Trust Board TB2008.5

From: Mrs Elaine Strachan-Hall, Director of Nursing & Clinical Leadership

Date: January 2008

Subject: **Governance, Quality and Risk Framework**[1]

For: **Decision**

Synopsis

The framework was reviewed by the Governance Committee at its meeting in December 2007 and the Committee recommended its endorsement by the Trust Board. The Committee noted the good progress made during the year and highlighted the importance of governance at all levels, particularly in linking with performance management and improvement.

Governance meetings are now being held within the Divisions and Directorates, supported by the corporate governance, quality and risk staff and reports of increasingly good quality are presented through the Divisions to the Governance Committee. The Governance Committee also reviews the Divisions' risk registers. Work has also been done on developing the structure for governance within the executive directorates and in particular all areas now have risk registers.

The Trust's risk register was developed significantly during the year and the Executive Board reviews risks (grouped into six areas) regularly, receiving updates on plans to mitigate risks from the divisions and corporate directorates. The risk register is now maintained corporately and updates are provided to the Governance Committee and the Trust Board.

The focus in the coming months will be on developing clinical audit and effectiveness, workplace risk assessments, quality metrics and to work towards achievement of NHSLA level 2.

The Trust Board is asked to review and agree the framework.

Financial, legal and risk impact

Organisations are required to review their arrangements for governance and risk regularly so that compliance with good governance (for example as expressed in standards 7a and 7c of the Standards for Better Health and within the ALE KLOE on

[1] Formerly known as the risk management strategy

internal control) can be achieved and subsequently maintained. The arrangements also reflect the need for integrated governance across all areas as outlined in the Integrated Governance Handbook. The framework has also been reviewed in the light of guidance from Monitor on appropriate governance arrangements.

Governance, quality and risk strategy framework

The Trust

1. The core activity of the Oxford Radcliffe Hospitals NHS Trust is the provision of high quality and accessible services to its patients in Oxfordshire and beyond. In addition, the ORH is a major teaching hospital working with Oxford University and Oxford Brookes University to support teaching, education and research activities. It is now one of the UK's Biomedical Research Centres in partnership with Oxford University. It has a turnover of approximately £500,000,000 and employs just under 10,000 people on its four sites. It will be seeking Foundation Trust status during 2008 and is one of the most cost efficient large trust in England.
2. The Board of the Oxford Radcliffe Hospitals NHS Trust has the following duties:
   - 2.1 The duty of quality – providing quality healthcare for patients
   - 2.2 Ensuring the safety and wellbeing of staff
   - 2.3 Working in collaborative partnership with other bodies in the NHS and in the wider community
   - 2.4 Achieving financial balance and delivering best value in their use of public resources
   - 2.5 The completion of an annual Statement of Internal Control
3. It recognises governance as the systems and processes by which the Board will lead, direct and control its functions in order to achieve organisational objectives, and relate to and work with its stakeholders. In addition, the Board recognises that risks to achievement of objectives exist and need to be identified and managed. There are a number of specific areas of governance including corporate governance, financial governance, clinical governance, research governance and information governance.
4. Integrated governance is defined as: 'Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'
5. The governance, quality and risk strategy framework sets down how all aspects of governance are to be **integrated** and how risks to the objectives of the ORH are identified and managed.

Introduction

6. A statutory duty for quality was placed on all NHS organisations in the Health Act, 1999. The framework for governance, quality and risk is the way in which Oxford Radcliffe Hospitals assures the quality of services, ensuring they are as safe as possible and continuously improving. Every member of staff has a responsibility for clinical governance and risk, and for governance generally.

7. The governance, quality and risk activities and supporting structures within the Trust have been refined over the last 12 months and two key principles have been established:

   7.1 the importance of embedding governance, quality and risk into practice,

   7.2 establishing the right structures and processes to support the activities of the Trust.

8. This framework has been established for taking governance, quality and risk forward within the ORH and and to integrate all aspects of clinical governance with other external standards (Auditors Local Evaluation [ALE] for example) and other aspects of governance. In addition, it is intended that the framework provides the means to provide evidence to support, for example, compliance with core standards, and can show how the quality of services is being developed and sustained.

