

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	No formal key indicators developed (Ref. NHSLA 1B4.5.1)		Risk management now integrated into performance management arrangements	Directors Board DIRECTOR LEAD: AF
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	<i>Interim</i> 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 <i>but PEC Chair and lead nurse will advise as needed.</i>	No designated Board lead for Child Protection. Audit of referrals of at risk children		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	No agreed policy on sharing information with local partners for the protection of children	No effective cover for school age children	<i>Countywide School Nurse Group set up.</i> <i>Process follows local and national Confidentiality and Information sharing policies.</i>	DIRECTOR LEAD: JM
1.5 To ensure that health care processes, practices and activities are continually reviewed and that improvements in practice are implemented									
1.4.1	Failure to implement improvements in practice as a result of analysis of	The Board receives information on changes to practice and improvements.	Clinical Governance and Integrated Governance Committee.	Reports to the Board from Clinical Governance & Integrated	Healthcare Commission. NHSLA. NPSA		Further development of processes to disseminate	NHSLA Level 1A achieved Sept. 04. An integrated	Clinical Governance Steering Group.

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

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	complaints, incidents, claims and user and career feedback	Learning is shared across the Trust	Countywide Risk Management Liaison Group. SHA forums in place	Governance Committee including Annual Reports. Minutes from meetings			information required e.g. newsletters, intranet. Review of existing structures and systems to ensure an integrated quality improvement programme is established	system to enable the organisation to learn from and take appropriate action in the light of complaints, incidents, patient feedback etc. <i>Operational Risk Group set up to agree process for dissemination</i>	PPI Group Trust Board DIRECTOR LEAD: JM (Clinical Governance) AF (Governance)

ASSURANCE FRAMEWORK – 2. CLINICAL AND COST EFFECTIVENESS

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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				PEC Board DIRECTOR LEAD: JF (INNFS management) HA (Public Health advice)

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

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	management of the prescribing budget to become ineffective	Previously Incentive Scheme.	Financial input into medicine management group to ensure closer monitoring on prescribing budget	Medicines Management Strategy in place. Regular reporting on all individual practice visits to the Medicines Management Group.		management agenda		initiative. Prescribing Incentive Scheme issued.	DIRECTOR LEAD: AF
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	Targets with secondary care providers to be agreed		GP (PEC) lead.	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			Medicines Management post filled.	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.	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.		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. <i>Medicines management issues to feed into IGC.</i>	Medicines Management Group. Clinical Governance Group DIRECTOR LEAD: AF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

ASSURANCE FRAMEWORK – 3. GOVERNANCE

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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	Current forecast overspend.	Clarity on savings targets and plans. Internal Audit Plan provides ongoing assurance on controls relating to financial systems, budgetary control etc.	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 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 Directors team and the SHA and Board.	Updates provided to the Board	Internal Audit. External Audit. SHA		SHA feedback on project management and rigour. <i>Only PCT given "Green" risk assessment in SHA review November 2005</i>	Audit Committee. Trust Board Directors meetings SHA. DIRECTOR LEAD: AF
3.1.3	Failures in probity and good governance of financial management	The Board receives reports from the Audit Committee including counter fraud updates	Internal financial control processes in place (SOs and SFIs). PCT Counter Fraud Group meets regularly and systems in place to prevent and detect fraud. Whistleblowing Policy. Ad hoc training	Reports to the Board from the Audit Committee including Counter Fraud Service. Annual Report to the Board on Counter Fraud	Internal Audit. External Audit. External Audit Annual Letter. SHA monitoring	Financial training requirements to be reviewed.	External Audit Annual Letter SFIs and SOs reviewed, updated and re-issued.	Audit Committee DIRECTOR LEAD: MT

