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**	S3 x L2 = 6
		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 and mock inspections systems 4)Synbiotix providing RTM and other patient experience information with local action planning 5)Divisional action plans in place addressing patient experience feedback 6)Executive committee and subcommittee structures 7)PMO system in place to review and improve compliance with regulatory standards (trust and divisional plans)	1) Embedding Synbiotix and improving usability of hardware (WiFi) 2) New Clinical and quality strategy needs to embed within Trust (linked to QGAF implementation)

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) Executive committee reviews of elements of quality of care and services 9) Division action planning following+Sit and See+sessions, surveys and Focus Friday working.	Positive (+) CQC current risk rating lowest possible (+) Registration status with CQC shows no concerns (+) Current performance high and sustained (+) Mock inspection (PwC data pack) and deep dive reviews Negative (-) Robust evidence of Trust wide learning from SI themes

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)Monitor QGAF 4)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)Under review 4)Complete 6)Deep dives underway and timetable shared with leads

Update by	FA 18/03/14	**Date discussed at Board**	To be discussed at March 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 (non-specific diagnosis coding) 2) Real time data sets for benchmarking

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 6) Deep dive service reviews	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 inconsistent, linked to winter pressures) (-) Surgical sight wound infections (improving but still under review) (-) Numbers community rehab beds (improving)

Gaps in assurance	**Assurance Level gained: RAG**
Audit of data quality for mortality indicators Embedding systems of shared learning across the trust	

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 and embedding mortality reviews	1)Underway 2)Underway, limited services in place 3)Underway 4)Complete 5)Underway 6)Underway 7)Underway 8)Commenced in Q4 9)Underway

Update by	BB 18/03/14	**Date discussed at Board**	To be discussed at March 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**	**S3 x L2 = 6**
		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. Reconfigured management boards 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 and Nursing staffing levels	1) Full implementation of Synbiotix (linked to WiFi coverage) 2) Incident reporting policy to be reviewed to include recent changes 3) Lack of system to differentiate between Trust and community acquired cases of VTE

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 (+) CQC risk rating, lowest possible (+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduction and sustained (+) MUST 100% (+) QGAF assessment and action plan (+) New EWS trialed and audited (+) Increase in reporting trends (+) National falls data benchmarks favorably (Trust desire to improve position) Negative (-) Never events incidence low (2 in last 12 Months, both low harm) (-) NRLS reporting timeframes

Gaps in assurance	Assurance Level gained: RAG
Ability to benchmark in real time National Safety Dashboard to be implemented once produced Patient tracking and analysis (Whiteboard project)	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1)Pressure damage board 2)Full implementation of systems to support Synbiotix 3)Policy update for Incident reporting and management 4)Clinical nurse Consultant for Falls	1) In place re-embedding 2) Implemented resolving initial hardware issues 3) To be ratified 4) To be agreed and established

Update by	FA 18/03/14	Date discussed at Board	To be discussed at March 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**	S3 x L4 = 12
		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 5) Site Management Team and Discharge Team 6) Circa 50 additional community beds made available 7) 7 day medical consultant ward rounds established	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 (+) Current forecast and performance indicates that this standard will be delivered Q4 (+) Process improvement (+) 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) Negative (-) Quality indicators for time to assessment / treatment. Surrey and Sussex local lead. (-) EDD Section 2 and section Patient tracking system (-) Number of patients safe to discharge at any one time

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 5) Monitoring planned elective surgery and day to day activity	1)Complete 2)Complete 3)Extra community beds made available 4)Complete 5)January 2014 through March 2014

Update by	PB 14/03/14	**Date discussed at Board**	To be discussed at March 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 5) Circa 50 additional community beds made available	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 (Cancer) 2) Implementation of additional community beds reducing risk of elective cancellation 3) Outsourcing of patients to private sector where appropriate	1) In place and embedding 2) Extra community beds made available 3) January through March 2014

Update by	PB 14/03/14	**Date discussed at Board**	To be discussed at March 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 Trust's 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) 4) Data review for pathway specific re-admissions	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 3) Regular audit review of readmissions at service level	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 2)Lack of agreement with CCG's over recent audit of readmission rates 3)Exact definition of re-admission required	

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) 6) Re admission data review process being updated to reflect activity to support coding	1) Under review 2) Underway 3) Underway 4) Underway long term plans 5) Underway 6) End of April

Update by	BB 18/03/14	**Date discussed at Board**	To be discussed at March Board

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

Priority ID and reference	1.7 Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.7 Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care	**Current rating**	S5 x L3 = 15
		Target risk score	S5 x L2 = 10
		Linked to Risk	1050

