Quality & Risk Assurance Committee - Item 7.2.1
SELF ASSESSMENT CHECKLIST – 2018/19

Ref	Issue	Yes/N	Supporting evidence
GENERAL GOVERNANCE			
1.	Does the Committee have recent written terms of reference that define the Committee's role?	Yes	Approved November 2019
2.	Have the terms of reference been adopted by the Board?	Yes	Last adopted January 2020
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 January 2019, and November 2019
4.	Has the Committee established a plan for the conduct of its own work across the year?		Draft Forward Planner attached
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). Committee action: to consider need for additional NED members.
6.	Are changes to the Committee's current and future workload discussed and approved at Board level?	Yes	This has been discussed in year with review of meeting frequency and agenda.
7.	Does the Committee report regularly to the Board?	Yes	Yes 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 and have taken part in the CQC mock inspection which was informative.
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 through individual portfolios. The Board has established a regular learning together programme to ensure there is development of knowledge across a broad range of areas including BAF, safeguarding and whistleblowing. The NED Buddy programme builds on knowledge of the organisation. Clinical Directors & other staff invited to attend/present on particular areas.
10.	Does at least one Committee member have a recent and relevant clinical/medical background?	Yes	See 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
13.	Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	Reports from QRMG and Members
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 reports from subgroups. The scheduling of these will be added to the forward planner. The Committee discussed reporting between Q&R and QRMG as there are Committees that formally report to Q&R whose minutes would also be received for review and dissemination thorough QRMG.
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 and have been reviewed in year.
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.
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 meeting frequency has been increased to a monthly cycle.
20.	Does the committee direct the work appropriately of and receive reports from its sub-groups?	Yes	The arrangements supporting this this will be given some additional scrutiny in this year.
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.
22.	Does the Committee assess its own effectiveness periodically?	Yes	This assessment
23.	Does the Annual Report and Accounts of the Trust include a description of the Committee's establishment and activities?	Yes	Reference to in AGS. Action: Committee to consider if additional wording required

TERMS OF REFERENCE			
24.	Has the Committee ensured that all statutory elements of clinical governance are adhered to within the Trust?	Yes	
25.	Has the Committee contributed to Trust-wide clinical and non-financial governance priorities?	Yes	
26.	Has the Committee approved the Trust's Quality Account before submission to the Board?	Yes	2018/19 QA approved in April 2019 and 2019/20 QA review 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 reviewed and reporting in place.
28.	Has the Committee considered matters referred to it by the Board?	Yes	Examples: Radiology Review; Heater Cooler resolution; Management of risk for patients waiting.
29.	Has the Committee considered matters referred to it by its sub- committees?	Yes	Scheduling issues;
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	
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	JR/RH action for Committee
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.*
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. Assurance system reviewed through the internal audit programme and rating of substantial assurance
41.	Has the Committee agreed the annual patient experience goals and monitored progress?	Yes	Patient Experience Strategy agreed and monitoring of Friends and Family scores.
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 each month along with feedback from patient surveys and FFT. Areas for improvement are identified and action put in place to address issues identified.
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
44.	Has the Committee sought and received assurance in respect of the efficient and effective use of resources through evidence- based clinical practice?	Yes	

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