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
3.1.4	Failure to maintain effective financial control of shared service arrangements	Service Level Agreements are in place and reviewed regularly. Financial monitoring of SLAs in place	SLAs reviewed. Recharging procedures in place.	Directors of Finance Forum. Monthly financial reports. Internal/External Audit	Internal Audit. External Audit.	Regular reviews of all SLAs. Key performance indicators not fully developed or routinely reported	<i>Over performance currently on Provider SLAs</i>	<i>Monthly monitoring and review processes in place.</i>	Audit Committee DIRECTOR LEAD: MT
3.2 To assess and manage risks through an effective risk management strategy									
3.2.1	Failure to develop and maintain an effective risk register	A comprehensive risk register is in place which is capable of recording clinical, financial, and organisational risks	Risk Management Strategy in place. Incident Reporting policy and procedure. Risk Register established which records all risks	Integrated Governance Committee provides reports to the Board. Risk Management Annual Report. Risk Register	Healthcare Commission. NHSLA	Risk register needs to be reviewed and updated to review gradings, action plans etc. (ref. 1A4.1.1, 1A4.1.3, 1A4.1.4, 1B4.1.5)	Lack of regular reporting to the Board	NHSLA Level 1A achieved Sept. 2004. <i>Risk register reviewed at IGC Dec 2005</i>	Audit Committee Risk Management Committee DIRECTOR LEAD: AF
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	All sources of risk, including those from the perspective of all stakeholders, need to be included (Ref. NHSLA 1B4.1.1)		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)	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 support 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. <i>LDP process from 2006/7 is risk based using same approach as business plan/assurance framework.</i>	DIRECTOR LEAD: AF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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.	Budgetary allocation to support emergency planning responsibilities	Evidence of reviews and evaluations of exercises and testing of emergency plans. Pandemic Flu high risk.	Countywide PCT emergency planning lead in place. PCT Emergency Planning led by Director with dedicated support. <i>Exercise glevum test in Nov 2005</i>	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	No business continuity policy/procedure in place	Evidence of audits/reviews	<i>Business continuity planning underway</i>	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	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.	DIRECTOR LEAD: AF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
			<i>Significant progress made with the implementation of the Knowledge and Skills elements of AFC.</i>						
3.5.6	Lack of appropriate, accurate workforce information leading to failure to achieve appropriate skill mix for current and future service delivery	The organisation uses appropriate workforce information	Workforce Development monitoring. Supervision structures in place	HR updates to the Board	Internal audit. Healthcare Commission. WDC		Lack of succession planning to cater for the future demands of a mature workforce and increased staff turnover due to retirement		HR Department DIRECTOR LEAD: AMc
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 <i>CFH Programme Board & Financial Sub Group</i>	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		No IM&T Annual Report to the Board.	Board approved IM&T strategy <i>Board appointment NCRS RO Business Case</i>	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				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	No IT Disaster Recovery Plan in place		<i>Financial Systems Project proceeding</i>	Board DIRECTOR LEAD:MT/AF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring	
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 Toolkit demonstrated gaps in achievement	Lack of an overall Information Governance Strategy	<i>Information Governance Seminar to be held 20/1/06</i>	Information Governance Group DIRECTOR LEAD: AF
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	Information Governance Toolkit identified incentives in records management	<i>Healthcare Commission annual health check lack of assurance: IGC to oversee action plan</i>	NHSLA Level 1A achieved Sept. 04	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				Information Governance Group DIRECTOR LEAD: AF
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	Caldicott Guardian and Data Protection Officer in place. Information Governance Group. Incident reporting procedure in place. Induction and training programme.	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		Information Governance Group

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

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		information	FOI Policy and procedure. Confidentiality Policy. Training provided to staff						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	Communications Strategy needs to be reviewed. More engagement with Patients' Forum required	<i>Media survey rated the PCT highly</i>		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	Communications Strategy needs to be reviewed.		IWL Practice Status achieved Nov. 2003 "Look West" staff newsletter. PCT Staff Survey results. IWL Practice status awarded	Directors DIRECTOR LEAD: AF

