Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1 If the Trust does not maintain expected regulatory standards this objective cannot be met	**Current rating**	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	1170

Controls in place (to manage the risk)	**Gaps in Control**
1)Safety priorities approved, KPI's in place and reported to Board 2)Patient Experience Group in place 3)Deep dives reviews of compliance 4)Synbiotix providing RTM and other patient experience information with local action planning 5)Divisional action plans in place addressing patient experience feedback	1) Embedding Synbiotix and improving usability of hardware (WiFi) 2) Review of compliance monitoring system in light of CQC consultation

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)CQC and external stakeholder inspection reports 2)Patient Experience feedback all sources 3)Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents 4)Quarterly internal incident reports 5)Internal Audit reports 6) Audits of nursing assessment and care plan tool 7) Patient experience reporting to Trust Board and Safety and Quality Committee. 8) Nursing audit framework includes Essence of Care Benchmarks 9) Division action planning following+Sit and See+sessions, surveys and Focus Friday working. 10)Nursing audit framework includes Essence of Care benchmarks	Positive (+) CQC current risk rating lowest possible (+) CQC formal feedback following two day inspection Feb 13, Compliant with outcomes 8 outcomes reviewed (+) Registration status with CQC shows no concerns (+) Current performance high and sustained Negative (-) CQC Risk profile shows areas of concern (based on public information, anticipated that this will improve) (-) SI themes in particular delayed diagnosis

Gaps in assurance	**Assurance Level gained: RAG**
1)Process of review for Provider Compliance Assessments 2)Triangulated reporting Complaints, Risks and Audits	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Review nursing documentation 2)Synbiotix monitoring system to be rolled out which provides real time access to clinical quality indicators 3)Develop and monitor QGAF 4) Awaiting CQC guidance to influence CCG quality review 5)Review and remodel Management Board to ensure review of quality and risk 6)Executive led specialty deep dives	1)Action complete Nursing documentation reviewed updated and in place 2)Resolving final roll out issues 3)In development, first draft complete and being reviewed 4)Outstanding 5)Changes agreed, implemented by 31 January 2014 6)Deep dives planned and timetable shared with leads

Update by	FA 04/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.2. Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.2 Failure to continue to maintain and improve mortality indicators (Global HSMR or condition specific) will effect the Trusts ambition to achieve best outcomes for its patients	**Current rating**	S4 x L2 = 8
		Target risk score	S5 x L1 = 5
		Linked to Risk	1270

Controls in place (to manage the risk)	**Gaps in Control**
1)Regular review of Dr Foster alerts 2)Regular review mortality rates in clinical services with appropriate areas focus as required 3)Standardised mortality review process 4)Mortality group established	1) Data quality of primary diagnosis and co morbidities in palliative care 2) Real time data sets for benchmarking 3) Palliative / EOLC coding

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) HSMR 2) KPI internal pathways (e.g. stroke) 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF and stroke cases presented and monitored by ECQR 5)Clinical effectiveness Committee	Positive (+) HSMR below 100 (better than predicted and falling) (+) SHMI below 100 (better than predicted) (+) Within expected mortality rate for all Dr Foster mortality indicators (+) Report to SQC on Mortality Negative (-) Access to specialist beds (ring fencing still bedding in) (-) Surgical sight wound infections (improving but still under review) (-) Numbers community rehab beds (improving but still risks over winter)

Gaps in assurance	**Assurance Level gained: RAG**
Audit of data quality for mortality indicators	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Healthcare of the elderly strategy 2)OPAL commenced in Surgery 3)Increasing Jnr Dr and reviewing enhancing quality programs 4)Service reviews following changes in mortality for fractured neck of femur 5)Trust piloting whole system approach to management of COPD 6)Ring fencing of stroke and fracture neck of femur beds 7)Recruiting healthcare of the elderly to work across primary and acute care 8)Implementing 7 day specialist physician working (with increasing AHP 7/7 access) 9)Continuing programs for improving data quality	1)Underway 2)Underway 3)Underway 4)Underway 5)Underway 6)Underway 7)Underway 8)Underway 9)Underway

Update by	DH 06/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.3. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse
		Initial Risk	**S4 x L3 = 12**
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1b Failure to maintain improvements in patient safety will effect the Trust's ability to achieve this objective	**Current rating**	**S4 x L2 = 8**
		Target risk score	**S3 x L2 = 6**
		Linked to Risk	1054,1055,1306,1447,1460

Controls in place (to manage the risk)	**Gaps in Control**
1) Groups to implement Patient safety plans in the Trust (falls, pressure ulcers and infection control) 2) Regular review of Synbiotix data and the Safety Thermometer 3) Groups/Committee established including SQC and N & M and Divisional Governance. 4) Policies and procedures are the framework in which risks and incidents are managed. 5) Matron on site 7 days a week 6) Clinical Site Matron established 24/7 7)Nursing and Maternity Strategy	1) Full implementation of Synbiotix (linked to WiFi coverage) 2) Incident reporting policy to be reviewed to include recent changes (target December 2013)