9. The framework recognises the Maternity Risk Strategy as an integral part of this approach.

10. The framework was first approved in March 2007 and reviewed in December 2007.

The approach

11. Governance, quality and risk systems must be directed to give ownership to staff who provide direct care or support the delivery of care. The corporate role is to devise systems, provide education, advice and support staff carrying out the activity. Managers in the Trust will be made accountable for the governance, quality & risk performance of their area and this performance will be measured.

12. The monitoring approach to governance, quality and risk should have the rigour of any financial or performance management process, and therefore performance indicators for these activities need to be developed at each level of the organisation. This will ensure that staff and managers are aware of their responsibilities and key tasks are being performed. This will be done by establishing a range of self assessment tools and outcome targets set against national and local priorities and a process of Directorate\Divisional performance assessments. A range of statistical quality measurements (metrics) from internal and external sources such as hospital standardised mortality rates and CCAD, will be used to gauge performance and impact of quality initiatives.

Leadership and accountability

13. The Chief Executive is the Accountable Officer for the Oxford Radcliffe Hospitals NHS Trust. He is accountable for ensuring that the Trust can discharge its legal duty for all aspects of governance and quality each year, and for the health & safety of staff, visitors and contractors in the Trust. The Director of Nursing and Clinical Leadership is the executive lead for governance, risk, health & safety and patient safety. The Director of Nursing, in partnership with the Medical Director, will ensure organisational arrangements are in place that satisfy the legal requirements of the Trust for quality and continuing quality improvements for patients and staff.

14. Executive Directors and Directors of Operations are accountable for the governance, quality and risk activities in their areas of responsibility; their organisational structure must be able to discharge the requirements of the Annual Health Check (including the Standards for Better Health, new and existing national targets and ALE), National Health Service Litigation Authority standards, legislative requirements and other specific NHS standards.

15. The Assistant Director of Governance has a particular responsibility for corporate governance, including the Statement of Internal Control [SIC] and the Board Assurance Framework [BAF], and for the coordination of the annual declaration of compliance with core and developmental standards, working with Executive and Divisional Directors of Operations. The Assistant Director provides support to both the Governance and Audit Committee and to the Chief Executive, the Director of Nursing and Clinical Leadership and the Medical Director in support of their governance, quality and risk responsibilities.

16. The Assistant Director of Quality and Risk has a particular responsibility for clinical governance and risk management for both clinical and non clinical (health and safety) and clinical information. He manages the quality, risk and legal teams which liaise closely with the Division and Directorate teams to support their activities. The Assistant Director is responsible for the maintenance of the database of incidents, complaints and of the risk register, drawing on information provided by the Executive Directorates and Divisions. The Assistant Director is responsible for a number of policies supporting the quality and risk agenda, making sure that these are reviewed, updated and made available for implementation.

17. The Assistant Director of Quality and Risk is responsible for ensuring that exception reports on SUIs are included in reports to both the Executive Board and the Governance Committee and for maintenance of the Trust Risk Register.

18. All staff are responsible for their own and others' health and safety within their immediate environment and for participating in wider governance, quality & risk management issues within their department. This includes ensuring that they:

    17.1 Have access to, understand and follow all Trust policies and procedures.

    17.2 Work in a safe manner at all times having due regard to any person who might be affected by their actions.

    17.3 In addition, all staff should have clear objectives set and documented as part of their annual performance reviews.

19. The Trust Board has specific duties placed on it in relation to all aspects of governance including financial, information, research, clinical and corporate governance. In addition, it needs to integrate these aspects so that it can be assured across all of these areas. A number of Trust Board Committees with Non-executive Director chairs and members have been established to make sure that the necessary assurances can be provided to the full Board in support of its responsibilities to assure that robust systems are in place to manage governance, quality and risk. A

20. These committees are:

    20.1 The Audit Committee

    20.2 The Governance Committee

    20.3 The Commercial Committee

    20.4 The Human Resources Committee

21. In addition, the Finance and Performance Committee has a role in the performance management of the organisation, particularly in relation to finance and activity, and the Remuneration and Appointments Committee has a specific role in the appointment of the Chief Executive and other Executives.

22. The governance arrangements at Board level will be reviewed during the Foundation Trust application process to ensure that they meet the new requirements for FTs.

