



**Manchester City Council
Report for Information**

Report To: Resource and Governance Overview and Scrutiny Committee
– 12 November 2009

Subject: Risk Management Practices and Efficiency Programme in
NHS Manchester

Report of: Zoe Cohen, Director of Corporate Affairs, NHS
Manchester

Summary

This report outlines NHS Manchester's risk management arrangements and provides an overview of its efficiency programme.

Recommendations

- To note the contents of this report
- To contribute any suggestions on the opportunities within the health economy for quality and cost improvement, as part of the Securing our Shared Future opportunity identification exercise

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

NHS Manchester Risk Management Strategy
NHS Manchester Risk Management Policy

1.0 Introduction

1.1 This report was prepared at the request of Councillor Mary Watson, Chair of the Resources and Governance Overview and Scrutiny Committee, and outlines the risk management arrangements of NHS Manchester and provides an overview of its efficiency programme, “The Quality and Productivity Challenge”.

Risk Management Arrangements

2.0 Background

2.1 As with all public sector organisations NHS Manchester has a highly developed system of internal control which is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

2.2 The PCT recognises that risk management is an integral part of good management practice and that to be most effective should be part of the PCT’s culture and ways of working. Risk management is a fundamental part of a total approach to quality, corporate and clinical governance – as set out in the NHS Integrated Governance Handbook.

3.0 Capacity to Handle Risk

3.1 The Board and Chief Executive have delegated responsibility for risk management to the Director of Corporate Affairs, who is supported by the Assistant Director Corporate Governance and Risk. A Committee structure has been established to assist the Board in the discharge of its responsibilities. This includes a Governance Committee, which is chaired by a Non-Executive Director, to take forward the development of integrated governance in the PCT and to oversee the work of a number of functional groups in key governance and risk areas. This includes the commissioning and corporate part of the PCT and Manchester Community Health.

3.2 Primary responsibility for risk management rests with PCT directors, managers and frontline staff and they are supported by a small team of staff within corporate governance and risk functions. This department has ensured that there has been organisational capacity to lead and manage risk issues at a corporate level

4.0 Risk Management Arrangements

4.1 The key elements of the PCT’s risk arrangements are:

- Clarity regarding organisational and personal responsibilities, particularly as the PCT moves to separate commissioning and provider functions.

- A Board Risk Assurance Framework, which is presented to the Board regularly during the year (see below 4.3). Manchester Community Health has recently developed its own Risk Assurance Framework to complement that of the PCT and support the move to greater separation.
- A Governance Committee, which meets bi-monthly and seeks assurance that integrated governance and risk processes are in place and prepares for the Board's declaration on the core standards.
- NHS Manchester's Risk Management Strategy which describes the framework for the management of risk and the key areas of strategic risk and actions being progressed to address these.
- NHS Manchester's Risk Management Policy.
- Treatment of identified risks by avoidance, reduction, transfer and acceptance.
- Development of directorate risk registers in order to evaluate, deal with, and monitor risk issues in a consistent manner. Directorate management teams have taken ownership of risk registers in order to embed risk processes within services. This process is assured by the Governance Committee.
- Provision of support and training for managers and staff from specialist staff with access to external assistance.

4.2 The system of internal control and risk management are underpinned by compliance with the requirements of corporate and clinical governance and risk management as part of the Standards for Better Health. The PCT assessed itself as compliant against the standards (C7a and C7c) for both commissioning and provider services in March 2009. Under the Audit Commission's Use of Resources Framework the PCT was scored "2" for KLoE 2.4 on management of risk and internal control.

4.3 The revised Board Risk Assurance Framework format is based on a model using the following elements; priority & links, goal, lead, principal risks, current controls, current assurances, potential gaps, current risk status, action plans and status, completion date for action and residual risk status. The Board Risk Assurance Framework is presented quarterly to the Board, to the Governance Committee and annually to the Audit Committee. It highlights how the PCT is dealing with the risks to the achievement of its objectives and therefore supports the preparation of the Statement of Internal Control. The most recent version of the Board Risk Assurance Framework is attached. Changes since the previous version are underlined which will give a flavour of how the document is "live" and kept under review. The next version in December 2009 will, for example, include the risks to delivery of the Securing Our Shared Future programme (see below).