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Synbiotix 2) Patient safety related KPI agreed and monitored at Board and Divisional Level 4) External reports and visits both scheduled and unscheduled (including new CCG quality visits)	Positive (+) Never events incidence low (2 in last 12 Months, both low harm) (+) Numbers of Hospital Acquired Pressure Ulcers reduction and sustained (+) MUST 100% June 2013 (+) QGAF assessment and action plan Negative (-) Falls SI incidence (-) Delayed diagnosis SI theme

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time National Safety Dashboard to be implemented once produced	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Pressure damage board 4)Full implementation of systems to support Synbiotix 5)New EWS to be trialled 6)Policy update for Incident reporting and management 5)Review and remodel Management Board to ensure review of quality and risk	1) In place re-embedding 4) Implemented resolving initial hardware issues 5) Pilot of EWS, planned roll out January 2014 6)December 2013 5)Changes agreed, implemented by 31 January 2014

Update by	FA 04/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care			
Priority ID and reference	1.4. Achievement of national best practice in clinical care.	**Director responsible**	Chief Operating Officer
		Initial Risk	S5 x L4 = 20
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.4 Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care	**Current rating**	S4 x L4 = 16
		Target risk score	S3 x L4 = 12
		Linked to Risk	1491,824

Controls in place (to manage the risk)	Gaps in Control
1) EDD Patient Pathway 2) Discharge management 3) Plans for escalation areas agreed and management tools in place 4) Reviewing all breaches on weekly to implement lessons learnt	1)Identified on a rolling basis as part of weekly review 2)It is difficult for the Trust to influence the output of decision making across the local health economy 3)Ambulatory pathways yet to imbed

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) NHS England aware 2) Combined weekly Quality and Performance Dashboard for ED reporting on a combination of quality and safety standards and the ED national indicators reported to exec meeting weekly 3) Performance Management Framework and reporting to Trust Board 4) External stakeholder inspections 5) Daily sit rep reporting to the TDA 6) Daily winter Sit Reps (Commenced November) Urgent Careboard Area Team.	Positive (+) Process improvement (+) Performance delivered since May 2013 (+) Reduction of 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Working with partners commisioners/parteners to expedite flow through hospital (Medihome and community beds) (+) 7/7 Working for Consultant Physicians in place (+) 36 Extra community beds in place Negative (-) Quality indicators for time to assessment / treatment. Surrey and Sussex local lead. (-) EDD Section 2 and section Patient tracking system (-)Approximately 100 patients safe to discharge

Gaps in assurance	Assurance Level gained: RAG
Winter plans and local health economy position going into winter months	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Site management team 2) Reinstatement of Discharge Team 3) 58 Additional community beds agreed to be used on a phased basis 4) 7day medical consultant ward rounds planned	1)Complete 2)Complete 3)20 due in December 4)Target date November

Update by	PB 02/12/13	Date discussed at Board	To be discussed at December Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.5. Achievement of national best practice in clinical care.	Director responsible	Chief Operating Officer
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.5 Failure to maintain and improve performance within national expectations (i.e. Cancer, 18 Weeks, Maternity) will significantly effect the Trusts ability to achieve high quality care	Current rating	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	1295

Controls in place (to manage the risk)	Gaps in Control
1) Cancer Division established (including tracking team) 2) 6 targets - well organised developed systems 3) Dedicated Monitoring 4) Patient tracking list	Identified on a rolling basis as part of monthly review. No significant gaps in control identified at present

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) Commissioner reports 2) National report 3) Performance monitoring 4) Target focused performance systems.	Positive (+) Performance and monitoring (+) 18 week performance (+) Overall performance of Trust (+) Delivering all key cancer targets since Oct 2013 Negative (-) Capacity issues

Gaps in assurance	Assurance Level gained: RAG
Link to 1.1c. Full plans for winter to be completed	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Virtual cover, division of leadership 2) Implementation of additional community beds reducing risk of elective cancellation	1) Embedding 2) 20 due in December

Update by	PB 02/12/13	Date discussed at Board	To be discussed at December Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care			
Priority ID and reference	1.6 Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S3 x L3 = 9
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.6 As readmission rates are an indicator of high quality care, failure to improve the Trustφs rate poses a risk to this objective	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	None identified

Controls in place (to manage the risk)	Gaps in Control
1) Discharge processes in place 2) Work with CCG July 2013 to look at readmissions following on from initial work 2012/13 3) Dr Foster report re-admission monthly (monitored by clinical effectiveness and ECQR)	1) All clinical and coding processes not standardised to reflect true readmissions 2) Temporary notes makes clinical coding more difficult 3) Some clinician practice makes coding inaccurate 4) Variation in primary care practice makes some readmission inevitable

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) KPIs 2) Dr Foster alerts	Positive (+) Re-admission data work by local physicians (+) Internal audit of readmission figures provides positive assurance (+) Feedback following initial work on discharge process 2013/14 Negative (-) Readmission data quality