23. Assurance of quality and risk systems is provided by the Expert Advisory Groups (H&S, Transfusion, Infection Control and Diversity etc.). These groups will be responsible for monitoring standards and systems, developing policy and training, providing advice and problem solving for the Divisions and Directorates. Their work will be reported to the relevant Trust Board Committee by means of Annual Reports. In addition, these groups may report or highlight specific issues to the Executive Board.

24. Assurance of governance, quality and risk activity will be provided by the Divisions and Directorates on a quarterly basis and will be established through their governance, quality and risk arrangements. This means that the key role for managers at this level is not only to direct governance activity and manage risk, but also to set up monitoring systems that assures them that this activity is being carried out.

25. The Directorates and Divisional arrangements will be an integral element of the Trust's framework and form a major part of the initial performance management focus.

26. The Trust will have clearly defined systems that reflect the pillars of clinical governance; e.g. clinical effectiveness, risk management, and satisfy the related external standards, including the provision of necessary evidence, e.g. legislation and the Standards for Better Health (core and developmental). These will be reflected in the standard terms of reference and agenda for meetings which will regulate the activity within the Division\Directorate governance, quality and risk arrangements. Using standard terms of reference and a set agenda will also provide structure to allow appropriate monitoring of activity.

27. The corporate governance, quality & risk staff will support the Divisions and Directorates in achieving their responsibilities by developing systems, education

programmes and providing expert advice and support for managers and staff and a range of Boards and committees.

Committee Structure

28. To enable the Trust Board to discharge its legal duty of quality, health & safety and other legislative requirements, it must establish effective communication and monitoring processes. The day-to-day management of governance, quality and risk is the duty of the Executive Board with support from the corporate governance, quality and risk staff. The assurance of these processes and activity has been delegated to the Governance Committee, supported by information from the Directors and Divisions and a network of specialty and expert committees (see above).

29. In addition and crucially, the Trust Board can then assure itself through its regular review of, for example, the Board Assurance Framework, the Trust Risk Register and the minutes of these assurance committees, that these processes and systems are in place.

30. The Executive Board is responsible for validation and managing significant risks to the operation of the Trust, and the governance and quality issues arising from the management of the Trust's activities. Twice a year it will meet to review and validate the most significant risks across the Trust, pulling together those key risks from the risk registers in place within the Divisions and corporate directorates.

31. The Executive Board will review the key risks regularly to ensure that plans in place to reduce and mitigate risks are effective. For example, performance against key targets and standards are monitored either weekly, fortnightly or monthly, a regular updates are provided to the Trust Board on Annual Health Check compliance and performance.

32. The Governance Committee will monitor governance, quality and risk systems and activity and provide assurance to the Trust Board that it is discharging its legislative requirements for governance, quality and risk and safety across all areas. It will discharge its duty by ensuring that there is an appropriate committee structure monitoring standards and reporting progress and concerns and by receiving reports from Directors and Division on governance, quality and risk activity.[2]

33. The Directorates and Divisions will set up and maintain systems to enable the following activity to occur:

    33.1 To performance manage governance, quality and risk activity in the Division.

    33.2 To maintain compliance with the Standards for Better Health and all other elements of the Annual Health Check from the start of each financial year. This will involve the collation and collection of supporting evidence across all relevant areas.

    33.3 To report exceptions and concerns to the Executive Board.

    33.4 To manage and review the Divisional Risk register by following the ORH risk management and assessment procedure. To validate the Directorate Risk

[2] Terms of reference for all Trust Board Committees are set down in the Standing Orders

Register and receive quarterly update reports. To report any significant risks to the Executive Board.

33.5 To monitor red and orange incidents, significant complaints, claims and inquests and their action plans. To monitor response times to complaints and to ensure that actions on issues raised are taken.

33.6 To monitor Directorate Annual Audit activity and plans. To co-ordinate responses for national reports relevant to the clinical area, and to monitor and report progress on NSFs, NICE and other guidance.

33.7 Demonstrate public and patient involvement and ensure actions are taken as necessary in response to the annual patient surveys carried out on behalf of the Healthcare Commission. [3]

33.8 To monitor quality outcomes across all activities and take appropriate actions. These may include reporting to Executive Board.

33.9 To monitor training and development activities.

33.10 To provide assurance to the Governance Committee on a quarterly basis across all areas of activity. (These assurances will update the Board Assurance Framework).

