

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2006/07: QUARTER 1: 1st APRIL 2006 to 30th JUNE 2006

ASSURANCE FRAMEWORK – 1 SAFETY

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring Action Plan Lead	
1.1 To ensure compliance with the statutory duty of quality and the delivery of safe, high quality patient care									
1.1.1	Failure to understand requirements leading to possible legal action against the Trust.	The Board has systems in place to ensure that the organisation is aware of and can react to information regarding legislation, statute, guidance etc.	DoH CE Bulletin scanned and actioned weekly. Other DoH Bulletins reviewed and actioned as appropriate by relevant director. Process for cascading alerts in place.	Reports to Board including Chief Executives Report detailing changes to legislation, actions to be taken. Legal Services Plan in place with Bevan Britton, who provides notification of changes in legislation etc. External Audit reviews of governance arrangements. NHSLA. HSE Reports.	Level 1A NHSLA Risk Management Standard achieved in September 2004. HSE Inspection 2003.	Overview process required to review documents and actions required and ensure changes in practice implemented.	Lack of recent review of Trust's reactions to changes in legislation or policy.	8	Clinical Governance, Integrated Governance Committee & Audit Committees DIRECTOR LEAD: AF
1.1.2	Failure to establish effective systems to comply with statutory duty of quality	The Board has approved a clinical governance strategy and risk management policy with supporting procedures. H&S policy and supporting procedures are in place.	Clinical Governance Strategy & Risk Management Strategy in place. Most supporting policies and procedures in place. Health & Safety Policy. Clinical audit programmes in place	NED representation on Integrated Governance Committee (IGC) that provides regular reports to the Board. Clinical Governance updates to the PEC and IGC. Healthcare Commission. NHSLA. HSE.	Level 1A NHSLA Risk Management Standard achieved in September 2004 SfBH declaration	Clinical Governance and The Risk Management Strategy should be subject to review on an annual basis (Ref. NHSLA 1A1.1.2)	Lack of comprehensive patient experience survey through primary and secondary care	8	Clinical Governance, Integrated Governance & Audit Committees. DIRECTOR LEAD: JM (Clinical Governance) AF (Governance)

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1.1.3	Responses to internal and external audits and reports are inadequate	The Audit Committee has in place an effective system for dealing with internal and external audits	Audit Committee in place and responsible for reviewing all audit reviews and for monitoring implementation of audit recommendations	Audit Committee in place and reports to Board. Internal Audit. External Audit	Annual Audit Letter Internal Audit annual review. ToR for Audit Committee recently reviewed and updated.	Clarify process for reviewing audits and reviews – role of Committee needs to be reviewed in line with move towards integrated governance	Need to tighten up on process for implementing actions arising from audits	6	Audit Committee DIRECTOR LEAD: MT
1.2 To identify and manage risks properly and appropriately									
1.2.1	Failure to develop and embed systems to identify and manage risks	The Board has a risk management strategy, policy and procedure, incident policy and assurance framework in place	Risk Management Policy. Incident reporting system. Risk register in place. Patient safety and other alerts reviewed regularly. Health & Safety Control Book system in place. Assurance Framework established and being developed	Integrated Governance Committees. Regular reports to the Board provided by the Committee. Healthcare Commission. NHSLA assessment process. HSE. Internal Audit. External Audit	Level 1A NHSLA Risk Management Standard achieved in September 2004. Integrated Governance Committee creates effective performance monitoring of organisation's risk management objectives.	Gap in reports on incidents to sub-committees or Board. Incident Reporting Policy and Procedure should be subject to annual review (Ref. NHSLA 1A2.1.2)	No designated Board lead for "Patient Safety". No PPI involvement in PCT risk management arrangements.	6	Clinical Governance Steering Group and Integrated Governance Committee. DIRECTOR LEAD: AF

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1.2.2	Failure to educate, train and communicate risk management strategy and procedures to all staff	Training strategy and programmes in place. All operational staff understand risk assessment and management processes and use these appropriately. There is a culture of clinical and environmental risk awareness throughout the Trust	Induction training. Education and Training Strategy in place. Risk Management sessions held with front-line staff. Training includes moving and handling, resuscitation, violence and aggression	Induction training arrangements in place. (Ref. NHSLA 1B11.4). Training Records – tracks attendance at mandatory training and updates and identifies a rolling programme of attendance (Ref. NHSLA 1B11.2). Training courses are evaluated to ensure they are meeting the correct objectives (Ref. NHSLA 1B11.3). Healthcare Commission. NHSLA. External Audit. Internal Audit	Level 1A NHSLA Risk Management Standard achieved in September 2004. Staff Survey feedback on awareness of incident reporting procedures	Training needs to be reviewed, re-assessed and documented (Ref. NHSLA 1B11.1.1). Audit of staff awareness of strategy and procedures required. Further work required on developing the culture of risk awareness throughout the PCT.	Review and improve training records as gaps may still exist. Outcome of audit/review of staff awareness of strategy and procedures (Ref. NHSLA 1B1.1.2)	6	Integrated Governance & Health & Safety Committees. Board & PEC Development Sessions DIRECTOR LEAD: AF