ASSURANCE FRAMEWORK – 4. PATIENT FOCUS

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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	Stakeholder identification is reactive - no formal identification strategy.		Active involvement at PPI Groups	PPI Group Trust Board DIRECTOR LEAD: JM

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	PPI Group reports to the Board. PPI Annual Report. Clinical Governance Reports. Patch Team minutes	Healthcare Commission. AGW. <i>National evaluation survey to expert patient programme.</i>	Lack of service user involvement with Clinical Governance & Integrated Governance Committees and Information Governance Group	Evaluation of Expert Patient Programme	Local interest and stakeholder group involvement Individual participant evaluation undertaken.	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	<i>Vacancy for PPI forum chair</i>	<i>JM/AF meeting with PPI forum to review</i>		Board DIRECTOR LEAD: JM
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 		PPI Group. Hotel Service standards in place	PPI reports to the Board. Reports to Integrated Governance Committee. Complaints and PALS reports. Patient feedback	Healthcare Commission. PEAT assessments. PCT Patient Survey			PCT Patient Survey. PEAT assessments	 DIRECTOR LEAD: JM

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

ASSURANCE FRAMEWORK – 5. ACCESSIBLE AND RESPONSIVE CARE

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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.	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		Ambulance 75% cat. A targets.	Action plans in place to deal with achievement of targets	Board 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	Dental Lead appointed. Dental access plan in place to achieve further 28,000 registrations.	Reports to the PEC and Board	Performance ratings. Healthcare Commission. PCT Patient Survey	Further delay in new dental contract.		Patient/public feedback	PEC Board DIRECTOR LEAD: JF
5.3 To ensure the provision of timely and better access to primary care services									
5.3.1	Failure to ensure 23/48 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		PCT patient survey results do not support national access audit results		PEC Board DIRECTOR LEAD: JF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	PEC Board DIRECTOR LEAD: JF (Delivery) JM (Clinical Engagement)
5.4 To improve access to services provided by the PCT									
5.4.1	Failure to deliver an effective Out of Hours service	The Trust has in place appropriate plans for developing and delivering effective OOH services. <i>To this end a full nursing team is now in place to support the service, and a GP consortia has expanded and is being strengthened locally.</i>	Service Level Agreement in place with Ambulance Trust. Clinical Governance OOH Group in place	Updates to the Board. Reviews of complaints and incidents.	External Audit. Internal Audit. Healthcare Commission. SHA monitoring	Capacity of GAT to effectively deliver SLA			PEC Board DIRECTOR LEAD: JF
5.4.2	Higher demand than supply for AHP services, community hospital and nursing services leading to quality risks and patient dissatisfaction	<i>Community Hospitals review to ensure services meet the needs of the local community. Case management Project developing the role of community nursing teams. Countywide management of AHP services should improve effectiveness and performance against targets.</i>		Regular reporting to the Board and PEC.	Healthcare Commission. External Audit. Internal Audit.		Pressure in OT services, particularly Children's waiting lists.		PEC Board DIRECTOR LEAD: JF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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	<i>Challenge in identifying actual effect of demand management schemes on referral patterns.</i>	<i>Resource constraints minimise opportunities for LDP developments.</i>	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. <i>GP referral incentive scheme.</i>	Referral Management Centre established. Database of e-referrals and referral activity data used to provide quality feedback loop to GPs and PCDMs	Reports to the Board & PEC	Healthcare Commission. SHA monitoring		<i>Choose and Book system will destabilise local referral management system.</i>	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. <i>Actively reviewing all existing domiciliary care packages to release capacity into the system.</i>	Weekly DToC group.	Reports to the Board & PEC				PEC Board DIRECTOR LEAD: JF
5.6.2	Inappropriate admissions to acute hospital	Demand Management Incentive Scheme. <i>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.</i>	Revised protocols in place for the in-house domiciliary care service	Reports to the Board & PEC. <i>Expanded weekly monitoring report to PCT and SSD Senior Managers. Practices receiving weekly admissions data as part of referral incentive scheme.</i>				PEC Board DIRECTOR LEAD: JF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