Gaps in assurance	Assurance Level gained: RAG
1)Re-admissions data quality paper to be submitted to MBQR or appropriate 2)Lack of agreement with CCGφs over recent audit of readmission rates 3)Exact definition of re-admission is different needs	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Safer discharge practices agreed by local healthcare providers 2) Data quality coding 3) OPAL Service linked to GP 4) Review storage of medical records to reduce need for temporary notes 5) Work to improve coding at ward level on clear signaling of planned readmission (TWOC)	1) Under review 2) Underway 3) Underway 4) Underway long term plans 5) Underway

Update by	DH 06/12/13	Date discussed at Board	To be discussed at December Board

<table>
<tr><td colspan="4">Objective 1 - Deliver Safe, High Quality, Co-ordinated Care</td></tr>
<tr><td rowspan="2">Priority ID and reference</td><td rowspan="2">1.7 Achievement of national best practice in clinical care.</td><td>Director responsible</td><td>Medical Director</td></tr>
<tr><td>Initial Risk</td><td>S5 x L3 = 15</td></tr>
<tr><td rowspan="3">Key Action for 2013/14 objectives and description of any potential significant risk to this priority</td><td rowspan="3">1.7 Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care</td><td>Current rating</td><td>S5 x L3 = 15</td></tr>
<tr><td>Target risk score</td><td>S5 x L2 = 10</td></tr>
<tr><td>Linked to Risk</td><td>1050</td></tr>
<tr><td colspan="2">Controls in place (to manage the risk)</td><td colspan="2">Gaps in Control</td></tr>
<tr><td colspan="2">1)IPCAS Group Team and group in place
2)Weekly taskforce in place
3)Infection control manual in place and information resources available
4)Antibiotic policy and guidelines in place
5) Infection control quality round implemented
6)Education for Jnr Doctors on induction
7)New cleaning products in use (effective against C. diff spores)
8)Develop pocket size antimicrobial guide
9)Consultant led RCA and presentation of HCAI (MRSA, MSSA, CDI and hip and knee operation wound infection)
10)Reviewed MRSA management policy in year
11)Temocillin added to antimicrobial guidelines (reduced diarrhoea risk)
12))SMART stool sampling implemented</td><td colspan="2">1)Risk assessment of patients with diarrhea is not consistent, in particular on admission and at first onset
2)Variation in line care demonstrated by audit</td></tr>
<tr><td colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</td><td colspan="2">Actual Assurances: Positive (+) or Negative (-)</td></tr>
<tr><td colspan="2">1)KPI indicators
2)Reducing numbers of cases of C. diff year on year
3)No confirmed outbreaks of C. diff commenced during 2013/14 to date
4)PCT and SHA visits focusing on infection control 2012/13
5)Recent CQC visit focusing on Nursing documentation and escalation</td><td colspan="2">Positive
(+)No C. diff outbreaks declared in year
(+)CQC visit Feb 2013 found no immediate concerns
(+)Antimicrobial prescribing audit compliance
(+)Actions taken as part of annual program
(+) Recent CQC inspection highlighted improvements in MRSA screening
(+)PCT visit inspecting controls and procedures
Negative
(-)1xMRSA BSI case in year
(-) Rising incidence of C. diff against trajectory</td></tr>
<tr><td colspan="3">Gaps in assurance</td><td>Assurance Level gained: RAG</td></tr>
<tr><td colspan="3">Extensive auditing and monitoring in place. Trust position known</td><td></td></tr>
<tr><td colspan="3">Mitigating actions underway</td><td>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</td></tr>
<tr><td colspan="3">1) Trial of 2 ICE-POD side rooms to commence in September 2013.
2) Considering screening for C. diff for all adult emergency admissions
3) Full list of actions in IPCAS annual programme of work</td><td>1) Commence September 2013
2) December 2013
3) Ongoing</td></tr>
<tr><td>Update by</td><td>DH 06/12/13</td><td>Date discussed at Board</td><td>To be discussed at December Board</td></tr>
</table>

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.8. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse and Medical Director
		Initial Risk	S4 x L4 = 16
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.8. Failure to recruit and retain clinical staff may result in excessive usage of agency and may impact negatively on Trust's quality of care provided to patients.	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L1 = 3
		Linked to Risk	1447

Controls in place (to manage the risk)	**Gaps in Control**
1) Ward staffing templates monitored daily by Matrons and escalated to the Divisional Chief Nurses to ensure safe levels to meet patient needs. 2)Gaps filled by using staff flexibly across the Divisions with Bank used in priority to agency. 3)Agency staff sourced from agencies known to and contracted by Trust. 4)Issues regarding agency staff practice are subject to formal arrangements between the agency and the Trust any unresolved concerns are escalated and managed by Deputy Chief Nurse. 5)SNCT tool being rolled out across the Trust with staffing being measured three times a year November, March and August 6)Robust recruitment process to both substantive and bank staff posts including overseas recruitment	1) E-Roster system is not updated out of hours 2) Trust does not currently have the latest version of E-Roster that is more effective at accessing and utilizing Bank Staff 3) Unfilled agency shifts 4) Staffing Ratios in some areas of the Trust at night are a concern 5) The Trust still carries a volume of vacancies specifically within medicine and theatres