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
1.2.3	<p>Failure to identify and manage risks associated with:</p> <ul style="list-style-type: none"> • Infection control • Medical devices • Decontamination • Medicines • Waste Management 	<p>Policies, procedures, and systems are in place for identifying and managing risks and training is provided to appropriate staff.</p>	<p>SLA with Infection Control service. MRSA plan. Safety Alert system in place. Policies and procedures in place. Mandatory training. Health & Safety Committee. Integrated Governance Committee. Countywide Infection Control Committee</p>	<p>Annual Infection Control Report to the Board. (Ref. NHSLA 1A5.1.1). Risk management implications of infection control issues etc. considered at Clinical Governance Steering Group. Clinical audits. Reviews of incidents and complaints. Training records. Reports to the Board. Healthcare Commission. NHSLA. Clinical audits. Environmental Health reports</p>	<p>Level 1A NHSLA Risk Management Standard achieved in September 2004</p>		<p>Regular review and reporting of incidents to the Board required (Ref. NHSLA 1B2.2.2 and 1B2.2.3)</p>	<p>9</p>	<p>Integrated Governance. Health & Safety Committees</p> <p style="text-align: right;">DIRECTOR LEAD: AF</p>

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1.3 To ensure that effective systems are in place to learn from patient safety incidents									
1.3.1	Failure to systematically review and analyse incidents to identify trends etc.	The Board receives information on incidents, complaints and claims. Incident reporting procedure raised at induction and further training provided for appropriate staff.	Monthly review meetings established between clinical governance, complaints and risk functions. Serious clinical incident review process in place. SUI process in place. Training records Operational Risk Group (ORG)	Clinical Governance and Integrated Governance Committees report to the Board. Healthcare Commission. NHSLA. NPSA	Level 1A NHSLA Risk Management Standard achieved in Sept. 2004. Incident coding structure approved by NPSA	Lack of a proper system for quality indicators. I.G and CGSC and Board do not receive regular updates on incidents. Training requirements to be reviewed and further training to be given to staff. No Patient Safety Champion at Board level.	Review training requirements and records. Need to Develop Sharing Learning Communication	6	Clinical Governance Steering Group and Integrated Governance Committee. DIRECTOR LEAD: AF
1.3.2	Failure to identify and develop key indicators capable of showing improvements in managing risk	The organisation has developed key indicators which are reviewed on a regular basis	Integrated Governance Committee in place	Reports to the Board. Healthcare Commission. NHSLA	Risk management now integrated into performance management arrangements	No formal key indicators developed (Ref. NHSLA 1B4.5.1)		6	Directors Board DIRECTOR LEAD: AF

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
1.4 To ensure that effective child protection arrangements are in place throughout the organisation and in partner organisations									
1.4.1	Failure to implement effective internal systems to protect children	The PCT has local policies and procedures in place for child protection and there are named leads for child protection	Interim named doctor/nurse leads. Training records. CRB checks undertaken.	Annual Child Protection Report to the Board. Training records. Action plans. Healthcare Commission. Audits		No named GP lead but PEC Chair and lead nurse will advise as needed.	No designated Board lead for Child Protection. Audit of referrals of at risk children	10	PEC Board DIRECTOR LEAD: JM
1.4.2	Failure to work with relevant partners and communities to protect children	The PCT works closely with all local partners to ensure that effective arrangements are in place		Annual Child Protection Report to the Board. Healthcare Commission	Countywide School Nurse Group set up. Process follows local and national Confidentiality and Information sharing policies.	No agreed policy on sharing information with local partners for the protection of children	No effective cover for school age children	10	DIRECTOR LEAD: JM

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1.5 To ensure that health care processes, practices and activities are continually reviewed and that improvements in practice are implemented									
1.5.1	Failure to implement improvements in practice as a result of analysis of complaints, incidents, claims and user and carer feedback	The Board receives information on changes to practice and improvements. Learning is shared across the Trust	Clinical Governance and Integrated Governance Committee. Countywide Risk Management Liaison Group. SHA forums in place	Reports to the Board from Clinical Governance & Integrated Governance Committee including Annual Reports. Minutes from meetings. Healthcare Commission. NHSLA. NPSA	NHSLA Level 1A achieved Sept. 04. An integrated system to enable the organisation to learn from and take appropriate action in the light of complaints, incidents, patient feedback etc. Operational Risk Group set up to agree process for dissemination.		Further development of processes to disseminate information required e.g. newsletters, intranet. Review of existing structures and systems to ensure an integrated quality improvement programme is established	6	Clinical Governance Steering Group. PPI Group Trust Board DIRECTOR LEAD: JM (Clinical Governance) AF (Governance)

