Board of Directors Meeting: Thursday 3 September 2009 BD2009.70

Subject	Governance, Safety, Quality and Risk Framework

Purpose of paper	The Framework (previously the Risk Management Strategy) outlines the arrangements for the management of risk throughout the Trust, by the establishment of appropriate and robust arrangements for governance, safety, quality and risk. It is a key document required by NHS Litigation Authority (NHSLA) in its Level I assessment of the Trust at the end of September 2009. The Framework identifies the role of the Board; the Trust's committee structure, including the Safety Action Groups; and the work of the directorates and divisions. It describes work underway to support good governance in all areas. The Care Quality Board considered the framework at its meeting on Wednesday 12 August 2009; endorsed it for submission to the Board of Directors; and recommended review in March 2010 so that account could be taken of any changes to the Trust's management structure.
Board Lead	Mrs Elaine Strachan-Hall, Director of Nursing and Clinical Leadership
Background papers (if any)	Quality Strategy Standing Orders

Action/decision required	To **approve** the Governance, Safety, Quality and Risk Framework for 2009/10; and to **review** it in March 2010			
Key purpose	Strategy	Assurance	**Policy**	Performance
Strategic Goals	All			
Strategic Objectives	All, and in particular: SO7: To provide demonstrably excellent clinical outcomes and indicators of patient safety SO8: To improve the overall patient experience by offering excellent customer care. SO10: To become a strategic, high performing and agile organisation supported by efficient and patient focused clinical processes, modern systems and business processes.			

Links to Board Assurance Framework/ Trust Risk Register/Annual Health Check element(s)/CQC Registration	A core framework document to support the management of risks and establish sound governance arrangements in line with C7ac. A key support to the Board Assurance Framework and a key document in the assessment for NHSLA
Also considered by	Care Quality Board, 12 August 2009

Resource and financial impact	Not applicable
Consideration of legal/equality/diversity/engagement/risk issues	Not applicable
Acronyms and abbreviations used	BAF: Board Assurance Framework CEAC: Central England Audit Consultancy CQC: Care Quality Commission HCC: Healthcare Commission HSE: Health and Safety executive NCEPOD: National Confidential Enquiry on Perioperative Deaths NHSLA: National Health Service Litigation Authority PROMS: Patient reported outcome measures RAG: Red Amber Green SAG: Safety Action Group SUI: Serious Untoward Incident
Author	Mrs Megan Turmezei, Associate Director of Governance

Governance, Safety, Quality and Risk Strategy

Title:	Governance, safety, quality and risk strategy framework.
Category:	Risk Management
Summary:	This strategy describes the integrated organisational governance, safety, quality and risk management structure. It identifies key committees and responsibilities. The strategy will be reviewed bi-annually by the Governance Committee and approved each year by the Board of Directors.
Date of Review:	August 2009 (endorsed by the Care Quality Board)
Approval Date/ Via:	Board of Directors September 2009
Distribution:	Via Safety, Quality and Risk Department to: Executive Directors, Divisional Directors and Directorate Managers Safety, Quality and Risk Web Site
Related Documents:	Risk Assessment Policy Health and Safety Policy Incident Reporting Policy (including SUI) Board Assurance Framework
Author(s)/Further Information:	Mrs Megan Turmezei, Associate Director of Governance Mrs Maggie Maxwell, Associate Director of Safety, Quality and Risk
This Document replaces:	Governance, Quality and Risk Framework March 2007

Issued by:	Associate Director of Safety, Quality and Risk Associate Director of Governance
Issue Date:	September 2009

Governance, safety, quality and risk strategy framework

The Trust

1. The core activity of the Oxford Radcliffe Hospitals is the provision of high quality, accessible and affordable services to its patients in Oxfordshire and beyond to the levels agreed with its commissioners. The Trust is also major teaching hospital working with the University of Oxford and Oxford Brookes University to support teaching, education and research activities. It is a Comprehensive Biomedical Research Centre in partnership with the University of Oxford. It has a turnover of approximately £600 m and employs just under 10,000 people on its three sites. It is working towards Foundation Trust status, and with partners across the Oxfordshire health economy, towards designation as an Academic Health Science Centre.
2. The Board of Directors (the Board) is developing plans for organisational and structural development and its detailed performance improvement and cost reduction programme, building on the work of the last few years.
3. The Board has the following duties:
   - 3.1 the duty of quality – providing quality healthcare for patients;
   - 3.2 ensuring the safety and wellbeing of staff ;
   - 3.3 working in collaborative partnership with other bodies in the NHS and in the wider community;
   - 3.4 achieving financial balance and delivering best value in their use of public resources; and
   - 3.5 the completion of an annual Statement on Internal Control.
4. 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, manage the risks to those objectives, and relate to and work with its stakeholders. There are specific areas of governance including corporate governance, financial governance, clinical governance, research governance and information governance.
5. 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[1]'
6. The governance, safety, quality and risk strategy framework sets down how all aspects of governance are to be **integrated** and how risks to the objectives of the Trust are identified and mitigated.