Quality and Productivity Challenge in NHS Manchester

5.0 Background

5.1 The application of Department of Health estimates of the likely impact on overall NHS funding to NHS Manchester suggests that, over the next 5 years, NHS Manchester will need to find £200m in efficiency savings. This equates to approximately 20% of its current budget.

5.2 At the same time, the NHS as a whole will be required to improve the quality and safety of its services, progress its commitment to improve health as well as treating illness, and maintain access to healthcare for the whole population.

5.3 The challenge of driving up quality and driving down costs is currently branded by the NHS nationally as 'the quality and productivity challenge', having formerly been known as 'QIPP' (quality, innovation, productivity and prevention).

6.0 NHS Manchester's approach

6.1 NHS Manchester is approaching this challenge on the basis that it is a whole health economy issue and involves the City Council, NHS Trusts, NHS Foundation Trusts, Manchester Community Health and Manchester Mental Health and Social Care Trust, as well as all other, smaller, providers within the city. NHS Manchester aims to develop a strategy to rise to the quality and productivity challenge with its partners.

6.2 As the first stage of developing its strategy, an 'opportunity identification exercise' has commenced. This exercise aims to identify from as wide a range of stakeholders as possible the scope for quality and cost improvement across the health economy. During this exercise, opportunities are being identified through a range of activities, including the following:

- Analysis of Manchester's performance and characteristics when compared to relevant benchmarks to identify where there may be outlying costs that could be reduced to benchmark levels.
- Identification of ideas through engagement with clinicians, the public and patients, staff and other interested parties. NHS Manchester is currently finalising its draft communications and engagement approaches, the latter being a description of its approach to engagement with public and patients which will be presented to the Health and Wellbeing Overview and Scrutiny Committee, subject to the agenda setting process.
- A series of thematic workgroups, each chaired by a chief executive and focused on a care pathway, namely: keeping adults and children healthy and well, planned care, urgent care, long term conditions, mental health and learning disabilities, and end of life and continuing care. These workgroups will study the opportunities for quality and cost improvement with clinicians and managers from the respective clinical areas.

6.3 To assist NHS Manchester in the process of opportunity identification, especially in relation to data analysis and in providing external challenge, the primary care trust has engaged the services of KPMG. The overall programme which has been developed with KPMG and NHS Manchester's partners and which is being described here, is currently branded as 'Securing our Shared Future.'

6.4 It is anticipated that, by mid February 2010, NHS Manchester and its partners will have identified on the basis of the opportunity identification exercise and the subsequent application of a series of prioritisation tests, a short list of projects which can be taken forward to 2015 which will enable the health community to deliver the quality and productivity challenge.

6.5 The Resource and Governance Overview and Scrutiny Committee is invited, at this opportunity identification phase, to contribute any suggestions or views on the opportunities within the health economy for quality and cost improvement.

7.0 Short-term Financial Position

7.1 Linked to, but distinct from, the above Securing our Shared Future programme, is the financial position of NHS Manchester for 2009/10. In order to balance its budget and mitigate against significant risks associated with demand for healthcare services, NHS Manchester commenced 2009/10 with a requirement to make savings of £40m.

7.2 By mid year, although progress had been made on making a significant level of savings, patient care activity especially that in acute hospitals, has proved to be even higher than anticipated, as has the potential cost impact of the second wave of the H1/N1 swine flu pandemic. This position has necessitated that NHS Manchester further review the opportunities for cost savings in the second half of 2009/10 and is currently in the process of finalising its revised recovery plan. Further details of the plan will be available following approval by the Board.