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ASSURANCE FRAMEWORK – 2. CLINICAL AND COST EFFECTIVENESS

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
2.1 To commission cost effective and evidence based responsive healthcare services for the local population								
2.1.1	Failure to maintain and update lists of INNFS to support commissioning agenda, NICE decisions etc.	The Board receives regular updates on issues impacting on commissioning decisions, including the INNFS list.	Regular review of the INNFS list by the Strategic Commissioning Group	Reports to the Board on updates to the INNFS list. Healthcare Commission. External Audit			Knowledge of implementation of NICE in primary care.	8 PEC Board DIRECTOR LEAD: JF (INNFS management) HA (Public Health advice)
2.1.2	Failure to adequately manage the commissioning process to ensure strategic change	The Board receives regular information on commissioning issues and is actively engaged in the LDP process	Joint Commissioning Board. Local Delivery Plan. SLA reviews. Practice Based Pilot Commissioning. Strategic Service Development Plan	Reports to the Board. External Audit SHA.		Consultation with and active involvement of partners, staff, users and carers re. strategic and organisational issues.	Expert patients are not actively involved in the commissioning process. Lack of strategic commissioning strategy	9 PEC Board DIRECTOR LEAD: JF
2.1.3	Lack of quality outcomes/measures for commissioning leading to failure to focus on quality indicators and lack of adequate information and methods of assessing quality for the services we commission	The Board has a comprehensive performance management framework in place and receives regular performance reports	Regular Performance Reports received by the Board. Regular reviews undertaken against contracts. Agreed quality standards in place. Foundation Trust Contract Quality Group.	Reports to the Board. Healthcare Commission. SHA.		Lack of qualitative data in current performance reports to the Board	9 PEC Board DIRECTOR LEAD: JF	

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances		Ongoing Monitoring
2.3.2	Failure to engage with secondary care prescribers to agree interface medicine management policies and cost savings for drugs	The Trust has developed effective engagement with secondary care and interface medicines management policies have been developed which support cost savings for drugs		Gloucestershire Medicines Management Committee. Prescribing audits	GP (PEC) lead.	Targets with secondary care providers to be agreed	Protocol to be agreed with GHNHSFT as part of ISIP work	9	Medicines Management Group DIRECTOR LEAD: AF
2.3.3	Inappropriate management of entry of new drugs including implementation of NICE technology appraisals related to drugs	Arrangements are in place to deal effectively with the introduction of new drugs, including the implementation of NICE guidance	Countywide policy guidance for the managed entry of new drugs. Local guidance and monitoring for controlled entry of new drugs	Medicines Management Group. Reports to the Board and PEC. PPA data Prescribing audits			Assurance of timely implementation not currently available until LDP resolved. Significant delay in implementation likely as a result of LDP decisions.	9	Medicines Management Group GHNHST Contract Board DIRECTOR LEAD: JF
2.3.4	Lack of public awareness on the safe and rational use of prescribed medication	The organisation has a programme in place to raise public awareness relating to prescribed medication	Medicines awareness campaigns/leaflets etc. Medicines use reviews completed as part of pharmacy contract.	Reports to the Board and PEC		Further advice and support to patients and carers on medicines management required	Patient & public feedback on level of awareness.	6	Medicines Management Group DIRECTOR LEAD: AF
2.3.5	Failure to take sufficient consideration of the clinical governance aspects relating to medicines management	Plans have been established to identify and address the clinical governance aspects of the medicines management agenda	Prescribing policies in place. Use PCT policy to intervene with inappropriate prescribers. Protected learning time sessions	Reports to the Board and PEC. Healthcare Commission.	PGDs all signed off by PEC Chair and Chief Executive. Medicines management issues to feed into IGC.			6	Medicines Management Group. Clinical Governance Group DIRECTOR LEAD: AF

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ASSURANCE FRAMEWORK – 3. GOVERNANCE

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
3.1 To ensure the sound administration of the PCT finances, achieve and maintain recurring financial balance and deliver on mandatory financial targets								
3.1.1	Failure to achieve financial balance	The Board receives regular reports on the FRP and progress and actions.	Budget monitoring in place. Regular reconciliation processes. CRES plans identified and monitored.	Monthly Finance Reports to the Board. Audit Committee minutes Directors/FRP meeting. SHA monitoring. External Audit. Internal Audit. Healthcare Commission.	Clarity on savings targets and plans. Internal Audit Plan provides ongoing assurance on controls relating to financial systems, budgetary control etc.	Current forecast overspend.	16	Audit Committee. Trust Board SHA DIRECTOR LEAD: MT
3.1.2	Failure to develop and deliver a robust recovery plan	A robust project plan is in place as part of a county ISIP savings programme with clear deadlines. The plan is monitored regularly and the Board is kept advised of progress	Outline plan exists and is being further developed. Financial recovery plan monitored by the local Chief executive and the SHA and Board.	Updates provided to the Board. Internal Audit. External Audit. SHA	Community Change Steering Group	Unidentified savings target. End of year run rate showing a deficit.	Forecast deficit. Evidence of actions to address risks if not achieving FRP	16 Audit Committee. Community Change steering Group Trust Board Directors meetings SHA. DIRECTOR LEAD: AF