Review

34. It is recognised that although excellent progress continues to be made in the Trust's governance arrangements, it will be important for progress to be continued.

35. The following have now been achieved:

35.1 The framework has been agreed by the Executive Board and the Governance Committee and reviewed during 2007.

35.2 Governance, quality and risk meetings have been re-established in the Directorates and Divisions and Corporate Directorates.

35.3 The role of the Executive Board in the monitoring of governance, quality and risk issues, has been established with specific reference to its role in the agreement of Trust-wide risks and the preparation of the Trust Risk Register.

35.4 The new risk assessment procedure is now in place across the ORH.

35.5 The detailed agenda for the Governance, quality and risk meetings (see Appendix A for standard agenda) have been agreed and are in place through the vast majority of directorates.

35.6 The development of a governance, quality and risk performance management framework to include risk assessment of core standards, self assessment, outcome measures and Divisional accountability reviews is in progress.

[3] This will link to the customer focus strategy to be developed and taken forward by the Director of Nursing and Clinical Leadership

35.7 The development of a Customer focus initiative in now underway led by the Director of Nursing and Clinical Leadership Infection control activities are well integrated into the governance arrangements of the Trust.

35.8 The Trust achieved the new Level one NHSLA acute hospitals standards.

Future plans - April 2008 – March 2009

36. Work in the coming months will focus on:

36.1 Review and update the Framework by January 2008 through submission to and approval by the Trust Board.

36.2 Implementation of the Clinical Effectiveness Strategy and structure across the ORH.

36.3 The roll-out of robust risk assessment across all areas.

36.4 Establishment of a project plan, supported by a detailed gap analysis to achieve level 2 of the NHSLA acute level standards.

36.5 Formalisation of new metrics for high level monitoring of the quality of care and include them as part of the Trusts performance monitoring systems.

Conclusion

37. The framework shows the developing governance, quality and risk agenda within the Trust. It will ensure that all the ORH's activities can be included within both a governance and performance management system that can then provide assurances to all parts of the organisation.

38. The structures to be put in place will integrate with, rather than be separate from, the day-to-day activities of the divisions and directorates and provide assurances to the Chief Executive and the Trust Board on the robustness and safety of patients, staff and visitors.

39. Further work will be done throughout 2008 to review the governance arrangements across the Trust, building on work done in 2007 and also to ensure that the arrangements are fit for an aspirant Foundation Trust.