Board Risk Assurance Framework - 29 September 2009



Priority & Links	Goal	Lead	Principal Risks	Current Controls	Current Assurances	Potential Gaps	Current risk status = or < or >	Action plan and status	Compl. date for action	Residual Risk Status
<i>Priorities stemming from objective with links to Standards and other objectives</i>	<i>Priority deliverable(s)</i>	<i>Lead director or sponsor</i>	<i>What could prevent this priority being achieved</i>	<i>Description of the control. i.e. what controls we have in place to assist in securing the delivery of our objective related priorities</i>	<i>Where we can gain evidence that our controls/ system on which are we placing reliance are effective</i>	<i>Identified gaps in evidence that our controls or systems on which we place reliance are effective. Identified gaps in controls/systems, which indicate a reduction in their effectiveness.</i>	<i>Current status level of risk (L) x (C) = (RR) with status indicator. = same < decreased > increased</i>	<i>Action plans to address gaps in assurance and/or control and progress to date</i>	<i>When the action to mitigate the risk is to be completed (late in RED)</i>	<i>Remaining risk status expected after completion date</i>

Objective:

Inequalities, Aspiration and Wellbeing

Help people live longer linked to standard C22	To increase the average life expectancy of Manchester residents to 80yrs by the systematic identification and support of individuals at increased risk of developing Cardiovascular disease via effective General Practice registers and in community settings	Sally Bradley	NHS Health Checks to be introduced in 2009-10 from a range of providers to maximise access. Majority of programme to be via General Practice contract to systematically identify, record & manage CVD risk. Most practices currently not delivering this level of service.	<u>PCT reducing inequalities team (RIQ) supporting implementation of NHS Health Check by developing GP practice capacity/ capability. Current resource is insufficient to work with all practices. Targeted approach being taken.</u>	Implementation Action Plan monitored by PCT CVD prevention steering group	<u>Funding for 2009-10 deferred. NHS Health Checks will not be introduced in 2009-10 as planned. RIQ team will continue to work with GP practices in order to commence Health checks in 2010-11, need to establish comprehensive services to identify, support and manage individuals at greatest risk of CVD.</u>	15 (5x3)	<u>Action plan will be reviewed at next meeting of CVD prevention steering group (Oct 2009) in context of deferring commencement.</u>	Mar-10	15 (5x3)
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Reduce the gap in health between different communities <i>linked to standard C22</i>	To ensure that the city is no longer among the top 5 most deprived local authorities in England.	Sally Bradley	Health Trainers Health Trainers provide motivational support and sign posting to services for individuals seeking to make lifestyle changes and improvements. No additional funding to expand the current provision further in primary care settings.	The current Health Trainer service is delivered through MCH Public Health Development Service.	All activity recorded on national HT database- Data Collection and Reporting System (DCRS).	Large numbers of the local population are unable to access lifestyle behaviour change support.	9 (3x3)	Improved targeting of current provision to those most in need.	Mar-10	9 (3x3)
	To improve breastfeeding rates: 1. To develop a citywide Breastfeeding Peer Support Programme. 2. To develop Infant Feeding Facilitator posts to support achievement of UNICEF Baby Friendly Initiative (BFI). 3. To develop Lead Midwife posts at UHSM and SMH to implement BFI via additional DH monies.	Sally Bradley	1 & 2 Funding has not yet been identified for this work. 3. Match funding guaranteed by NHS Manchester (to sustain this work for a further year) may not be identified.	1 & 2 n/a. 3. Action plan developed and reporting mechanism to DH via GONW in place.	1 & 2 n/a. 3. Action plan reviewed with GONW and progress monitored.	1& 2 n/a. 3. Possibility of maternity units failing to implement BFI if match funding is not identified.	1. 6 (2x3) medium 2. 6 (2x3) medium 3. 9 (3x3) moderate	1& 2 n/a. 3. Action plan in place and monitored by GONW. GONW aware of match funding risks.	Apr-10	1& 2 n/a. 3. 4 (2x2)