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk	Ongoing Monitoring
3.2.2	Failure to systematically identify, record, assess and analyse risks on a continuous basis	The Trust has established an effective risk management and risk assessment system. Appropriate staff training has taken place	Risk Management Strategy. Incident Reporting Policy and procedure in place. Induction and other staff training in place as appropriate	Reports to the Board. Risk Register. Training records. Healthcare Commission. NHSLA. External Audit. Internal Audit	NHSLA Level 1A achieved Sept. 04 High level risk would be identified by various assessments e.g. IWL, NHSLA Level 1, PEAT etc. are added to the risk register (Ref. 1B4.2.1)	All sources of risk, including those from the perspective of all stakeholders, need to be included (Ref. NHSLA 1B4.1.1)		6	DIRECTOR LEAD: AF
3.2.3	Failure to develop an integrated approach to governance and risk management leading to poor and ineffective processes for managing risk	The Trust has a coordinated and integrated approach that links risk management, clinical governance and business planning	Committee structures (Clinical Governance, Risk, Audit) have overlapping membership which helps to supports integration. Assurance Framework supports integrated approach.	Reports to the Board. Healthcare Commission. NHSLA. External Audit. Internal Audit. AGW	Integrated governance structure/system supports risk management strategy. LDP process from 2006/7 is risk based using same approach as business plan/assurance framework.			6	DIRECTOR LEAD: AF

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk	Ongoing Monitoring	
3.3 To ensure that effective emergency planning and business continuity arrangements are in place throughout the Trust									
3.3.1	Failure to implement effective emergency planning arrangements, including major incident planning	The Trust has an identified lead for emergency and major incident planning and plans are in place which outline the Trusts role in the event of a major incident. Staff are trained, as appropriate and plans are evaluated and reviewed	PCT Emergency Planning Group established. Major Incident Plan in place. Director and Senior Manager on-call arrangements in place. PCT involvement in emergency planning exercises. Appropriate training in place	Training records. On-call rota and on-call pack for senior managers. Emergency Planning Group minutes. External Audit. Internal Audit. Healthcare Commission.	Countywide PCT emergency planning lead in place. PCT Emergency Planning led by Director with dedicated support. Exercise glevum test in Nov 2005	Budgetary allocation to support emergency planning responsibilities	Evidence of reviews and evaluations of exercises and testing of emergency plans. Pandemic Flu high risk.	8	Emergency Planning Group. (PCT and county) DIRECTOR LEAD: AF
3.3.2	Failure to implement effective business continuity arrangements leading to loss of service quality or continuity	The Trust has effective arrangements in place to deal with emergency situations which may affect the provision of normal services	Emergency Planning Group	Emergency Planning Group minutes. External Audit. Internal Audit	Business continuity planning underway. Draft business continuity policy/procedure in place		Evidence of audits/reviews	8	Emergency Planning Group. DIRECTOR LEAD: AF
3.4 To ensure that systems and working practices support quality improvement and assurance across the clinical and corporate governance agendas									
3.4.1	Failure to prioritise risks across the organisation in a consistent manner	The organisation has an integrated system in place which ensures that all risks are prioritised consistently	Risk Management Strategy. Incident Reporting Policy and procedure. Risk Register in place with risk treatment action plans. Integrated Governance Structure.	Reports to the Board. Audit Committee. External Audit. Internal Audit. Healthcare Commission. NHSLA	NHSLA Level 1A Assessment achieved Sept. 04. Quarterly review of Assurance Framework and Risk Register. Integrated Governance structure.			6	DIRECTOR LEAD: AF

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
3.5.3	Lack of understanding of training needs, inability to deliver appropriate training and failure to adequately fund training and development programmes	There is a Board approved Training and Development Strategy. Appraisal process and Personal Development Plans are in place.	Education & Training Strategy approved by the Board. Learning & Development Manager in post. Budget for Training and Development.	Training needs analysis. IWL assessment process	IWL Practice Status achieved Nov. 2003 NHSLA Level 1A achieved Sept. 04. Individual records of appraisals and central database of training and development records	Insufficient funding available to fully support all training needs.	No regular reporting to the Board on HR/Workforce issues.	6	HR Department DIRECTOR LEAD: AMc
3.5.4	Failure to ensure appropriate systems are in place to prevent unqualified or unregistered staff from practising	There are HR systems and procedures in place to ensure that all staff are appropriately qualified and duly registered	Policy and processes are in place for newly appointed staff re. checking qualifications and registration and this process ensures registration is appropriate and kept up to date (NHSLA Ref. 1A6.1)	Monthly reports to Managers. Ability to check all records on-line. Internal audit. Healthcare Commission. NH	SLA			8	HR Department DIRECTOR LEAD: AMc