[1] Dept of Health, Integrated Governance Handbook for Executives and Non-executives in Healthcare Organisations – February 2006

Introduction

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

8. The framework sets out the arrangements for governance, safety, quality and risk and the integration of all aspects of governance with other external standards. The framework provides also a means to support compliance monitoring core standards and (from 1 April 2010) the requirements of the CQC with respect to registration.

9. Attention has been paid to the detailed review of the HCC's reports on Mid Staffordshire Hospital and Birmingham Children's Hospital which highlighted significant failures in governance. The Board of Directors submitted its report to the Strategic Health Authority on how its assures itself in relation to the specific recommendations in these reports. Work continues on the small number of areas identified for improvement and progress will be monitored by the Board.

10. The Board has continued its focus on patient safety and quality and is looking to develop this further through the coming months. The requirement for Quality Accounts to be published in June 2010, has focused attention on all aspects of patient safety, experience and outcomes and how these can be brought together. The Board agreed its Quality Strategy in July 2009 which includes both the patient and staff safety strategies, and highlighted a number of key areas of work for the coming months.

11. The Board will lead and promote the culture of openness and honesty so that staff and patients feel able to raise concerns that they have about the quality of care and the safety of services. The directorates will continue to look at all areas of risk but also will support their staff and clinical teams by ensuring that all areas of concern are discussed and analysed appropriately so that the necessary information can be brought together to support decision–making at all levels.

The approach

12. The Trust's approach to governance, safety, quality and risk systems is intended to give ownership to staff who provide direct care or support the delivery of care. The corporate role is to devise systems, and to provide education, advice and support staff carrying out the activity. Managers are accountable for the governance, safety, quality and risk performance of their area and this performance will be measured through a number of means including service–specific indicators as well as performance against nationally defined standards and indicators.

13. The monitoring approach to governance, safety, quality and risk will have the rigour of any financial or performance management process, and therefore performance indicators for these activities are being developed at each level of the TRUST. This will ensure that staff and managers are aware of their responsibilities and that 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 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 the impact of quality initiatives.

14. Performance metrics are now being developed for the individual clinical specialities through a process overseen by the directorates and the Care Quality Board. The intention is that the Board will (within the next few months) receive monthly performance 'dashboards' that integrate operational, safety and quality performance metrics to provide the overall view and to assure the Board.

15. The approach will also taken account of the registration process to start in January 2010 to ensure that all regulated activities of the TRUST can be registered with the Care Quality commission with effect from 1 April 2010. The governance arrangements that have supported declarations of compliance with Core Standards and will continue to do so to the end of 2009/10 will be built on to ensure that registration, once achieved, can continued to be complied with.

Leadership and accountability

16. 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 and safety of staff, visitors and contractors in the Trust. The Director of Nursing and Clinical Leadership is the Executive lead for governance, health and 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 improvements for patients and staff.

17. Executive Directors are accountable for the governance, safety, quality and risk activities in their areas of responsibility; their organisational structures must be able to discharge the requirements of the Annual Health Check (including both the Standards for Better Health and ALE), National Health Service Litigation Authority standards, legislative requirements and other specific NHS standards. From 1 April 2010, the organisational structures must be able to support compliance with statutory regulations for the registration of the TRUST with the CQC.

18. The Associate Director of Governance has a particular responsibility for corporate governance, including the Trust Risk Register, the Statement on Internal Control and the Board Assurance Framework, and for the coordination and provision of assurance of the annual declaration of compliance with core standards and the forthcoming registration process, working with the Executive Directors. The Associate Director provides support to the Director of Nursing and the Medical Director in support of their governance, safety, quality and risk responsibilities.

19. The Associate Director of Safety, Quality and Risk has a particular responsibility for clinical governance and risk management for both clinical and non clinical (health and safety), audit and effectiveness and clinical information. She manages the Safety, Quality and Risk and legal team that liaise closely with the Directorate teams

to support their activities. The Associate Director is responsible for the maintenance of the database of incidents and complaints, drawing on information provided by the Executive Directorates and Divisions. The Associate Director is responsible for a leading the development, review and implementation of a number of policies and procedures supporting the quality and risk agenda, making sure that their implementation is monitored.

20. The Associate Director of Safety, Quality and Risk is responsible for (inter alia) ensuring that exception reports on SUIs are included in reports to the Care Quality Board, the Governance Committee and the Board of Directors. The Associate Director will also provide support for a number of the committees and groups engaged in governance activities.

21. The Board Secretary is responsible for the work of the Board and its Committees and for ensuring integration of their activities with respect particularly to their governance and regulatory responsibilities. In addition, the Board Secretary oversees the production of policies and other key documents.