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5.6.3	Failure to adequately use bed capacity in community hospitals	<i>Weekly DTOC meeting. Monitor and circulate information on escalation status weekly. Community hospitals review to ensure robust plans for effective use of beds.</i>	Local escalation agreement developed to ensure optimum use of bed capacity in community hospitals	Reports to the Board & PEC		<i>Gap identified in ensuring patients transferred effectively. Plans to implement 'Nurse at end of bed scheme' not yet finalise.</i>			PEC Board DIRECTOR LEAD: JF
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. <i>Support to patients making choices to ensure that they make informed choices.</i>	E Referrals project underway. Patient Choice Adviser appointed	Regular reports to the Board & PEC	Healthcare Commission. AGW	<i>Inability to influence national supplier delivery performance and supplier capacity.</i>	<i>Possible failure of choose and book system and delivery of nationally procured choice leaflet.</i>		PEC Board DIRECTOR LEAD: JF

ASSURANCE FRAMEWORK – 6. CARE ENVIRONMENT AND AMENITIES

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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	<i>Monthly monitoring and patient feedback.</i>	Modern Matrons in place	Reports to the Board and PEC. <i>Use of ACI system to identify gaps with regular reporting to the board.</i>	Healthcare Commission. PEAT Inspections				PEC Board PPI Forum Director Lead: JF

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

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6.1.2	Failure to meet the requirements of the Disability Discrimination Act	Monitoring and patient feedback	PCT Strategic Service Development Plan	<i>Use of ACI system to identify gaps with regular reporting to the board.</i>		Known lack of meeting all DDA requirements <i>due to limitations in estates and capital programme.</i>	<i>No proactive training to facilitate attitudinal change.</i>		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	Estates Sub-Group. DIRECTOR LEAD: MT

ASSURANCE FRAMEWORK – 7. PUBLIC HEALTH

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
7.1 To develop effective partnership working across the local health community and wider SHA									
7.1.1	Failure to work in partnership across the health community leading to breakdown in community relationships	The Trust works effectively with voluntary organisations and agencies	Gloucestershire Strategic Forum in place. Gloucestershire Strategic Partnership and Local Strategic Partnerships in place and achieve engagement of CDRPs.	Reports to the Board/PEC. Minutes of Partnership and VCS meetings. PH Annual Report <i>Minutes of (Board level) Health Improvement and Partnerships Group</i>	Healthcare Commission	Skills and competencies in partnership working to be developed throughout the whole organisation. Financial control/review of VCS grants.	Partnerships don't routinely self-assess effectiveness of partnership working. VCS funding not identified within current LDP		Board

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

ASSURANCE FRAMEWORK 2005/06 : UPDATED DECEMBER 2005

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
		<i>NSF Review of terms of reference for county and local implementation teams to ensure joined up working.</i>				<i>public health / prevention / voluntary sector to support delivery.</i>	<i>GPT/ commissioner management focus on FT status may divert attention from delivery of services.</i>		
7.3.3	Failure to deliver the older person NSF	<i>Primary Care falls audit tool to ensure professionals are appropriately identifying and managing fallers.</i>	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.		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		DIRECTOR LEAD: JF (Delivery) HA (NSF)
7.3.5	Failure to deliver the diabetes NSF			Reports to the Board and PEC	Healthcare Commission		Need to develop countywide obesity strategy backed by local action plans and adequately resourced		DIRECTOR LEAD: JF (Delivery) HA (NSF)
7.3.6	Failure to deliver the children's NSF	<i>New county Director lead based at C&V to ensure delivery across the county of the NSF.</i>		Reports to the Board and PEC	Healthcare Commission				DIRECTOR LEAD: JF (Delivery) HA (NSF)