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3.6 To develop a comprehensive, robust and reliable information management and technology infrastructure									
3.6.1	Failure to adequately resource IM&T developments	The Trust has arrangements in place to ensure that decisions around IM&T developments are made with financial, Board and clinical input	IM&T funding reserved in the LIS Programme. IM&T Sub-Group CFH Programme Board & Financial Sub Group	Finance Reports to the Board. Capital programme report to the Board. IM&T updates to the Board. Healthcare Commission. SHA monitoring. External Audit. Internal Audit	Board approved IM&T strategy Board approved NCRS RO Business Case DoF Co-ordinates Finance input to county IMT projects.		No IM&T Annual Report to the Board. Staff without access to I.T facilities.	6	Board LIS DIRECTOR LEAD: MT
3.6.2	Failure to implement IM&T plan	The Trust has an effective IM&T plan which is implemented in accordance with agreed timescales	IM&T Sub-Group. Participation in county IM&T Programme Board	Reports to the Board. IM&T Sub-Group minutes. External Audit. Internal Audit. SHA monitoring	PCT represented on county CfH Programme Board and IT project boards.			6	IM&T Sub-Group Board DIRECTOR LEAD: MT
3.6.3	Major failure of IT systems	The organisation has effective procedures in place to address potential IT failures. Service continuity/recovery plans are in place	IM&T Sub-Group. Emergency Planning Group	IM&T Sub-Group and Emergency Planning Group minutes. External Audit. Internal Audit	Financial Systems Project proceeding	No IT Disaster Recovery Plan in place		12	Board DIRECTOR LEAD: MT/AF
3.7 To establish and maintain robust information governance arrangements									
3.7.1	Data quality is compromised by lack of standardised policies and procedures	Standardised policies and procedures are in place for all aspects of data quality. Staff are trained and performance is monitored	Information Governance Group. Policies and procedures in place.	Information Governance Group reports to the Board. Training records. Performance ratings. Data accreditation. Healthcare Commission	Information Governance Seminar held on 20/1/06	Information Governance Toolkit demonstrated gaps in achievement	Lack of an overall Information Governance Strategy	9	Information Governance Group DIRECTOR LEAD: AF

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3.7.2	Failure to develop and implement an effective records management strategy and policy	The organisation has a Records Management strategy and supporting policies and procedures in place that have been communicated to all staff	Records Management Strategy including Retention Schedule in place. Information Governance Group	Baseline assessment of all records in the PCT undertaken and recommendations based on assessment have been made (Ref. NHSLA 1A7.1, 1A7.3). Information Governance Group reports to the Board. Clinical audit reports. External Audit. Internal Audit. Healthcare Commission. NHSLA	NHSLA Level 1A achieved Sept. 04	Information Governance Toolkit identified incentives in records management	Healthcare Commission annual health check lack of assurance: IGC to oversee action plan	6	Information Governance Group DIRECTOR LEAD: AF
3.7.3	Failure to effectively implement the requirements of the Freedom of Information Act	The Trust has in place a policy and procedure to support the requirements of the FOI Act and appropriate training has been given to staff. A nominated lead has been appointed	FOI Policy and procedure in place. Database for responding to requests established. Records Management Strategy and records retention schedule. Training provided to staff	Information Governance Group report regularly to the Board. Training records. NHS Information Authority. Information Commissioner				6	Information Governance Group DIRECTOR LEAD: AF

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3.7.4	Failure to keep patient data confidential	The Board has appointed a Caldicott Guardian and Data Protection Officer to support the Trust in effectively managing its responsibilities relating to patient identifiable information	Caldicott Guardian and Data Protection Officer in place. Information Governance Group. Incident reporting procedure in place. Induction and training programme. FOI Policy and procedure. Confidentiality Policy. Training provided to staff	Information Governance Group reports to the Board. Incident Reports and Complaints Reports. Training records. Healthcare Commission. Information Commissioner			Audit of staff understanding of policies and procedures	9	Information Governance Group DIRECTOR LEAD: AF
3.8 To communicate effectively with internal and external stakeholders									
3.8.1	Failure to engage and communicate effectively with external stakeholders	The organisation has an effective communications strategy in place to engage with external stakeholders	Communications Strategy in place. PCT website. PPI Group & Patient Forum	Feedback from PPI Group to the Board. SHA monitoring. Overview & Scrutiny Committee. Patients/public	Media survey rated the PCT highly	Communications Strategy needs to be reviewed. More engagement with Patients' Forum required		6	PEC Board DIRECTOR LEAD: AF
3.8.2	Failure to communicate effectively with staff	The organisation has an effective communications strategy and plan in place for internal communications	Communications Strategy in place. PCT Newsletter. Staff intranet	Reports to the Board. Staff feedback. IWL assessment. SHA monitoring	IWL Practice Status achieved Nov. 2003 "Look West" staff newsletter. PCT Staff Survey results. IWL Practice status awarded	Communications Strategy needs to be reviewed.		9	Directors DIRECTOR LEAD: AF

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ASSURANCE FRAMEWORK – 4. PATIENT FOCUS