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

    22.1 have access to, understand and follow all Trust policies and procedures.

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

    22.3 have clear objectives that are documented as part of their annual performance reviews.

23. The 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 must integrate these aspects so that it can be assured across all of them. Following a review of the Board Committees and their roles in May 2008, the number of Board Committees with Non-executive Director chairs and members has been reduced to provide a focus on the key assurance areas; hence full Board can be provided with assurance that robust systems are in place to manage governance, safety, quality and risk.

24. These committees will also have a role acting on behalf of the Board in the approval of key policies. A key role for the Non-executive members is to seek assurance and provide a challenge to the Executive team.

25. These committees are:

    25.1 the Audit Committee;

    25.2 the Governance Committee;

    25.3 the Finance and Performance Committee; and

    25.4 the Remuneration and Appointments Committee.

26. Following a review of the role of the Executive Board in April 2009, a new executive–led committee structure is now in place and a number of these bodies have specific

duties in relation to governance, safety, quality and risk, including the consideration and approval of key policies and procedures. These committees are:

26.1 the Care Quality Board – chaired by the Director of Nursing and Clinical Leadership

26.2 the Operational Performance Board – chaired by the Chief Operating Officer

26.3 the Cost Reduction Programme Board – chaired by the Chief Operating Officer; and, in addition

26.4 the Clinical Services Strategy Group – chaired by the Chief Operating Officer

26.5 the HR and Commercial Committees – chaired by the Director of HR and the Director of Finance respectively.

27. The chairs of the above groups are responsible for ensuring that common business, e.g. the plans for the mitigation of risks that impact on patient safety, the quality of care and operational and financial performance, are considered and that appropriate plans are taken to identify and manage these risks and inform the Board accordingly.

28. Assurance of quality and risk **systems** will be provided by a number of groups as outlined in Appendix 1. These groups include Safety Action Groups for patients and for staff and a number of subject specific groups such as Information Governance Group, Radiation Protection, Organ Donation and Human Tissue. These groups will be responsible for monitoring standards and systems, developing policy and training, providing advice and problem solving for the directorates. Their work will normally be reported to the Care Quality Board via the relevant Executive Director. In addition, reports on specific areas will be made to the Governance Committee on an agreed basis. For example, information governance is reported to the Governance Committee on a quarterly basis and annual reports are provided on Health and Safety and Medicines Management.

29. Assurance of governance, safety, quality and risk **activity** will be provided by the Directorates on a regular basis through their own governance, safety, 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. Monthly or quarterly high level exception reports are provided for review by the Care Quality Board with quarterly assurance reports provided to the Governance Committee.

30. The Trust systems reflect the pillars of clinical governance; e.g. clinical effectiveness and audit, risk management, and satisfy the related external standards including core standards. The directorate performance dashboard, submitted for assurance to the Governance Committee, reflects all key governance areas using a RAG rating.

31. The corporate governance, safety, quality and risk staff will support the clinical teams in achieving their responsibilities by developing systems, education programmes and providing expert advice and support for managers, staff and the Board and supporting committees.

Committee Structure

32. To enable the Board to discharge its legal duty of quality, health and safety and other legislative requirements, it must establish effective communication and monitoring processes. The day to day management of governance, safety quality and risk is the duty of the Executive Directors, and is discharged in a number of ways with support from the corporate governance, quality and risk staff. The formal assurance of these processes and activity has been delegated by the Board to the Governance Committee, supported by information from the Executive team and a network of specialty and expert committees (see above and also Appendix 1).
33. The Board of Directors will approve the Governance, Safety, Quality and Risk Framework each year in line with the requirements of NHSLA.
34. The Care Quality Board reviews the Trust Risk Register each month and prepares a report on the Trust's red risks for review by the Board at each public meeting. It will also oversee the preparation and updating of the full risk register (containing all those risks with an initial assessment rating of 16 or over) for review by the Governance Committee at least twice a year.
35. The Governance Committee will be the overarching Board committee that monitors governance, quality and risk systems and activity, and provides assurance to the Board that it is discharging its legislative requirements for governance, safety, quality and risk across all areas. It will discharge its duty by ensuring that there is an appropriate committee structure to monitor standards and report progress and concerns and by receiving reports from Directors and Divisions on governance, quality and risk activity.
36. The Directorates and Divisions will set up and maintain systems to cover all aspects of governance and outline terms of reference for relevant groups are included as Appendix 2. These groups will ensure reports (usually by exception) are provided to the Care Quality Board and assurance reports are provided to the Governance Committee on a quarterly basis.
37. In summary, the arrangements with respect to key policies, key committees and key documents are as follows:

	Review Body and frequency of review	Comment
Policy/strategy frameworks[2]		
Governance, safety quality and risk framework	Annually by the Board of Directors	(previously known as the Risk Management Strategy)
Quality Strategy	Approved by Board of Directors and updated annually	Incorporates specific work programmes agreed in the patient and staff safety strategies