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Daily ward staffing review 2)Incident reporting via Datix demonstrating patient or staff harm 3)Staff absence reports 4)% of vacant shifts filled by Trust and agency staff 5)Number /severity of issues escalated to relevant agency 6)SNCT data when available	Positive (+)SNCT data when available (+)Vacancy rates and turnover rates are monitored (+)Further recruitment planned has been undertaken Negative (-) Benchmarked high proportion of agency staff usage against other Trust's

Gaps in assurance	**Assurance Level gained: RAG**
?is there any information we are not collecting or using associated to this issue	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Continue to monitor recruitment drives	1) Underway and ongoing

Update by	FA 12/12/13	**Date discussed at Board**	To be discussed at December Board

<table>
<tr><td colspan="4">Objective 1 - Deliver Safe, High Quality, Co-ordinated Care</td></tr>
<tr><td rowspan="2">Priority ID and reference</td><td rowspan="2">1.9. Achievement of national best practice in clinical care.</td><td>Director responsible</td><td>Chief Nurse</td></tr>
<tr><td>Initial Risk</td><td>S3 x L4 = 12</td></tr>
<tr><td rowspan="3">Key Action for 2013/14 objectives and description of any potential significant risk to this priority</td><td rowspan="3">1.9. If the Trust does not put into place systems to assess, monitor and evaluate nursing staffing levels this may impact negatively on Trust's quality of care provided to patients.</td><td>Current rating</td><td>S3 x L3 = 9</td></tr>
<tr><td>Target risk score</td><td>S3 x L1 = 3</td></tr>
<tr><td>Linked to Risk</td><td>1447</td></tr>
<tr><td colspan="2">Controls in place (to manage the risk)</td><td colspan="2">Gaps in Control</td></tr>
<tr><td colspan="2">1)Ward staffing templates monitored daily by Matrons and escalated to the Divisional Chief Nurses to ensure safe levels to meet patient needs.
2)Process under development to monitor planned versus actual staffing levels on a shift by shift basis and evidence actions taken
3)Procurement of updated e roster system underway.
4)SNCT tool being rolled out across the Trust with staffing measured in November with a plan to undertake continuously from January 2014.
5)Agency staff sourced from agencies known to and contracted by Trust.
6)Issues regarding agency staff practice are subject to formal arrangements between the agency and the Trust any unresolved concerns are escalated and managed by Deputy Chief Nurse.
7)Robust recruitment process to both substantive and bank staff posts including overseas recruitment
8)Monitoring of Safety Thermometer, patient experience and staff turnover, sickness at ward level</td><td colspan="2">1)E-Roster system is not updated out of hours
2)Trust does not currently have the latest version of E-Roster that is more effective at accessing and utilizing Bank Staff
3)Unfilled agency shifts
4)Staffing Ratios in some areas of the Trust at night are a concern
5)The Trust still carries a volume of vacancies specifically within medicine and theatres</td></tr>
<tr><td colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</td><td colspan="2">Actual Assurances: Positive (+) or Negative (-)</td></tr>
<tr><td colspan="2">1)Daily ward staffing review
2)incident reporting via Datix demonstrating patient or staff harm
3)Staff absence reports
4)% of vacant shifts filled by Trust and agency staff
5)Number /severity of issues escalated to relevant agency
6)SNCT data and gap analysis when available
7)Increased reporting of positive patient experience in relation to staffing/high quality care and compassion reported</td><td colspan="2">Positive
(+) Daily ward staffing review
(+) Reports regarding reducing vacancy rates, sickness, absence
(+) Incident reporting via Datix
(+) Patient experience data by ward or unit</td></tr>
<tr><td colspan="3">Gaps in assurance</td><td>Assurance Level gained: RAG</td></tr>
<tr><td colspan="3">Some processes are under development</td><td></td></tr>
<tr><td colspan="3">Mitigating actions underway</td><td>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</td></tr>
<tr><td colspan="3">1)Gap analysis against 'Right Staffing' report and current ward staffing levels being undertaken
2)Gaps filled by using staff flexibly across the Divisions with bank staff used in priority to agency.</td><td></td></tr>
<tr><td>Update by</td><td>Fiona Allsop 05/12/13</td><td>Date discussed at Board</td><td>To be discussed at December Board</td></tr>
</table>

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.10. Ensure patients are cared for in the right place at the right time	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.10. If the Trust does not maintain and improve ability to allocate the right bed first time there is an increased risk of receiving poor quality of our care (effectiveness, experience and safety)	**Current rating**	S4 x L4 = 16
		Target risk score	S3 x L2 = 6
		Linked to Risk	1501

Controls in place (to manage the risk)	**Gaps in Control**
1) Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists 2) Daily Board rounds by ward team 3) Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed 4)Matrons walk round 5)Matron on site 7 days a week and Clinical Site Matron post established 6)Management of escalation areas, procedures and systems 7)Ring fencing of specialty beds 8)Establishment of virtual bed in the community	1)Additional workload for MDT having to cover significant numbers of patients outside their bed base 2)The external influences outside of SASH control e.g.) demand management and delayed discharges in care

