This Framework comprises:

Risk Framework -Introduction
Context
Interaction with Policies and other documents

Strategic & external context and background

The Risk Framework – Staff involved
- Roles and Responsibilities

- **CEO**
- **CNO CMO CFO**
- **Other Chief Officers**
- **Head of Governance**
- **Company Secretary**
- **Chairman**
- **Non-executive Directors Divisional**
- **Directorate Managers**
- **All Staff**

Structure & approach - Integrated Governance
Risk Identification
Risk Management Structures Types and levels of assurance Aspects of assurance

Risk Management Assurance System - Risk Management Systems
Sources of Risk Identification Risk Management Process

- **1-4 Risk Registers**
- **Risk Prioritisation Risk Escalation**
- **Board Assurance Framework Trust Risk Register**
- **Local Risk Registers Improvement, actions,**
- **Monitoring – Quality, Compliance, CQC, Safeguarding**
- **Information and reporting**
- **Assurance**
- **Clinical Audit**
- **Quality Improvement**
- **Risk Management Assurance Structure - Tiers 1-4**
- **Board and Board Committees**
- **Groups supporting Board Committees**
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Appendix 1 - Glossary
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1.0 Risk Framework

1.1 Introduction

The Governance and Risk Framework (the Framework) replaces the previous Risk Management Assurance Strategy. The operational and developmental aspects of Risk Management are covered by the Quality and Safety Strategy for the Trust, the Risk Management Policy and in the Risk Management Delivery Plan. The detail of the systems, processes and accountability are described in the Risk Management Policy (OP10).
The Framework is designed to describe the 'high level' – Trust Board and below Risk Management Structure, the Risk Management Processes, the Risk Management Accountability and Risk Management Assurance.

1.2 Context

The framework supports the aim of the Trust continuing and striving to be **'**An NHS organization that continually strives to improve patients' experiences and outcomes**'.**

It describes the overall systems, structures, processes, accountability (roles and responsibilities) and assurance that underpins

- internal controls and the
- means by which assurance on risk management is provided to the Board.

The Risk Framework aims to:

- Produce and challenge evidence-based assurance
- Provide clear accountability from Ward to Board
- Provide examples of risk development
- Achieve continuous Quality and Safety improvements through sound systems, processes and outcomes
- Describe and thereby strengthen governance arrangements from Ward to Board
- Maintain adherence to regulatory, performance and contractual standards including Care Quality Commission, NHS Improvement/NHS England (NHSI/E) Commissioners, NHS Resolution, National Patient Safety Agency, Department of Health et al.
- Describe the aggregation and reporting of Risk information
- Support a culture that is open to sharing learning, best practice and continuously improve the patient experience and healthcare
- Support the work to reduce adverse incidents, patient harm, litigation and claims.

1.3 Interaction

This is not an exhaustive list of those key document linkages;

- **GP01, Corporate Governance – Principles of Public Life**– Details the principle and underpinning Board activities as required following Nolan Principles and Turnbull report.
- **OP95, Introduction of new Clinical Techniques and Interventional Procedures Policy** – Details the application, approval and risk management process applied where new techniques and procedures are introduced.
- **OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines** – Details the processes that must be followed to create or review existing Trust-wide strategies, policies, procedures or guidelines and local procedures or guidelines.
- **Review and implementation of NICE guidance and National Confidential Enquiries Procedure –** Outlines the process for management and response to NICE guidance and the process for management and response to National Guidance.
- **Management of External Reviews Procedure**– Details the preparation and response process for inspections carried out by external agencies.
- **OP60, Being Open Policy** – Explains the practice, approach and necessary documentation for implementing the Being Open process.
- **OP10, Risk Management and Patient Safety Reporting Policy** – Details both the reactive and proactive systems for risk identification / incident reporting, trends analysis, investigation, controls and action monitoring. The policy instructs staff practice at all levels of the organisation.
- **HS01, Management of Health and Safety Policy** – Details the actions and monitoring required across the Trust to ensure the safety of patient, staff and the public is achieved.
- **Clinical Audit and Quality Improvement SOP** – Details the audit process including implementation and monitoring of clinical audit.
- **OP31, Legal Services Policy** – Details the system and process for claims handling and links with operation risk management to reducing litigation costs.
- **OP13, Information Governance Policy** – Identifies patient expectations for confidentiality and specifies how the Trust undertakes to protect those expectations.
- **OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines** –

Provides standards for the development and management of strategies, policies, guidelines, protocols which require board or committee approval.

- **CP41. Safeguarding Children in Hospital** – Describes the arrangements within the Trust to safeguard and promote the welfare of children and young people.
- **CP53. Safeguarding adults at risk** – Describes the Trust arrangements for safeguarding adults and delivery of the inter-agency strategy.
- **Patient Experience, Engagement and Public Involvement Strategy 2019 - 2022 -** Sets out the Trust approach to measuring, capturing and improving patient experience.
- **Clinical Audit and Quality Improvement Delivery Plan 2019 – 2022 -** This strategy document sets the medium and long term direction of clinical audit and quality improvement.
- **Mortality Delivery Plan 2019 – 2022 -** designed to ensure that the organisation is learning from mortality though the development of a strong mortality governance framework.
- **Our Patient Quality and Safety Strategy – 2019 – 2022** - Sets out how the Trust ensures high standards of quality and safety are sustained and expected at RWT and the benefits we expect the public to see as a result.
- **Infection Prevention Delivery 2019 - 2022 –** Describes arrangements to ensure the Trust has suitable and sustainable infection prevention and control arrangements in place.
- **Information and Communication Technology (ICT) Digital Strategy 2020 - 2023 -** highlights the direction of travel for ICT including the major outcomes and associated action required.

A glossary of terms is provided in Appendix 1.

2.0 Strategic & External Context and Background

Previously organisational failures in the public and private sectors have, to some extent, been attributed to poor governance or failings in risk management. The response to this has tended to be increased control and reporting via legislation, codes and guidance.

In this environment, clear lines for accountability and assurance are important. This supports the public Annual Governance Statement made by the CEO as part of the Trust Annual Report. Previous reviews have sought to identify and eliminate duplication of effort and resources, and reduce the burden of bureaucracy. This document summarises the position the Trust has reached at a point in time.

3.0 The Risk Framework

The Trust has a system of internal controls that support and inform future innovation and improvement, using risk intelligence and assurance to inform and direct proactive management action. Integrated Risk Management operates through proactive risk and compliance assessment and reactive analysis for learning and improvement. There are also close links with Quality and Patient Safety Initiatives and their related monitoring.

