West Gloucestershire NHS
Primary Care Trust

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

Assurance Framework

2004/05

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST – ASSURANCE FRAMEWORK

Background

All NHS organisations are required to have in place an Assurance Framework that covers the whole organisation at a strategic level and is embedded at Board level. The Assurance Framework supports the annual Statement of Internal Control (SIC) and outlines the principal and secondary objectives of the PCT, any risks to delivery of these objectives, management controls on the risks and assurances on controls, external/independent sources of assurance and outcomes on assurances given.

The Trust has developed risk management, control and review processes to support the Board Assurance Framework. The Board Assurance Framework was originally developed following a number of Board Development sessions in 2003 and the final version for 2003/04 was ratified at the Board meeting in April 2004. Since then the risks identified in the Assurance Framework, together with risks identified from the controls assurance standards baseline assessments, have continued to be reviewed and have been integrated into the PCTs risk register, which supports the Trusts risk management system.

During 2004 the Trust commenced a major review of the Assurance Framework in order to align the strategic and principal objectives to the seven domains of the Standards for Better Health. It is clear that the healthcare standards will play a central part in the assurance processes for the NHS. The Healthcare Commission intends to ensure that a specific declaration on the extent to which the core standards are met becomes an important part of the local accountability of trusts. In order to make such a declaration, Trust Boards will need to have systems in place to assure their compliance with the core standards. Aligning the strategic and principal objectives to the seven domains will help to ensure that the Trust's approach to the standards and risks are properly integrated.

During 2005 further work will be required; in particular there is an urgent need to review existing committee structures, including the Clinical Governance Steering Committee, the Governance and Risk Management Committee and the Audit Committee, in order to develop a more integrated approach to governance across the Trust. Focussing on the integration of governance will encourage a broader perspective on the impact of delivering clinical services covering both commissioner and provider activities as well as overseeing governance issues which relate to and have an impact on staff. The main challenge for integration and the development of the Assurance Framework will be the need to develop a much tighter alignment between the planning process, ongoing objective setting, risk assessment, the Standards for Better Health, performance management and the various internal and external monitoring systems. The main objective driving this integration is the need to identify overlaps and omissions and produce an overall structure which enhances Board decision making, direction and control.

The Framework itself is divided into two sections. The first section identifies the strategic objectives as identified by each of the seven domains of the Standards for Better Health:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus
- Accessible and Responsive Care
- Care Environment and Amenities
- Public Health

Alongside these domains are the core and developmental standards and the PCTs principal objectives which have been approved by the Board. The second section of the Framework identifies the principal risks associated with the achievement of the objectives. Alongside each of the risks are the expected management controls, the actual controls in place, the management assurances and the external/independent assurances. Gaps in the controls and/or assurances have also been identified together with positive assurances, where appropriate, and the identification of ongoing monitoring arrangements, including the responsible lead director.

The Assurance Framework process is an ongoing process which requires continual review. As such there are still some areas that need updating and these will be taken forward by the appropriate director lead.

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
1.0	**SAFETY** To ensure that patient safety is enhanced by healthcare processes, working practices and systematic activities that prevent or reduce the risk of harm to patients	C1	Health care organisations protect patients through systems that a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales	**1.1**	**To ensure compliance with the statutory duty of quality and the delivery of safe, high quality patient care**
		C2	Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations	**1.2**	**To identify and manage all risks properly and appropriately (in particular those risks associated with infection control, medical devices, decontamination, medicines and waste management)**
		C3	Health care organisations protect patients by following NICE Interventional Procedures guidance	**1.3**	**To ensure that effective systems are in place to learn from patient safety incidents**
		C4	Health care organisations keep patients, staff and visitors safe by having systems to ensure that: a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA; b) all risks associated with the acquisition and use of medical devices are minimised; c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; d) medicines are handled safely and securely; and e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	**1.4**	**To ensure that effective child protection arrangements are in place throughout the organisation and in partner organisations**
		D1	Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another	**1.5**	**To ensure that health care processes, practices and activities are continually reviewed and that improvements in practice are implemented**