[2] Not an exhaustive list but includes v high level documents

	Review Body and frequency of review	Comment
Annual Risk Report	Board of Directors annually	Prepared by the Safety, Quality and Risk Team
Policy on documents	Every two years for agreement by Board of Directors	To the Board of Directors September 2009
Risk Assessment procedure	Every two years by Care Quality Board for agreement by Governance Committee	Due for review in 2010
Key committees		
Governance Committee	Membership reviewed annually as part of review of Standing Orders by the Board	Committee of the Board of Directors
Audit Committee	Membership reviewed annually as part of review of Standing Orders by the Board	Committee of Board of Directors required by DH and Monitor – Monitor has produced Audit Code
Care Quality Board	Membership agreed by Directors and Divisions Specific role in delivery of high quality safe patient care and for identifying and managing associated risks prior to report to the Board	Monthly meetings with minutes submitted to Governance Committee Works closely with other Executive-led Boards including Operational Performance and Cost Reduction Programme Boards
Key documents		
Board Assurance Framework	Twice-yearly by the Board of Directors; quarterly review by Governance Committee	Based on strategic goals and objectives agreed each year as part of Business Plan Routinely updated by Executive Directors prior to review
Trust Risk Register	Review at each public Board meeting of Trust Risk Register summary which includes all 16+ risks post mitigation. Full Register of all 16+ risks prior to mitigation considered at least twice a year by Governance Committee following detailed review by directors, divisions and corporate Directorates and Care Quality Board	Developed using Risk Assessment procedure which populate the directorate and divisional risk registers Referenced in the Board Assurance Framework
Statement on Internal Control	Agreed by Board of Directors as part of the Annual Accounts	Prepared for review by the Audit Committee, the Board of Directors and sign off by Chief Executive

Proposals for 2009/10

38. The external environment has changed with the establishment of the CQC. CQC will regulate the quality of health and adult social care and look after the interests of people detained under the Mental Health Act.

39. The key change is the registration process – a move away from the retrospective declarations of compliance required by the Healthcare Commission. The TRUST is now registered by CQC in respect of healthcare associated infections and the process for full registration with the CQC for all its regulated activities (as defined in legislation) is now being planned for. It is expected that the registration will be applied for in January/February 2010 with registration being awarded by 1 April 2010. Full details on the requirements and the process are awaited.

40. A declaration on compliance with core standards will be made for the period 1 April 2009 to 31 October 2009 in November 2009. Providers are expected to maintain compliance with all core standards throughout the whole year.

41. In order to meet the new environment, and to ensure that the Board's governance arrangements are fit for purpose, the following have been focused on:

    41.1 clear assurance processes that support the delivery of performance and quality, and meet the requirements of core standards and the registration system to be put in place;

    41.2 development of a safety and quality dashboard to read alongside the operational performance dashboard; the dashboard will include compliance with core standards, metrics associated with SUIs, incidents (e.g. falls) and complaints;

    41.3 a clear risk management and assessment process at all levels – the Board will continue to review the red risks at each public meeting;

    41.4 an understanding of the performance monitoring and regulatory requirements put on FTs by Monitor;

    41.5 the development of the quality account, to be published for the first time in June 2010; drawing on the quality strategy agreed by the Board in July 2009;

    41.6 delivery of the agreed safety action group plans for patient and staff safety, working closely aligned to the SHA's priorities;

    41.7 a review of the committee arrangements within the Trust that support these arrangements (and meet the requirements of the developing AHSC organisational arrangements and Monitor's requirements);

    41.8 a process for the receipt and management of external reports, reviews and inspections received by the Trust, in line with the procedure agreed in 2007. (These include, inter alia, special reviews and studies by the CQC, and inspection visits by Specialist Advisory Committees for medical training);

    41.9 continued Leaders' Briefings on the development of governance and assurance systems to support the delivery of safe and high quality patient care; and

41.10 a stocktake of current committee arrangements and their terms of reference, and a review to establish any changes required below Board level as part of the preparation for NHLSA Level 1 assessment due to take place at the end of September 2009. (See Appendix 1)

Conclusion

42. The document provides the framework for governance, safety quality and risk within the Trust and it describes the current work and the roles of key committees. It will ensure that all the Trust's activities can be covered within an integrated governance and performance management system that can then provide assurances to all parts of the organisation.