Staff involvement

Staff must ensure they comply with arrangements contained in this Framework and in all related policies and mandatory training as set out in the Mandatory Training Policy (OP41).

All staff are required to demonstrate the Trust values in their behaviour and role functions thus ensuring that good governance is achieved in process, outcome, behaviour and assurance.

4.0 Roles and responsibilities

4.1 Chief Executive

The Chief Executive has overall responsibility for maintaining a sound system of internal control within the Trust and for preparing an Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility as outlined below.

The Chief Executive is accountable to the chair and Non-Executive Directors for ensuring that the board is empowered to govern the organization and that the objectives set are accomplished through effective and properly controlled executive action.

4.2 Chief Nursing Officer (The Chief Nursing Officer may delegate some of these responsibilities to the local Director of Nursing)

The Chief Nurse has the following responsibilities:

- Ensuring adequate clinical governance systems, processes and internal controls (jointly with the Medical Director);
- Ensuring the effective operation of systems for the management of clinical and corporate risk
- Overall performance of Corporate Governance functions (including maintenance of the Board Assurance Framework with Executive Directors)

- Ensuring that there are robust systems and processes to manage the assurance against CQC registration regulations, CQC Fundamental Standards of Care, NHSR risk history/profile and other national guidance;
- Executive Lead for Patient and Public Involvement
- Executive Lead for Health and Safety
- Executive Lead for the Governance
- Executive Lead for Safeguarding
- Executive Lead for Infection Prevention
- Executive Lead for Education - Non-Medical Professions
- Executive Lead for Nurse Revalidation

4.3 Chief Medical Officer

The Medical Director has the following responsibilities:

- Ensuring adequate clinical governance systems and processes and internal controls (jointly with the Chief Nurse)
- Ensuring the effective operation of systems for the management of clinical and corporate risk
- Ensuring effective operation of Corporate governance processes (jointly with the Chief Nurse)
- Fulfil role of Caldicott Guardian
- Executive Lead for Mortality management
- Executive Lead for Information Governance
- Executive Lead for Clinical Audit, NICE guidelines and National Guidance
- Executive Lead for Medical Education and Training
- Medical Director is the Responsible Officer and executive lead for medical revalidation

4.4 Chief Finance Officer

The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Fraud

The Trust's Chief Financial Officer has a responsibility to ensure that the Trust has adequate Counter Fraud measures in place to manage the risk of fraud in accordance with the NHS Counter Fraud Authority's Counter Fraud Strategy. The Government Functional Standard 013: Counter Fraud applies to all NHS organisations from 1 April 2021. This standard requires the Trust to carry out a comprehensive local risk assessment on an annual basis to identify fraud, bribery and corruption risks, and have a counter fraud provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession fraud risk assessment methodology. It is recorded and managed in line with this risk management policy and included on the appropriate risk registers. Measures to mitigate identified risks, such as specific proactive reviews, are included in the annual counter fraud workplan and progress is regularly reported to the audit committee. The local counter fraud specialist (LCFS) will inform the Trust of potential fraud risks so they can be effectively assessed. Where risks are identified these will be included on the Trust risk register so they can be proactively addressed. Similarly, all fraud risks identified by the Trust will be communicated to the LCFS. The audit committee and the Chief Financial Officer are kept abreast of any issues relating to fraud throughout the year. In addition, the Trust will participate in national and local pro-active exercises throughout the year, designed to identify fraud and reduce the likelihood of specific fraud risks to which it may be vulnerable.

Bribery

The Bribery Act 2010 introduced a corporate offence of failure to prevent bribery by persons working on behalf of a business. However, for the Trust to have a statutory defence to the corporate offence, it must demonstrate that the 6 adequate procedures have been considered, assessed, and where appropriate, measures taken. The 6 adequate procedures are as follows: 1. Proportionate procedures to prevent bribery. 2. Top level commitment. 3. Risk assessment. 4. Due diligence. 5. Communication (including training). 6. Monitoring and review.

4.5 Chief Officers

(Executive Directors – Voting and Non-voting, Directors (Attending and Non-attending) The Executive Directors have responsibility for the management of strategic and operational risks within their individual portfolios. Responsibilities include the development of robust governance arrangements and systems that ensure monitoring, challenge and oversight of risk as well as compliance with

statutory/legal responsibilities.

4.6 Head of Governance

The Head of Governance is accountable to Chief Nursing Officer for the management and leadership of the Central Governance Team; and for the development of this Governance and Risk Management Framework and the operation of governance, risk management assurance processes.

4.7 Company Secretary

Responsible for the delivery of Corporate Governance functions on behalf of the Board and related Committees, including Board meeting administration, board business planning, and provision of advice.

4.8 Chairman

The overall role of the chair is one of enabling and leading so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- ensuring the provision of accurate, timely and clear information to directors
- ensuring effective communication with staff, patients and the public
- arranging the regular evaluation of the performance of the board, its committees and individual directors
- facilitating effective contribution of non-executive directors, and ensuring constructive relations between executive and non-executive directors

A complementary relationship between the chair and chief executive is important.

4.9 Non-Executive Directors

Non-executive Directors have a duty to ensure that the Trust has sufficient control measures to be able to effectively manage its risk.

4.10 Divisional Management

All Divisional management are responsible for implementing the Risk Framework and its systems and processes. They are responsible for internal monitoring and operation of all internal control for assurance in their areas of responsibility e.g. risk registers, incident and risk management, compliance and audit processes.

4.11 Directorate Management

All Directorate management (including ward managers) are responsible for the implementation of Trust strategies, Frameworks, policies and procedures; and for implementing systems that support internal controls and assurance within the Trust.

4.12 All Staff

All staff have the responsibility to contribute to good governance by complying with all Trust policies, procedures and systems including reporting and investigation of incidents and near misses and reporting risks and hazards.

