment and activities?	Yes	Set out in the Annual Governance Statement.

TERMS OF REFERENCE			
24.	Has the Committee ensured that all statutory elements of clinical governance are adhered to within the Trust?	Yes	Our evidence: CQC outstanding across Quality & Safety and Caring domains. Our own internal self-assessment against KLOE on an ongoing basis

25.	Has the Committee contributed to Trust-wide clinical and non-financial governance priorities?	Yes	QA Priorities and prioritisation of Workforce and EDI agenda.
26.	Has the Committee approved the Trust's Quality Account before submission to the Board?	Yes	2020/21 QA review and approved prior to Board approval and 2021/22 review is scheduled.
27.	Has the Committee reviewed the terms of reference and membership of its reporting sub-committees and receive reports from them?	Yes	Terms of reference are reviewed at Committee and reporting in place.
28.	Has the Committee considered matters referred to it by the Board?	Yes	Examples: Oversight of M. Abscessus review process. Review of Trust plans for responding to COVID19 Trust plans for optimizing capacity in critical care
29.	Has the Committee considered matters referred to it by its sub- committees?	Yes	Examples: VTE compliance issue raised via QRMG Royal Papworth School from ESG CRR reporting raised via QRMG Workforce and CCL
30.	Has the Committee received and approved the annual Clinical Audit Programme ensuring that it is approved by Board consistent with the audit needs of the Trust?	Yes	Clinical Audit summary included in Annual Report.
31.	Has the Committee overseen the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998?	Yes	
32.	Has the Committee made recommendations to the Audit Committee concerning the annual programme of Internal Audit work, to the extent that it applies to matters within these Terms of Reference?	Yes	Two internal Audits undertaken on Risk Maturity & Quality Governance. Chair of Q&R on Audit Committee to support link across committee agendas.
33.	Has the Committee reviewed and approved relevant policies and procedures?	Yes	
34.	Has the Committee fostered links with patient representative groups and other stakeholders?	Yes	Chair of PPI a Member Chair of PCEG a Member

35.	Has the Committee maintained an overview of responsibility for the following outcomes as described by the Care Quality Commission?: Outcome 1 – respecting and involving and Outcome 7 – safeguarding people.	Yes	
36.	Has the Committee ensured that quality and risk standards are set and monitored?	Yes	Review of PIPR KPIs
37.	Has the Committee promoted within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern and monitoring the implementation of that policy?	Yes	QRMG papers and minutes include evidence of reporting; Board receives FTSU and Guardians reports. We have expanded FTSU roles this year. Increased focus on workforce reporting from CCL programme and EDI/staff survey.
38.	Has the Committee overseen the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust?	Yes	Registration and regulatory requirements have been complied with.
39.	Has the Committee monitored the Trust's compliance with those licensing standards of the Care Quality Commission that are relevant to Committee's area of responsibility, in order to provide relevant assurance to the Board so that the Board may approve the Trust's annual Declaration of Compliance?	Yes	
40.	Has the Committee ensured that risks to patients are minimised through the application of a comprehensive risk management strategy and system including, the Risk Management Strategy, BAF and Corporate Risk Register?	Yes	Risk Management Strategy and system in place. CRR and BAF reporting in place. CRR 'star chamber' put in place in response to reporting showing overdue assessments. Action plans in place to address recommendations from internal audits on Risk Maturity & Quality Governance.
41.	Has the Committee agreed the annual patient experience goals and monitored progress?	Yes	Patient experience goals & monitoring set out in Quality Accounts. Patient Experience Strategy (January 2021 review - deferred) agreed and monitoring of Friends and Family scores in place.
42.	Has the Committee sought and received assurance that the Trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected?	Yes	Patient stories are received at Board along with feedback from patient surveys and FFT. Areas for improvement are identified and action put in place to address issues identified. We also use patient complaints and have introduced local resolution meetings

43.	Has the Committee identified areas for improvement in respect of incident themes and complaint themes from the results of local surveys, national patient survey / PALS and ensure appropriate action is taken?	Yes	Regular reporting on actions on complaints through the Quality and Risk Reports. Reports have been revised following discussion at Committee to improve clarity.
44.	Has the Committee sought and received assurance in respect of the efficient and effective use of resources through evidence-based clinical practice?	Yes	Reports received setting out external assessment through ICNARC, GIRFT and NICE & we apply relevant guidance & assessments. Paper Health Inequalities. SN presentation of Euroscore.

Additional comments to Anna Jarvis, Trust Secretary, anna.jarvis4@nhs.net

Royal Papworth Hospital
NHS Foundation Trust

Quality & Risk Committee – Summary Self-Assessment February 2021

Establishment, Composition, Organisation, Resources, Duties		Strong	Adequate	Needs Improvement	Comments
1	The Q&R Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities and have been approved by the Committee and the Board of Directors.	X			*Review details are as set out above.*
2	The Board was active in its consideration of the Q&R Committee composition.	X			
3	The Q&R Committee's actions reflect independence, ethical behavior, adherence to good practice guidance and the best interests of the Trust and its stakeholders.	X			
4	The Q&R Committee reports to the Board of Directors throughout the year demonstrating compliance with its terms of reference and provides the Board of Directors with assurance on the effective operation of systems and procedures within the remit of the Committee.	X			

Establishment, Composition, Organisation, Resources, Duties		Yes	No	Comments
5	Are the terms of reference reviewed annually to take into account governance developments and the remit of other Committees within the organisation?	X		
6	Are changes to the Committee's current and future workload discussed and approved at Board level?	X		The Committee agreed that the changes made over the past year, including the new workforce reporting, and improvement in reporting on Quality was working well and had given clarity as to accountability between the Q&R and the Performance Committee.
7	Are Committee members able to act in the best interests of the Trust?	X		

Agenda Management, Oversight of the Reporting Process, Compliance with the Law and Regulations governing foundation trusts		Yes	No	Comments
8	Is the Committee's role clearly defined and complementary to the Board of Directors?	X		
9	Does the Board of Directors ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and/or sensitive matters?	X		

Oversight of Trust Processes		Strong	Adequate	Needs Improvement	Comments
10	There is appropriate consideration of assurance reports (from a variety of sources). The Board of Directors is clearly sighted on the issues that arise which require action by the Quality & Risk Committee.	X			The Committee acknowledged that due to the pandemic some elements of reporting and assurance had suffered, for example quality improvement, and agreed a focus for 2022/23 would be to regain momentum and return to detailed scrutiny of business as usual. The noted the importance of understanding methodology and discussed the example of work already undertaken, including closing the loop around SIs.

Overall Evaluation		Strong	Adequate	Needs Improvement	Comments
11	What is the overall assessment of the performance of the Quality & Risk Committee?	X			

Additional Comments:

Discussion of the Committee's focus in 2021/22 noted that the selection and setting of Quality Account priorities and their review should be given greater consideration and that discussion to inform 2022/23 priorities would be scheduled in the Autumn. This was brought forward to the Committee as planned.

Oversight of the workforce agenda by Q&R: The Board considered setting up a separate Committee, but this was not supported, and the management of this agenda is to be

monitored to ensure that this can be given sufficient priority given the size of this work programme.

Areas for Committee focus for 2022/23:

The Committee noted that one of its roles was to gain reassurance that the Trust had not only to look at its own performance carefully but to benchmark this to ensure that current practices were as high quality and effective as they should be.

The Committee reiterated the importance of ensuring clearer mapping of the full range of quality and audit initiatives to ensure that the Committee could identify gaps and track progress.