West Hertfordshire Hospitals NHS Trust

Committee Terms of Reference

Integrated Risk and Governance Committee

Status:	Sub-committee of the Trust Board
Chair:	Non-Executive Director of the Board
Clerk:	Asst Director of Clinical Governance and Risk
Frequency of meetings:	Bi-monthly
Frequency of Attendance	All members are expected to attend at least 4 meetings during the year.
Quorum:	One third of the members, of which one must be a Non-Executive Director

1. Context

1.1 The terms of reference of the Trust's Integrated Risk and Governance Committee reflect the requirements of the National Health Service Litigation Authority's standard 1.3 (2009/10). This requires the organisation to have a high level Committee with overarching responsibility for risk.

1 Remit

2.1 The Committee has delegated authority from the Board of Directors to investigate any activity within its terms of reference. It is also authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

3. Membership:

3.1 Chair of the Audit Committee (Deputising in the absence of the Chair)
Chief Executive*
Director of Patient Safety/Medical Director*
Director of Nursing*
Director of Workforce
Director of Partnerships*
Director of Strategy and Infrastructure
Director of Corporate Affairs
Director of Finance*
Ass't Director of Clinical Governance and Risk*
Assoc Director of Integrated Governance
CQuaC Members: (* names above are also members)
Director of Delivery
Director of Medical Education
Divisional Director of Surgery & Anaesthetics

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Divisional Director of Medicine
Divisional Director of Clinical Support
Divisional Director of Women's and Children's
Clinical Director of Surgery
Clinical Director of Anaesthetics
Clinical Director Physician / Lead for Clinical Audit
Clinical Director of Pathology
Clinical Director of Obstetrics/Gynaecology/Paediatrics
Deputy Director of Strategy & Infrastructure
Associate Director of Hotel Services
Head of Midwifery
Chief Pharmacist
Trust Lead for Cancer
Patient Representative

3.2 Chairman

The Chairman of the Committee will be appointed by the Board of Directors and will be a non-executive director (NED). In the absence of the Chairman, the Chair of the Audit Committee will be delegated the responsibility of Deputy Chairman.

3.3 Clerk of the Integrated Risk and Governance Committee

The Clerk of the Committee will be the Ass't Director of Clinical Governance and Risk.

4. Accountability and Reporting Arrangements

4.1 The Committee will be directly accountable to the Board.

4.2 The Chairman of the Committee will report on the proceedings of each meeting to the next meeting of the Board. The IRaGC will ensure that the Trust Board receives the Trust's High Level Risk Register for scrutiny at each Board meeting. The Chairman of the Committee will draw to the attention of the Board any matters of concern in relation to the effective management of the organisation's risks.

4.3 The minutes of the meeting will be sent to the Trust Board and copied to the Audit Committee.

4.4 The IRaGC will present an Annual Report to the Board on progress in implementing the Trust's Risk Management Strategy

4.5 The following Committees will report to the IRaGC:

- Business Integrated Standards Executive (Risks)
- Health and Safety Committee
- Information and Implementation Governance Group
- Carbon Reduction and Sustainability Committee
- Emergency Preparedness Group

4 Responsibilities

4.1 Risk Management and Governance

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The Integrated Risk and Governance Committee (IRaGC) will promote Integrated risk management as intrinsic to all of the organisation's activities and specifically promote local level responsibility and accountability for identifying and managing the organisation's risks.

The IRaGC will oversee the maintenance and further development of the Trust Risk Registers as key tools to support the achievement of a high level of internal control, patient safety and clinical quality and which inform risk-based Board decision-making. It will work closely with the Trust's Audit Committee to ensure the two Board Committees maintain no significant overlaps or gaps between the remit and overview.

The Committee will challenge risk assessment and risk management arrangements in areas of Trust activity where robust controls are not in evidence.

The IRaGC will be supported through the work programme of the Business Integrated Standards Executive.

4.2 Duties

The duties of the Committee are to:

- Provide the Board with a shared and clear understanding of the key risks in the Trust, what mitigation is in place to minimise risks and which risks have been accepted and how they are being managed.

- Oversee the implementation and further development of the Trust's Risk Management Strategy which establishes the risk management processes and assurance requirements for the Trust;

- Review progress against the annual Risk Management Strategy Action Plan, ensuring it supports the achievement of the Trust's Strategic Objectives and the Integrated Business Plan;

- Ensure the processes of risk management produce a co-ordinated programme of risk management, through which risks are identified and mitigating actions ensure integration of clinical, financial and organisational risks that recognise the potential impact of individual risk across the organisation's activities;

- Assess and review the composition and ongoing development of the format of the Board Assurance Framework, ensuring it provides a robust tool through which the Audit Committee can monitor management of the organisation's key strategic risks, ensuring that effective control and assurance mechanisms are in place and that effective actions are being taken to address gaps in control and assurance;

- Assess and review the Trust's High Level Risk Register, which records all risks scoring 20 or above, not on the Board Assurance Framework. The IRaGC will ensure ongoing actions are in place to effectively manage, mitigate and reduce such risks. Specifically, where the Committee is not satisfied that mitigating action is effective, to consider escalating such risks to the Board;

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- Promote the development of a consistent approach to risk scoring to ensure scores accurately reflect the risk to the Trust.

- As reported via the Trust's Business Integrated Standards Executive (BISE), review progress reports on the implementation of action plans resulting from risk assessments of the Trust's activities;

- Through the offices of the BISE receive assurance in relation to compliance with the National Health Service Litigation Authority (NHSLA) Risk Management Standards and ensure progress towards increasing the level of assurance to NHSLA (Acute Services) Level 3;

- Through the offices of the BISE, receive assurance in relation to the achievement of the Trust's Maternity Risk Standards through the Clinical Negligence Scheme for Trusts (CNST) assessments, and ensure progress towards increasing the level of assurance to CNST Level 3.

- Review the findings and ensure implementation of recommendations arising from internal audits of Trust risk processes.

6. Notice of Meetings

6.1 Meetings will be scheduled in advance at the beginning of each calendar year**.**

6.2 Details of each meeting, including agenda and supporting papers will be forwarded to each member of the Committee at least 7 days in advance of the meeting.

7. Minutes of Meetings

7.1 Minutes of the meetings will be circulated, together with associated Actions Log Tracker to all members of the Committee and those in attendance as soon as reasonably practical.

8. Monitoring of Effectiveness

8.1 The Committee shall, once a year by self-assessment, review its own performance, constitution and Terms of Reference, to ensure it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, recommend any changes to its terms of reference to the Board.

8.2 These terms of reference will be approved by the Board and formally reviewed at intervals not exceeding two years.

Terms of Reference Ratified by:

Date of Ratification:

Date of Review:

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