Structure and Approach

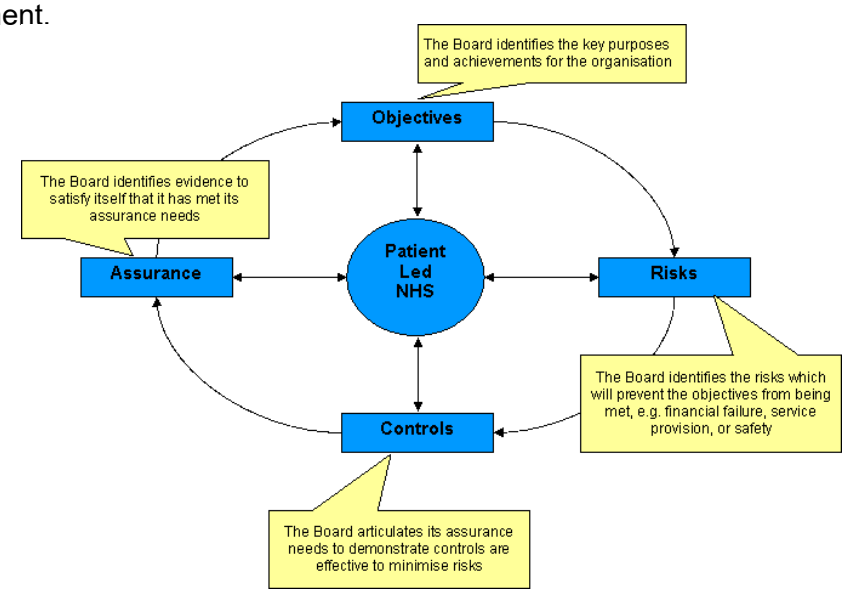
5.0 Integrated Governance (a prerequisite of integrated risk management)
is described as 'the systems, processes and behaviours by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of service'. *(Integrated Governance Handbook (2006)).*

In practice this means:

- Establishing and developing standard risk management systems and processes
- Analysing reactive risk management intelligence (from incident reporting, complaint and PALs feedback, claims, inquests, inspections etc.)
- Assessing proactive Trust performance against national standards, best practice, benchmarks and regulation (from risk assessment, prospective audit, compliance measurement)
- Identifying and assessing sources and strength of assurance(s)
- Triangulating internal and external intelligence to inform decisions & changes

- Validation and quality assurance checks of data used/referred to.
- Implementing a consistent approach to data collection and collation
- Identifying and addressing all risks and any gaps within the process

The framework enables reporting on internal controls to support the Board in signing off the Annual Governance Statement.



Process – Risk identification
Trust Strategic Objectives and Aims lead to the identification of strategic prospective risks that threaten the achievement of the objectives as well as controls and actions as appropriate to manage risks, as expressed in the Board Assurance Framework (BAF) and Trust Risk Register (TRR).

The cascade of the strategic objectives to Divisions and Directorates coincides with the delegation of risks relevant for local management (TRR).

5.1 Structures – Level of Risk management

- At Trust Board level – the BAF and high-level TRR Risks
- At the levels of assurance (see below) below the Board.
- The Risk and Incident Reporting and Management System (Policy);
- Clinical audit/National benchmarks;
- National Standards and regulatory compliance;
- Quality and Safety Improvement indicators (Quality, Safety, Performance);
- Policy Governance (Policy);
- Internal/External/Peer review;
- Management/Governance/Committee reporting (accountability structures).

Types and Levels of assurance
Assurance provide is assessed in terms of the strength and value in acting on the originally identified risk. The Trust uses three lines of defence model contained in HM Treasury Assurance Framework.

There are various **types of assurance** that can be sought: verbal, written and empirical. All can be of use depending on the circumstances. Each will be valued differently depending on the necessity of the risk. Verbal assurance in isolation can be the least relevant and must be substantiated as it may be deemed reassurance rather than assurance.

In line with HM Treasury Assurance framework guidance 2012 – three lines of defence or **levels of assurance** have been adopted depending on the **source of the assurance**;

- Level 1 – Operational/Internal (routine local management/monitoring, performance data)
- Level 2 – Oversight functions/Internal (Committees, internal compliance assessment, internal audits)
- Level 3 – Independent/External (External Audits/Reviews/Inspections)

Aspects of assurance
Regardless of the type, source and level of assurance there are other aspects that impact on the

'value' that can be placed on the assurance;
Age – the time elapsed since assurance obtained
Durability – whether it endures as a permanent assurance on an historical matter
e.g. Auditors' Report on Financial Statements, or work that loses relevance over passage of time e.g. clinical audit
Relevance – the degree to which assurances aligns to the specific area or objective over which it is required
Reliability – trustworthiness of the source of assurance
Independence – the degree of separation between the function over which assurance is sought and the provider of assurance

Finally, a **level of confidence in the assurance** can be established relating to whether the assurance has, is or is likely to act on the risk – that is, either reduce the risk rating or significantly add to mitigations, controls or address gaps in assurance. This judgement is ultimately in the hands of the lead Director and Trust Board via the Board Committee functions.

5.2 Risk Management Assurance System

Risk is an inherent part of the delivery of healthcare. Attempting the achievement of objectives is subject to uncertainty which gives rise to threats and opportunities.

Risk Management Systems

The Trust has implemented standard risk management systems and processes seeking to minimise or mitigate threats and maximise opportunities to continuously improve.

A Standard Risk Management System in practice means applying a consistent approach to identifying, reporting, assessing, responding to and, where appropriate, escalating risks.

Having Clear objectives means services and functions can:

1. Identify risks to achieving their objectives,
2. Define and record risks on a risk register
3. Maintain the risk register and act on the risk with mitigations, controls and actions, and
4. Escalate and de-escalate where appropriate subject to controls and assurances.

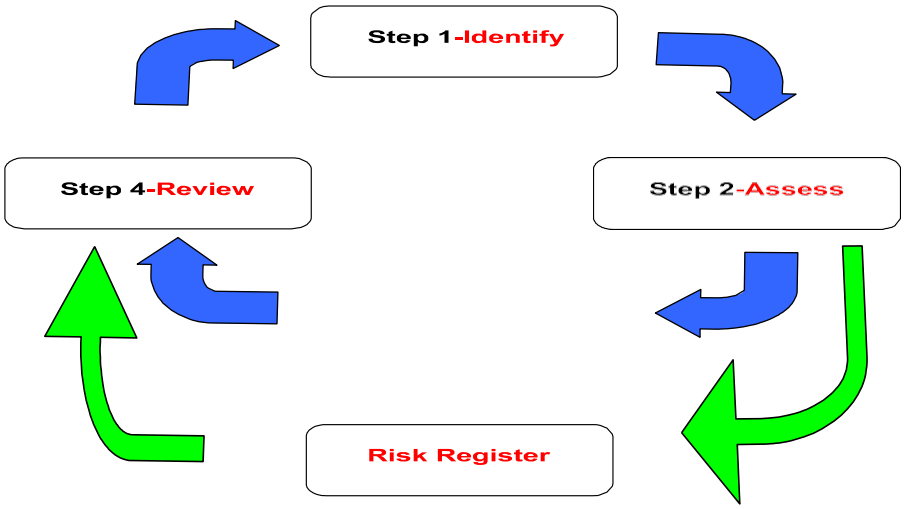
Sources of Risk Identification

Actual and potential risks are identified from numerous sources including: incidents, complaints, claims, trends, investigations, compliance standards/benchmarks, audits, assessments/ inspections, cost improvement programmes and others.