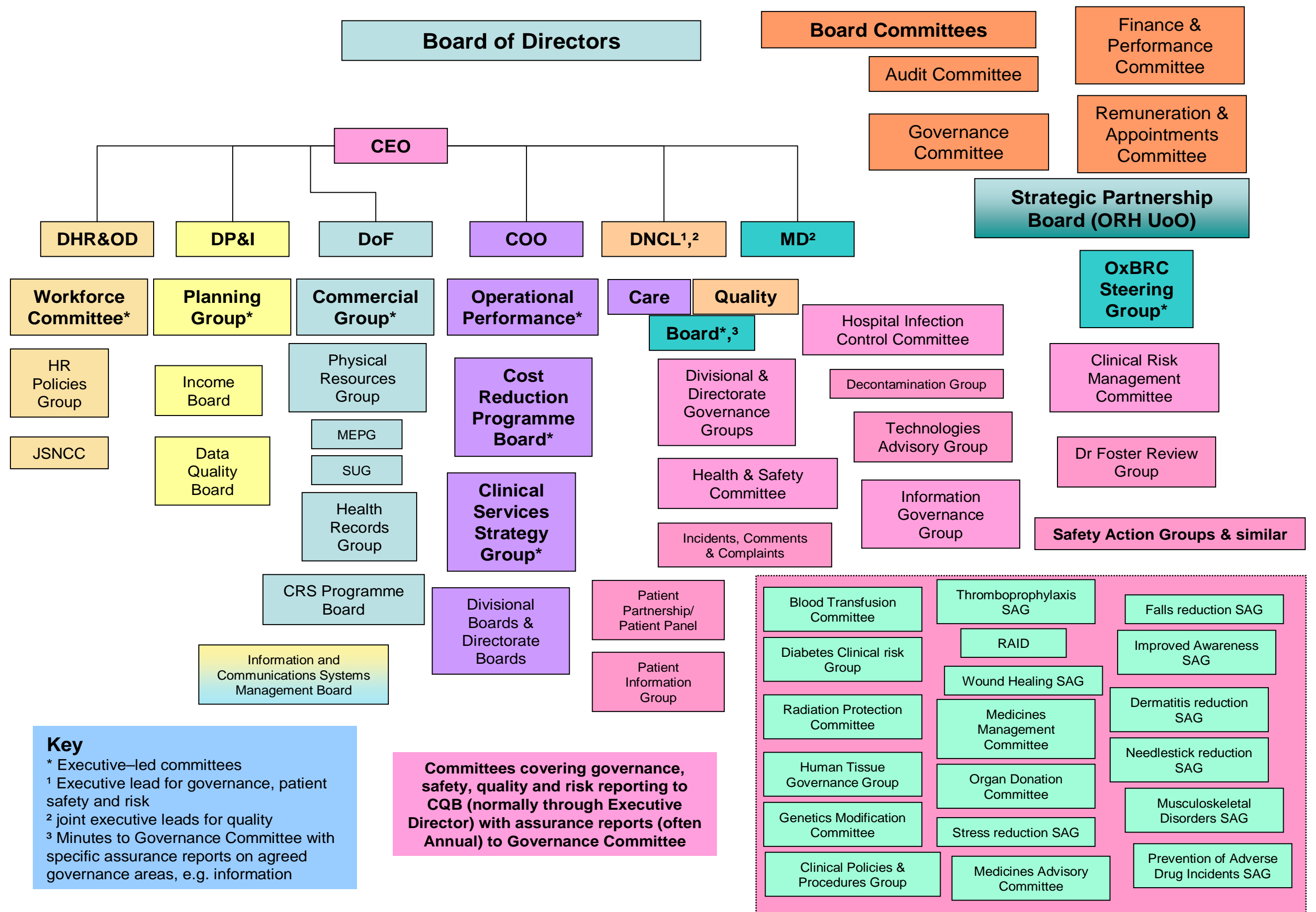
43. The structures in place will integrate with, rather than be separate from, the day to day activities of the divisions and directorates, and provide assurances to the Chief Executive and the Board on the robustness of systems and the safety of patients, staff and visitors.

44. The Trust is currently reviewing its organisational arrangements, and hence current divisional and directorate structures may change. However, the arrangements described in the framework can apply to revised structures, and will support the continued development of quality governance and assurance systems.

Monitoring the Framework

45. The Board of Directors will approve the Framework and it will also be subject to review by the Governance Committee each March and December.

Appendix 1



Appendix 2

The Board Committees

46. The **Board** has the ultimate responsibility for determining the strategic direction 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.

47. Through its Standing Orders, the Board has established the Board committees below to provide proper systems to manage governance, safety, quality and risk, and to provide the Board with assurances on the arrangements it has in place.

    47.1 The **Governance Committee** is the overarching committee 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 on the non financial aspects of assurance and risk management, ensuring that there is integrated consideration of clinical and non clinical issues. The minutes of the Governance Committee are presented to public meetings of the Board and the chair raises key issues to the Board.

    47.2 The Board considers the BAF twice a year, but delegates quarterly review and monitoring of the BAF to the Committee. The BAF incorporates the Trust's objectives, the risks to those objectives, and the controls and assurances on the management of those risks. The Committee reviews the Trust's full Risk Register at least twice a year.