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
4.1 To strengthen the capacity of patients, carers and the wider public to participate in health and healthcare planning and delivery								
4.1.1	Failure to engage with key stakeholders	Identification of key stakeholders strategy and guidance for engagement of stakeholders cross-referenced to PPI strategy	PPI Strategy. Communications Strategy in place.	PPI Group reports to the Board. PPI Annual Report. Patch Team minutes. External Audit. Healthcare Commission. AGW. Overview & Scrutiny Committee	Active involvement at PPI Groups	Stakeholder identification is reactive - no formal identification strategy.	6	PPI Group Trust Board DIRECTOR LEAD: JM
4.1.2	Insufficient service user representation on policy/planning and other groups	The organisation is able to demonstrate that there is effective patient and public involvement on relevant groups	PPI Strategy. Patient/public representation on key PCT groups. Expert Patient Programme. Active involvement with local media to ensure that PCT profile is active and visible. Health Needs Assessments.	PPI Group reports to the Board. PPI Annual Report. Clinical Governance Reports. Patch Team minutes. Healthcare Commission. AGW. National evaluation survey to expert patient programme	Local interest and stakeholder group involvement Individual participant evaluation undertaken.	Evaluation of Expert Patient Programme	6	PPI Group DIRECTOR LEAD: JM
4.1.3	Lack of engagement with the Patients' Forum	The Trust engages effectively with the local Patients' Forum	Nominated point of contact with Patients' Forum agreed	Patients' Forum lead attends Board meetings. Patch Team minutes. Healthcare Commission. AGW Standards for Better Health input	JM/AF meeting with PPI forum to review		6	Board DIRECTOR LEAD: JM

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4.2 To improve the five key dimensions of the patient experience									
4.2.1	Failure to demonstrate improvement in terms of: <ul style="list-style-type: none"> • Access & Waiting • Better Information, More Choice • Building Closer Relationships • Clean, Comfortable, Friendly Place to be • Safe, High Quality, Co-ordinated Care 	The PCT can demonstrate an understanding knowledge of the pt. experience and improvement in these key discussions.	PPI Group. Hotel Service standards in place. <ul style="list-style-type: none"> • Community Hospital Clinical Governance Group • Essence of Care • SfbH • Complaints Management 	PPI reports to the Board. Reports to Integrated Governance Committee. Complaints and PALS reports. Patient feedback. Also see 5, 6. Healthcare Commission. PEAT assessments. PCT Patient Survey	PCT Patient Survey. PEAT assessments		Targeted pt experience surveys and pt participation.	6	DIRECTOR LEAD: JM

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ASSURANCE FRAMEWORK – 5. ACCESSIBLE AND RESPONSIVE CARE

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring	
5.1 To ensure the provision of timely and better access to elective and emergency services									
5.1.1	Failure to deliver key national and local targets	GHNHSFT Contract and other Service Level Agreements which ensure sufficient activity to meet access targets are GHNHSFT agreed. The Board has access to regular information on key performance targets. Activity being revised in line with resource allocation in LDP.	Clear performance management process in place for commissioning arrangements. Contract and SLAs negotiated and documented and regularly reviewed. Monitoring takes place with key providers. LDP Action Plans monitored and reviewed.	Regular Board and PEC Performance Reports. Waiting list modelling undertaken to ensure appropriate activity to meet targets. LDP and LDP Action Plan monitored by the Board. External Audit. Internal Audit. Healthcare Commission. AGW. PCT Patient Survey	Action plans in place to deal with achievement of targets	2008 waiting time targets. Meeting 2007 interim targets	Ambulance 75% cat. A targets. MRSA Cancer 62 day target	9	Board SHA DIRECTOR LEAD: JF (Delivery) AF (Performance Management)
5.2 To improve access to NHS dentistry									
5.2.1	Failure to improve access leading to lack of provision or quality and frustration over lack of service	The organisation has developed action plans to improve access to NHS dentistry	Contract signed for 06/07.	Reports to the PEC and Board. Performance ratings. Healthcare Commission. PCT Patient Survey	DofH agreement to £1m Gloucestershire growth for 06/07.	Immediate reduction in capacity following contract signing.	Gap in capacity as a result of some new contracts being signed.	8	PEC Board DIRECTOR LEAD: JF

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring	
5.3 To ensure the provision of timely and better access to primary care services									
5.3.1	Failure to ensure 24/48 hours access for primary care professionals and GPs	The Trust ensures sustained delivery of primary care access targets	PCT primary care lead.	National access audit undertaken monthly. Waiting times reported to the Board and PEC through Performance Report. PCT Patient Survey. Performance ratings. Healthcare Commission. AGW monitoring	Results of monthly audit of practices indicate compliance with standard.		PCT patient survey results do not support national access audit results	4	PEC Board DIRECTOR LEAD: JF
5.3.2	Failure to effectively engage clinical colleagues in developing services	The Trust engages effectively with clinical colleagues	Engagement of GPs and clinical colleagues via PEC and PHCT Reps. Meetings. Clinical representation on Clinical Governance Steering Group. Weekly information packs sent to all practices	Attendance and participation at meetings and minutes of meetings. Reports to the Board PEC Clinical Strategy. PEC Chair provides updates to the Board	PEC Clinical Strategy Rheumatology Renal disease, Capacity and Access programmes e.g. endoscopy.		Lack of universal process to engage clinicians ~ currently occurs on an ad hoc basis.	4	PEC Board DIRECTOR LEAD: JF (Delivery) JM (Clinical Engagement)