At a Board level, potential strategic risks are often identified as part of strategic objectives and planning work, horizon scanning and local/regional/national/international events.

Process

Policy OP10 details the process for the identification of risks from all sources of service activity as outlined in Procedure 2, OP10 for further management.
The risk management cycle is applied to all levels and types of activity:



1. **Identify**
   From a range of potential sources – Incidents, risks or near misses already incurred – from the reporting of incidents, complaints, claims, inquests, trends review**,** underachievement of targets, budgetary review, external visit or review outcome.

   Potential risks can be proactively identified via Corporate/local objective setting, risk assessment processes for Infection Prevention and Control, Health and Safety, National guidance/ benchmarks or feedback raised by staff or other stakeholders.

2. **Assessment**
   Risks and threats must be considered in all activities and transactions. The Trust uses a categorisation matrix (The New Zealand Matrix) that grades the likelihood and consequence to determine the risk score. Risks (actual or potential) that have been assessed as 12 or greater (having an unacceptable residual or ongoing impact on quality, safety or patient experience) will be managed in line with the risk escalation process as per Policy OP10.

3. **Treat**
   The identification of controls and or actions to manage and/or reduce the threat/risk. Controls can be identified to reduce the likelihood of occurrence or the impact if realised. Controls must be measurable to assess the mitigation of risk.
   Mitigation can be achieved through:

- Management of staff accountabilities
- Policies, procedures and guidelines
- Systems and processes
- Feedback procedures/methods
- Staff training, education and management
- Key performance indicators/monitoring reports
- Internal/independent audit
- Process analysis and re-design

   Controls identified require an evidence base. Actions require to be clear and measurable, and 'Treatment Plans' must use the 3 "T" options –

- Terminate - stop the activity/risk,
- Tolerate - accept the risk with no mitigation or control or,
- Transfer - to another party.

4. **Review**
   All local risk registers are reviewed regularly with a defined process for risk escalation detailed in Procedure 2 OP10.

   The Trust Risk Register (TRR) and Board Assurance Framework (BAF) are reviewed regularly by the Trust Board (monthly) and delegated Committees (monthly).

   The outcomes are used to inform policy development, key performance indicators and internal/external audit plans.

   Risk Registers Framework:
   The Trust operates three levels of risk register; BAF, TRR and local risk registers. This allows a bottom-up/top-down approach to informing the overall Trust Assurance Framework and includes all risks to the organization including strategic, clinical, Health and Safety, business, marketing and financial.

   Each entry contains the following minimum information:

- Source of risk;
- Description of risk;
- Risk score;
- Controls and gaps in controls;
- Residual risk score;
- Mitigating actions;

- Date of assessment and date for review.

Risk Prioritisation
A standardised approach to risk prioritisation provides consistency and directions for staff. The Matrix (likelihood x consequence) allows the actual and potential severity to be considered and thereby prioritised.

This is reviewed and challenged, clarified and confirmed by management at the level assigned by the relevant Division/Directorate and reviewed at least quarterly.

Where rated 12 or above, the risk escalation process applies. The central governance team conducts regular checks of the risk recording system in order to identify trigger grades and validate scores. Bespoke training is available to staff where grading inconsistencies are identified.

Risk Escalation
All risks confirmed as 12 or above must be escalated to Trust Risk Register. Risks identified at each level (Division/Directorate/Ward/Department) must be reviewed with a view to further escalation, downgrade or local management.

A Risk Register review meeting is conducted monthly for oversight, attended by the Chief Nurse (or Deputy) and Governance representatives. Risk updates are followed up and appropriate risk escalations monitored for compliance with Trust process.

The Board Assurance Framework (BAF)
The BAF details the strategic potential or prospective risks to the Trust meeting its strategic objectives. The BAF sets out controls in place to mitigate these risks and details assurances on the effectiveness of these controls.

The BAF provides a starting point for the Trust Board to record risks that may impact on it achieving the strategic objectives. Related risks or elements of a BAF risk may be delegated or already exist for local management/monitoring on Divisional/Directorate risk registers. This cascade approach ensures management alignment with the BAF and local risks and the strategic objectives they support.

The BAF provides a control structure to support the Annual Governance Statement. The BAF is reviewed regularly by the Trust Board and delegated Committees.

Trust Risk Register (TRR)
The TRR is the corporate record of high-level operational risks escalated from service areas as well as risks identified for Director portfolios or delegated from the strategic objectives for local/operational management. It provides the link between local risk management processes and board level review of operational risk.

The Trust risk register will automatically include all approved risks graded at score 12 and above using the categorisation matrix and will include risk mitigation/ control actions. Equally the identified causes of BAF risks can be transferred to the TRR where appropriate. Used correctly the TRR ensures an effective risk management and escalation approach operates within corporate and operational levels of the Trust. The TRR is reviewed regularly by the Trust Board and delegated Committees.

Local Risk Registers (Divisional and Directorate registers)
Each Division and Directorate manages a risk register and operates the risk escalation process. Local risk registers will be regularly reviewed and all risks graded at 12 or above will be escalated (once agreed by the Division/Directorate) to the Trust risk register for the attention of Directors. The Division/Directorate will ensure it has a system for approving and reviewing risks including controls and action monitoring. Divisions must have oversight of Directorate risks ensuring that risks highlighted or escalated through the risk register hierarchy are considered in the context of other risks already on the register in other areas or at other levels.

Sharing lessons for improvement
OP10 details the methods for identifying and sharing lessons and learning. These are shared at all levels of the Trust via standardised reporting at local and Trust committees, newsletters and a Learning

from Experience Group (LEG).

The LEG identifies learning and trends from looking across and triangulating incidents, complaints, claims or inquests in order to determine improvement actions/strategies. A future Learning Toolbox is planned including learning systems, tools, portal, logs and communication platform.

Action tracking
The has systems for monitoring and tracking actions resulting from serious incident investigation, national compliance measures, national/internal audits or other sources where significant risks are identified.

This can be undertaken at local operational level with local management having delegated accountability for assurance of closure. An action oversight report for SUI, National Guidance including CQC compliance, Clinical Audit will be made to an appropriate Trust committee/group. Action tracking is recognised as vital to closing the loop and to ensure an improved outcome is achieved.

Monitoring of Quality, Safety and Compliance risk
The Trust will take a holistic and evidence-based view of assurance using hard and soft evidence as pointers to monitor quality and safety; and to detect poor performance.
Measures include:

- Performance indicators (i.e. Nurse/Quality metrics, CQC surveillance data)
- Incidents, complaints, claims trends
- CQC domains and Fundamental Standards assessment
- NHS Resolution claims profile
- Health and Safety compliance
- Information Governance compliance
- Patient/staff feedback
- External assessment/Inspection
- Internal Quality review programme
- National benchmarks, Independent and external assurance used for triangulation

The review of quality and compliance measures is assigned across the Trust committee/group structure within their terms of reference.

