Surrey and Sussex NHS Healthcare NHS Trust

Board Assurance Framework November 2014

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An Associated University Hospital of
Brighton and Sussex Medical School

Putting people first
Delivering excellent, accessible healthcare

Objective 1 - Safe –Deliver safe services and be in the top 20% against our peers			
Priority ID and reference	1.A Consistently meet national patient safety standards in all specialties and across divisions	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L3 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	1.A.1 There is a risk that the Trust will not meet its objective to deliver continuous improvement in reducing avoidable harm, if all national and local standards are not embedded within divisions and specialties, supported by robust monitoring mechanisms. (Falls management is a specific focus and therefore highlighted)	**Current rating**	S4 x L3 = 12
		Target risk score	S3 x L2 = 6
		Linked to Risk	1055 and 1545

Controls in place (to manage the risk)	Gaps in Control
1) Clinical teams to implement patient safety plans in the Trust (falls, pressure ulcers and infection control) 2) Regular review of patient safety data including the Safety Thermometer at divisional, executive and board level 3) Groups/Committee established including SQC, ECQR and its subcommittees, N & M and Divisional Governance. 4) Policies, procedures and guidelines provide the framework by which risks and incidents are managed. 5) Matron on site 7 days a week 6) Clinical Site Matron established 24/7 with enhanced team (2xB7 and 1x B8a) 7) Nursing and Maternity Strategy and Nursing staffing levels with daily real-time escalation 8) Incident reporting policy to be reviewed to include recent structural changes 9) Ward safety boards 10) Serious incident review group established to monitor and evaluate investigation progress and progress against actions **Specific Falls management controls** 1) Falls management policy in place 2) Training undertaken for clinical staff in the assessment and management of patients at risk of falls 3) Falls pathway developed and operational for assessment of patient fall risk and those at risk of falling line in with NICE guidance June 2013 4) Patient falls strategic group meet monthly and report KPIs to the patient safety and clinical risk committee. 5) Falls Operational Board meet weekly to share investigation and learning from all complex, major and moderate falls. 6) Audit of falls policy and falls process undertaken and results and actions escalated to the appropriate operational and governance groups 7) Monthly reporting at Executive committee for Quality enabling improved understanding of falls and any gaps in falls management strategies 8) Divisional reporting, oversight and ownership of falls 9) Equipment audit and review undertaken 10) Falls and patient safety consultant nurse appointed, start date 1 December 11) Datix incident reporting in place and all serious falls investigated using SI	1) Lack of system to differentiate between Trust and community acquired cases of VTE **Specific gaps in Falls management controls** 1) ED Falls pathway – under development 2) Consistency of joint working with community falls teams

methodology 12) Lead trust in south area falls network	

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) Patient safety related KPI agreed and monitored at Board and Divisional Level 2)Meeting minutes and action plans, evidence of presentations and board discussion 3) External reports and visits both scheduled and unscheduled (including new CCG quality visits) 4) CQC intelligent monitoring rating 5) Patient tracking and analysis (Whiteboard project) 6) 15 Steps quality program **Specific Falls management sources of assurance** 1) Datix incident reporting and analysis 2) Monthly trust wide reporting using national benchmarking 3) Training data 4) Annual Falls Report 13/14	Positive (+) CQC Chief Inspector of Hospitals Report (+) CQC risk rating, lowest possible (+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduced and sustained (+) MUST 100% (+) QGAF assessment and action plan (+) New EWS trialed and audited (+) Increase in reporting trends Negative (-) Never events incidence low (1 in last 12 Months, low harm) (-) NRLS reporting **Specific assurances regarding Falls management** Positive (+) Annual Falls report 2013/14 reduction in falls with harm in year (+) Resource focus on patient safety and falls (+) Evidence of improved SI investigation management and closures (+) Improved reporting of patient falls has enabled the Trust to understand fall profile and identify gaps in the falls management strategies available

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) Clinical Nurse Consultant for Falls and Patient Safety 2) Falls ward round to be established running twice a month 3) Establish links with falls team within community 4) Develop Emergency Department falls pathway	1) Recruited awaiting start 2) December 2014 3) December 2014 4) December 2014

