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This Document Supports: *standards and legislation – include exact details of any CQC*	Annual Governance Statement CQC National Standards
Key Associated Documents:	NHS Audit Committee Handbook 2024 DN142 Standing Orders DN140 Standing Financial Instructions DN137 Scheme of Delegation Audit Committee Term of Reference
Keywords	Internal Control, Annual Accounts, Assurance, Fraud, Bribery, Internal Audit, External Audit, Q&R Committee, Quality, Risk
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Key points of this document

- Terms of Reference for a Committee of the Board of Directors

Version Control table

Date Ratified	Version Number	Status
02/05/2024	13	Approved
27/03/2025	14	Q&R Committee

1 Authority:

1.1 The Quality and Risk Committee is a Committee of the Board of Directors.

2 Purpose:

2.1 Provide Assurance to the Board there is an effective structure, process and system of control for:

- Clinical Governance (including Board compliance statements on Care Quality Commission, Quality Strategy and Quality Governance)
- Research Governance
- Information Governance
- Non-Financial Resource Governance
- Clinical and Non-clinical Risk Management
- Quality Reporting to support assurance for the annual Quality Report
- Data Quality
- Board Assurance Framework to support the clinical/quality statements in the Annual Governance Statement.
- Health & Safety Committee
- Ethics Committee
- Health inequalities
- Receive annual reports according to cycle of business

2.2 The Committee will provide assurance to the Board that there is an effective structure, process and system of management of workforce matters in as far as these effect the delivery of the duties of the Committee:

2.3 Work with Internal Auditors to deliver Assurance.

2.4 Informing the Audit Committee and/or Board of Directors of any risks relating to the Committee's areas of responsibility.

3 Delegated Authority:

3.1 The Quality and Risk Committee is authorised by the Board of Directors to undertake any activity within its terms of reference, and to seek any information it requires from staff, who are requested to co-operate with the Committee in the conduct of its enquiries.

3.2 The Quality and Risk Management Group reports to this Committee. Other reporting committees are set out in the Trust Governance Structure.

3.3 The Quality and Risk Committee advises the Audit Committee of concerns as relevant to the Annual Governance Statement.

4 Duties:

4.1 Monitor and review performance in the three domains of Quality (Patient Safety, Patient Experience and Effectiveness of Care), as well as Innovation and Risk Management in these areas.

4.2 To oversee the arrangements that are in place to manage Health & Safety and ensure there are effective system of control to prevent accidents and ill-health and to promote positive health and wellbeing promotion for patients and the general public (The Workforce Committee will oversee arrangements relating to our staff).

4.3 Monitor and review the Board Assurance Framework (BAF) and action those areas that fall within the remit of the Committee.

4.4 To approve policies on behalf of the Board of Directors.

4.5 To receive draft strategies before being presented to the Board of Directors.

4.6 To approve the annual Clinical Audit programme.

4.7 To receive regular reports on the action being taken to remove or mitigate the principal risks on the Corporate Risk Register that fall within the remit of the Committee, and review and approve updates, monitor controls and examine assurance sources.

4.8 To receive regular reports on the metrics comprising the Quality Accounts.

4.9 To co-ordinate and oversee the work of the Quality and Risk Management Group.

4.10 To receive the Bi-annual ~~quarterly~~ Quality & Safety Report.

4.11 Review information governance processes and assurance and receive reports from the Senior Information Risk Officer (SIRO) and Caldicott Guardian.

4.12 To review reports on data quality

4.13 Internal Assurance
The Committee will receive internal assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control, in relation to:

(a) annual reports and development plans relating to e.g. research governance, clinical governance, clinical audit, infection control, safeguarding, end of life care and complaints

(b) internal risk management arrangements incorporating the risk register and assurance framework for areas within the Committee's remit
the work plan and delivery of the Quality and Risk Management Group

(c) ~~serious incident reports (SIs~~Patient safety incident investigations (PSII)~~) and investigations~~

(d) progress reports against clinical indicators

(e) Department of Health submissions and reports

(f) ICT Information Governance

(g) Tthe work-plan and delivery of the Fundamentals of Care Board including the programme ~~of mock inspection programme~~of ward/department accreditation of ~~the CQC~~ Fundamental Standards.

(h) Receive updates on CQC preparedness including ward and department ~~self assessment~~self-assessment reports and action plans.

(i) In carrying out this function the Committee may request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the organisation, as they may be appropriate to the overall arrangements.

External assurance

4.16 The Committee will receive external assurance from:

(a) Department of Health (DoH) arms' length bodies or regulators/inspectors (e.g. Care Quality Commission, the Regulator, NHS resolution), professional bodies with responsibility for the performance of staff or functions (eg royal colleges, accreditation bodies).

(b) Care Quality Commission - reports relevant to Royal Papworth.

(c) statements from internal or external audit opinion relating to matters that fall within the Committee's remit.

(d) compliance with national quality imperatives including National Service Framework requirements and Learning From Patient Safety Incidents (LFPSE) and Patient Safety Incident Response Framework (PSIRF) ~~National Patient Safety Agency reporting.~~

(e) compliance with relevant regulatory, legal and code of conduct requirements relating to matters that fall within the Committee's remit.

(f) The output of peer review visits and reports.