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Patient Experience feedback all sources 2)Feedback from ward round project 3)Themes in safety reports demonstrate controls effectiveness 4)Length of stay data by specialty and ward 5)Trends in staff sickness linked to wards and specialty	Positive (+) Improved In-patient Survey results (Time to wait to be allocated a bed, privacy, treated with respect and dignity all improved) (+) Numbers of formal complaints are now significantly reduced (Patient Experience Group Report) (+)"Your Care Matters" provides qualitative assurance (+) Improved patient opinion data Negative (-) Internal reporting high against target bed occupancy levels (-) Complaints and incident data (-) Delayed discharge of medically fit patients

Gaps in assurance	**Assurance Level gained: RAG**
SQC comparison of PT journeys indicated further development of process of right bed first time Lack of documented evidence of effect on MDT caused by not getting patients into the right bed first time	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Board round and ward round project and implementation of professional standards 2)Site team improvements 3)Reducing bed occupancy to 95%	1) Being implemented 2) December2013 3) Ongoing

Update by	FA 04/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 2 - Ensure Patients are cared for and cared about

Priority ID and reference	2.1 Be recommended on the basis of "customer care"	**Director responsible**	Director of Information and Facilities
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	2.1 The Trust's objective to ensure all patients are cared for and about, will be significantly hampered If the Trust does not embed a coordinated approach for learning from patient feedback such as %Your Care Matters+, Complaints and PALS	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L1 = 3
		Linked to Risk	None identified

Controls in place (to manage the risk)	**Gaps in Control**
1)Friends and Family Test implemented in inpatient areas, ED and Maternity 2)Your care matters implemented in OP / Endoscopy/ DSU across all sites 3)Trust wide monitoring system developing for complaints and PALS 4)Divisional responsibility for actioning complaints investigation 5)Patient Experience Delivery Committee monitoring 6)Use of patient opinion to listen to and respond to patients	1)Delays in administration of complaints, including signature and final editing

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)External Audit TDA - Confidence, 2)Board Performance Information 3)Friends and Family	Positive (+)Plans developed to continue implementation (+) Presentation to CQPM (Commissioner Quality Meeting) (+) Implementation of ward dashboards (+) Number of new complaints significantly lower than last year (+) Low numbers of cases referred to the Ombudsman (+) Patient opinion and your care matters trends/information Negative (-) Numbers of complaints cases reopened (-) Performance in closing complaints (-) Supporting corporate function establishment (-) Friends and Family data (-) Case specific patient opinion and your care matters feedback

Gaps in assurance	**Assurance Level gained: RAG**
Effective function of the patient experience and delivery forum and the linkage of patient experience data and responses/actions	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Implement YCM in Maternity 2)Develop SQC Reports 3)Review complaints policy to ensure it is fit for purpose and is aligned with new structures	1)Ongoing 2)First report received, iterative process of development 3)31/12/13

Update by	IM 04/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 2 - Ensure Patients are cared for and cared about

Priority ID and reference	2.2. Always treat all patients and their families/carers with compassion, courtesy and privacy and dignity	Director responsible	Chief Nurse
		Initial Risk	S4 x L3 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	2.2 The Liverpool Care Pathway has been removed from use. Whilst an alternative management process is developed there is a probability that patients receiving palliative care will not receive the high quality care expected.	Current rating	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	None identified

Controls in place (to manage the risk)	Gaps in Control
1)End of Life (EOL) care team 2)EOL working group 3)Withdrawal of LCP, replacement system for management of palliative care being trialed 4)Nursing care review daily and Focus Fridays 5)Nursing Clinical Effectiveness weekly audits commenced	1)Board approved EOL process 2)Lack of national guidance or local health economy

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1)RTM (Synbiotix, MUST, pressure ulcers) data available and monitored by SQC and patient experience group 2)All sources of patient feedback, internal and external 3)Compliments and PALS 4)Meet the Matron session feedback and equivalent sessions that are Consultant lead	Positive (+) Steering Group (+) "Your Care Matters" feedback (+) Care pathway material replaced EOL guidance (+) Low trend of complaints with EOL as main issue (+) Initial management process discussed and agreed at September MBQR Negative (-) Audit highlight gaps in delivery of care (-) Training and release of staff to support wards (-) NHS Choices negative comments

Gaps in assurance	Assurance Level gained: RAG
1)Clinical audit of suggested process 2)Triangulation of training, appraisal and quality	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1)Review all patient feedback systems for trends 2)New care plan for EOL care 3)Provide training of new care plan 4)Investment in Nurses and Palliative care team 5)CEO and Medical Director liaison with St Catherines 6)Protocol and EOL care information being developed for patients and staff	1)December 2013 2)September 2013 (draft complete) 3)Initiate by November 2013 4)6 day service being implemented, recruiting to a 7 day service 5)Ongoing

