London Ambulance Service NHS
NHS Trust

Assurance Framework

For use By: Audit Committee, Risk Compliance and Assurance Group and the Trust Board

Introduction

The Chief Executive is required to sign a Statement of Internal Control (SIC) and in accordance with new Department of Health guidance, provide evidence underpinning it. The Assurance Framework provides the supporting evidence for the SIC and follows the table format as set out in Appendix 1, the risk ID corresponding to the number in the Trust Risk Register. This evidence should provide the LAS with confidence that our systems are safe and are subject to appropriate scrutiny and that the Board is able to show that they have been informed about all aspects of risk in the Trust.

There are five questions that this process sets out to answer:

1. Can the LAS achieve its objectives?
2. What are the risks that may prevent the LAS achieving its objectives?
3. What controls does the LAS have to manage those risks?
4. How do we know those controls are working?
5. Consequently can the LAS be confident that its objectives can be achieved?

So that a robust system of assurance can be set up the following steps should be followed:

- Establish principal objectives - strategic & directorate level
- Identify principal risks that may threaten the achievement of these objectives. The LAS has currently identified about 100 significant risks which are logged on the Risk Register.
- Identify and evaluate the design of key controls intended to manage these principal risks, underpinned by core healthcare standards.
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
- Evaluate the assurance across all areas of principal risk
- Identify positive and negative assurances and areas where there are gaps in controls and / or assurances

- Put in place plans to take corrective action where gaps have been identified in relation to principal risks
- Maintain dynamic risk management arrangements including, crucially, a well founded risk register

This Assurance Framework has been developed for use by the LAS and represents an ongoing process.

1. The Assurance Framework Flow Chart

The following diagram depicts how this will work for the LAS and provides the structure for the evidence to support the SIC (see Appendix 2 for guidance).

BOARD ACTION PLAN

Through this framework gaps will be identified, action decided, leads nominated and timescales decided.
For instance performance data will highlight risks with our core business and indicate controls are not working effectively, action should be decided and monitored.

BOARD REPORTS
Positive Assurances
Gaps in Control
Gaps in assurance

The Board is informed of gaps in control through the reporting structure of the Risk Register. Positive assurance reports are received in the form of external review reports e.g. RPST, HSE etc. Other reports include performance statistics, financial data, SIP reports and Complaints data etc.

ASSURANCES ON CONTROLS

Assurances include: Internal Audit, Clinical Audit, External Audit, CFS, NHSLA, HCC, RPST, HSE, NPSA etc.
As well as management checks, accident/incident reporting, sickness and absence, performance, SIP, clinical audit, non-clinical/operational audit and review etc.

KEY CONTROLS

Controls in place are identified during risk assessment and gaps form the action plan to manage them and are recorded on the register. Risk control systems from the Risk Management Standard include:

- Risk Management Framework (including clear accountability, committee structure, effective and coherent process) which is continually monitored and reviewed.
- Incident Reporting Procedure
- Claims/Complaints procedures
- Staff training

PRINCIPAL RISKS

The Trust Risk Register contains risks that are managed at varying levels through the Risk Management Committee Structure. The principal risks are linked to the principal objectives.

PRINCIPAL OBJECTIVES **as described in the Trust Service Plan**

2.1 Principal Objectives

The Assurance Framework is a process that links clinical governance, healthcare standards and risk management systems so that they provide support to enable the LAS Board to meet the challenge of Governance. As the NHS embraces a culture of decentralisation, increasing local autonomy and local accountability, the LAS Board needs to have the confidence to say that the systems, policies and people they have put in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. This integrates risk management into the structure of the organisation so that it can be used as a tool to achieve objectives rather than just another external requirement to comply with.

The Trust Board should identify LAS objectives, clinical, financial and generic. Boards must focus on objectives that are crucial to the achievement of its overall goals – these are **principal objectives.** This process needs to visibly state that risk is linked to objectives and can be shown as an integrated part of the organisations activity.

An example of principal objectives from the Service Plan are included in Appendix one. These will change from time to time as the strategic direction of the LAS changes. LAS objectives (such as those in the Risk Management Policy, and the Service Improvement Programme) are linked together so that they are consistent with external strategic level objectives which include those of the NHS Plan, the Priorities and Planning Framework, compliance with governance and risk management standards, health improvement and partnerships. Our current Service Plan links to these objectives together.

LAS objectives link to directorate/sector objectives and we may wish to record these lower objectives with strategic assurances over time to provide evidence that the whole trust is engaged in risk management activity.