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
2.0	**CLINICAL AND COST EFFECTIVENESS** To ensure that patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes	C5	Health care organisations ensure that: a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care; b) clinical care and treatment are carried out under supervision and leadership; c) clinicians continuously update skills and techniques relevant to their clinical work; and d) clinicians participate in regular clinical audit and reviews of clinical services	**2.1**	**To commission cost effective and evidence based responsive healthcare services for the local population**
		C6	Health care organisations co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	**2.2**	**To provide efficient and effective local services through a primary care focus**
		D2	Patients receive effective treatment and care that: a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery; b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences; c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and d) is delivered by health care professionals who make clinical decisions based on evidence-based practice	**2.3**	**To ensure that all prescribing within the PCT is appropriate, safe and cost-effective**

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
3.0	**GOVERNANCE** The Trust will make sure that managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation	C7 C8 C9 C10	Health care organisations a) apply the principles of sound clinical and corporate governance; b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources; c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards); d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources; e) challenge discrimination, promote equality and respect human rights; and f) meet the existing performance requirements Health care organisations support their staff through a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation of minority groups Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required Health care organisations a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and b) require that all employed professionals abide by relevant published codes of professional practice	**3.1** **3.2** **3.3** **3.4** **3.5** **3.6** **3.7** **3.8**	**To ensure the sound administration of the PCT finances and achieve and maintain recurring financial balance and deliver on mandatory financial targets** **To assess and manage risks through an effective risk management strategy** **To ensure that effective emergency planning and business continuity arrangements are in place throughout the Trust** **To ensure that systems and working practices support quality improvement and assurance across the clinical and corporate governance agendas** **To ensure that the Trust recruits, retains, develops and empowers staff in order to provide high quality services** **To develop a comprehensive, robust and reliable information management and technology infrastructure** **To establish and maintain robust information governance arrangements** **To communicate effectively with internal and external stakeholders**

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
	GOVERNANCE (Cont.)	C11	Health care organisations ensure that staff concerned with all aspects of the provision of health care a) are appropriately recruited, trained and qualified for the work they undertake; b) participate in mandatory training programmes; and c) participate in further professional and occupational development commensurate with their work throughout their working lives		
		C12	Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied		
		D3	Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks		
		D4	Health care organisations work together to a) ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service; b) implement a cycle of continuous quality improvement; and c) ensure effective clinical and managerial leadership and accountability		
		D5	Health care organisations work together and with social care organisations to meet the changing health needs of their population by a) having an appropriately constituted workforce with appropriate skill mix across the community; and b) ensuring the continuous improvement of services through better ways of working		
		D6	Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning		
		D7	Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction		

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
4.0	**PATIENT FOCUS** Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being	C13	Health care organisations have systems in place to ensure that a) staff treat patients, their relatives and carers with dignity and respect; b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and c) staff treat patient information confidentially, except where authorised by legislation to the contrary	**4.1**	**To strengthen the capacity of patients, carers and the wider public to participate in health and healthcare planning and delivery**
				4.2	**To improve the five key dimensions of the patient experience**
		C14	Health care organisations have systems in place to ensure that patients, their relatives and carers a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services; b) are not discriminated against when complaints are made; and c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery		
		C15	Where food is provided, health care organisations have systems in place to ensure that a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day		
		C16	Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care		
		D8	Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives		

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
	PATIENT FOCUS (Cont.)	D9	Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are a) encouraged to express their preferences; and b) supported to make choices and shared decisions about their own health care		
		D10	Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care		

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
5.0	**ACCESIBLE AND RESPONSIVE CARE** Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway	C17 C18 C19 D11	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services Health care organisations plan and deliver health care which a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice; b) maximises patient choice; c) ensures access (including equality of access) to services through a range of providers and routes of access; and d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services	**5.1** **5.2** **5.3** **5.4** **5.5** **5.6** **5.7**	**To ensure the provision of timely and better access to elective and emergency services** **To improve access to NHS dentistry** **To ensure the provision of timely and better access to primary care services** **To improve access to services provided by the PCT** **To ensure that national targets are met to effectively manage referral patterns** **To effectively manage delayed discharges** **To ensure the effective implementation of patient choice initiatives**

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
6.0	**CARE ENVIRONMENT AND AMENITIES** Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients	C20	Health care services are provided in environments which promote effective care and optimise health outcomes by being a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and b) supportive of patient privacy and confidentiality	**6.1**	**To develop and provide local services that meet patients needs and preferences**
		C21	Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	**6.2**	**To ensure that appropriate environmental standards are maintained across provider and commissioned services**
		D12	Health care is provided in well designed environments that a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and b) are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections		