Controls in place (to manage the risk)	**Gaps in Control**
1)IPCAS Team and Group in place, Weekly taskforce in place 2)Infection control manual in place and information resources available 3)Antibiotic policy and guidelines in place 4)Daily (Monday to Friday) Infection Prevention & Control Nurses (IPC), to facilitate assessment and advice for infection control issues. 5)Education for Jnr Doctors on induction 6)New cleaning products in use (effective against C. diff spores) 7)MicroApp implemented for antimicrobial stewardship guidelines 8)Consultant led RCA and presentation of HCAI (MRSA, MSSA) 9)Reviewed MRSA management policy in year 10)Temocillin added to antimicrobial guidelines (reduced diarrhoea risk) 11) SMART stool sampling implemented 12) Part time Practice Development Nurse for IPC now in post. 13) Prevalence studies and Enhanced surveillance of catheter-associated UTI part of annual programme. 14) 3 ICE-POD units in place . ED, HDU and Hazelwood.	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

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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)TDA and SHA visits focusing on infection control 2013/14 5)Recent CQC visit focusing on Nursing documentation and escalation 6) Peer review carried out December 2013.	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 (+)TDA visit inspecting controls and procedures Negative (-)3xMRSA BSI case in year

Gaps in assurance	**Assurance Level gained: RAG**
Extensive auditing and monitoring in place. Trust position known	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Trial of Urology/Infection control ward round in progress, to review long term catheters. 2) Roll out of Urinary catheter Passport 3) Full list of actions in IPCAS Annual Programme of work	1) Commence September 2013 2) December 2013 3) Ongoing

Update by	BB 18/03/14	**Date discussed at Board**	To be discussed at March Board

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 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) Unfilled agency shifts 3) Staffing Ratios in some areas of the Trust at night are under review 4) The Trust still carries a volume of vacancies specifically within ITU 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 7)Daily Nursing review %planned vs actual+	Positive (+)SNCT data when available (+)Vacancy rates and turnover rates are monitored (+)Further recruitment planned has been undertaken (+)Agency spend reduced Negative (-) Benchmarked high proportion of agency staff usage against other Trust's

Gaps in assurance	**Assurance Level gained: RAG**
Trust position known no identified gaps in assurance	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Continue to monitor recruitment drives 2)Implement latest version of E-Roster (better utilisation of bank staff) 3)7 day working plans for medical staff under development across the Trust	1) Underway and ongoing 2) June implementation

Update by	FA 18/03/14	**Date discussed at Board**	To be discussed at March Board

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

Priority ID and reference	1.9. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse
		Initial Risk	S3 x L4 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.9. If the Trust does not put into place systems to assess, monitor and evaluate nursing staffing levels this may impact negatively on Trustqs 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)Planned versus actual staffing levels on a shift by shift basis and evidence actions taken 3)Procurement of updated e roster system. 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	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 under review 5)The Trust still carries a volume of vacancies specifically within ITU 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 and gap analysis when available 7)Increased reporting of positive patient experience in relation to staffing/high quality care and compassion reported	Positive (+) Daily ward staffing review (+) Reports regarding reducing vacancy rates, sickness, absence (+) Incident reporting via Datix (+) Patient experience data by ward or unit

Gaps in assurance	**Assurance Level gained: RAG**
Trust position known no identified gaps in assurance	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Gap analysis against ±Right Staffingq 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. 3)Review of maternity staff ratio	1)Complete 2)Embedding 3)Underway

Update by	FA 18/03/14	**Date discussed at Board**	To be discussed at March Board

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**	S3 x L3 = 9
		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 bed in the community (50 beds)	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 6)Matron ward rounds	Positive (+) Improved In-patient Survey results (Time to wait to be allocated a bed, privacy, treated with respect and dignity all improved) (+)"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**
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% 4)White board project to support management of this standard	1) Being implemented 2) Completed 3) Ongoing 4) Planned for 2014/15

Update by	FA 18/03/14	**Date discussed at Board**	To be discussed at March 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 (-) Internal Audit Complaints system (-) 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)Target end of March 2014

Update by	IM 14/03/14	**Date discussed at Board**	To be discussed at March 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**	S3 x L2 = 6
		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)New EOL care plan developed and agreed 3)Nursing care review daily and Focus Fridays 4)Nursing Clinical Effectiveness weekly audits commenced	1)Lack of national model to benchmark against