2.2 Principal Risks

There should be a strategic view undertaken to identify risks affecting all or large parts of the organization. The Risk Register details our risks and is populated through the approval of identified risks (sources of risk identification shown in Appendix 2, Risk Management Policy) by the Risk Compliance and Assurance Group.

Principal Risks are those that threaten the achievement of the organisation's principal objectives. It is essential that boards understand that they need to manage potential principal risks, rather than reacting to the consequences of risk exposure. Good governance means that "principal risks should be routinely

identified from the risk management arrangements". For the LAS these are detailed on the Risk Register which is constantly updated through the processes set out in the Risk Management Policy endorsed by the Board.

2.3 Key Controls

Controls are the elements of the LAS (including our resources, systems, processes, culture, structure, and tasks) that, taken together, support our staff in the achievement of the LAS objectives. Our key controls in risk management are as follows.

- Risk Management Policy (including clear accountability, committee structure, effective and coherent process which is continually monitored and reviewed).
- Incident Reporting Procedure
- Claims / Complaints procedures
- Staff training

It is essential to identify existing controls in the risk management process so that they can be assured for their continuing efficacy thus proactively prevent risks occurring by highlighting problems with these elements. We record these controls as part of the risk assessment process and their effectiveness in the light of the governance and risk management framework they work within is used to assess gaps in control leading to appropriate action to manage the risk. This forms the action plan on the risk register. One control may relate to more than one risk.
Systems and processes are assured by the core healthcare standards.

2.4 Assurances and Co-ordination

These recorded controls should be subject to scrutiny by independent reviewers where feasible. Internal assurance by management will be used if external assurance is not available. This assurance is necessary because the controls are essential to the achievement of the Trust's objectives and the management of the identified risks.

To ensure effective management of risks to meet stated objectives and enable the Board to make the SIC with the evidence required, there is a need to be more systematic about assurance activity relating to the organisation's principal risks. Working in this way, the LAS Board can identify gaps in assurance and allocate resources for meeting them. Independent sources of assurance include Internal Audit, Healthcare Commission (HCC) and Health and Safety Executive (HSE) amongst others and are often mandatory; whilst management assurance can be

obtained from LAS internal quality assurance, clinical audit, Service Improvement Programme (SIP) monitoring, and management information, for example.

2.5 How the LAS will implement this policy

In order to reach this point the Risk Register will be used as the focus. Each of the high priority risks will be mapped to the strategic objectives in our service plan which has been endorsed by the Board. Once this is complete, assurances that we have received on the controls of these risks will be recorded along with the date it was given.

2.6 Board Reporting

Reports on positive assurances, gaps in control or assurance will enable the Board to improve its key controls to manage its principal risks and gain assurances where required.

This framework, when fully implemented, using the structure described, will enable the LAS to achieve an integrated approach to all our activities which can be used to inform the SIC. This will benefit the LAS by providing our stakeholders with confidence that our systems for managing healthcare are effective e.g. NHS London, Primary Care Trusts. It also fulfills NHS requirements in terms of Governance. As it is a continuous process this Framework will require annual review to ensure its ongoing effectiveness. It will need to reflect the changing priorities of the Trust as principal objectives are reviewed, and consider more robustly the effectiveness of the controls in place.

References:

Risk Management Policy – TP / 005
Service Improvement Programme

Signature: 

Peter Bradley
Chief Executive Officer

Appendix 1 Board Assurance Framework

Table 1 links the Standards for Better Health Domains to the LAS Service Plan Objectives and Table 2 is a representation of the first part of the London Ambulance Service Assurance Framework where we have stated what our principal risks are in relation to achieving our principal objectives. The principal risks are recorded on the Trust-wide Risk Register where gaps in control are being addressed by time bound action plans which are monitored by our risk management committee structure,. It enables us to review the effectiveness of the management of these risks by examining key controls, independent and management assurance. Any significant internal control issues arising where a weakness would impact on the achievement of our principal objectives will be highlighted. This approach is the beginning of an ongoing process and it will be supplemented with further objectives as they are reviewed and developed in strategic plans.