    47.3 The Committee meets quarterly, and is chaired by a Non-executive Director. It is a Non-executive committee, with at least three Non-executive members. The Chief Executive, the Medical Director, the Director of Nursing, other Corporate Directors, the Divisional Chairs, the Divisional Directors of Operations, the Associate Director of Governance, and the Associate Director of Safety, Quality and Risk also attend meetings of the Committee. To be quorate at least two Non–executive members must be presented with either the Director of Nursing or the Medical Director. Those in attendance are able to send senior representatives in their place but should normally attend at least three meetings a year.

    47.4 The Committee receives regular reports on quality and risk, and on other aspects of governance, including research and information governance, as standing items on its agenda. It may also review reports from such bodies as CEAC, the Audit Commission, NCEPOD, HSE and the CQC to assure itself, and the Board, that the necessary steps are being taken to deal with any issues raised.

    47.5 The Care Quality Board submits its minutes to the Governance Committee for review and will ensure that appropriate items are brought to the attention of the Committee. Specifically, it will ensure that reports from the safety action groups and similar are brought to the attention of the Governance Committee.

47.6 The Governance Committee will review and evaluate its effectiveness each year.

47.7 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 relates to other elements of the Trust's governance and assurance structure. It works closely with the Governance Committee, and the Board Secretary supports both Committees.

47.8 The Committee meets quarterly, and is chaired by a Non-executive Director. It is a Non-executive committee, with at least three Non-executive members, and the Chairman is excluded from membership. The Director of Finance, the Deputy Director of Finance, and the Trust's internal and external auditors also attend part or all of its meetings.

47.9 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. All members of the Board attend its meetings.

47.10 The **Remuneration and Appointments Committee** is responsible for the appointment of the Chief Executive and for the remuneration (including any provision of any performance-related elements, or other benefits, including pensions and cars) of Executive Directors and other most senior managers within the Trust. It can assure the Board on the appropriateness of arrangements for the recruitment of Executive and other directors.

47.11 It is a Non-executive committee, chaired by the Chairman of the Trust. The Chief Executive may also attend those meetings at which his own remuneration and employment are not under discussion.

Executive–led committees

48. The executive committee structure was reviewed in May 2009 to ensure that sufficient time could be made available to deal with the increasingly wide range of operational, performance, financial, resource and strategic matters. The following committees were put in place from May 2009.

48.1 **Operational Performance Board (fortnightly - 1st/3rd weeks)**. This meeting is chaired by the Chief Operating Officer, and includes the Divisional Directors of Operations, Director of Commissioning, Assistant Director of Finance, members of the performance improvement and information teams and Directorate Managers on an exception basis. It reviews operational delivery (including performance against national indicators) and budget performance with a focus on developing accurate forecasting.

48.2 **Care Quality Board (monthly - 2nd week)**. This meeting is chaired by the Director of Nursing and Clinical Leadership and includes the Medical Director, Chief Operating Officer, the Divisional Directors and Chairs, Associate Director

of Governance, Associate Director of Safety, Quality and Risk, Clinical Director Medicines Management, and members of the infection control and information teams. It will review the safety and quality of care delivered, including measures of performance such as HSMR, infection rates, SUIs, PROMS and CQUINS, with a focus on improving patient safety and patient experience, and developing additional measures of performance. It works with both the Operational Performance Board and the Cost Reduction Programme Board to ensure that risks arising from the tensions between operational, financial and quality demands are identified and managed. Its minutes are presented to the Governance Committee together with an 'At a Glance' report.

48.3 **Cost Reduction Programme Board (monthly - 4th week)**. This meeting is chaired by the Chief Operating Officer and includes a clinical lead, Director of HR and OD, Director of Commissioning, Deputy Director of Finance, Divisional Directors of Operations, workstream leads and Directorate Managers/ Directorate Chairs on an exception basis. It will review the delivery of cost reduction plans with a focus on effective use of resources.

48.4 **Clinical Services Strategy Group (monthly)**. This meeting will be chaired by a clinician and, in the first instance, will include a selection of strategically-minded clinicians from across the Trust/University, supported by the Chief Operating Officer and Director of Planning. It will be responsible for developing the Trust's clinical services strategy with a focus on delivering financial sustainability. (Note the terms of reference are to be finalised: currently the meeting is chaired by the Chief Operating Officer.)

48.5 **Workforce Committee** – is chaired by the Director of HR and will provide assurance to the Executive on all workforce issues including education and training strategies, HR policies and procedures, workforce risks, terms and conditions of employment for all staff groups (below Executive) and the management of organisational change. Members include the Medical Director or a Divisional Chair, the Director of Nursing and Clinical Leadership, a Divisional Director of Operations, the Deputy Director of Finance and the Director of Commissioning. It will meet at least four times a year and produce an annual workforce report for the Board.