Update by	FA 04/12/13	Date discussed at Board	To be discussed at December Board

Objective 3 - Work in partnership with our community

Priority ID and reference	3.1. Work with patients, the public and partners to develop services that meet the needs of our community	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	3.1 There is a risk that the Trust will fail to achieve a sufficient geographic and demographic representation of its membership to meet Foundation Trust requirements	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	None identified

Controls in place (to manage the risk)	**Gaps in Control**
1)FT Membership Strategy & Action Plan agreed by Trust Board July 2)WebPages live and online recruitment commenced	1)Delivery of controls

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Achievement of FT membership recruitment milestones 2)Proposals for FT Shadow Governor's Council 3)Membership Engagement Plan 4)Elections to Shadow Governor's Council 5)Representative membership 6)FT Consultation (Public and Staff)	Positive (+)FT Project Board engagement with draft FT membership plans (+)Initial proposals for Council of Governors (+)FT Program Manager in place (+)Corporate Governance Officer in place to manage membership (+)FT membership forms finalised (+)Face to face membership recruitment has begun (+)FT public consultation commenced Negative (-)Attendance at FT public consultation

Gaps in assurance	**Assurance Level gained: RAG**
None identified	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Develop and implement roll out 2)Agree FT milestones with TDA 3)Increasing publicity for consultation events 4)Attend voluntary and community sector events 5)Actively recruit FT members in local community settings	1) Complete 2) Complete 3) 31/01/13 4) 28/02/13 5) Ongoing

Update by	GFM 12/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 3 - Work in partnership with our community

Priority ID and reference	3.2 Improve the way people see and talk about SaSH	Director responsible	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	3.2 Failure to engage with local media has a significant effect on the Trust reputation	Current rating	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	None identified

Controls in place (to manage the risk)	Gaps in Control
1)Board Approved Communications Strategy and action plan 2)Proactive and positive press and media coverage and relationships	Current Communications Strategy not entirely fit for purpose

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1)Implementation of Communications Strategy & Action Plan 2)Implement outcome of Communications Team re-organisation 3)Positive results of Staff Survey	Positive (+) Proactive national and local media coverage. (+) Positive feedback from Your Care Matters (+) Positive Feedback from Patient Opinion (+) Head of communications in post (+) Recruiting to full communications team (+) Draft Communications strategy in development stage (+) FT Communication Plan approved Negative (-) Minimal adverse media coverage

Gaps in assurance	Assurance Level gained: RAG
Communications strategy not yet finalised	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1)Development and implementation of communications & PR strategy (in draft) 2)Implement Outcome of communications team consultation 3)Communications Strategy to FWC	1)31/01/14 2)Complete 3)31/01/14

Update by	GFM 12/12/13	Date discussed at Board	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.1.Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.1 Failure to deliver income plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1479

Controls in place (to manage the risk)	**Gaps in Control**
1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Signed contract with commissioners. 3) Contract management process in place - clearer and better structure than last year 4) Health system Local Transformation Board (LTB) - now augmented (July 2013) with a Finance e sub-group which is discussing forecast outturn on the contract 5) Financial reporting, including forecast scenarios presented to Board	1) CCG activity plans not fully profiled against their own plans at Jun 2013 - updated - still not done at August 2013 2) Issues over contract process 3 Decision over non recurrent support is still outstanding

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with CCGs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output and reporting from health system management (e.g.: System Management Team meeting) 5) Output of Contract Management Process	Positive: (+) Activity at M07 aligns overall with Trust plan - shortfall in elective activities is noted (+) Overall forecast I&E position is balanced - income covers spend (+) Forecast shared transparently with CCGs (+) M01-4 reconciliation completed - over performance is being paid in cash terms (+) CCGs engaging over LTB community bed scheme . deal has been done Negative: (-)Under delivery of elective income puts significant risk against the plan (-) Too much non elective activity, not enough elective... (-) No resolution to significant contractual dispute over the readmission audit at M07. (-) extent of financial challenge from CCGs

Gaps in assurance	**Assurance Level gained: Amber**
(1) Output from reconciliation process from M05 onward (2) Effective operation by CCGs and CSU of contract process	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
I) Regular Contract monitoring meetings now in place - action is to ensure they run properly and the hierarchy of meetings around them (CQPM and Chief Officer meetings) also run properly [CFO: update at M05]; ii) Range of actions on unscheduled care: internal U/S Care Board running, engagement with other providers now part of weekly business - but CCG actions to support unscheduled care actions not yet visible [to Trust] [COO: update at M05]. iii) Discussion with CCGs over adequate CHC assessment arrangements to get those in place in the summer [COO: update at M05] and participation in LTB to expedite actions around unscheduled care. This has progressed since last BAF update and is very live currently iv) Escalation with TDA.	Actions proceeding to timetable - no suggestion currently that CCG actions on unscheduled care will resolve.