Table 1

Standards for Better Health Domains	LAS Service Plan Objectives
1) Safety - 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) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Restbreaks (b) Individual Performance Monitoring (c) Home responding (d) Improved standby and area cover arrangements (e) Reduced job cycle times (f) Shift Change over (roster changes).
2) Clinical and Cost Effectiveness - Patients receive effective treatment and care that: (a) conform to nationally agreed best practice, particularly as defined in the 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) (a) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support, with particular attention to national performance targets, e.g. financial balance, Improved Working Lives, NHS Litigation Authority, complaints reduction/resolution with lessons learnt (b) To meet Accident and Emergency targets and prepare for new ones, as follows:- (1) 75% category A 8 minute (for the year as a whole), (2) 95% Category A 19 minute (for the year as a whole), (3) 95% Category B 19 minute by March 2007, (4) Doctors Urgent (15 minute) by March 2007.
3) Governance - 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 health care organisation,	3) (a) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard. (b) Implement Actions from diversity plan. (c) Disability Equality Scheme. (d) Review and changes to recruitment practice and policy (including life skills). (e) Gender Equality Scheme prepared for publication in April 2007. (f) Work with DH to prepare a single Equality Scheme. (g) Introduce summary level SMG balanced scorecard. (h) Complete key supplier review. (i) Replace EROS purchasing system. (j) Revise Trust Standing Orders. (k) Implement ESR.

4) Patient Focus - Health care 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.	4) Public Education Strategy and PPI Strategy have local implementation plans that are followed through by Senior Managers in all areas.
5) Accessible and Responsive Care - Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience delay at any stage of service delivery or of the care pathway.	5) (a) Develop standard package of referral pathways in each borough (Minor injuries units, walk in centres, intermediate care teams, district nursing and mental health services). (b) Develop accurate measurement of patients receiving appropriate alternatives to Accident and Emergency and increase the number, which includes: ensure that crews have method of reporting use of alternative pathways (i.e. appropriate destination and disposition codes) and publicise these; encourage use both of the pathways and of the correct codes; increase the number of patients receiving clinical telephone advice and the numbers of calls handled by UOC and by ECPs.
6) Care Environment and Amenities - Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preference in that they are designed for the effective and safe delivery of treatment, care or specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.	6) (a) Implementation of the Department of Health/NHS "Essential steps to safe, clean care" framework. Complete self assessment process and produce/implement action plan to respond to issues identified. (b) Establish local ownership of infection control issues by creation of "champions" on each station complex. Lead person to co-ordinate issues relating to audits and resulting actions plans and monitoring of standards. Also this person can assist in local swabbing programmes if required. (c) Establish business case for the Nurse Specialist in Infection Control (full time).
7) 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.	7) (a) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement Initiative, with particular attention to responding to recommendations of reviews. (b) Processes with DH to prepare Single Equality Scheme for publication in 2007. (c) Improve Trust administrative and five management process.

Table 2

London Ambulance Services NHS Trust Assurance Framework											
Principal Objectives	**Principal Risks**					**Domains and Standards**	**Key Controls**	**Assurances on Controls**	**Board Assurance**		**Compliance**
	Risk ID	**Description of Risk**	**Risk Category**	**Current Risk Rating**	**Risk Lead Person**				**Positive Assurance**	**Gaps in Control**	
What the Organisation aims to deliver		***What could prevent this objective being achieved***	***Which area within our organisation this risk primarily relate to***			***Standards that the Government have set and expects all Trust's to aspire to in order to improve the quality of care and treatment provided to patients.***	***What controls/systems we have in place to assist in securing delivery of our objective***	***Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective.***	***We have evidence that shows we are reasonably managing our risks and objective are being delivered.***	***Where are we failing to put controls /systems in place. Where are we failing in making them effective***	
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, in relation to national priorities, including National Service Frameworks,	**7**	Failure to reduce reported incident risks through incident information not being shared with all relevant depts & committees.	**HS**	**9**	**Director of Human Resources**	1. Safety - C1 (a) Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experiences and information derived from the analysis of	Adverse incidents and near misses are reported, analysed and acted upon/incidents graded for severity using the Risk Grading Matrix. Policy and Protocol on incident investigation and Root Cause Analysis/ systematic identification, recording,	• Current CPD cycle in EOC includes a session on risk management that emphasises the Continuous Quality Improvement cycle and the importance of the Incident Report Form in the Process. • Incident Reporting Procedure (references reporting to MHRA, NPSA reporting high priority risks to	Risk Information Report.Trend analysis to inform decision and evidence risks is presented at Corporate Health and Safety Group	Recommendation needs to be time limited and implementation to be audited.	√

risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology. To achieve agreed modernisation in working practices by:- (a) Restbreaks (b) Individual Performance Monitoring (c) Home responding (d) Improved standby and area cover arrangements (e) Reduced job cycle times (f) Shift Change over (roster changes).						incidents	assessment and analysis of risks - All red/high risk incidents are forwarded to the Complaints Unit, who deal with all Serious Untoward Incident and Complaints using Root Cause Analysis. All Health and Safety incidents are investigated reflecting the level of grading.• Incidents are reported externally to the NPSA. • Incident Reporting Procedures • Issuing of Bulletins & H&S Minutes • LA52s copied to Estates and Fleet as appropriate. • Training and Clinical Updates produced by Management Information and put on intranet • Sector H&S meetings on a quarterly basis. • Risk Reporting and Assessment Procedure	Complaints Department and Serious Untoward Incidents Policy). • Staff updated about the importance of investigations by ongoing H&S, Operations bulletins, RIB, The Pulse and LAS news as appropriate. • Quarterly Incidents Statistics are reviewed by the Corporate Health and Safety Group and Clinical Governance Committee which feeds into the Risk Compliance and Assurance Group. Local action is determined at complex meetings led by H&S representatives. • Incidents are graded according to severity of impact and likelihood of re-occurrence. • Incident procedure training provided to Managers (including grading) • Incidents are reported externally to the NPSA.			

							• Notification of Local Police • Industrial injury absence statistics produced on a quarterly basis and considered by Strategic Committee Internal Audits of Complaints				

Appendix 2

Guidance on the Statement of Internal Control

ELEMENTS RELEVANT IN CONSIDERING WHETHER APPROPRIATE RISK MANAGEMENT, CONTROL, AND REVIEW PROCESSES ARE IN PLACE TO SUPPORT THE SIC

NHS organisations should have risk management, control and review processes in place, appropriate to their circumstances and business. The detail of these processes will vary from one organisation to another depending on circumstances such as size and the complexity of the risks faced.

This Annex offers a summary of detailed characteristics (*italic text*) under six high level elements (**bold text**) to help with consideration of the completeness of the processes which have been put in place in a particular body.

Organisations should ensure that they have evidence which they deem sufficient to demonstrate that they have implemented processes appropriate to their circumstances under each of the high level elements to support their SIC for 2003/4.

1. LEADERSHIP AND STRATEGY
There should be a risk management strategy.

1.1 There should be a risk management strategy which:

- *is endorsed by the Board;*
- *sets out the organisation's attitudes to risk;*
- *defines the structures for the management and ownership of risk and for the management of situations in which control failure leads to material realisation of risks;*
- *specifies the way in which risk issues are to be considered at each level of business planning ranging from the corporate process to the setting of individual staff's objectives;*
- *specifies how new and existing activities are assessed for risk and incorporated into risk management structures;*
- *ensures common understanding of terminology used in relation to risk issues;*
- *defines the structures for gaining assurance about the management of risk;*
- *defines the criteria which will inform assessment of risk and the definition of specific risks as "key";*

- *defines the way in which the risk register and risk evaluation criteria will be regularly reviewed.*

1.2 Whether the strategy is set out in a single document or in a series of related documents or resources, it should be easily available to all staff and reviewed at least annually to ensure it remains appropriate and current.

2. BOARD ASSURANCE FRAMEWORKS
Board Assurance Frameworks should be embedded

2.1 A framework should be in place that:

- *covers all of the organisation's main activities;*
- *identifies which objectives and targets the organisation is striving to achieve;*
- *identifies the risks to the achievement of objectives and targets;*
- *identifies and examines the system of internal control in place to manage the risks;*
- *identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control;*
- *records the actions taken by the Board to address control and assurance gaps*

3. CONTEXT FOR RISK MANAGEMENT
The context in which risk has to be managed should be identified:

Identifying the context for risk management should incorporate consideration of Stakeholders, as appropriate to the organisation including:

- patients;
- *public interests;*
- *service user interests;*
- *Ministers and the Department of Health;*
- *wider societal interests;*
- *risk aspects of relationships inside and outside of the NHS (including key suppliers of goods and services), to incorporate:*
  - *ways in which the behaviour of "partners" affects the organisation;*
  - *ways in which the behaviour of the organisation affects the "partners";*
  - *the risk priorities of "partners."*

4. RISK IDENTIFICATION AND EVALUATION

Risk should be identified and evaluated in a structured way.

There should be documentation which:

- *records identified risks in a structured way;*
- *records dependencies between risks;*
- *records linkages between lower level risks and higher level risks;*
- *identifies key risks;*
- *facilitates assignment of ownership at a level which has authority to assign resources to the management of the relevant risk;*
- *evaluates risks using defined criteria which are applied consistently;*
- *identifies assigned ownership of the risk at a level or grade with sufficient authority to assign appropriate resources to control the risk;*
- *records, in as far as it can be defined:*
  - *the acceptable level of exposure in relation to each risk;*
  - why it is considered that the defined acceptable level of exposure can be justified.

5. CRITERIA FOR EVALUATION OF RISK

There should be specific criteria for evaluating risk encompassing a range of factors.