Monitoring CQC Regulation Compliance Risk
The Care Quality Commission (CQC) monitors compliance with the regulations. The Trust has developed from a self-assessed approach to a compliance monitoring approach against the regulations and fundamental standards of care. This includes monitoring with specialist lead and group oversight, key performance indicators and observational peer review.

An Internal Quality Review Programme (QRP) uses observational and peer review methods to monitor quality and safety of patient care in line with the new regulations and Fundamental Standards of Care.

The Trust will further develop an IT solution to record compliance and quality monitoring, with the capacity to capture compliance at different levels of the organisation. Monitoring of this is also regarded as a potential early warning alert to risk.

Monitoring Safeguarding Risk
Safeguarding Assurance is provided by case investigation, referral monitoring, training, external audit, performance indicators derived from Trust policies and the Wolverhampton Safeguarding Boards. Safeguarding activity and performance will report through Trust level group to inform the assurance framework.

Potential Risk Information Management and reporting
Reporting templates, terms of reference and escalation mechanisms are used to provide consistency in reporting in relation to;

- Relationship to Trust Strategic objectives and identified risks;
- Impact upon key national priority indicators, standards and regulatory requirements;
- High impact metrics covering safety, clinical effectiveness and patient safety;
- Potential advanced warning indicators;

- Adverse event priorities, trends and patterns - from incidents, complaints and claims;
- Impact of Harm reduction priorities;
- Quality and Safety strategic priorities
- Qualitative descriptions relating to quantitative information.

High-level reports are defined and backed up by a pyramid of more granular reports from specialist groups, divisional/directorate management and specialist leads. Reporting lines and content are subject to periodic review and re-design.

Policy Management and Risk Assurance

Policy implementation, audit and monitoring is a key part of the risk assurance process. The Trust operates a policy management system which ensures consistency in the minimum content, format, communication and review of Trust policies. A designated Policy group is assigned for review of Trust Policies. Each policy must identify the monitoring and audit requirements for key deliverables in order to inform assurance. Where compliance/quality risks are identified this must follow the standard process for risk escalation. The Trust has governance arrangements for local procedural documents, via a central register. Both are managed using a dedicated software system.

Clinical Audit and Continuous Quality Improvement

Clinical audit is delivered through a structured and risk-prioritised annual programme monitored by a sub-group (Clinical Audit group) responsible for monitoring delivery of the annual audit plan and to ensure that actions are disseminated for improvement.

Risks identified through audit must be reported and managed in accordance with the risk management process detailed in the Risk management Reporting Policy (OP10).

Risk Management Assurance - Structure Overview

The Trust Board has set in place a committee and management structure to manage the internal controls, the Quality/Safety and business/operational risks of the Trust. This Framework summarises the collective responsibility of committees/groups, individual managers and staff for ensuring the safety of patients, staff and visitors.

From the Board to the Ward, the effective function of each tier relies on the appropriate discharging of membership roles, behaviour and the culture within the Trust. In monitoring risks, the Board, its committees, groups and specialist working groups consider:

- The adequacy of existing controls to mitigate risk
- Any additional actions needed by whom and by when
- Whether the risk score and current level is appropriate
- Whether the risk requires upward escalation;
- Whether there are links between identified risk(s) pointing to broader corporate issue(s)
- What are the appropriate next steps;
- Whether the identified risk(s) represent a threat to the Trust strategic aims and must therefore be escalated for consideration for the BAF;
- Whether to accept the risk with no further possible mitigation.
- Whether the actions of the advisory groups and its subgroups are or have been sufficient/adequate.

Tier 1 - Board Committees

The Trust Board has established 6 Board Committees to provide assurance regarding strategic areas and responsibilities to the Board. The foci of each Committee is assurance, challenge and triangulation. Each committee has terms of reference (agreed by the Trust Board) and a prescribed portfolio of work aligned to Corporate Objectives and to statutory/specialist necessities and assigned BAF Risk(s).

These Committees utilise a network of groups to lead on various area of work and review reports on performance/risk to inform overall assurance. This level of reporting and review looks at levels and types of assurance, summary overview reports with exception reporting (where agreed, based on triggered performance criteria and levels so as not to duplicate delegated responsibilities of reporting groups).

Detailed reports or further assurance may be requested from groups or others in response to assurance and/or performance questions and issues for triangulation. A programme of themed reviews

is scheduled to ensure the breadth and depth of required assurance over the year.
Board committees utilise multiple means of seeking/testing assurance including written reports, verbal reports by key leaders, area visits with feedback, focal points using safety or leadership walkabouts and/or peer reviews and/or proactive audit assurance (internal and independent).

Tier 2 - Groups
Groups are subject-specific or cohorted (e.g. Trust-wide Patient Safety or Compliance Projects) to enable large and disparate areas of work to be co-ordinated and managed. The focus of a sub-group is on action delivery, monitoring and escalation. This level of review is more granular by location and underpins Trust-wide dashboards and reporting. Each group has the role of challenging performance in specific areas and reviewing and monitoring of improvement actions. Groups are established on a functional requirement basis by a lead Director and approved by a Board Committee.

Tier 3 - Specialist Groups
Specialist groups are derived from professional/specialist guidance or best practice requirements. They may be permanent or fixed-term entities which contribute to assurance in a specific area. Reporting is against agreed measures with the parent Group and they review Trust-wide performance in a specialist subject or area (e.g. Medicines Management, Resuscitation, Medical Devices), establish and report on the impact of risks or gaps on Trust compliance, and develop and monitor improvement plans.

Tier 4 - Divisional Governance
Divisional governance is described in the Divisional Governance Frameworks and outlines local structures and arrangements for the delivery of core functions of Governance, Risk Management and Assurance (e.g. NICE, national guidance, standard compliance, safety alerts, investigations, Information Governance, audit). Details of the Divisional Governance meetings (inc TOR, agenda etc) are found in the Divisional Governance framework.

Requirements are defined at each level as follows – Division, Directorate, Ward or Department and details meeting arrangements, a template governance agenda, terms of reference with meeting frequency and reports produced and any specific review requirements. Each operational area has standard governance and risk management systems and processes in operation.