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
5.5 To ensure that national targets are met to effectively manage referral patterns								
5.5.1	Failure to deliver detailed objectives as outlined in the Local Delivery Plan		Detailed action plans to meet objectives developed for the LDP.	Reports to the Board & PEC. Healthcare Commission. SHA monitoring		Challenge in identifying actual effect of demand management schemes on referral patterns.	Resource constraints minimise opportunities for LDP developments.	12 PEC Board DIRECTOR LEAD: JF
5.5.3	Failure to make appropriate referrals and consequence for FRP.	Development of specific demand management plans to support the FRP. GP referral incentive scheme in 05/06. National DES scheme in 05/06.	Referral Management Centre established. Database of e-referrals and referral activity data used to provide quality feedback loop to GPs and PCDMs Hotline. ISIP schemes.	Reports to the Board & PEC. Healthcare Commission. SHA monitoring	Referral Incentive scheme and DES	Lack of direct influence on practice and individual GP behaviour.	DES for 2006/07. 12	PEC Board DIRECTOR LEAD: JF
5.6 To effectively manage delayed discharges								
5.6.1	Insufficient capacity in domiciliary care market to cope with demand	Use of Healthcare Assistant staff. Actively reviewing all existing domiciliary care packages to release capacity into the system.	Reviews under weekly DToC group. Reviews have taken place.	Reports to the Board & PEC		Social Services contracts not able to always determine provider response because of for example shortage of provider staff, business failure, etc.	Continuing delays in responding to DToC and other urgent requests for immediate care. 12	PEC Board DIRECTOR LEAD: JF

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
5.6.2	Inappropriate admissions to acute hospital	Demand Management Incentive Scheme. Development of Hotline for GPs/Case Managers. Development of Community Hospitals as alternative to admission to DGH. Case Management Project to better support people with LTC in the community. New ISIP projects.	Revised protocols in place for the in-house domiciliary care service	Reports to the Board & PEC. Expanded weekly monitoring report to PCT and SSD Senior Managers. Practices receiving weekly admissions data as part of referral incentive scheme. Change Agent Review.		Lack of control over thresholds. Non delivery of the ISIP projects	No evidence of a decrease in admissions.	9	PEC Board DIRECTOR LEAD: JF
5.6.3	Failure to adequately use bed capacity in community hospitals	Weekly DTOC meeting. Monitor and circulate information on escalation status weekly. Community hospitals review to ensure robust plans for effective use of beds. Countywide review of beds to be established in the light of the reduction in overall bed capacity across the whole system.	Local escalation agreement developed to ensure optimum use of bed capacity in community hospitals Meetings with GPs to discuss potential use.	Reports to the Board & PEC		Gap identified in ensuring patients transferred effectively. Nurse presence established at GRH to work with discharge team.		9	PEC Board DIRECTOR LEAD: JF

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring	
5.7 To ensure the effective implementation of patient choice initiatives									
5.7.1	Failure to develop and implement an effective choice strategy including the implementation of choose and book initiatives	Close monitoring against targets. Support to patients making choices to ensure that they make informed choices.	Weekly monitoring on C&B uptake by GP practices 1:1 support available to practices needing additional support Countywide C&B Executive & Project Board	Regular reports to the Board & PEC. Healthcare Commission. AGW.	Steady increase in take up (provisional figure for June 06 approximately 23%)	Inability to influence national supplier delivery performance and supplier capacity. Delays in delivering a compatible system within GHT – putting Dec 06 (financial target) and March 07 (utilisation target) at risk	Revised plans currently being developed within GHT to implement a temporary upgrade of the existing PAS system from Oct 06	6	PEC Board DIRECTOR LEAD: JF

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ASSURANCE FRAMEWORK – 6. CARE ENVIRONMENT AND AMENITIES

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
6.1 To develop and provide local services that meet patients needs and preferences								
6.1.1	Failure to achieve safety, privacy and dignity standards	Monthly monitoring and patient feedback.	Modern Matrons in place	Reports to the Board and PEC. Use of ACI system to identify gaps with regular reporting to the board. Healthcare Commission. PEAT Inspections			6	PEC Board PPI Forum Director Lead: JF
6.1.2	Failure to meet the requirements of the Disability Discrimination Act	Monitoring and patient feedback. Investment in minor improvement in practices.	PCT Strategic Service Development Plan Minor improvement planned for 06/07 developed.	Use of ACI system to identify gaps with regular reporting to the board.	Positive result from PEAT inspections. Limited programme being implemented in 06/07.	Known lack of meeting all DDA requirements due to limitations in estates and capital programme.	9	PEC Board PPI Forum Director Lead: JF
6.2 To ensure that appropriate environmental standards are maintained across provider and commissioned services								
6.2.1	Failure to ensure that appropriate physical and environmental standards are met leading to poor patient care experience	The Trust ensures that an effective well-run physical environment is in place for both provider and commissioned services to help ensure that patients and visitors are safe and comfortable	Director lead for estates. Capital budget plan in place together with investment programme. Maintenance arrangements via Estates Shared Service	Estates Sub- Group. PPI Group. Reports to the Board. Registers of equipment. Asset register. Annual health and safety risk assessments. PEAT Assessments. Internal Audit. Healthcare Commission. HSE NHS Estates	Surveys of patient and user satisfaction		6	Estates Sub-Group. DIRECTOR LEAD: MT