	STRATEGIC OBJECTIVES		CORE/DEVELOPMENTAL STANDARDS		PCT PRINCIPAL OBJECTIVES
7.0	**PUBLIC HEALTH** Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas	C22	Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by a) co-operating with each other and with Local Authorities and other organisations; b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships	**7.1**	**To develop effective partnership working across the local health community and wider SHA**
				7.2	**To develop effective local multi-agency partnerships with statutory, voluntary and community organisations e.g. Local Strategic partnerships, Crime and Disorder Reduction Partnerships, Community Counts/Neighbourhood Management, Sure Start, Healthy Schools Partnership GNPN etc.**
		C23	Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections	**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**
				7.4	**To address the health inequalities agenda, focussing on areas of proven effectiveness and responding to specific local health needs**
		C24	Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services	**7.5**	**Where appropriate, to develop specific local action plans/guidelines to underpin the countywide and PCT policies, strategies and plans e.g. emergency immunisation guidelines**
		D13	Health care organisations a) identify and act upon significant public health problems and health inequality issues, with Primary Care Trusts taking the leading role; b) implement effective programmes to improve health and reduce health inequalities; c) protect their populations from identified current and new hazards to health; and d) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services	**7.6**	**To ensure appropriate continuing professional development (CPD) in support of the public health agenda, maintaining standards in public health practice e.g. public health clinical audit**

ASSURANCE FRAMEWORK - SAFETY

	Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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. Induction and appropriate training programmes in place. SABs scheme for cascading alerts in place. H&S Manager & Fire Safety Adviser 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 provide notification of changes in legislation etc.	External Audit reviews of Governance arrangements. NHSLA. HSE Reports. External Audit	More rigorous process required to review documents and actions required		Level 1A NHSLA Risk Management Standard achieved in September 2004. HSE Inspection 2003	Clinical Governance, Risk Management & Audit Committees DIRECTOR LEAD: ALL
1.1.2	Failure to establish effective systems to comply with statutory duty of quality	The Board has in place 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 Clinical Governance Committee & Risk Committees. Both Committees provide regular reports to the Board. Clinical Governance updates to the PEC	Healthcare Commission. NHSLA. HSE	Risk Management Strategy should be subject to review on an annual basis (Ref. NHSLA 1A1.1.2)		Level 1A NHSLA Risk Management Standard achieved in September 2004	Clinical Governance, Risk Management & Audit Committees DIRECTOR LEAD: JM/AF
1.1.3	Responses to internal and external audits and reports are inadequate	The Board 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	Clarify process for reviewing audits and reviews – role of Committees needs to be reviewed in line with move towards integrated governance	Need to tighten up on process for implementing actions arising from audits	Annual Audit Letter Internal Audit annual review	Audit Committee DIRECTOR LEAD: MT