Reporting
Reporting to the Board from committees, and from groups and committees is a combination of the Chairs' report (exception/escalation/assurance reporting), approved minutes and, where appropriate, a specific report and Reference Pack information with greater levels of detail and performance reports.
All committees and groups have a standing item for 'issues for escalation' and for 'evaluation of the meeting' to reflect on its effectiveness, and any items requiring consideration either for the Trust Risk Register and/or as a potential BAF Risk. At different levels focus will be placed towards assurance, escalation, challenge, monitoring and implementation and further described within terms of reference for each meeting.

Summary of structure – Internal Control Trust Board (TB)
Lead by the Chair, the TB is accountable for assuring itself that systems and processes for governance and risk management (internal controls) are functioning effectively.

Key responsibilities include:

- Set and monitor strategic objectives and direction for the organization;
- Review the effectiveness of the Trust internal controls supporting the Annual Governance Statement and BAF;
- Oversee performance and risk assurance for the organization ensuring appropriate corrective action;
- Ensure financial stewardship;
- Ensure dialogue with external bodies and the local community.

The Management and Governance Committee structures help to deliver the responsibilities for internal control. Trust Board has delegated responsibility for monitoring and managing risk across the organization to:

- Trust Management Committee Audit Committee
- Finance and Performance Committee Quality Governance Assurance Committee Remuneration Committee
- Charity Committee

- Workforce and Organisational Development Committee
- Innovation and Integration Committee

The Operation of the Board and Board Committees are set out in the Trust Standing Orders (SOs).

Trust Management Committee (TMC)
Lead by the CEO, the Trust Management Committee is responsible for the development and delivery of the Trust business plan and the identification and control of operational risks to the delivery of that plan.

Key responsibilities are:
- Identify and control of operational risks to the delivery of the Trust business plan;
- Review operational performance reports to include red incidents, complaints, risks, business case proposals and national compliance;
- Approve Trust policies and strategies for implementation;
- Manage delegated BAF risks, monitoring controls to provide assurance.

Audit Committee (AC)
The Audit Committee provides the Board with a means to undertake and obtain independent assurance through objective reviews and audits of strategic, operational and financial risks / systems and help ensure compliance with relevant law, guidance and codes of conduct.

Key responsibilities include:
- To provide reasonable assurance for safeguarding of assets, for waste or inefficiency avoidance, and that best value for money is continuously sought;
- To obtain independent and objective reviews of key operational and financial systems / information;
- To review the Annual Governance Statement together with any accompanying Head of Internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- To advise the Board as to the nature and accuracy of the Annual Governance Statement.

Finance and Performance (F&P) Committee
The Finance and Performance Committee provides assurance to the Board on the effective delivery of financial and external performance targets of the organisation. It will also support the development, implementation and delivery of the Medium-Term Financial Plan (MTFP) and the efficient use of financial resources. Key responsibilities include:
- Monitor income and expenditure against planned levels;
- Monitor and support the development of a Medium and Long Term Financial and investment Plan in relation to capital and revenue;
- Utilise the assurance reporting processes to inform the Trust Board of Finance, performance, investment related risk and redress actions;
- Manage delegated BAF risks, monitoring controls to provide assurance.

Quality Governance Assurance Committee (QGAC)
The QGAC has responsibility for scrutinising and gaining assurance in relation to management and control of clinical, non-clinical, and corporate risk. It is the main committee through which the organisation is assured that risks are mitigated through appropriate control and reduction mechanisms.

Key responsibilities include:
- Review and assure on indicators relating to patient experience, patient care and quality and patient safety;
- Monitor the BAF and Trust risk register management framework and where necessary make recommendations/challenges to assurances/updates provided;
- Monitor the operation and effectiveness of risk management, quality and safety controls through the Advisory Group
- Utilise the assurance reporting processes to inform the Audit Committee and Trust Board on the management of risk;
- Receive and act upon any feedback / reports from the Audit Committee following their review of the internal audit plan;

- Provide reports to Trust Board via minutes and executive summary reports following every meeting;
- Provide minutes to the Audit Committee to inform on the adequacy of governance processes, corporate risk management and controls;
- Approve terms of reference and receive reports from key sub subgroups e.g. Advisory Group
- Manage delegated BAF risks, monitoring controls and actions to provide assurance;
- Co-ordinate the identification and management of risks utilising the BAF/TRR framework to manage controls, assurances/gaps in assurance and further action.

Remuneration Committee
The Remuneration Committee agrees and executes the framework by which the remuneration and conditions of the Chief Executive and other Executive Directors are set.

Charity Committee
The Charity Committee is established to ensure the management and administration of the Royal Wolverhampton NHS Trust Charity, in accordance with the Charity's purposes, as set out in its Governing Documents.

Innovation, Integration and Research Committee
The Innovation and Integration Committee enables and leads the Trust's adaptation to and adoption of new, changed or different ways of working using innovative techniques, research–based evidence and new technologies to improve service quality, patient and staff experience and increase efficiency and effectiveness across regional priorities and local 'place-based' services.

Groups supporting QGAC
The responsible Board Committee – Quality Governance Assurance Committee (QGAC) – has a revised reporting structure and cycle increasing the potential for risk intelligence triangulation. Reporting groups focus on the review, examination and advice to the Board Committee on all matters by theme/topic/issue, operational area compliance and with any associated information available.

Quality and Safety Advisory Group
1. Collects and collate data and information from all the necessary sources on quality, safety and risk monthly.
2. Provides examination, expert opinion, triangulation with other appropriate sources of key aspects of quality, safety and risk, including (for example) use of statistical process charts, data and assurance level assessments using a Matrix of Divisional and Trust-wide robust collective debate, challenge and accountability.
3. Provides any required analysis, summary and assurance information (including gaps in assurance) to the Quality Governance Assurance Committee of the Board.
4. Has a regular schedule of reporting, examination and analysis from key parts of the Trust and from Groups focused on key issues clinical, non-clinical and where appropriate, corporate.
5. Has a membership that reflects the complexity and diversity of the sources and resources required including key staff from clinical/operational, non-clinical and corporate functions.
6. Provides a summary assurance level and oversight of actions undertaken to address issues, deficits and provide improvement in key areas.
7. Has a cycle of business matched to the Board Committee e.g. Advisory Group aims to meet at least 1 week prior to Committee of the Board and provides a summary report.

Role of Central Teams - Governance Team
The central Governance function facilitates and delivers:
- A standardised approach to risk management process/outcome and assurance;
- Centrally-managed governance and risk management systems and processes;
- Provision of assurance in the form of standard and exception reports (within the portfolio);
- And oversee controls (within the portfolio) e.g. Investigations, risk registers, Audit etc.