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Reduce the number of teenage conceptions <i>linked to standards C18, C22, C23</i>	To reduce the under 18 conception rate by 55% from the 1998 baseline	Sally Bradley	Failure to engage young people in accessing contraceptive services or in delaying sexual activity	Setting up extended range of sexual health services for young people; engaging with schools, youth services and families in order to promote safer sex messages for teenagers	Teenage Preganancy Board and subgroups	Delays in accessing data on teenage pregnancy - this is now improving. Additional contraceptive services are planned and will be implemented in 2009/10	12 (4x3)	Action plans in place and monitored via TP Board	Mar-10	12 (4x3)
Reduce the number of alcohol related hospital admissions <i>linked to standards C22, C23</i>	To halt the expected rate of growth in alcohol related admissins	Sally Bradley	Delay in establishing Acute sector screening and BI projects	Each project will have an SLA with specified outcomes	Monthly reporting once programme is established with accountability to Improving health Implementation board and ultimately Alcohol Joint Commissioning Group/DAAT	None. Main risk rests with provider implementation	6 (3x2)	3 steering groups working to establish activity asap	Mar-10	4 (2x2)
Reduce the number of children who are overweight <i>linked to standard C23</i>	To reduce and sustain a reduction in levels of childhood obesity	Sally Bradley	Limited investment in 2009-10 means that prevention programmes are not operating at the scale required.	Delivery of current MEND (11 programmes 09-10) and other school/community based programmes.	NCMP annual report on obese and overweight school children. Schools coverage monitored by School Nurse Service- Strategic Healthy Weight Executive Group (1 April, 3 June, 16 Sept.).	Large numbers of overweight and obese children (and adults) in the population not having access to suitable weight management services.	16 (4x4)	Exploring partnership funding opportunities and external support (NW) to deliver early years/family based interventions and training.	Mar-10	12 (4x3)

Objective:

Safe and Effective Services

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To ensure the PCT is able to effectively respond to the impact of a swine flu pandemic	A robust pandemic flu plan; effective business continuity plans, organisation-wide	Sally Bradley	Pandemic flu plan not finalised following revision; difficulties engaging all teams in business continuity planning	Pandemic plan revision a current high priority; business continuity templates circulated and all areas aware of need to develop BC plans	Pandemic flu plan and business continuity planning processes	Vaccination plan; individual teams or directorates not producing a business continuity plan	20 (5 x 4)	Considerable work, being led by PCT shadow silver swine flu group, to address remaining gaps	Dec-09	8 (2x4)
Make sure health services are safe <i>linked to standards C1a, C1b, C4a, C7a</i>	To meet vital signs targets for HCAs, including to reduce and sustain the number of C Difficile infections by 45%	Sally Bradley	Unable to 1. ensure Community Infection Control Team delivers effective infection control and 2. that MCH management engages sufficiently in infection control agenda	Focusing work of CICT fully on infection control; engagement of MCH in action planning process	Health Act action plan	Possibility of team failing to deliver work programme when in post; possibility of insufficient MCH management engagement	8 (2x4)	Health act plan in place, and being further revised and developed with CICT and MCH colleagues	Sep-09	6 (1x4)

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Improve the quality and availability of primary care services <i>linked to standards C1, C7a, C17, C18</i>	To increase the percentage of practices offering extended opening, in compliance with Department of Health guidelines. Procure three GP practices and a GP Led Hc to increase capacity in the system	<u>Karen O'Brien</u>	The new practices are not procured and mobilised by end December 09 to provide capacity.	We have commissioned CBS to support the procurement process. We have a project manager for the mobilisation	Project Board. We have a Project Initiation Document for the two sites we need to go back to market for		9 (3x3)	Longsight a contract has been awarded the service commencement date is February 2010 due to problems with the site. Levenshulme the consultation is complete and we are at ITT stage with a good response to the PCT advert. Service commencement date is Dec 2009.	Dec-09	3 (1x3)

Objective:

Accessible personalised services

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Mental Health linked to standards C18, C22	To ensure that the level of follow up within seven days following discharge of patients on the Care Programme Approach is a minimum of 98%	Craig Harris	<u>Risk that urgent care not reformed, efficiencies are not released from in-patient services, delayed discharges are not reduced and A&E breaches continue. Managing these risks may be difficult to achieve together with the objective of maintaining provider stability which is a key aim of the Boyington review of Manchester's mental health services.</u>	Director-level meetings are held between acute providers, NHS Manchester and the Care Trust to identify improvements and track progress. Overall system monitoring is reviewed by the Joint Commissioning Executive	Minutes of director-level meetings; minutes of JCE meetings; performance dashboard prepared for JCE meetings. We are monitoring this via the Contract Monitoring meeting and through the new JCE Governance Structure, in the Priority and Service Development sub group.	There is a clear need for a project group with a dedicated focus on urgent mental health care reform. This will be established as part of the CSP implementation process. Achieving efficiency savings within mental health services is very challenging and needs to be considered in the context of the PCT's overall efficiency programme.	12 (3x4)	The review of urgent care is a priority for 2009/10 and has been included in the heads of terms with Manchester Mental Health and Social Care Trust. The reform of the whole urgent care system is a strong feature of the new mental health strategy and is included in the PCT's CSP. The Care Trust are implementing plans to achieve zero mental health breaches in A&E in 2009. The Psychiatric Liaison service should be fully established in year.	Review of Urgent Care system by 31 March 2010. Zero breaches for A&E by 31 December 2009.	8 (2x4)
Improve access to planned care linked to standard c18	To ensure that 90% of admitted and 95% of non admitted patients are seen within 18 weeks (at each provider in each month)	Simon Whotton	Performance risks of not achieving 90% of admitted and 95% of non admitted are seen within 18 weeks (at each provider in each month)	Weekly reporting of 18 week waits at each Acute Hospital Pennine and UHSM most at risk of failing. Weekly meetings have been instigated with utilisation of independent sector to aid target	Through weekly reporting/ monitoring and escalation arrangements.	Increased Demand has placed increased pressures on all acute trusts. Management of this demand needs implementing	9 (3x3)	Gateway systems (city wide, and through local PBC incentive scheme now developed and in place to tackle this, along with use of Independent sector) Development of PBC Primary Care Referral gateway is occurring to go live October for South Hub and Q4 for North and Central Hubs.	Dec-09	6 (2x3)

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Improve access to urgent care linked to standard C18	To ensure that at least 98% of patients spend less than 4 hour in A&E 9at each provider in each Month	Helen Speed	1. Performance risks of not achieving 4 hour 98% A&E target - causes include demand on the system and incompatible organisational drivers	Formal reporting still in place at North Manchester General. Routine reporting of performance from Central and South. Continued development and implementation of service models and improvement plans.	1. CMFT consistently achieving, some concern about sustainability at UHSM and consistent failure on NMGH site. Daily reporting/monitoring. NMGH weekly site based recovery meetings and weekly SHA and NE sector meetings. Escalation planning. Urgent Care Delivery Board met for the first time in July, now meeting monthly to performance manage reform programme.	Further development of system wide escalation plans (progress has been helped by pandemic flu planning). Concerns about impact of flu and other winter pressures on winter A&E performance, especially at NMGH.	16 (4 x 4)	1. Reform programme focused on reducing admissions and A&E attendances. UHSM invited Emergency Care Intensive Support in; PCT will lead review process. Focus admission avoidance - offers best opportunities to achieve 98% (especially at NMGH where most breaches are admitted patients). Escalation planning especially surge management.	Reform programme seeking achievement of 98% access target by March 2010. ECIST in UHSM October 2009. Escalation planning by October 2010	12 (3x4)

Objective:

Organisational Development Plan

Priority & Links	Goal	Lead	Principal Risks	Current Controls	Current Assurances	Potential Gaps	Current risk status = or < or >	Action plan and status	Compl. date for action	Residual Risk Status
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Developing our people and systems for WCC linked to C7, C8, C11, C17	To achieve level "2" in all WCC competencies by the end of 2009 plus 5 or more at level "3"	Zoe Cohen	Competing demands and limited available resources and skills restrict the progress we can make. DoH has changed the criteria for year 2, added greater challenge. DoH reliance on survey evidence for a number of competencies.	2nd edition PCT Organisational Development Plan now Board approved. WCC leads group up and running and meeting monthly. Leads allocated for each competency.	WCC panel report provides clear indication of all sub competencies where NHS Manchester achieved level "2" and those at level "1" where improvement is required. External Audit annual report for 2008/09 found that PCT made adequate progress on competencies 7 and 9 to enable the PCT to achieve an unqualified vfm opinion. Initial draft self assessment presented to Commissioning Committee in August 2009.	Updated assessment of status in sub competencies scored at level "1" together with action plans and monitoring. (Audit Committee 10 June 2009). New competency 11 on effectiveness and efficiency is very challenging.	9 (3x3)	Revised Organisational Development Plan will address gaps in controls and assurance. WCC leads groups being established. Internal audit plan to support self assessment. Tony Ullman to act as overall coordinator and quality assure evidence from November 2009.	15 January 2010 for submission	6 (2x3)

Objective:

Other high risk trust activities identified

Priority & Links	Goal	Lead	Principal Risks	Current Controls	Current Assurances	Potential Gaps	Current risk status = or < or >	Action plan and status	Compl. date for action	Residual Risk Status
<i>Priorities stemming from objective with links to Standards and other objectives</i>	<i>Priority deliverable(s)</i>	<i>Lead director or sponsor</i>	<i>What could prevent this priority being achieved</i>	<i>Description of the control. i.e. what controls we have in place to assist in securing the delivery of our objective related priorities</i>	<i>Where we can gain evidence that our controls/ system on which are we placing reliance are effective</i>	<i>Identified gaps in evidence that our controls or systems on which we place reliance are effective. Identified gaps in controls/systems, which indicate a reduction in their effectiveness.</i>	<i>Current status level of risk (L) x (C) = (RR) with status indicator. = same < decreased > increased</i>	<i>Action plans to address gaps in assurance and/or control and progress to date</i>	<i>When the action to mitigate the risk is to be completed (late in RED)</i>	<i>Remaining risk status expected after completion date</i>
Patient Safety and Service Quality. Links to core standard C1. SO 2 - We will ensure safe, effective services	Safe and high quality care in all services provided and commissioned by the PCT	Rajan Madhok	Commissioned services may pose unknown risks to patient safety	New arrangements for specifying and assuring patient safety and governance requirements for providers are being put in place	<u>Assurance on Controls Service specifications and business cases approved by clinical governance team; Quality profiles for hospitals as basis for reviews; Positive Assurances Business case approval and Governance Committee / Board reporting process Quarterly Quality Sub Groups for all main providers commenced</u>	Gaps in Assurance implementation of processes not yet complete (e.g. governance input into procurement and monitoring) Gaps in Control Many existing services have no business cases or have not been formally assessed as competent or are being monitored comprehensively	9 (3X3)	Requires a <u>coordinated approach across the whole organisation and will of necessity take time. Progress made in terms of creating systems and processes for specifying/monitoring and performance managing quality and safety standards in many areas including the major providers and MCH and in terms of professional affairs affecting independent contractors. Our current priorities are maintaining the gains made and developing new work in jointly commissioned</u>	work ongoing as part of World Class Commissioning CSP plans; <u>Apr 2010</u>	6 (2x3)
			Independent contractor services may pose unknown risks to patient safety	Arrangements in place to monitor, support and challenge clinical performance of independent contractors	Assurance on Controls Regular reporting to Clinical Governance Group and to Governance Committee Positive Assurances Cases of concern are risk scored and investigated / supported	Gaps in Assurance Limited assurance about GPs can be given at this stage; work is ongoing to look at other contractors Gaps in Control Information is not used systematically to assess quality and risk of contractors				