Andrew Seaton
Assistant Director of Quality and Risk

Megan Turmezei
Assistant Director of Governance

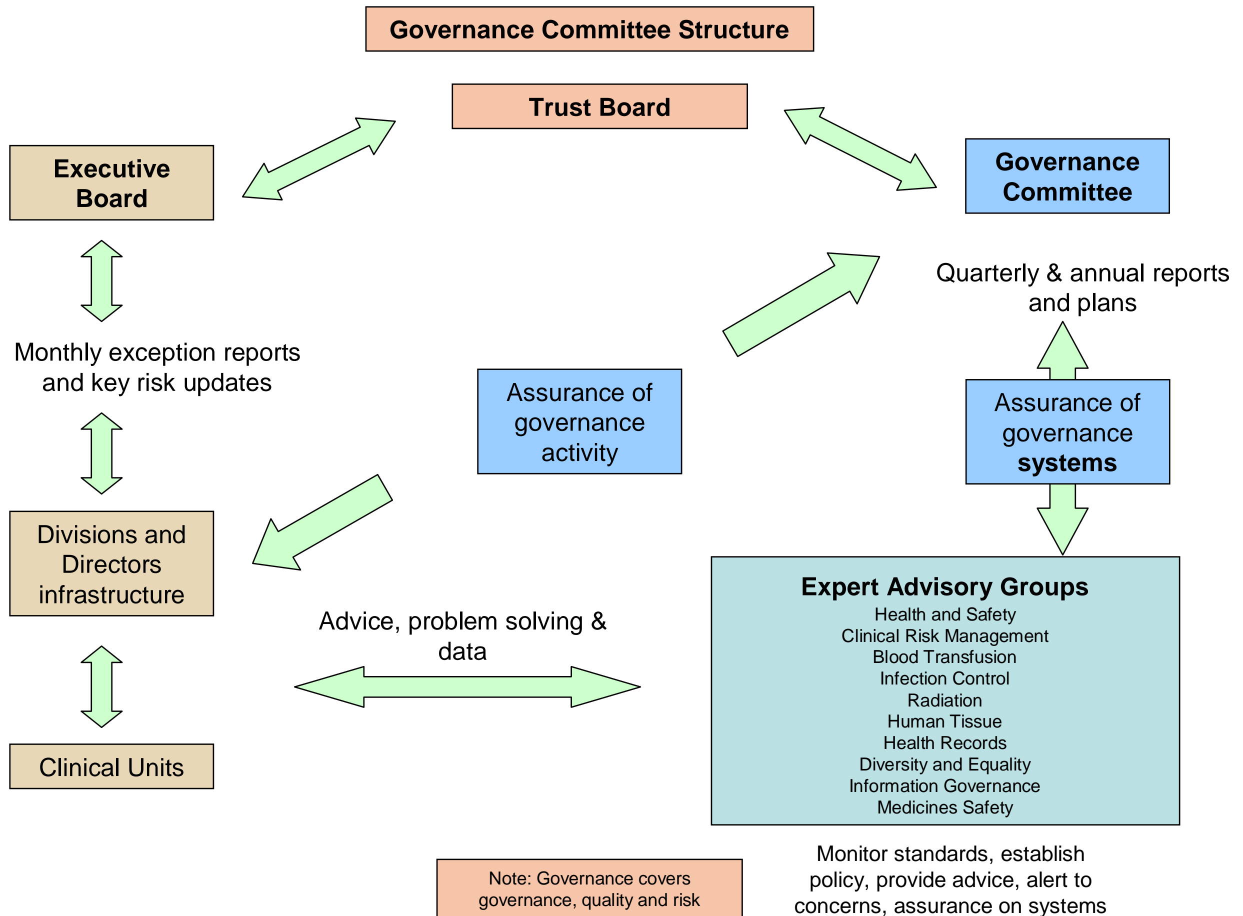
Updated December 2007and agreed by the Governance Committee

Appendix A – Committee structure

Appendix B – standard annual agenda for Directorate/Divisional governance, quality and risk

Appendix C – terms of reference of key Committees – Governance Committee, Executive Board, Clinical Risk Management, Health & Safety, Information Governance Group, Transfusion Committee, Medicines Management Strategy Committee, Control of Infection, Radiation Committee, Health Care Records Committee, Incidents, Comments and Complaints Committee, Technology Advisory Group and Human Tissue Governance Committee.

Appendix A



Appendix B

Governance, Quality & Risk Meetings

Model Terms of Reference and items to be covered

1. Membership
    - Director of Operations\Chair of Division (Chair) or nominated lead
    - Senior Clinical Nurse/Clinical Services Manager/Service Delivery Manager
    - Relevant Clinicians including those from other relevant disciplines
    - Medical Registrar/Senior House Officer representation
    - Nursing staff
    - Allied Health Professionals, Practice Development Nurses and Directorate Pharmacist where appropriate.
    - Consideration should be given to include service users and service providers (i.e. Estates & Facilities)
    - Clinical Governance Co-ordinator for the Division
    - Corporate Risk Advisor for the Division
    - Representative from Clinical Coding
    - Where required a member of PALS Dept can be invited to attend for specific issues
    - Members represent all relevant sites (if your service runs on more than one site)
2. Frequency of meetings
    - Monthly or quarterly
3. Duties and responsibilities
    - Review current implementation of NICE guidance, NSFs and Confidential Enquiries
    - Report on any outstanding NICE guidance and reasons for non-compliance/progress towards compliance
    - Report on progress against NSFs (e.g. benchmarking and action plans)
    - Respond to any Confidential Enquiries (e.g. compliance with recommendations and action plans)
    - Report on outcomes from audit
    - E.g. action plans, changes in practice
    - Review and action external reports (National reviews, HSE investigations etc)
    - Provide a forum to consider other relevant indicators regarding safety, quality, performance and infection
    - Discuss quality indicators data and report on relevant actions arising
    - Review patient survey / satisfaction data and progress against action plans
    - Report on progress against action plans from patient surveys, list changes in practice and service re-design
    - Provide a forum for discussion and action relating to any practice development issues