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	Clinical Governance & Risk Management Committees. Regular reports to the Board provided by both Committees	Healthcare Commission. NHSLA assessment process. HSE. Internal Audit. External Audit	Vacant Risk manager post has not been replaced. No regular 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. No effective performance monitoring of organisation's risk management objectives in place. (Ref. NHSLA 1A1.5.2)	Level 1A NHSLA Risk Management Standard achieved in September 2004.	Clinical Governance & Risk Management Committees DIRECTOR LEAD: AF
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	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 and "fair blame" throughout the Trust	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)	Level 1A NHSLA Risk Management Standard achieved in September 2004. Staff Survey feedback on awareness of incident reporting procedures	Clinical Governance, Risk Management & Health & Safety Committees. Board & PEC Development Sessions DIRECTOR LEAD: AF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
1.2.3	Failure to identify and manage risks associated with: • Infection control • Medical devices • Decontamination • Medicines • Waste Management	Policies, procedures, and systems are in place for identifying and managing risks and training is provided to appropriate staff.	SLA with Infection Control service. MRSA plan. Safety Alert system in place. Policies and procedures in place. Mandatory training. Health & Safety Committee. Clinical Governance and Risk Management Committees	Annual Infection Control Report to the Board. (Ref. NHSLA 1A5.1.1). Risk management implications of infection control issues etc. considered at Clinical Governance Committee. Clinical audits. Reviews of incidents and complaints. Training records. Reports to the Board	Healthcare Commission. NHSLA. Clinical audits. Environmental Health reports	No policy on hand hygiene and hand care (Ref. NHSLA 1A5.2.1, 1B5.2.1, 1B5.2.2, 1B5.2.3)	Regular reporting of incidents to the Board required (Ref. NHSLA 1B2.2.2 and 1B2.2.3)	Level 1A NHSLA Risk Management Standard achieved in September 2004	Clinical Governance, Risk Management & Health & Safety Committees DIRECTOR LEAD: JM
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. Training records	Clinical Governance and Risk Management Committees report to the Board.	Healthcare Commission. NHSLA. NPSA	Lack of a proper system for quality indicators. Board does not receive regular updates on incidents. Training requirements to be reviewed and further training to be given to staff	Review training requirements and records. Committee structures need to be formally reviewed	Level 1A NHSLA Risk Management Standard achieved in Sept. 2004. Incident coding structure approved by NPSA	Clinical Governance & Risk Management Committees DIRECTOR LEAD: JM
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	Risk Management Committee in place	Reports to the Board	Healthcare Commission. NHSLA	No formal key indicators developed (Ref. NHSLA 1B4.5.1)	Committee structure needs to be reviewed. Risk management to be integrated into performance management arrangements		Directors Board DIRECTOR LEAD: AF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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 Trust has local policies and procedures in place for child protection and there are named leads for child protection	Named doctor/nurse leads. Training records. CRB checks undertaken.	Annual Child Protection Report to the Board. Training records. Action plans	Healthcare Commission. Audits		No designated Board lead for Child Protection. Evidence of on-going audit of practice. 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 Trust 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			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 complaints, incidents, claims and user and career feedback	The Board receives information on changes to practices and improvements. Learning is shared across the Trust	Clinical Governance and Risk Management Committees. Countywide Risk Management Liaison Group. SHA forums in place	Reports to the Board from Clinical Governance & Risk Committees, including Annual Reports. Minutes from meetings	Healthcare Commission. NHSLA. NPSA	Lack of an integrated system to enable the organisation to learn from and take appropriate action in the light of complaints, incidents, patient feedback etc.	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	NHSLA Level 1A achieved Sept. 04	Clinical Governance Committee. PPI Group Trust Board DIRECTOR LEAD: JM/AF

ASSURANCE FRAMEWORK – 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 update lists of INNFs to support commissioning agenda, NICE decisions etc.	The Board receives regular updates on issues impacting on commissioning decisions, including the INNF list.	Regular review of the INNF list by the Strategic Commissioning Group	Reports to the Board on updates to the INNF list	Healthcare Commission. External Audit				PEC Board DIRECTOR LEAD: JF/HA
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. SAFF reviews. Locality Commissioning initiative. Strategic Service Development Plan	Reports to the Board	External Audit AGW	Consultation with and active involvement of partners, staff, users and carers re. strategic organisational issues	Expert patients are not actively involved in the commissioning process. Lack of strategic commissioning startegy		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	Reports to the Board	Healthcare Commission. AGW	Lack of qualitative data in current performance reports to the Board			PEC Board DIRECTOR LEAD: JF
2.2	**To provide efficient and effective local services through a primary care focus**								
2.2.1	Failure to develop suitable primary care facilities and services	The Board has approved an overall PCT Strategy and Strategic Service Delivery Plan to support the provision of local services through a primary care focus	Strategic Service Delivery Plan in place. Review of Community Hospitals	Reports to the Board	AGW		Overall PCT Strategy linked to LDP to be agreed		Directors PEC Board DIRECTOR LEAD: JF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
2.3	**To ensure that all prescribing within the PCT is appropriate, safe and cost effective**								
2.3.1	Practices and pharmacists do not fully engage with the medicines management agenda causing schemes for the management of the prescribing budget to become ineffective	Arrangements are in place to ensure effective engagement of practices and pharmacists in medicines management issues	Monthly finance reports issued to practices identifying key issues e.g. high cost drugs. Targeted support provided to practices. Financial input into medicine management group to ensure closer monitoring on prescribing budget	Medicines Management Group. Regular Medicines Management Reports to Board and PEC. Prescribing incentive scheme reports. Medicines Management Strategy in place. Regular reporting on all individual practice visits to the Medicines Management Group. Prescribing reports and action plans to achieve practice prescribing savings circulated to GPs	PPA data. Internal Audit Prescribing audits. External Audit	Training events with practices and community pharmacists to ensure engagement with medicines management agenda	Head of Medicines Management post currently vacant		Medicines Management Group. Trust Board DIECTOR LEAD: JF
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			Prescribing audits	Targets with secondary care providers to be agreed	Head of Medicines Management post currently vacant		Medicines Management Group DIRECTOR LEAD: JF
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		Head of Medicines Management post currently vacant		Medicines Management Group 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: JF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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.				Medicines Management Group. Clinical Governance Group DIRECTOR LEAD: JF