Update by	PS 21/11/13	**Date discussed at Board**	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.2 Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.2 Failure to stop divisional overspending against budget	**Current rating**	S5 x L3 = 15
		Target risk score	S3 x L2 = 6
		Linked to Risk	1477,1365

Controls in place (to manage the risk)	**Gaps in Control**
1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans agreed & signed off 3) Additional activity budget being allocated after agreement of specific pressures 4) Internal Performance Review process 5) Programme Management Office weekly CEO review 6) M03 forecast scenarios presented to Board	1) Specific savings plans risky - all subject to particular scrutiny.

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with CCGs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output in financial reporting describes improvement and risk mitigation. Linkage between activity levels and spend is clear from 2012/13 5) PMO review process (monthly)	Positive (+) Overall forecast I&E position is balanced from profiled reserves - income covers spend at M07 . savings on track (but see about mitigation below) Negative (-) Three clinical divisions and E&F overspent at M07 (-) Although savings on target, savings are requiring mitigation (-) Nursing agency spend remains very high . recruitment plans in Medicine Division have slipped a few months

Gaps in assurance	**Assurance Level gained: Amber**
(1) Savings delivery . mitigation is significant (2) Divisional management of overspends . cost controls have had to be put in place.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
I) PMO structure continues [PMO is proving effective] (CFO - update at M08]; ii) Controls are being exercised in divisions - these are now being applied centrally - non pay requisition management, agency booking, general tightening of control & ADO escalation (ongoing) (CFO - update at M08] iii) Further budget changes have now been halted unless absolutely necessary. iv) Escalation to TDA over resolution of non recurrent funding issue - discussed at Board (update M08)	Actions proceeding to timetable.

Update by	PS 21/11/13	**Date discussed at Board**	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation			
Priority ID and reference	4.3 Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.3 Unable to provide realistic medium term financial plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1493

Controls in place (to manage the risk)	**Gaps in Control**
1) Items referred to in 4.1a and 4.1b above 2) SECOND draft long term financial model and integrated business plan completed (submitted to SHA in September . feedback received) 3) TDA Plan submitted end of May 2013 4) Timetable for refreshed IBP and LTFM going forward	1) Items listed above equally applicable here

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Delivery of current year financial plans 2) Delivery of long term financial model and integrated business plan	Positive (+) Long term financial model provides realistic plan and scenarios describe wider robustness against downsides (+) Delivery of performance in 2012/13 notable - delivery now needed in 13/14 (+) The submitted LTFM (September 2013) passed muster with TDA high level review although it has not been subject to full challenge and scrutiny. (+) LTFM submitted describes viable position (+) TDA have provided approval to go out to FT consultation in line with FT timetable Negative (-) Savings and income levels in future years provide challenging targets and the LTFM assumptions are subject to change dependent on activity and income (-) Delivery of stated CCG commissioning plans for 2013/14 and future years risky - potential change in shape of commissioning intentions Overall, on basis of current assumptions and delivery of LTFM, RAG kept at amber [but subject to review]

Gaps in assurance	**Assurance Level gained: Amber**
Review of LTFM (long term financial model) and IBP (Integrated Business Plan) within Trust Development Authority timetable	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Review of LTFM (long term financial model) and IBP (Integrated Business Plan) according to TDA timetable	1) 30/10/13

Update by	PS 21/11/13	**Date discussed at Board**	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.4 Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L5 = 25
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.4 Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L3 = 12
		Linked to Risk	1459

Controls in place (to manage the risk)	**Gaps in Control**
1) Bi weekly review of forward cash flow by finance team and CFO 2) Cash and working capital policy and strategy 3) Annual cash plan linked to business plan and capital plan (see link with Risk 1134)	No significant gaps in control identified

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2) Monthly finance reporting to Management Board and Trust Board	Positive (+) Positive cash flow reported for every month in 2011/2012, and throughout 2012/13 - although borrowing required in 11/12, temporary borrowing needed in 2013/14, but forecast is that this will genuinely be temporary only (+) Liquid ratio has followed expectations Negative (-) no confirmed additional cash to resolve underlying liquidity problem . likely to be resolved in FT application process . potentially through a working capital loan (-) cash flow dependent on financial outturn described in 4.1a and 4.1b above. Assurance RAG "amber" - no current cash problem but underlying problem unresolved.

Gaps in assurance	**Assurance Level gained: Amber**
In terms of cash flow management to end year, no material gaps in assurance. In terms of resolving the actual risk (liquidity), there is no confirmation of additional cash to resolve SoFP weakness.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Day to day cash control is main action currently, coupled with actions to maintain service income and manage spend 2) Long term financial model, and TDA plan now provides additional validation of the level of cash injection required and the interaction from an improving financial position within the model 3) Discussion will continue with the TDA as the FT timeline progresses.	Actions proceeding to timetable

Update by	PS 21/11/13	**Date discussed at Board**	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.5. Delivery of agreed milestones to achieve Foundation Trust status	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.5. If the Trust does not progress and deliver its Foundation Trust plans it is unlikely to be able to successfully authorised. This could leave the Trust without local autonomy and could lead to an alternative organisational form being imposed on the Trust. Which could reduce choice and focus on local health provision	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L2 = 8
		Linked to Risk	None identified