5 Membership/Quorum:

Voting Membership

5.1 The Chair and members of the Quality and Risk Committee shall be appointed by the Board of Directors.

5.2 The Committee shall be made up of at least three Non-executive Directors

Chair: A nominated Non-executive Director
At least two further nominated Non-executive Directors

Chief Executive Officer
Deputy Chief Executive
Medical Director
Chief Nurse
Director of Workforce and Organisational Development
Chair of Quality and Risk Management Group (QRMG) –
Associate Medical Director for Clinical Governance
~~Clinical Lead for Risk Management~~
Deputy~~Assistant~~ Director of Quality and Risk

Quorum

5.3 The Committee shall be deemed quorate if there is representation of a minimum 3 members, including two Non-executive Directors and one Executive Director.

Membership Attendance Requirements

5.4 The Committee will be required to have an overall attendance level of 50% from members in a rolling twelve month period.

5.5 In accordance with the Code of Governance for NHS Providers attendance will be recorded during the year and reported in the Annual Report and Accounts.

5.6 In Attendance
The following will normally be in attendance:
Associate Director of Corporate Governance
2 Governors

Other Executive Directors will be expected to attend when agenda items require.

An Internal audit representative may be invited attend, specifically as per agenda items.

Other Directors or officers may be invited to attend at the discretion of the Chair or the Lead Executive Director particularly when the Committee is discussing an issue that is the responsibility of that Director or officer.

5.7 A full set of agenda papers will also be sent to the Chairman, Chief Finance Officer, Chief Operating Officer and Chief Information Officer. NEDs to receive full set of papers on request.

6 Meetings:

6.1 In the event of the Chair of the Committee being unable to attend, the remaining members shall elect one of their members as Chair for the meeting.

6.2 The Committee shall be supported administratively by a member of the Trust's staff.

6.3 The Committee will meet on a monthly basis.

6.4 Agendas and briefing papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

7 Conduct of Business:

7.1 The conduct of business will conform to guidance set out in the Board of Directors' Standing Orders, unless alternative arrangements are defined in these Terms of Reference.

8 Equality Statement:

The Committee will ensure that these terms of reference are applied in a fair and reasonable manner that does not discriminate on such grounds as race, gender, disability, sexual orientation, age, religion or belief.

9 Monitoring:

9.1 Minutes of Committee meetings should be formally recorded and distributed to Committee members and Attendees. Subject to the approval of the Chair, the minutes will be submitted to the Board of Directors at its next meeting and may be presented by the Committee Chair/Committee Member/Executive Lead.

The Chair of the Committee or Executive Lead shall draw to the attention of the Audit Committee or Board of Directors any issues that require disclosure to the full Board of Directors, or require executive action.

9.2 All Board Committees and the Audit Committee have a shared responsibility to provide assurances to the Board of Directors. As such, all Board Committees need to work collaboratively, to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances on Royal Papworth Hospital's business and activities.

9.3 Where deficiencies in reporting arrangements are identified the Board of Directors will seek assurance from the Audit Committee that recommendations have been implemented.

Monitoring Table

What key element(s) need(s) monitoring as per local approved policy/ procedure or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others.	What tool will be used to monitor/check/ observe/assess/ inspect/ authenticate that everything is working according to this key element from the approved policy/ procedure?	How often is the need to monitor each element? How often is the need complete a report? How often is the need to share the report?	Who or what committee will the completed report goes to. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?	How will system or practice changes be implemented the lessons learned and how will these be shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
All	Chief Finance & ~~Commercial~~ Officer (CF~~C~~O) Associate Director of Corporate Governance	N/A	Annually	Audit Committee	Audit Committee	Any changes in practice and lessons shall be shared with the relevant internal stakeholders

Rapid Equality Impact Assessment Tool

When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:
In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

EQUALITY IMPACT ASSESSMENT – WHAT IS THE IMPACT TO DIFFERENT GROUPS IN SOCIETY?		
If you believe there has been No impact or a Positive impact, please choose Yes for Negative impact please choose No. Please provide supporting comments, both on positive and negative impacts. You may be asked to complete a FULL EQUALITY IMPACT ASSESSMENT to understand the impact further.		**COMMENTS**
Age: Consider and detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.	Yes	N/A
Disability: Consider and detail on attitudinal, physical and social barriers.	Yes.	N/A
Race: Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.	Yes	N/A
Sex: Consider and detail on men and women	Yes	N/A
Gender reassignment: (including transgender) Consider and detail on transgender and transsexual people. This can include issues such as privacy of data and harassment	Yes	N/A
Sexual orientation: Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people.	Yes	N/A
Religion or belief: Consider and detail on people with different religions, beliefs or no belief.	Yes	N/A
Pregnancy and maternity: Consider and detail on working arrangements, part-time working, and infant caring responsibilities.	Yes	N/A
Marriage and civil partnership status	Yes	N/A
Environment: Consider impact on transport, energy and waste	Yes	N/A
Other identified groups: Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.	Yes	N/A
Were any NEGATIVE impacts identified?	No	
If YES, you will need to complete a full Equality Impact Assessment. Please contact the Equality, Diversity and Inclusion team papworth.edi@nhs.net for the full assessment template.		N/A