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 financial status and progress on CRES plans	Budget monitoring in place. Regular reconciliation processes. CRES plans identified and monitored. Director of Finances Forum in place	Monthly Finance Reports to the Board. Audit Committee minutes	SHA monitoring. External Audit. Internal Audit. Healthcare Commission	Lack of regular budget monitoring meetings with budget holders. Lack of regular review of CRES programme	No overall financial strategy in place linked to LDP. Lack of 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 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 Director of Finance	Updates provided to the Board	Internal Audit. External Audit. SHA	Detailed project plan to be developed.			Audit Committee. Trust Board DIRECTOR LEAD: MT
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. SFIs and SOs to be reviewed, updated and re-issued. Lines of financial accountability to be clearly defined.		External Audit Annual Letter	Audit Committee DIRECTOR LEAD: MT
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			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	Risk Management 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	Audit Committee Risk Management Committee DIRECTOR LEAD: AF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	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	All sources of risk, including those from the perspective of all stakeholders, need to be included (Ref. NHSLA 1B4.1.1)	High level risk identified by various assessments e.g. IWL, NHSLA Level 1, PEAT etc. should be added to the risk register (Ref. 1B4.2.1)	NHSLA Level 1A achieved Sept. 04	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	Lack of integrated governance structure/system to support risk management strategy – review of arrangements required	Lack of integration with LDP/business planning processes		DIRECTOR LEAD: AF/JM
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	Reports to the Board. Training records. On-call rota and on-call pack for senior managers. Emergency Planning Group minutes.	External Audit. Internal Audit. Healthcare Commission.	Inconsistent Director/senior manager support for emergency planning. Budgetary allocation to support emergency planning responsibilities	Evidence of reviews and evaluations of exercises and testing of emergency plans. Annual independent audit of the major incident plan	Countywide PCT emergency planning lead in place	Emergency Planning Group. Risk Management Committee 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		Emergency Planning Group. Risk Management Committee DIRECTOR LEAD: AF

	Principal Risks	Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	Lack of integrated governance structure/system to support quality improvement	Quarterly review of Assurance Framework and Risk Register. Committee structures need to be formally reviewed	NHSLA Level 1A Assessment achieved Sept. 04	DIRECTOR LEAD: AF/JM
3.4.2	Failure to deliver risk treatment/action plans to alleviate or minimise risks	The organisation has effective risk treatment plans in place for all risks. Risk treatment plans are regularly reviewed	Risk Management Committee review risk register and risk treatment action plans. Clinical Governance action plans.	Audit Committee review risk management processes. Risk Management Committee reports to the Board. Clinical audit	Healthcare Commission. NHSLA. Internal Audit. External Audit	Lack of integrated governance structure/system to support quality improvement	Quarterly review of risk register including treatment plans	NHSLA Level 1A achieved Sept. 04	DIRECTOR LEAD: AF/JM
3.5	**To ensure that the Trust recruits, retains, develops and empowers staff in order to provide high quality services**								
3.5.1	Failure to recruit and retain the right calibre of staff	Recruitment and selection procedures in place. Job descriptions and person specifications for all posts. Effective induction processes. Appraisal process in place. Flexible working policies in place	Recruitment and selection procedures recently reviewed and revised. Hard to recruit areas reviewed and recruitment targeted to these areas if necessary. Revised corporate induction programme. Recruitment analysis and review of vacancies. Monitoring of procedures and retention and turnover rates Flexible working policies in place.	HR Annual Report to the Board. Workforce planning features in the LDP. Working towards IWL Practice Plus status	Internal Audit. External Audit. IWL assessment process. AGW	Inability to predict changing workforce needs which could impact on our ability to recruit in a timely manner. Failure to assess impact of loss of key staff. Current freeze on staff recruitment due to financial pressures. Some gaps in appraisals and PDPs	No regular HR performance reports to the Board. No retention strategy or process for succession planning in place. Workforce planning is not effectively embedded into the LDP process	IWL Practice Status achieved Nov. 2003	HR Department DIRECTOR LEAD: AMc