5.1 Criteria for evaluating risk should give consideration to:

- *financial / value-for-money issues;*
- *service delivery / quality of service issues;*
- *reversibility or otherwise of realisation of the risk;*
- *the quality or reliability of evidence surrounding the risk;*
- *the impact of the risk on the organisation / stakeholders / partners / others;*
- *defensibility of the realisation of the risk.*

5.2 The criteria should be applied consistently and methodically across the whole range of risks.

6. RISK CONTROL MECHANISMS

Appropriate controls should be in place in relation to each risk:

6.1 The controls should be:

- *based on active consideration of the options for controlling that risk to an acceptable level of residual exposure;*
- *promulgated to all those who need to know about the controls;*
- *regularly reviewed to consider whether they continue to be:*
  - *effective*

- *the best value for money response to the risk*
- *documented by the relevant managers.*

6.2 For key risks, contingency plans should be developed and documented to guard against significant control failure.

7. REVIEW AND ASSURANCE MECHANISMS

Review and assurance mechanisms should be in place.

7.1 Review and assurance mechanisms should ensure that:

- *each level of management, including the Board, regularly reviews the risks and controls for which it is responsible;*
- *these reviews are monitored by / reported to the next level of management;*
- *any need to change priorities or controls is clearly recorded and either actioned, or reported to those with authority to take action;*
- *lessons which can be learned, from both successes and failures, are identified and promulgated to those who can gain from them;*
- *an appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control;*
- *the methodology for gaining independent assurance is defined with particular reference to the role of internal audit and to the role of any other review bodies working within the organisation*.

7.2 *Significant Control Issues*

The purpose of this disclosure is to deliver assurance that significant internal control issues have been, or are being, addressed and that the SIC is a balanced reflection of the actual control position. Although not required, it may help the disclosure in relation to a "significant internal control issue" if description of the weakness and its impact is given to provide context for the actions taken. NHS bodies may need to exercise discretion in such disclosure to avoid further adverse impacts or exploitation of the weakness.

A single definition of a "significant internal control issue" is not possible. NHS organisations will need to exercise judgement in deciding whether or not a particular issue should be regarded as falling into this category. Factors which may be helpful in exercising that judgement include:

- *the issue seriously prejudiced or prevented achievement of a principal objective*

- *the issue has resulted in a need to seek additional funding to allow it to be resolved, or has resulted in significant diversion of resources from another aspect of the business;*
- *the external auditor regards it as having a material impact on the accounts;*
- *the Audit Committee advises it should be considered significant for this purpose;*
- *the Head of Internal Audit reports on it as significant, for this purpose, in their annual opinion on the whole of risk, control and governance;*
- *the issue, or its impact has attracted significant public interest or has seriously damaged the reputation of the organisation.*

PROFORMA: STATEMENT ON INTERNAL CONTROL 2003/04

ORGANISATION NAME

Key: Normal script: wording to be incorporated as set out
Italic script: *Indicates the need for a short commentary or explanation of the actual processes in place in the organisation*.

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

Accountable Officers should add to this paragraph to provide an explanation of the accountability arrangements surrounding their role. In particular they should comment on:

Processes in place by which they work with the Strategic Health Authorities and partner organisations.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to 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.

The system of internal control has been in place in [organisation name] for the year ended 31 March 200x and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Describe the key ways in which

- *leadership is given to the risk management process*
- *staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Include comment on guidance provided to them and ways in which you seek to learn from good practice*

4. The risk and control framework

Describe the key elements of the risk management strategy including the way in which risk (or change in risk) is identified, evaluated, and controlled.

Describe key ways in which risk management is embedded in the activity of the organisation

Describe the elements of the Assurance Framework and how this provides the evidence to support SIC.

Describe the key elements of the way in which public stakeholders are involved in managing risks which impact on them

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage

the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by [*detail major sources of assurance on which reliance has been placed during the year - for example comments made by the external auditors, CHI, clinical auditors etc]*

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the [*detail the* relevant internal mechanisms e.g. *Board*, *Audit Committee, Governance Committee, Clinical Governance Committee, Assurance Committee, Risk Committee etc*). A plan to address weaknesses and ensure continuous improvement of the system is in place.

Describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the role of:

- *the Board*
- *the Audit Committee*
- *the relevant Committees, e.g. Governance, Audit, Risk, Clinical Governance etc*
- *executive managers*
- *Internal Audit*
- *Other explicit review / assurance mechanisms – Assurance Frameworks, Controls Assurance etc*

Include an outline of the actions taken, or proposed, to deal with any significant internal control issues. Guidance on the definition of significant control issues is provided at section 7.2.