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring	
7.3 To develop appropriate disease programmes which meet the requirements of the National Service Frameworks to promote, protect and improve the health of the population									
7.3.1	Failure to deliver the national cancer plan	C&T PCT lead on this service area. Palliative Care strategy/Gold Standard Framework and development of hospice at home scheme in the Forest of Dean. Support form three counties cancer network to deliver this.	Weekly monitoring of performance against targets. Monthly meeting with JF and AF with C&T leads.	Reports to the Board and PEC. Healthcare Commission	31/62 targets monitoring NICE Action for pathway Improvement on 62 days	Not meeting 62 day target		12	DIRECTOR LEAD: JF (Targets) HA (NSF)
7.3.2	Failure to deliver the mental health NSF	Countywide commissioning lead now in place at C&T PCT and tasked with developing a strategy for mental health to ensure delivery of the NSF Review of terms of reference for county and local implementation teams to ensure joined up working. Draft Mental Health strategy has now been developed and consultation is planned for next few months.	PCT lead for mental health. Mental Health local Implementation Group	Reports to the Board and PEC. Healthcare Commission. External review of NHS Plan		Lack of robust performance and financial information means unable to identify gaps in services. No investment in public health / prevention / voluntary sector to support delivery. Is potential for county Financial savings plans to negatively impact on the ability to deliver a fully PIG compliant mental health service	Lack of investment in early intervention means delivery standards will not be met. GPT/ commissioner management focus on FT status and financial recovery may divert attention from delivery of services.	6	DIRECTOR LEAD: JF (Targets) HA (NSF)

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
7.3.3	Failure to deliver the older person NSF	Primary Care falls audit tool to ensure professionals are appropriately identifying and managing fallers.	Older Persons Group	Reports to the Board and PEC. Healthcare Commission			Electronic links to support development of local ESAP lacking, should be supported through local IM&T strategy.	6	DIRECTOR LEAD: JF (Delivery) HA (NSF)
7.3.4	Failure to deliver the CHD NSF		CHD Local Implementation Team	Prescribing data. Reports to the Board and PEC. Healthcare Commission			Need to develop countywide obesity strategy backed by local action plans and adequately resourced	6	DIRECTOR LEAD: JF (Delivery) HA (NSF)
7.3.5	Failure to deliver the diabetes NSF		Diabetes Managed Network	Reports to the Board and PEC. Healthcare Commission			Need to develop countywide obesity strategy backed by local action plans and adequately resourced	6	DIRECTOR LEAD: JF (Delivery) HA (NSF)
7.3.6	Failure to deliver the children's NSF	New county Director lead based at C&V to ensure delivery across the county of the NSF. Cross county health change for children working group to support this role.		Reports to the Board and PEC. Healthcare Commission	Clear strategic business plan has been developed for health which is integrated with social services and children and young people's plan.		Lack of priority given to children's issues in ISIP and local delivery plans	6	DIRECTOR LEAD: JF (Delivery) HA (NSF)

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Principal Risks	Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring	
7.4 To address the health inequalities agenda, focussing on areas of proven effectiveness and responding to specific local health needs									
7.4.1	Failure to effectively implement the countywide strategies for tobacco control, smoking cessation, suicide prevention, older people's active ageing, sexual health, teenage pregnancy, healthy eating, physical activity and reducing overweight and obesity	The Trust effectively implements the countywide health promotion strategies in line with specific local health needs	<p>PCTs Health Improvement & Partnerships Group with strong NED participation.</p> <p>Countywide Public Health Network Committee.</p> <p>Countywide CHD LIT.</p> <p>Countywide Smoking Cessation Steering Group and Tobacco Action Gloucestershire Steering Group (TAG).</p> <p>Teenage Pregnancy Steering Group.</p> <p>Health Promotion Management Committee.</p> <p>Robust health needs assessment in place</p>	<p>PH Annual Report. Reports to the Board and PEC.</p> <p>Project and Study reports e.g. HNAs in Barton, Tredworth and White City</p> <p>Minutes of service reports of various groups</p> <p>Quarterly Performance Monitoring Report to The Board.</p> <p>Rolling programme of health equity audits. Health needs assessments, audits and evaluations</p> <p>Audit of Weight Management 2005</p> <p>Evaluation of GSAS 2005</p>	<p>PH Information Analyst now in post.</p> <p>Heart Failure Equity Audit now underway & Equity Audits integrated into HNAs</p>	Public health indicators for regular monitoring	Public health equity audits	6	Board
								DIRECTOR LEAD: HA	

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Principal Risks		Expected Management Controls	Actual Controls	Management Assurances External / Independent Assurance	Positive Assurances	Gaps in Controls	Gaps in Assurances	Risk Likelihood * Consequence	Ongoing Monitoring
7.4.2	Failure to deliver on Choosing Health (Public Health White Paper) & related PSA Targets	Monitoring through Public Health Directorate	Countywide Choosing Health Working Group Health Improvement & Partnerships Group	Public Health Annual Report Reports to Board and PEC. Audits and Evaluations Audit of Weight Management Evaluation of GSAS Quarterly Reports to the Board.	Audit of Weight Management Evaluation of GSAS		No financial allocations to Choosing Health – will impact on Targets.	8	DIRECTOR LEAD: HA