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<u>Delivering national targets linked to standard C7f, C18</u>	<u>Achieve existing and new national targets for 2009/10</u>	Iain Bell	<u>Failure to achieve targets will affect the annual health check assessment by the Care Quality Commission (CQC) as well as indicate poor performance for the people of Manchester</u>	<u>Named leads identified for each target. Performance Improvement Plan for Annual Health Check and Performance Monitoring Framework developed by performance team. Monthly updates co-ordinated by performance team and shared with PCT Board at monthly Board me</u>	<u>All versions of Performance Improvement Plan and Performance Monitoring Framework on Performance Team shared drive. Quarterly Vital Signs submissions 26th Jan, April, July and October each year. Performance Board reports 1.4.09, 6.5.09 and 3.6.09. Interna</u>	<u>Demonstrating continuous improvement in performance towards existing and new national indicators</u>	12 (4x3)	<u>Establish quarterly performance reviews with directorates</u>	<u>Nov-09</u>	9 (3x3)
<u>Fit for Purpose Demand Management Systems and supporting IM&T linked to core standard C18.</u>	<u>Management of demand and capacity - maximising the benefits of booking systems through contracting processes and timely accurate information disseminated amongst key leads</u>	Iain Bell	<u>Failure to control demand will lead to financial pressures and a distortion of CSP priorities</u>	<u>Contracting processes (agreements of SLA's, monitoring and escalation processes) Demand management 5+1 process</u>	<u>Demand management and 5+1 reports Output from dashboard Minutes from monthly contracting meetings with each provider Minutes from performance sub-group meetings PBC Accountability Framework</u>	<u>Evidence of delivering to demand management targets</u>	20 (5x4)	<u>Monthly performance reviews with Commissioning Directorate. Regular Briefings on Demand Management. Performance on Gateways (number of referrals through by practice and specialty). Review with PBC / Practices of performance. Using accountability to shape</u>	<u>Oct-09</u>	16 (4x4)

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<i>Priorities stemming from objective with links to Standards and other objectives</i>	<i>Priority deliverable(s)</i>	<i>Lead director or sponsor</i>	<i>What could prevent this priority being achieved</i>	<i>Description of the control. i.e. what controls we have in place to assist in securing the delivery of our objective related priorities</i>	<i>Where we can gain evidence that our controls/ system on which are we placing reliance are effective</i>	<i>Identified gaps in evidence that our controls or systems on which we place reliance are effective. Identified gaps in controls/systems, which indicate a reduction in their effectiveness.</i>	<i>Current status level of risk (L) x (C) = (RR) with status indicator. = same < decreased > increased</i>	<i>Action plans to address gaps in assurance and/or control and progress to date</i>	<i>When the action to mitigate the risk is to be completed (late in RED)</i>	<i>Remaining risk status expected after completion date</i>
<u>Having the information to manage and monitor performance (clinical and non-clinical) linked to standard C7</u>	<u>Production of timely accurate and quality management information to support the changing business priorities</u>	<u>Iain Bell</u>	<u>Failure of the data warehouse system and associated technologies</u>	<u>Team focus on technical leadership. Rapid Application Development (RAD) team developing information delivery tool (NhsMagic) and additional information products. Dedicated Hub Analysts focus on HUB information requirement management.</u>	<u>Products from data warehouse</u>	<u>Technical competence of the team</u>	6 (3x2)	<u>AD to provide technical leadership and development of the technical competence of the team</u>	<u>Mar-10</u>	4 (2x2)
<i>Meet the PCT's statutory financial duties linked to quality of financial management in annual performance rating</i>	<i>Operate within a modern financial regime and meet six key financial duties</i>	<i>Gary Raphael</i>	<i>Not achieving planned savings. New in-year pressures not anticipated. Relevant managers not having sufficient control and information to manage budgets. Arrangements for delegated budgets not being as effective as need to be.</i>	<i>Standing Orders, SFIs. Scheme of delegation. Budgets. Financial systems. Training of budget holders.</i>	<i>Internal and External Audit. Financial systems and procurement project team. Review and monitoring of financial information. Internal control environment.</i>	<i>Coverage of training is not comprehensive. Spending and savings profiles not yet determined. Contingency Plan not developed. Development of strategic approach to making substantial savings in current and future years not in place. Need to achieve system wide best value for money.</i>	20 (5x4)	<u>Project mandates are now available for £33m worth of savings required.</u>	<u>KPMG reviewing and to complete report by 15/10/09</u>	16 (4x4)