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
3.5.2	Unacceptable levels of sickness absence which affect the operation of the Trust	Sickness Absence Management Policy in place and sickness absence rates are monitored. Occupational Health Service available	Sickness Absence Management Policy issued to all managers and copies of monthly sickness absence reports provided. HR Operations Managers oversee sickness absence monitoring	HR monitoring and Workforce Information reports. HR Annual Report to the Board	Internal audit IWL assessment process	Lack of management intervention to deal with absence problems	No regular reporting to the Board on HR/Workforce issues	IWL Practice Status achieved Nov. 2003	HR Department DIRECTOR LEAD: AMc
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	Insufficient funding available to fully support all training needs. Lack of training and development implementation plan	No regular reporting to the Board on HR/Workforce issues.	IWL Practice Status achieved Nov. 2003	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. NHSLA			NHSLA Level 1A achieved Sept. 04. Individual records of appraisals and central database of training and development records	HR Department DIRECTOR LEAD: AMc
3.5.5	Failure to effectively implement and adapt to Agenda for Change resulting in low morale and disruption to services	There are plans in place to implement Agenda for Change and the Board is kept updated on progress. Plans are in place to achieve IWL Practice Plus status	Project management procedures in place. Regular staff communications on Agenda for Change. Implementation of IWL Practice Plus standards. Team briefing system in place and regular production of "Look West" newsletter	Notes of joint staff consultative committee meetings. Regular reports to the Board on IWL progress	IWL Reports. Staff Survey. SHA Workforce Groups. Internal audit. IWL practice plus assessment process	Knowledge and Skills Framework to be implemented	No regular HR report/Agenda for Change update to the Board.		HR Department. Directors DIRECTOR LEAD: AMc

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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	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. No PCT Board approved IM&T strategy		Board 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			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 Toolkit return due 1/4/05	Lack of an Information Governance Strategy		Information Governance Group DIRECTOR LEAD: AF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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 return due 1/4/05	Lack of an Information Governance Strategy	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 Toolkit return due 1/4/05	Lack of an Information Governance Strategy		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 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	Information Governance Toolkit return due 1/4/05	Audit of staff understanding of policies and procedures		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	Communications Strategy needs to be reviewed. More engagement with Patients' Forum required		Public involvement at PPI Groups/ Board meetings etc.	PEC Board DIRECTOR LEAD: AF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
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. Staff intranet site currently being reviewed and redeveloped	IWL Practice Status achieved Nov. 2003	"Look West" staff newsletter. PCT Staff Survey results. IWL Practice status awarded	Directors DIRECTOR LEAD: AF

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 - need overall formal identification to improve strategic understanding		Active involvement at PPI Groups	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	PPI Group reports to the Board. PPI Annual Report. Clinical Governance Reports. Patch Team minutes	Healthcare Commission. AGW.	Lack of service user involvement with Clinical Governance & Risk Management Committees or Information Governance Group	Evaluation of Expert Patient Programme	Local interest and stakeholder group involvement	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				Board DIRECTOR LEAD: JM

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
4.2	**To improve the five key dimensions of the patient experience**								
4.2.1	Failure to demonstrate improvement in terms of: • 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 Clinical Governance & Risk Management Committees. Complaints and PALs reports. Patient feedback	Healthcare Commission. PEAT assessments. PCT Patient Survey			PCT Patient Survey. PEAT assessments	DIRECTOR LEAD: JM

ASSURANCE FRAMEWORK – 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	FT Contract and Service Level Agreements which ensure sufficient activity to meet access targets are agreed. The Board has access to regular information on key performance targets.	Clear performance management process in place for commissioning arrangements. FT Contract and SLAs negotiated and documented and regularly reviewed. Monitoring takes place with key providers. LDP Action Plans monitored and reviewed. Managing Emergency Demand Group	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	Board DIRECTOR LEAD: JF/AF
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	Reports to the PEC and Board	Performance ratings. Healthcare Commission. PCT Patient Survey			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. PCDMs work with individual practices experiencing difficulties to facilitate service improvement	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