48.6 **Commercial Committee** – chaired by the Director of Finance and considers a range of items including the Care Records Service, information technology and estates and facilities matters.

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

49.1 The **Divisional Boards** have the responsibility, through the Chairs and Directors of Operations, for governance, safety, quality and risk of their services and for the putting in place of appropriate arrangements for the identification and management of risks. 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.

49.2 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 Care Quality Board and, quarterly, the Governance Committee.

50. A number of committees are in place that assist the Chief Executive and Executive Directors in discharging their responsibilities for governance, safety, quality and risk. The terms of reference for these committees are outlined below.

50.1 **Health and Safety Committee (HSC)** is responsible for ensuring the development and implementation of a Health and 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. It reports to the Care Quality Board through the Director of Nursing and Clinical Leadership. It will produce an 'At a Glance' report after every meeting for wide circulation.

50.2 **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 chaired by the Medical Director. Divisional Directors of Operations are responsible for ensuring the appropriate level of divisional membership. It will produce an 'At a Glance' report after every meeting for wide circulation. It provides reports to the Care Quality Board.

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

50.4 **The Planning Committee** is responsible for assuring the quality of business cases which require the approval of the Executive and/or the Board of Directors. It includes representatives from each Division and from corporate directorates to ensure that cases adequately consider the full impact on all parts of the organisation. It also monitors the implementation of business cases that have been approved. It reports to the Executive Committee.

50.5 **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 and supports compliance with the conditions of registration. Infection control reports are provided to the Care Quality Board and also to the Executive Directors. It includes members from the PCT and all relevant internal departments including estates and facilities. The **Decontamination Group**, chaired by the Medical Director, considers all aspects of decontamination, involving staff from all relevant areas, including compliance with the relevant core standard.

51. The Executive Directors, the Care Quality Board, Health and Safety Committee and the Clinical Risk Management Committee have access to experts and the work of a number of committees covering specific areas. It is the responsibility of the Associate Directors of Safety, 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.

51.1 **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 Associate Director of Safety, Quality and Risk and should be attended by senior clinicians and senior specialty managers (HandS related, medical devices etc) and provides regular updates on SUIs to the divisions, the Care Quality Board and the Board of Directors.

51.2 **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 committee reports directly to the Physical Resources Group.

51.3 **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.

51.4 **Technologies Advisory Group,** chaired by the Nuffield Professor of Surgery is responsible for examining the impact of 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 and skills of staff, the impact on other clinical areas, as well as financial and technical implications. An annual report will be provided through the Care Quality Board to the Governance Committee.

52. In addition, a number of Safety Action Groups for specific areas of activity have been established for patient and staff safety. These are as follows:

    52.1 **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.

    52.2 The **Medicines Management 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. The Clinical Director for Medicines Management sits on the Care Quality Board.

    52.3 **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.

    52.4 **Wound Healing Professional Advisory Group** will ensure that information, policies and guidelines on tissue viability activities are effectively communicated to staff and patients through the Corporate & Divisional structures. It will also work across a number of other specific areas and additional details are available in CQB09.05.

    52.5 **RAID**[3] will formulate Trust policy and standards for the identification and management of patients at risk of unexpected acute clinical deterioration and recommend strategies which aim to prevent patient acute clinical deterioration across the Trust.

    52.6 **Diabetes Clinical Risk SAG** will identify and prioritise clinical risks associated with Diabetes across the Trust, ratify risk assessment, validate action plans and nominate lead for each risk to address and support and monitor compliance with Action Plans.

    52.7 **Prevention of adverse drug incidents PADI** will review adverse drug incidents, including the 'high five injectable medications and related metrics.

    52.8 **Thromboprophylaxis Committee SAG** will ensure that all adult in-patients have their need for thromboprohylaxis assessed against accepted guidelines and that the decision is recorded, implemented and audited. The aim is to produce a measurable reduction in the incidence of hospital acquired venous thromboembolism (VTE).

    52.9 **Fall Reduction SAG** aims to reduce the number of avoidable falls to patients in hospital and to establish a culture in which both the internal and external

[3] Recognising the Acutely Ill and Deteriorating Patient

environments are maintained to a standard that minimises the possibilities of falls by staff and visitors.

52.10 **Improved Awareness SAG** aims to improve awareness of policies, procedures and risk/safety related issues across the Trus

52.11 **Dermatitis Reduction SAG** aims to reduce the number of avoidable occupational dermatitis cases *(including latex)* to staff; to establish an expert group in the Prevention & Management of Occupational Dermatitis *(including latex)*; and to manage the Trust's response to the formal letter & recommendations from the Health & Safety Executive on the Management of Dermatitis Risks.

52.12 **Needlestick Reduction SAG** aims to reduce the number of avoidable needlestick injuries to staff; to co-ordinate and recommend the introduction of safer needle devices and to establish an expert group in the prevention and management of needlestick injuries across the Trust.