4. Review clinical outcome data quarterly

- Feedback from morbidity & mortality meetings and any actions taken/agreed and lessons learned

5. Review clinical coding (including validation data) and record content
   - Report on discrepancies/areas of concern and areas of good practice

6. Review incidents / complaints / claims with a view to lessons learned quarterly
   - Report on progress against action plans for serious incidents (SUIs/Red incidents)
   - Trends analysis and actions taken to address
   - Identify lessons to be shared across the trust.
   - Risk safety improvement targets and action to achieve.
   - Monitor investigation of , and outcomes (i.e. learning) from orange incidents
   - Review of claims and trends analysis
   - Review outcomes from serious (red) complaints and progress against action plans
   - Trends analysis of complaints

7. Review and validation of risk assessments & registers (initially quarterly) to ensure appropriate control measures are in place to minimise risk
   - Report on current risk assessments and monitor control measures

8. Monthly review of patient information
   - Review ongoing patient information programme in line with CNST standards and clinical effectiveness

9. Review monitoring arrangements for training and induction (induction, clinical competencies, skills and medical devices, mandatory training)
   - Feedback on progress with training and monitoring arrangements

   Give number of staff who have attended/not attended this training

10. Consent
    - Report on any consent issues

11. Guidelines
    - Review of guidelines (e.g. updated/on intranet)

Governance, Quality & Risk Meetings for Specialities

Model Agenda

1. Apologies
2. Minutes of previous meeting
3. Review of current identified risks
4. Review of recent incidents, complaints, claims, HSE recommendations\ improvement notices within the speciality and lessons to be learnt.
   - 4.1 Progress against action plans from incidents, complaints and safety targets.
   - 4.2 Organisational learning: review of lessons from incidents, complaints, claims either from within your own specialty, via corporate reports or from other specialities, and any changes required
5. Review and discuss recommendations from audit, case review meetings and morbidity and mortality meetings and agree action plans
6. NICE
   - 6.1 Review recent guidance and report compliance
7. NSFs and Confidential Enquiries
8. Report on progress and benchmarking and actions taken/required
9. Review of clinical outcome data (i.e. quality indicators e.g. infection rates), relevant performance management data and clinical coding
10. Review of training progress (induction, statutory, clinical competencies and skills, medical devices)
11. Review of patient information and consent process
12. Monitoring of attendance at mandatory induction and annual updates (at least six monthly)
13. Practice Development issues
    - 13.1 List of issues and actions taken to address them
14. Guidelines
    - 14.1 Review and approval of policies, guidelines (e.g. updated/on intranet)
15. Any specific items relevant to the speciality
16. SABs/NPSA/MDA Alerts
17. Issues for the clinical director / directorate
    - 17.1 Note: These items should be considered by providing a summary of the issue:
    - 17.2 the reason why this committee is unable to resolve it
    - 17.3 the issues arising (governance / risk / safety etc.)

17.4 the action proposed / required:

17.5 any decision required by the Clinical Directorate meeting

18. Feedback from corporate committees
19. Any other business
20. Date and time of next meeting

Appendix C

Trust Board Sub-Committees

21. The **Trust Board** has the ultimate responsibility for determining the strategic direction for the organisation, for ensuring the operational activities are managed, and for creating the environment and the structures for governance, quality and risk to operate effectively. The Trust Board is responsible for agreeing the Trust's strategic objectives each year, ensuring that these take account of both national statutory requirements, guidance, standards and targets and local factors.

22. The Trust Board has a number of committees which act to support its duties to ensure that it has the proper systems in place to manage governance, quality and risk and to provide it with assurances on the arrangements it has in place.

    22.1 The **Governance Committee** is responsible for providing the means of independent and objective review of and assurance on the effectiveness of the Trust's arrangements for corporate, clinical, information and research governance, and the non financial aspects of assurance and risk management, ensuring that there is a coordinated approach to clinical and non clinical issues. The Trust Board has delegated the review and monitoring of the board assurance framework (BAF) to the Governance Committee, receiving bi-annual updates and reports. The BAF incorporates the objectives, the risks to those objectives and the controls and assurances on the management of those risks. It meets quarterly and is chaired by a Non-executive Director.