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 Committee. Regular attendance by PCT officers at LMC meetings. Weekly information packs sent to all practices	Attendance and participation at meetings and minutes of meetings. Reports to the Board	PEC Chair provides updates to the Board	PEC vacancies exist. Lack of communication of PEC discussions/ issues to wider health community. Clinical lead structure to be reviewed. No PCT Clinical or Primary Care Strategy in place	Lack of clinical engagement from the PEC. Lack of clinical lead structure for all key areas		PEC Board DIRECTOR LEAD: JF/JM/HA
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	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			Regular reporting to the Board and PEC.	Healthcare Commission. External Audit. Internal Audit.				PEC Board DIRECTOR LEAD: JF
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				PEC Board DIRECTOR LEAD: JF
5.5.3	Failure to make appropriate referrals		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				PEC Board DIRECTOR LEAD: JF

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
5.6	**To effectively manage delayed discharges**								
5.6.1	Insufficient capacity in domiciliary care market to cope with demand			Reports to the Board & PEC					PEC Board DIRECTOR LEAD: JF
5.6.2	Inappropriate admissions to acute hospital		Revised protocols in place for the in-house domiciliary care service	Reports to the Board & PEC					PEC Board DIRECTOR LEAD: JF
5.6.3	Failure to adequately use bed capacity in community hospitals		Local escalation agreement developed to ensure optimum use of bed capacity in community hospitals	Reports to the Board & PEC					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		E Referrals project underway. Patient Choice Adviser appointed	Regular reports to the Board & PEC	Healthcare Commission. AGW				PEC Board DIRECTOR LEAD: JF

ASSURANCE FRAMEWORK – 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		Modern Matrons in place	Reports to the Board and PEC	Healthcare Commission. PEAT Inspections				
6.1.2	Failure to meet the requirements of the Disability Discrimination Act								
6.1.3									
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. Service strategy 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	No overall PCT Estates Strategy in place. Review of Estates Shared Service function		Surveys of patient and user satisfaction	Estates Sub-Group. DIRECTOR LEAD: MT

ASSURANCE FRAMEWORK – 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. Community strategies developed and in place and aligned to LDP where possible. VCS funding procedure in place	Reports to the Board/PEC. Minutes of Partnership and VCS meetings. PH Annual Report	Healthcare Commission	Skills and competencies in partnership working to be developed throughout the whole organisation. Financial control/review of VCS grants. No specific reports to the Board. VCS funding not identified within current LDP	Partnerships don't routinely self-assess effectiveness of partnership working. VCS funding not identified within current LDP		Board DIRECTOR LEAD: HA
7.2	**To develop effective Local Authority partnerships**								
7.2.1	Failure to develop effective health and social services partnerships and inability to progress integration/develop pooled budgets	The Trust develops effective partnerships which support integration and pooled budgets	Gloucestershire Strategic Forum. Joint appointments with social services in place. OT integration. Joint meeting structures for key areas of work e.g. Single Assessment Process	Reports to the Board and PEC. Regular CE meetings with Director of Social Services and updates reported to the Board. Audit Committee	External Audit		Partnerships don't routinely self-assess effectiveness of partnership working		Board DIRECTOR LEAD: HA
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			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/HA
7.3.2	Failure to deliver the mental health NSF		PCT lead for mental health. Mental Health Group	Reports to the Board and PEC	Healthcare Commission. External review of NHS Plan				DIRECTOR LEAD: JF/HA

Principal Risks		Expected Management Controls	Actual Controls	Management Assurances	External / Independent Assurance	Gaps in Controls	Gaps in Assurances	Positive Assurances	Ongoing Monitoring
7.3.3	Failure to deliver the older person NSF		Older Persons Group	Reports to the Board and PEC	Healthcare Commission				DIRECTOR LEAD: JF/HA
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/HA
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/HA
7.3.6	Failure to deliver the children's NSF			Reports to the Board and PEC	Healthcare Commission				DIRECTOR LEAD: JF/HA
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	PCTs Partnership & Health Inequalities Group with strong NED participation. Countywide Public Health Network Committee. Countywide CHD LIT. Countywide Smoking Cessation Steering Group. Teenage Pregnancy Steering Group. Health Promotion Management Committee. Robust health needs assessment in place	PH Annual Report. Reports to the Board and PEC. Project and Study reports e.g. HNAs in Barton, Tredworth and White City Minutes of service reports of various groups	Rolling programme of health equity audits. Health needs assessments, audits and evaluations	Public health indicators for regular monitoring	Public health audit		Board DIRECTOR LEAD: HA