52.13 **Musculo–skeletal disorders reduction SAG** will work towards reducing the severity of musculoskeletal disorders to staff and to establish an expert group in the prevention and management of musculoskeletal issues across the Trust.

52.14 **Stress Management SAG** is working towards an assessment of current levels across the organisation.

53. There are a number of specialist groups covering a number of specific interest areas. These all contribute to the governance of the TRUST and its activities and their details are available from the Associate Director of Governance[4]. These committees are:

53.1 Organ Donation Committee

53.2 Genetics Modification Committee

53.3 Human Tissue Governance Group

They each report to the Care Quality Board.

[4] To be collated

Governance, Quality and Risk Meetings – Model Terms of Reference

1. **Membership**

   1.1 Director of Operations/Chair of Division (Chair) or nominated lead

   1.2 Senior Clinical Nurse/Clinical Services Manager/Service Delivery Manager

   1.3 Relevant Clinicians including those from other relevant disciplines; medical Registrar/Senior House Officer representation, nursing staff and Allied Health Professionals, Practice Development Nurses and Directorate Pharmacist where appropriate.

   1.4 Consideration should be given to include service users and service providers (i.e. Estates and Facilities)

   1.5 Clinical Governance Co-ordinator for the Division, corporate Risk Advisor for the Division and representative from Clinical Coding

   1.6 Where required a member of PALS Dept can be invited to attend for specific issues

   1.7 Members represent all relevant sites (if your service runs on more than one site)

2. **Frequency of meetings** – meeting should be monthly and at least quarterly

3. **Duties and responsibilities**

   3.1 Review compliance with core standards, and develop systems to ensure preparedness for registration and subsequent monitoring of registration compliance.

   3.2 Review and validation of risk assessments and registers (initially quarterly) to ensure appropriate control measures are in place to minimise risk, report on current risk assessments and monitor control measures and contribute to the Trust Risk Register

   3.3 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)

   3.4 Respond to any Confidential Enquiries (e.g. compliance with recommendations and action plans); Review and action external reports (National reviews, HSE investigations etc)

   3.5 Report on outcomes from audit; e.g. action plans, changes in practice

   3.6 Provide a forum to consider other relevant indicators regarding safety, quality, performance and infection – discuss quality indicators data and report on relevant actions arising

   3.7 Review patient survey / satisfaction data and progress against action plans

   3.8 Report on progress against action plans from patient surveys, list changes in practice and service re-design

3.9 Provide a forum for discussion and action relating to any practice development issues and the actions taken to address them

3.10 Review clinical outcome data quarterly and take feedback from morbidity and mortality meetings and any actions taken/agreed and lessons learned

3.11 Review clinical coding (including validation data) and record content – report on discrepancies/areas of concern and areas of good practice

3.12 Review incidents / complaints / claims with a view to lessons learned quarterly, review trends analysis and actions taken to address; monitor investigation of , and outcomes (i.e. learning) from orange and red incidents and complaints

3.13 Report on progress against action plans for serious incidents (SUIs/Red incidents) and identify lessons to be shared across the trust.

3.14 Monthly review of patient information – review ongoing patient information programme in line with NHSLA standards and clinical effectiveness

3.15 Review monitoring arrangements for training and induction (induction, clinical competencies, skills and medical devices, mandatory training) and consider feedback on progress with training and monitoring arrangements; Monitor the number of staff who have attended/not attended this training

3.16 Consent – report on any consent issues

3.17 Guidelines – ensure the review of guidelines (e.g. updated/on intranet)

Governance, Quality and Risk Meetings for Clinical Services

Annual Model Agenda

1. Apologies
2. Minutes of previous meeting
3. Review of current identified risks and plans for mitigation
4. Review of recent incidents, complaints, claims, HSE recommendations\ improvement notices within the speciality and lessons to be learnt.
5. Progress against action plans from incidents, complaints and safety targets.
6. 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
7. Review of compliance with core standards and (from 1 April 2010) compliance with conditions of registration with CQC.
8. Review and discuss recommendations from audit, case review meetings and morbidity and mortality meetings and agree action plans
9. NICE – review recent guidance and report compliance; NSFs, Confidential Enquiries and any relevant external reports – Report on progress and benchmarking and actions taken/required
10. Any specific items relevant to the speciality including development of service specific performance indicators
11. Review of clinical outcome data (i.e. quality indicators e.g. infection rates), relevant performance management data and clinical coding
12. Review of training progress (induction, statutory, clinical competencies and skills, medical devices). Monitoring of attendance at mandatory induction and annual updates (at least six monthly)
13. Review of patient information and consent process
14. Practice Development issues – List of issues and actions taken to address them
15. Guidelines – Review and approval of policies, guidelines (e.g. updated/on intranet)
16. SABs/NPSA/MDA Alerts
17. Issues for the clinical director / directorate