Update by	FA 12/11/2014	Date discussed at board	To be discussed at November Board

Objective 1 - Safe –Deliver safe services and be in the top 20% against our peers

Priority ID and reference	1.A.1 Consistently meet national patient safety standards in all specialties and across divisions	**Director responsible**	Medical Director
		Initial Risk	S4 x L3 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	1.A.1 Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care	**Current rating**	S4 x L3 = 12
		Target risk score	S5 x L2 = 10
		Linked to Risk	1049 and 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)MicroApp implemented for antimicrobial stewardship guidelines 6)Consultant led RCA and presentation of HCAI (MRSA, MSSA). This presentation is done in departmental meetings with IC doctor and Nurse attendance. This increases learning in the clinical team when compared to consultant attendance at IC meeting. 7) Prevalence studies and Enhanced surveillance of catheter-associated UTI part of annual programme. 8) 3 ICE-POD units in place – ED, HDU and Hazelwood. 9) Developed a system where site team and matrons during the weekend are responsible in checking wards that have received positive results (See 4 above) 10)Focus on risk and mitigation of VHF involving ED/Micro/ITU/PHE 11)Antibiotic Stewardship group revitalized 12)Decontamination group informing development of strategy for IPCAS	1)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 2)Variation in line care demonstrated by audit 3)High bed occupancy can cause infection control risk to increase (e.g. side room availability)

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)Divisional and departmental governance meeting minutes	Positive (+)No C. diff outbreaks declared in year 2013/14 (+)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 (+)PHE and NHSE walkthrough ED for VHF risk provides good assurance (+)Data quality indicated in Internal Audit of Quality Account (2013/14) Negative (-)3xMRSA BSI case during 2013/14, 0 to date 2014/15 (-)Incidence of CDI 2013/14, 10 to date 2014/15

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) Roll out of Urinary catheter Passport 2) Full list of actions in IPCAS Annual Programme of work 3) Ongoing discussion with commissioners about penalties applying only to cases with poor/inadequate care. This conversation is nationally mandated			1) Embedding 2) 2014/15 3) Ongoing
Update by	DH 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 2 - Effective –Deliver effective and sustainable clinical services within the local health economy

Priority ID and reference	2.A Achieve the best possible clinical outcomes for our patients	**Director responsible**	Chief Nurse / Clinical Leads
		Initial Risk	S3 x L3 = 9
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	2.A.1 There is a risk that patient outcomes will not continue to improve if monitoring and benchmarking outcomes are not utilised and implemented appropriately across divisions and specialties	**Current rating**	S3 x L2 = 6
		Target risk score	S2 x L2 = 4
		Linked to Risk	844

Controls in place (to manage the risk)	**Gaps in Control**
1) Safety thermometer data is reviewed by wards and specialties at regular meetings 2) HSMR/SHMI/Datix incidents are reviewed at divisional and trust level 3) Groups/committees established including SQC, ECQR and its subcommittees 4) Specialty deep dive process identified areas of best practice and also areas for improvement, which have been actioned and monitored by relevant clinical leads	1) Evidence of learning from incidents/outcomes

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Regular data collection 2) PROMS 3) Minutes of divisional meetings including M & M 4) Minutes of Clinical Effectiveness and Patient Safety and Risk subcommittees 5) Patient tracking and analysis (whiteboard project) 6) Datix reporting and analysis	Positive (+) CQC Chief Inspector of Hospitals Report (+) CQC risk rating, lowest possible (+)The latest HSMR data shows overall Trust mortality is lower than expected for our patient group (+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduced and sustained (+) MUST 100% (+) New EWS implemented (+) Increase in reporting trends (+) National falls data benchmarks favorably (Trust desire to improve position) Negative (-) Never events incidence low (1 in last 12 Months, low harm) (-) NRLS reporting

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time National safety Dashboard to be implemented when available	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Recruitment of Clinical Nurse Consultant for Patient Safety and Falls	1) Start date 02/12/14