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 5)Trial of new EOL care plan 6)National guidelines and local services available for reference/consultation	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 (+) Cancer service data (lag time in data publication) Negative (-) Audit highlight gaps in delivery of care (-) Training and release of staff to support wards

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)Review of Godstone Ward services linked to expertise in palliative care	1)Complete 2)Complete 3)Initiated 4)6 day service being implemented, recruiting to a 7 day service 5)Business case developed 6)Underway

Update by	FA 18/03/13	**Date discussed at Board**	To be discussed at March 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**	S3 x L2 = 6
		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 & face to face 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 FT membership plans (+) Initial proposals for Council of Governors approved (+) FT Program Manager in place (+) Corporate Governance Officer in place to manage membership (+) FT membership forms being completed (+) Face to face membership recruitment in place (+) FT public consultation closed (+) Face to Face recruitment activities at voluntary sector & public venues continuing to show positive gains in membership (+) Postal recruitment launched and returns are positive (+) Procurement of a partner to host membership database and conduct targeted recruitment activities has been awarded and is in implementation phase Negative (-) Attendance at FT public consultation has been variable

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 6) Procurement of membership organisation to support targeted membership recruitment	1) Complete 2) Complete 3) Complete 4) Ongoing 5) Ongoing 6) Complete

Update by	GFM 19/03/14	Date discussed at Board	To be discussed at March 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 being finalised and due for approval at March 14 FWC (+) FT Communication Plan approved Negative (-) Minimal adverse media coverage

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

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 for approval	1)31/01/14 2)Complete 3)25/03/14

Update by	GFM 19/03/14	**Date discussed at Board**	To be discussed at March 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) Issues over contract process . we are having to adapt to CSU and CCG timetables and the fact there are two CSUs, occasionally with differing views, and the secondary layer between several CCGs and their CSUs (which adds time) 2) Previous control gaps have been remedied . a CCG activity plan has been received (although not adapted to actual activity) and the on recurrent support has been invoiced.

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 M10 aligns overall with Trust plan . and there is over performance (+) Non recurrent support resolved (+) Overall forecast I&E position is balanced - income covers spend (+) Forecast shared transparently with CCGs (to M10) (+) M01-7 reconciliation completed - over performance is being paid in cash terms (+) CCGs engaging over LTB community bed scheme . deal has been done Negative: (-) Winter emergency activity puts pressure on elective income (-) Too much non elective activity, not enough elective. (-) No resolution to significant contractual dispute over the readmission audit at M10. (-) extent of financial challenge from CCGs RAG kept at red (15) because of disputes over income.

Gaps in assurance	**Assurance Level gained: Amber**
(1) Effective operation by CCGs and CSU of contract process, although this has reduced and all issues are now either resolved or in a formal process. Amber because of that formal process (we still disagree)	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
I) Regular Contract monitoring meetings in place and working; II) Range of actions on unscheduled care: internal U/S Care Board running, engagement with other providers now part of weekly business - III) LTB agreed community beds plan is having an impact; IV) Formalised disputes now in train with CCGs on outstanding issues. Note: CHC assessment remains an issue and other actions to support unscheduled activity reductions not visible [to Trust]	Actions proceeding to timetable - no suggestion currently Health System actions on unscheduled care will resolve.

Update by	PS 20/02/14	**Date discussed at Board**	To be discussed at March Board

<table>
<tr><td colspan="4">Objective 4 - Become a Sustainable, Effective Organisation</td></tr>
<tr><td>Priority ID and reference</td><td>4.2 Live within our means both in year and ensure sustainability into the future</td><td>Director responsible</td><td>Chief Finance Officer</td></tr>
<tr><td></td><td></td><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">4.2 Failure to stop divisional overspending against budget</td><td>Current rating</td><td>S4 x L3 = 12</td></tr>
<tr><td>Target risk score</td><td>S3 x L2 = 6</td></tr>
<tr><td>Linked to Risk</td><td>1365</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) 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 and CEO review
6) Forecast scenarios presented to Board</td><td colspan="2">No significant gaps in control identified</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) 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)</td><td colspan="2">Positive
(+) Overall forecast I&E position is balanced from profiled reserves - income covers spend at M10 . savings on track (but see about mitigation below)
(+) Control totals agreed with all Divisions, in line with income forecast