Controls in place (to manage the risk)	**Gaps in Control**
1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Foundation Trust project board 4)Timeline agreed with TDA 5)QGAF assessment carried out and action plan being developed	Foundation Trust Task and Finish group not yet embedded

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)BGAF action plan and self assessment 2)LTFM 3)FT Project board 4)FT Project plan 5)Integrated Business Plan 6)Public Consultation 7)QGAF Action Plan and self assessment 8)Speciality deep dives to inform Trust on readiness for assessments	Positive (+) Active FT Project Board (+)Draft IBP (+)LTFM (+)Draft membership strategy (+)BGAF action plan (+)Initial QGAF action plan Negative (-)Timeline to be agreed with TDA

Gaps in assurance	**Assurance Level gained: RAG**
Yet to undertake external assessments . but planned for December 2013 Chief Inspectors of Hospitals opinion required	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Detailed BGAF action plan developed and currently under review 2) Board Development Programme 3) Membership Strategy 4) Foundation Trust timeline awaiting approval by TDA 5) Public & staff consultation due to begin Nov 2013 6) External assessment by Deloitte agreed to commence in Dec 2013	1) Board Governance Memorandum approved 2) Plans are being driven forward by Director of Corporate Affairs, phase 2 commenced 3) Ongoing 4)Complete and approved 5)Commenced 6)Commenced

Update by	GFM 12/12/13	**Date discussed at Board**	To be discussed at December Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.6. Ensure that the estate and infrastructure supports our sustainability	**Director responsible**	Director of Information and Facilities
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.6 There is a risk that the Trust isn't able to deliver service in an effective timely manner due to the estate not fully supporting the clinical strategy	**Current rating**	S5 x L2 = 10
		Target risk score	S5 x L1 = 5
		Linked to Risk	969,1092,1431,1494

Controls in place (to manage the risk)	**Gaps in Control**
1) Capital program 2) Finance Workforce Committee 3) Weekly Capital Plan 4) Estates Strategy 5) Ward improvement Group 6)Development of estates strategy	None identified at time of review

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)All sources of patient feedback 2)Your Care Matters	Positive (+) Front entrance (+)ED refurbishment and recent projects achieved and improvements demonstrated (+)Capital group (+)Theatres refurbishment Negative (-)Patient feedback involving estates issues

Gaps in assurance	**Assurance Level gained: RAG**
No significant gaps identified	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Theatres refurbishment 2) Radiotherapy capital work 3) Hospital infrastructure. 4) Electrical supply capacity upgrade 5) Long term Respiratory Unit (BoC) 6) Minor works program	1) 2013/14 2) 2013/14 3) Ongoing 4) 31/03/14 5) July 14 6) Ongoing

Update by	IM 04/12/13	**Date discussed at Board**	To be discussed at December Board

<table>
<tr><th colspan="4">Objective 4 - Become a Sustainable, Effective Organisation</th></tr>
<tr><td rowspan="2">Priority ID and reference</td><td rowspan="2">4.7. Ensure that the estate and infrastructure supports our sustainability</td><td>Director responsible</td><td>Director of Information and Facilities</td></tr>
<tr><td>Initial Risk</td><td>S5 x L3 = 15</td></tr>
<tr><td rowspan="3">Key Action for 2013/14 objectives and description of any potential significant risk to this priority</td><td rowspan="3">4.7. There is a risk that the Trust does not fully realise the benefits available from well embedded IT systems</td><td>Current rating</td><td>S5 x L2 = 10</td></tr>
<tr><td>Target risk score</td><td>S5 x L1 = 5</td></tr>
<tr><td>Linked to Risk</td><td>988,996,999,1502</td></tr>
<tr><td colspan="2">Controls in place (to manage the risk)</td><td colspan="2">Gaps in Control</td></tr>
<tr><td colspan="2">1) IT Strategy
2) Clinical Informatics Group
3) EPR User Group
4) Various project group (EPMA etc)
5) Internal Audit</td><td colspan="2">1)Investment in Infrastructure
2Insufficient focus on change benefits realization due to financial constraints</td></tr>
<tr><td colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</td><td colspan="2">Actual Assurances: Positive (+) or Negative (-)</td></tr>
<tr><td colspan="2">1)Efficiencies being delivered through IT enabled change</td><td colspan="2">Positive
(+) Improving infrastructure (e.g. WiFi)
(+) Development of existing EPR platform (e.g. EPMA)</td></tr>
<tr><td colspan="3">Gaps in assurance</td><td>Assurance Level gained: RAG</td></tr>
<tr><td colspan="3">1)IT strategy not yet fully aligned with overall Trust clinical strategies</td><td></td></tr>
<tr><td colspan="3">Mitigating actions underway</td><td>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</td></tr>
<tr><td colspan="3">1)Upgrades for Cerner applications
2)Hospital wide WiFi
3)E prescribing project</td><td>1) 31/03/14
2) 31/03/14
3) 31/03/14</td></tr>
<tr><td>Update by</td><td>IM 16/09/13</td><td>Date discussed at Board</td><td>To be discussed at December Board</td></tr>
</table>