Update by	FA 12/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 2 - Effective –Deliver effective and sustainable clinical services within the local health economy			
Priority ID and reference	2.B Deliver services differently to meet need of patients, the local health economy and the Trust	**Director responsible**	Chief Operating Officer
		Initial Risk	S4 x L3 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	2.B.1 There is a risk of a loss of elective business to outside provider if we do not align our activity to local commissioning priorities	**Current rating**	S4 x L3 = 12
		Target risk score	S4 x L1 = 4
		Linked to Risk	No specific risk recorded on the operational risk register

Controls in place (to manage the risk)	Gaps in Control
1) Local Transformation Board 2) 3x3 meetings 3) CEO strategic meetings 4) Partnership boards	1)Contract to be agreed with BICS, undefined staff model (TUPE) and activity undefined 2)Pathway redesign may not be fit for purpose

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1)Letters of intent 2)Contracts 3)Meeting minutes	Positive (+) Commitment from all parties, initial plans and agreements good (+) Consultant engagement in pathway redesign (+) Recent experiences and management of Dermatology services (+) Current referral flows likely to remain until Q1 2015/16 Negative (-) Other services provided could be effected by the outcome of this model

Gaps in assurance	Assurance Level gained: RAG
Contract to be agreed with BICS, undefined staff model (TUPE) and activity undefined	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1)Appropriate pathways to be determined and developed	1)Q4 2014/15

Update by	PB 17/11/14	Date discussed at Board	To be discussed at November Board

Objective 3 - Caring – Ensure patients are cared for and feel cared about

Priority ID and reference	3.B Deliver high quality care around the individual needs of each patient	**Director responsible**	Chief Nurse and Medical Director
		Initial Risk	S3 x L3 = 9
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	3.B.1 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 L4 = 12
		Target risk score	S3 x L2 = 6
		Linked to Risk	1416

Controls in place (to manage the risk)	**Gaps in Control**
1) Workforce KPIs including vacancy rates, turnover and temporary staffing monitored by Workforce subcommittee, Exec Committee and the Board 2) Nursing Recruitment plans developed by DCN and DCM in response to Right Staffing review and monitored through Agency PMO, Workforce subcommittee and divisional team meetings 3) Recruitment process reviewed, KPIs under development to provide assurance 4) Bank workstream developed and bank recruitment in progress to reduce use of agency nursing staff 5) Review of MAST and induction processes to be undertaken to ensure they meet operational requirements 6) Marketing plan in development 7) Weekly PMO focusing on agency usage 8) SASH funded by HEKSS to develop and lead on physician associate training and recruitment for SEC	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 5) Imperfect induction for short notice, short term medical locums 6) Aiming for full recruitment (influenced by HEKSS)

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Ward staffing templates monitored daily by Matrons and escalated to the Divisional Chief Nurses to ensure safe levels to meet patient needs. 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 analysed and will be presented at November Board 7)Daily Nursing review "planned vs actual" 8) References from other local employers 9) Revalidation (GMC) for locums 10) SOP developed for the management of nursing staffing	Positive (+)SNCT data (+)Further recruitment planned has been undertaken Negative (-)Benchmarked high proportion of agency staff usage against other Trust's (-)Vacancy rates and turnover rates

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) Being implemented 3) Embedding and under review

Update by	FA 12/11/14 and DH 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 3 - Caring – Ensure patients are cared for and feel cared about			
Priority ID and reference	3.B Deliver high quality care around the individual needs of each patient	**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	3.B.2 If the Trust does not put into place systems to assess, monitor and evaluate nursing staffing levels there may be negative impact 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) 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 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 9) Matron for workforce recruited	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 and reporting 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 undertaken and for presentation at November Board 7)Increased reporting of positive patient experience in relation to staffing/high quality care and compassion reported 8)Gap analysis against 'Right Staffing' report and current ward staffing levels undertaken 9)Gaps filled by using staff flexibly across the Divisions with bank staff used in priority to agency. 10)Review of maternity staff ratio undertaken 11)Monthly reporting of nursing staffing levels with actions taken to mitigate to Trust Board	Positive (+) CQC Chief Inspector of Hospitals Report (+) Daily ward staffing review (+) Reports regarding reducing vacancy rates, sickness, absence (+) Incident reporting via Datix (+) Patient experience data by ward or unit Negative (-)Benchmarked high proportion of agency staff usage against other Trust's (-)Vacancy rates and turnover rates