Negative
(-) At M10 one Division has exceeded control total . risk in 2 others.
(-) Although savings on target, savings are requiring mitigation
(-) Nursing agency spend reducing, but overall agency cost remains high.</td></tr>
<tr><td colspan="3">Gaps in assurance</td><td>Assurance Level gained: Amber</td></tr>
<tr><td colspan="3">(1) Divisional management of overspends . M10 shows some weakness in some Divisional processes .</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">I) PMO/Performance structure continues [PMO is proving effective]
II) Controls are being exercised in divisions and are being applied centrally . Control totals have been agreed;
III) Further budget changes have now been halted unless absolutely necessary.</td><td>Actions proceeding to timetable.</td></tr>
<tr><td>Update by</td><td>PS 20/02/14</td><td>Date discussed at Board</td><td>To be discussed at March Board</td></tr>
</table>

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) THIRD draft long term financial model and integrated business plan completed (submitted to TDA in February 2014) 3) TDA Plan submitted January 2014 4) Timetable for refreshed IBP and LTFM going forward is part of national planning guidance	1) Items listed above equally applicable here 2) The 2013/14 planning process is behind timetable with the local Health economy, and NHS England . no clarity yet on Better Care Fund implications.

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 2013/14 . but the year isn't finished (+) The 2nd submitted LTFM (September 2013) passed muster with TDA high level review although it has not been subject to full challenge and scrutiny. A revised LTFM has now been issued (+) LTFM submitted describes viable position (+) TDA have provided approval to go out to FT consultation in line with FT timetable, set up a Readiness Review and the CQC inspection is timetabled for May 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 (-) Lack of clarity on significant changes from Better Care Fund and CCG contracting . unlikely to sign a Contract on 28 February. Overall, on basis of current assumptions and delivery of LTFM, RAG kept at red noting level of risk [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 20/02/14	**Date discussed at Board**	To be discussed at March 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 2012/13 - temporary borrowing needed in 2013/14, but reasons for that are delays in agreements (CCG and TDA) and 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 20/02/14	**Date discussed at Board**	To be discussed at March 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	S3 x L2 = 6
		Linked to Risk	None identified

Controls in place (to manage the risk)	**Gaps in Control**
1)BGAF assessment carried and action plan in place 2)Corporate governance framework 3)Foundation Trust project board 4)Timeline agreed with TDA 5)QGAF assessment carried out and action plan in place	No significant gaps in control identified

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 submitted to TDA for Readiness Review (+) LTFM submitted to TDA for Readiness Review (+) FT membership strategy (+) External review of BGAF & QGAF undertaken (+) BGAF action plan in place (+) QGAF action plan in place (+) Readiness Review agreed with TDA (+) FT Timeline agreed with TDA Negative (-) Awaiting outcome of public and staff consultation

Gaps in assurance	**Assurance Level gained: RAG**
Chief Inspectors of Hospitals opinion required	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Board Development Programme 2) Membership Strategy in place 3) Outcome of Public and staff consultation	1) Ongoing 2) Plans are being driven forward 3) Feedback being collated

Update by	GFM 19/03/14	**Date discussed at Board**	To be discussed at March 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 isnq able to deliver service in an effective timely manner due to the estate not fully supporting the clinical strategy	**Current rating**	S5 x L1 = 5
		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	No significant gaps in control identified

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 (+) Ward Improvement Group (+) General Refurbishment Group (+) Estates Strategy signed off by board with clear five year programme covering (+) Estates Infrastructure (+) Wide range of projects delivered (+) Capital Group (+) FWC Focused on delivery of Estates Strategy (+) Picking up and responding to Patient comments via Your Care Matters

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 14/02/14	**Date discussed at Board**	To be discussed at March Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.7. 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	4.7. There is a risk that the Trust does not fully realise the benefits available from well embedded IT systems	**Current rating**	S5 x L2 = 10
		Target risk score	S5 x L1 = 5
		Linked to Risk	988,996,999,1502

Controls in place (to manage the risk)	**Gaps in Control**
1) IT Strategy 2) Clinical Informatics Group 3) EPR User Group 4) Various project group (EPMA etc) 5) Internal Audit	1)Investment in Infrastructure 2)Insufficient focus on change benefits realization due to financial constraints

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Efficiencies being delivered through IT enabled change	Positive (+) Improving infrastructure (e.g. WiFi) (+) Development of existing EPR platform (e.g. EPMA)

Gaps in assurance	**Assurance Level gained: RAG**
1)IT strategy not yet fully aligned with overall Trust clinical strategies	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Upgrades for Cerner applications 2)Hospital wide WiFi 3)E prescribing project	1) 31/03/14 2) 31/03/14 3) 31/03/14

Update by	IM 14/02/14	**Date discussed at Board**	To be discussed at March Board