This includes:
- Risk management (Incident and risk reporting, investigation and follow up) Governance and risk management systems and processes
- Local Procedures management
- Clinical audit and effectiveness
- Health and Safety

- Standards Compliance management (CQC, NHSR, NICE, National guidance, Inquiries, Professional College reports etc.)
- Trust Committee and Group administration
- Trust Registration/Licensing

Other Governance related functions

The **Company Secretary** provides Legal Services, Trust-wide Policy and Procedure, Board Assurance Framework maintenance and Board and Board Committee (and associated meetings) co-ordination and administration. It works with the Governance and Strategy/Performance Team and the Chief Nurses Team.

The **Strategy/Performance Team** provides co-ordination and management of the Strategy formation, approval and governance process alongside Performance data and information and Quality Improvement information and reporting.

The **Chief Nurses Team** (including the Governance and Company Secretary functions) also supports the Board, Board Committee and Group structures alongside a range of other quality, safety and governance aspects including Maternity, Infection Control, Patient Experience, PALs and complaints, Nursing and Allied Healthcare Profession initiatives.

The **Chief Medical Officers Team** supports the Board and Board Committees in relation to patient data security and data compliance, Learning from deaths, Medicines Management, Medical practice issues and alerts.

Monitoring of this Framework

The Framework will be monitored and review at least annually to amend in the light of any changes or revisions to parts of the Framework.

The implementation of this Framework will be monitored in the following ways:

- Audit of high level indicators derived from this Framework, the Risk Management Delivery Plan, the Quality and Safety Strategy and supporting policies (OP10, OP01, OP60, OP45, OP95 etc.);
- Monitoring objectives and other risk priorities e.g. Health and Safety outcomes, NHS Resolution risk profile, IG toolkit scores.
- Monitoring of the Quality and Safety Strategy and priorities

Counter Fraud

This Framework contains elements that are potentially open to fraud. Reference is made to the Trust's Local Anti-Fraud, Bribery and Corruption Policy, GP02 and the consequences of failing to comply with that policy can include disciplinary action, civil action, criminal prosecution and/or action by a relevant regulatory body.

10.0 References

The development of this Framework is underpinned by the mandates of a number of external governance and risk management drivers:

- The National Patient Safety Agency (NPSA) combined with other emerging national safety organisations, has set out detailed standards it expects NHS organisations to achieve in their risk management arrangements.
- Care Quality Commission (CQC) is the regulator of adult health and social care in England and Wales. CQC collates quality, safety and risk information relating to the organization in order determine compliance with the Fundamental Standards of Care. A risk profile is made for each organization (CQC Insight system) and used along with other intelligence to inform decisions for unplanned visits/inspections and/or enforcement action.
- NHS Improvement (combines NHSI & NHSE); a combined regulator with a focus on supporting providers to become more efficient as well as providing higher quality care. NHSI produces guidance for Boards of NHS Provider organisations which informs the Risk Management Assurance Strategy e.g. Well Led Framework May 2014.
- Other external regulators and stakeholders include Health and Safety Executive (HSE), Department of Health (DoH), Clinical Commissioning groups (CCG) and Local Area Team (LAT), NHS Resolution (NHSR), Royal College and National guidance reports.
- Francis Reports 1 and 2 (2010 and 2013),

- Department of Health (2006) Integrated governance handbook. A handbook for executive and non-executives in healthcare organisations. London. Available at: www.dh.gov.uk
- Monitor (2010) Quality Governance Framework. Available at: www.monitor- nhsft.gov.uk
- Monitor (2010) Compliance Framework 2010 / 11 London. Available at: www.monitor-nhsft.gov.uk
- Monitor (2010) The NHS Foundation Trust Code of governance. London. Available at: www.monitor-nhsft.gov.uk
- NHS Appointments Commission. [2009]. The Intelligent Board. London: NHS Appointments Commission. Available at: www.appointments.org.uk
- Board Assurance Frameworks – A simple rules guide for NHS – Good Governance Institute 2009
- Assurance Frameworks – HM Treasury 2012
- NHS Improvement Single Oversight Framework – September 2016
- Well Led Review as directed by Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (June 2017)
- Learning from developmental reviews of leadership and governance using the well-led framework (November 2018)

Further standards considered / adhered to when setting this Framework and with which all NHS Trusts are required to comply are set out in the following NHS documents:

- Taking it on Trust. Audit Commission – April 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission Guidance about compliance with the Health and Social Care Act 2008 [Registration requirements] Regulations 2009
- Building a Safer NHS for Patients. Implementing an organization with a memory 2001
- National Guidance [National Institute for Health and Care Excellence, National Service Frameworks, National Confidential Enquiries and special enquiry reports]
- Professional reports and recommendations i.e. Royal College and Professionals Allied to Medicine
- NHS Resolution Extranet reports
- Health & Safety Executive regulations and directives
- Kirkup Report January 2018 (Report of the Liverpool Community Health Independent Review)

Glossary of Terms in use in this document are defined as follows:

Assessment – a review of evidence in order to form an opinion; this can be undertaken either internally in the form of a self-assessment or by a third party.
Assurance – 'confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved' (*Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health)*
Clinical audit - 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change'. *(Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence)*
Compliance – to act in accordance with requirements
Controls – actions to reduce likelihood and or consequence of a risk
Corporate Governance – the 'system by which organisations are directed and controlled in order to achieve their objectives and meet the necessary standards of accountability and probity' (*Department of Health)*. Corporate Governance refers to many areas including clinical, information, human resources etc.
Empirical – based on observation or experience
Escalation – the act of advancing an issue to the next appropriate management level for resolution, action or attention
Evidence – information that allows a conclusion to be reached
External Audit – the organization appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust
Internal Audit – the team, which may be part of the Trust or an outsourced provider, responsible for evaluating and forming an opinion of the robustness of the system of internal control
Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control **Key Risk / Key Control** – risk to the achievement of a strategic objective / control to mitigate key risks
Reasonable – based on sound judgement
Reassurance – the process of telling others that risks are controlled without providing reliable evidence in support of this assertion
Risk – the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events
Risk Management – the system for identifying, assessing and responding to risks
Risk Register – the tool for recording identified risks and monitoring actions and plans against them
Risk Tolerance – the level of risk the Trusts is prepared to accept, tolerate or be exposed to at any point in time
Sufficient – in relation to the definition of assurance given above sufficient is defined as whatever is adequate to provide the level of confidence required for the Trust Board

Abbreviation listing:

AC – Audit Committee BAF – Board Assurance Framework CCG – Clinical Commissioning groups CQC – Care Quality Commission CQI – Continuous Quality Improvement CLIP – Complaints, Litigation, Incidents and PALs group CP – Clinical Policy DoH – Department of Health F&O – Finance and Performance Committee HSE – Health and Safety Executive HM – Her Majesty ICT – Information Communication and Technology IT - Information technology IG – Information Governance IMR – Intelligence monitoring report KLOE – Key lines of enquiry KPI – Key Performance indicator	MTFP – Medium term Financial plan NHS – National Health Service NHSE – National Health Service England NHSI – NHS Improvement NHSE/I – National Health Service - England and National Health Service – Improvement combined NHSR NICE – National Institute for Health and Care Excellence NPSA – National Patient Safety Agency OP – Operational Policy PALs – Patient Advice and Liaison service – NHS Resolution QSAG – Quality and Safety Advisory Group QGAC – Quality Governance Assurance Committee QI – Quality Improvement
LAT – Local area team	SOP – Standing Operational Procedure TRR – Trust Risk Register TB – Trust Board TMC – Trust Management Committee

Trust Board

Appendix 1
Re-designed Reporting items & frequency

Quality Governance Assurance Committee

Quality & Safety Advisory Group

For assurance only

Monthly
- BAF
- TRR
- IQPR

Bi-Monthly
- CQC Well-led Report

Quarterly
- CQI Report
- Mortality Quality Improvement Plan

Twice a year
- External Review Registry Report
- NPSA NRLS Organizational Feedback Report
- Clinical Audit Plan & Update
- Health & Safety Update Reports
- Safeguarding Assurance Report (Adults & Children)

Annually
- Annual Governance Statement
- Internal Audit Opinion
- Internal Audit Plan
- Litigation & Inquests Report
- Clinical Audit Report
- Information Governance Annual Report
- CQC Annual Report
- Quality Account

Ad Hoc
- Internal Audits
- External Audits
- Internal Reviews
- External Reviews
- Risk Triggered Assurance Reports

Monthly
- Divisional Integrated Governance Reports (x3)
- 104 day Harm Review Group—Scheduled Cancer Waits/104 Day Breach Harm Review Report
- SUI Report
- Risk Registry Review Meeting

Bi-Monthly/Three times a year*
- Information Governance*

Quarterly
- Deteriorating Patient Group
- Mental Health Operational Oversight Group
- Medicines Management
- Safeguarding
- CQC Action Plan
- CQC KLOE Compliance Report

Twice a year
- WHO Checklist
- SUI Actions Audit Report
- Leadership Walkabout Report
- MRG (Mortality) Report including Annual Header Report
- Critically Ill and Injured Chlid (CIICG)
- Falls Prevention Group
- Tissue Viability
- Resuscitation
- Hospital Transfusion
- Thrombosis (VTE)
- Organ Donation
- Nutrition
- Infection Prevention
- End of Life Care
- Health & Safety
- Clinical Audit
- Radiation Protection
- NICE
- Equality & Diversity
- Learning from experience Group
- Pleural*
- Patient Experience Forum
- Medical Devices & Clinical Product Evaluation
- Consent

Annually
- National Guidance Monitoring Plan & Report
- Review National Confidential Inquiries
- Duty of Candour Being Open Report
- Review of Integrated Governance Strategy

Ad-hoc
- Individual External Visit Reports
- Quality Review Visit Reports
- Risk Management Policy Review
- National Review Reports e.g. NCISH, Better Births, Radiological Investigation Physical Abuse in Children

Finance and Performance Committee

- Capital Review Group
- Financial Recovery Group

Workforce and Organizational Development Committee (WODC)

- Attraction & Retention Steering Group
- Equality & Diversity Group
- Academy Steering Group
- Medical Workforce Group
- Role Development Steering Group

Trust Charity Committee

Remuneration Committee

Audit Committee

Innovation, Adoption & Research Committee

- Digital Forum
- IM&T
- Research & Development

Trust Management Committee

- Emergency Planning Group
- Policy/ Clinical Practices Group
- Divisional Governance & Safety
- Contracting and Commissioning
- Patient and Service User Innovation Group

Tier	Meeting	Purpose/Function
Tier 1	Sub board Committee	Assurance
Tier 2	Sub-group	Trust Oversight, Action monitoring
Tier 3 & Reports	Specialist Working Groups, Divisions & Directorates , Reports to **Quality Governance Assurance Committee**	Performance monitoring, oversight of controls outcomes and improvement, specialist/project implementation & monitoring
Tier 3 & Reports	Reporting Group/Reports to Groups/Committees to **Quality Advisory Group**	Performance monitoring, oversight of controls outcomes and improvement, specialist/project implementation & monitoring

Trust Board

Executive Directors Meeting

Quality Governance Assurance Committee

Finance and Performance Committee

People and Organizational Development Committee (PODC)

Remuneration Committee

Audit Committee

Innovation, Adoption & Research Committee

Trust Charity Committee

Trust Management Committee

Quality & Safety Advisory Group

For assurance only

Capital Review Group

Financial Recovery Group

Attraction & Retention Steering Group

Equality & Diversity Group

Academy Steering Group

Medical Workforce Group

Role Development Steering Group

Digital Forum

IM&T

Research & Development

Clinical Audit Group*

Information Governance Group*

Safeguarding Steering Group*

Mortality Review Group*

Health & Safety Group*

Emergency Planning Group

Policy/ Clinical Practices Group

Patient and Service User Innovation Group

Medicines Management Group

Infection Prevention Group

Nutrition Group

Organ Donation Group

Thrombosis VTE Group

Radiation Protection Group

Risk Registry Review Meeting

External Visits Review Group

Hospital Transfusion Group

Resuscitation Group

Falls Prevention Group

Mental Health Oversight Group

NICE Group

Tissue Viability Group

104 Day Harm Review Group

Critically Ill Child Group

End of Life Care Steering Group

Equality & Diversity Group

Medical Devices Group

Deteriorating Patient Group

Learning from Experience Group

Patient Experience Group

Pleural Services Group

Division 1 (incl. BCPS)

Division 2

Division 3

Consent Group

Clinical & Theatre Product Evaluation Group

Appendix 2—Re-designed Groups Structure v1.12

Tier	Meeting	Purpose/Function
Tier 1	Sub board Committee—Governance	Assurance
Tier 2	Sub-group	Trust Oversight, Action monitoring
Tier 3 & Reports	Specialist Working Groups, Divisions & Directorates , Reports to **Quality Governance Assurance Committee**	Performance monitoring, oversight of controls outcomes and improvement, specialist/project implementation & monitoring
Tier 3 & Reports	Reporting Group/Reports to Groups/Committees to **Quality Advisory Group**	Performance monitoring, oversight of controls outcomes and improvement, specialist/project implementation & monitoring