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)Implement e-roster upgrade and utilize core functionality (bank and messaging) 2)Implement plans to manage staffing issues in ITU and Theatres			1) March 2015 2) TBA
Update by	FA 12/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 3 - Caring – Ensure patients are cared for and feel cared about

Priority ID and reference	3.D Treat patients and their families with dignity, respect and compassion	**Director responsible**	Chief Nurse / Director of HR
		Initial Risk	S2 x L4 = 8
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	3.D.1 There is a Risk that the Trust may not deliver continuous improvement to patient experience if the wider care and compassion strategy, vision and values are not embedded and sustained with all members of staff.	**Current rating**	S2 x L3 = 6
		Target risk score	S2 x L1 = 2
		Linked to Risk	No specific risk recorded on the operational risk register, 20 risk monitored by the Executive patient experience committee

Controls in place (to manage the risk)	**Gaps in Control**
1) Trust values embedded and disseminated across organization 2) Nursing and Midwifery Strategy implemented including 6 C's 3) Values based recruitment integral to nursing and midwifery recruitment and performance management/appraisal 4) Customer care training undertaken with OPD and ED front line staff 5) YCM and F&FT feedback shared with clinical and non-clinical staff. Actions plans developed in response 6) Work underway to ensure that staff are treated with respect by patients and other staff	1) Evidence of shared learning across divisions and clinical units 2) Standarised appraisal and performance management process 3) Ability to roll out customer care training across organisation
Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Work in progress to develop and roll out GE leadership development including values and organisational development (SASH Plus) 2) YCM and FFT 3) Datix and patient compliments and complaints	Positive (+) CQC Chief Inspector of Hospitals Report (+) Staff survey (+) YCM and FFT score (above average for inpatients) (+)The August FFT score for ED was +81, the highest score to date. Since December 2013, the (+)ED FFT score has been between +75 and +81, well above the National average. (+) The Inpatient score has risen by 2 points this month to +84, the inpatient FFT scores have been between +80 and +84 since March2014. (+) Incident reporting (+) pilot of 8a and above appraisal process incorporating assessment against behaviours Negative (-) Complaints received relating to patient experience (-) FFT response rates variable (-) Appraisal rates recorded

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)Customer care training pilot 2)Evaluate effect of pilot and consider wider role out 3)Role out Behavioral Anchors developed through SASH Plus and embed values in staff appraisal	1)Complete 2)Sep 2014 3)Dec 2014

Update by	SB 12/11/14 and JM 22/09/14	**Date discussed at Board**	To be discussed at November Board

4 - Responsive to people's needs – Become the secondary care provider of choice for the catchment population

Priority ID and reference	4.A.1 Deliver access standards	**Director responsible**	Chief Operating Officer
		Initial Risk	S3 x L4 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	4.A 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 L3 = 9
		Linked to Risk	1220 and 1491

Controls in place (to manage the risk)	**Gaps in Control**
1) EDD Patient Pathway 2) Site management team and 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 8) Additional community beds 9) Extra 10 surgical beds for 3 months (Dec –Feb) to support elective flow and reduced cancellations	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. 7) Whole system operational resilience plans signed off for 14/15	Positive (+) ED Standard delivered 2013/14 and on target for delivery 2014/15 (+) Process improvement (+) No 12 hour breaches (+) Working with partners commissioners / partners to expedite flow through hospital (Medihome and community beds) (+) Top 20 patient delay weekly meetings 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 (-) Adult Bed occupancy remains higher than plan due to increased activity

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) Winter planning 2) Extra 20 bed decant ward decant ward to provide flex capability as and when required	1)Ongoing 2) Due 1st December 2014

Update by	PB 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 4 - Responsive to people's needs – Become the secondary care provider of choice for the catchment population

Priority ID and reference	4.A.2 Deliver access standards	**Director responsible**	Medical Director
		Initial Risk	S3 x L3 = 9
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	4.A.2 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	No specific risk recorded on the operational risk register, 20 risk monitored by the Executive patient experience committee