    22.2 The Governance Committee receives regular reports on quality and risk, prepared from discussions at the relevant operational management committee and also receives reports on other aspects of governance as standing items on its agenda. In addition, it receives updates on the performance against core and developmental standards and the Governance, Quality and Risk reports from the Divisions and their Directorates. Similarly, reports are also received from the Executive Board twice a year following its review of all the Trust-wide risks.

    22.3 The Governance Committee will also review reports from such bodies as CEAC, the Audit Commission, NCEPOD, HSE and the Healthcare Commission, to assure itself, and the Board, that the necessary steps are being taken to deal with any issues raised.

    22.4 The **Audit Committee** is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management for financial matters and link with other elements of the Trust's governance and assurance structure. It works closely with the Governance Committee and the Assistant Director of Governance provide support to both these Committees. It meets at least quarterly and is chaired by a Non-executive Director.

    22.5 The **Human Resources Committee** has a particular responsibility to assure the Trust Board on compliance with HR governance issues, including assurance

on compliance with relevant core standards and targets that make up the Annual Health Check, the management of HR risks, e.g. employment, training & development as articulated within the BAF and as identified by the Director of Human Resources. In addition, the HR Committee will support the HR Director in setting and monitoring strategic direction for HR, which will support the delivery of the Trust's key strategic objectives. It meets quarterly and is chaired by a Non-executive Director.

22.6 The **Finance and Performance Committee** has a particular role in reviewing performance against financial and operational targets, including regular monitoring of the Performance Improvement and Cost Reduction Programme and the associated risks, including those that impact on the overall performance of the Trust. It meets monthly and is chaired by the Chairman of the Board.

22.7 The **Commercial Committee** is responsible for overseeing commercial activities, including private practice, the relocation schemes and elements of estates and facilities. In addition, it reviews the state compliance with relevant core standards as part of the Annual Health Check. It meets bi-monthly and is chaired by a Non-executive Director.

22.8 The **Remuneration and Appointments Committee** is responsible for the appointment of the Chief Executive and for the remuneration of Executive Directors and other most senior managers within the organisation. It can assure the Trust Board on the appropriateness of arrangements for the recruitment of Executive and other directors.

Executive Board

23. The Executive Board is responsible for the operational and financial management of the Trust, for the delivery of services and for the employment of adequate numbers of appropriately trained staff. It therefore takes overall responsibility for managing all types of risk and for dealing with the resource implications of those risks. It will sit twice a year (November and March) to review the Red risks from the Divisions' and the Executive Directorates' risk registers and other specific specialties such as Infection control, relocation and medicines safety.

24. The risks that have a substantial affect on the Trust objectives will be added to the Trust risk register for high level monitoring by the Trust Board. The resulting corporate risk register will inform the BAF and exception reports on the management of these risks will be made throughout the year to the appropriate Board Committees, including the Governance and Finance and Performance Committees.

25. The Executive Board will review regularly the risks against performance in a number of key areas:

25.1 Safety of patients and staff (including hospital acquired infections, medicines management, failure to rescue, staff well being and health and safety)

25.2 Finance

25.3 Performance (including all elements of annual health check – core standards, existing national targets and new national targets)

25.4 Use of resources (including staff, equipment and capacity)

25.5 Capital projects and developments (including PFIs and CRS)

25.6 Reputation and the external environment

26. **Executive Directors** will put the necessary arrangements in place within their areas for proper governance, quality and risk management.

26.1 The **Divisional Boards** have the responsibility, through the Chairs and Directors of Operations, for governance, quality and risk through their services and for the putting in place of appropriate arrangements for the identification and management of risks across these services. The Divisions will develop, populate and review their risks, drawing on risk processes within the Directorates, to ensure that both Directorate Risk Register and Divisional Risk Registers are kept up to date. In doing this, due account will be made of the Trust's strategic objectives, particularly in terms of meeting national guidance, standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular Division and Directorate. **Directorate Boards** similarly will review the Risk Registers and contribute to the development of the Divisional Risk Register and ensure local risk registers are in place.

26.2 The Divisional Boards will be responsible for the preparation of Annual Quality and Audit Plans, bringing together plans from each Directorate, and for preparing exception reports on governance, quality and risk for inclusion in the quality reports prepared for the Governance Committee.

26.3 A number of committees are in place that assists the Chief Executive and Executive and Divisional Directors in discharging their responsibilities for governance, quality and risk. These are outlined below.

26.4 **Health & Safety Committee (HSC)** is responsible for ensuring the development and implementation of a Health & Safety Policy and Safety Management System for dealing with all safety risk management issues, and for encouraging and fostering greater awareness of safety risk management throughout the Trust at all levels. Both the Fire Strategy Group and Security Group report directly to the HSC which meets six-weekly. Executive Directors and Divisional Directors of Operations are responsible for ensuring the appropriate level of divisional membership.

26.5 **Clinical Risk Management Committee** is responsible for ensuring that proactive, progressive and continuous improvements in the Trust's approach to clinical risk management are achieved, paying due attention to all aspects of clinical governance and quality. This includes overseeing preparation for CNST Assessments and the development of clinical aspects of associated initiatives such as the Risk Register. The committee meets six weekly and is

26.6 The Health & Safety Committee and the Clinical Risk Management Committee both have access to experts and the work of a number of committees covering specific areas. It is the responsibility of the Assistant Directors of Quality and Risk and Governance to ensure that issues arising are brought to the attention of the appropriate individual or committee and included within both exception and regular reports.

26.7 The **Infection Control Committee** is responsible for ensuring that there is a managed environment which minimises the risk of infection to patients, staff and visitors, which fosters greater awareness of infection prevention throughout the Trust at all levels.

26.8 The **Blood Transfusion Committee** is responsible for promoting a high standard of safe transfusion practice, in line with recommendations on Hospital Transfusion Committees in the Health Services Circular Better Blood Transfusion (HSC 1998/224), to enable the Trust to have clear arrangements for clinical governance in relation to blood transfusion. It will regularly review clinical transfusion practice, the performance of the Blood Bank and National Blood Service.

26.9 The **Medicines Management Strategy Committee** is responsible for setting and overseeing the strategy for all aspects of effective medicines management across the Trust and ensuring they are linked to governance arrangements across the Trust and reflect medicines management across Oxfordshire.

26.10 **The Radiation Protection Committee** is responsible for ensuring the development and implementation of a Radiation Safety Policy and Safety Management System for dealing with radiation risk management issues, and for encouraging and fostering a greater awareness of radiation safety throughout the Trust at all levels.

26.11 **The Incident, Comments and Claims Committee** is responsible for monitoring the investigation and implementation of action plans following the investigation of Serious Untoward Incidents, serious complaints (including HCC referrals) and serious claims and inquests. It will identify any significant trends from these areas and refer for further action to the appropriate committee. It is chaired by the Assistant Director of Quality and risk and should be attended by senior clinicians and senior specialty managers (H&S related, medical devices etc)

26.12 The **Information Governance Group** reports to the Governance Committee and is responsible for all aspects of Information Governance including the annual self assessment, the Freedom of Information Act, security of information, Data Protection and confidentiality, and the management of records. It is chaired by the Caldicott Guardian and meets monthly.

26.13 **The Physical Resources Group** agrees and prioritises financial allocations to support Statutory and Ministerial Estates Requirements and the minor service development programme. It provides reports, through the Director of Estates and Facilities, to the Commercial Committee. The following committees report directly to the Group.

26.14 **Medical Equipment Prioritisation Group** is responsible for distributing the allocation of capital funding for medical and scientific equipment, which is agreed annually by the Physical Resources Group. In addition, the Group will be informed of all other procurement of medical equipment where funding has come from alternative sources, for example.

26.15 **Technologies Advisory Group** is responsible for monitoring and overseeing the introduction of new Clinical Techniques and New Technologies on the Trust. The Group looks at this in terms of advancement, improvement and safety of clinical services, the competence of staff to perform new techniques, the impact on other clinical areas, as well as financial and technical implications.

26.16 **Human Tissue Governance Committee** will oversee the activities of the Trust in respect of its obligations under the Human Tissue Act and to ensure compliance with the provisions of said act and report to the Governance Committee.

26.17 **The ORH Ethics Committee** will act as a source of advice and comment in all appropriate as outlined in its detailed terms of reference. It reports to the Governance Committee.

The Governance, quality and risk framework maintains all the agreed principles and develops governance, quality and risk within the divisions and directorates.