Controls in place (to manage the risk)	**Gaps in Control**
1) Discharge processes in place, Medical and MDT fit 2) Dr Foster report re-admission monthly (monitored by clinical effectiveness and ECQR) 3) Data review for pathway specific re-admissions 4) Change of some patient episodes to reflect out-patient contact rather than readmission 5) Establish Frailty Service in community staffed with HCE Consultants to reduce need for readmission 6) White board project facilitates agreement and work towards agreed date of discharge.	1) Temporary notes makes clinical coding more difficult , but are reducing in numbers 2) Not all elements of pathway under central oversight

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 4) Joint Audit with Clinical Commissioning Groups 5) Triangulation with other data sets (e.g. VTE)	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 (+) RCA on areas highlighted by Dr Foster Negative (-) Readmission data quality

Gaps in assurance	**Assurance Level gained: RAG**
1)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, discharge to access pilot 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) Tendering at present 5) Underway

Update by	DH 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 4 - Responsive to people's needs – Become the secondary care provider of choice for the catchment population

Priority ID and reference	4.D Develop local services as appropriate at East Surrey Hospital, other Trust sites and in the community	**Director responsible**	Chief Operating Officer
		Initial Risk	S4 x L3 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	4.D There is a risk that the Trust may not realise the benefits of service development opportunities which are fully appropriate for the local community unless partnership working and links between strategic partners are improved	**Current rating**	S4 x L3 = 12
		Target risk score	S4 x L2 = 8
		Linked to Risk	1501, 1270, 1491, 1164, 1332

Controls in place (to manage the risk)	**Gaps in Control**
1) Local Transformation Board 2) 3x3 meetings 3) CEO strategic meetings 4) Partnership boards	1)Length of stay needs to reduce 2)Repatriation of tertiary services effected and influenced by external factors

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Letters of intent 2)Contracts 3)Meeting minutes	Positive (+) Joint working with Royal Surrey County (Chemeo and Radiotherapy) (+) Pathology joint venture BSUH (+) Bowel screening (+) BOC respiratory unit (+) Initial work on repatriating Cardiology Lab (+) Winter beds initiative 2013/14

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)Decant ward 2)Discharge Unit	1)Q4 2014/15 2)Q3 2014/15

Update by	PB 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 4 - Responsive to people's needs – Become the secondary care provider of choice for the catchment population

Priority ID and reference	4.E Develop local services as appropriate at East Surrey Hospital, other Trust sites and in the community	**Director responsible**	Director of Human Resources
		Initial Risk	S3 x L4 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	4.E There is a risk that recruitment and retention strategies are not effective in attracting and retaining staff which will impact on our ability to develop and maintain services.	**Current rating**	S3 x L4 = 12
		Target risk score	S3 x L2 = 6
		Linked to Risk	1580

Controls in place (to manage the risk)	**Gaps in Control**
1) Workforce & OD Strategy with vision to be "Employer of Choice" 2) Key Theme of W&OD Strategy is Recruitment and Retention with key objectives for short, medium and long term 3) Finance and Workforce Committee receives monthly updates on key themes 4)Executive Committee for Quality & Risk through Workforce Sub-group considers workforce metrics and risks. 5)Workforce metrics – turnover and vacancy rate reported at Divisional and Trust level. 6)Specific Nursing Recruitment & Retention workstream Chaired by Chief Nurse reports into Workforce Committee via Deputy Chief Nurse	1) Nature of workforce skills means that "Employer of Choice" must not be restricted to catchment populations of Surrey & Sussex. The Trust must be free to recruit for the skills required as these may not be present in the locality. The benefits of employment on population health and life expectancy mean that the Trust should where appropriate recruit from the locality.

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Performance reports and minutes of committee meetings 2) Progress on Workforce Strategy	Positive (+) Trust vacancy rate (+) Hospital Intelligent Monitoring report for July 2014 – no elevated risks flagged for workforce Negative (-) Trust Turnover rate (-)Draft Hospital Intelligent Monitoring report for Oct 2014 – indicates low risk relating to nursing turnover benchmark

Gaps in assurance	**Assurance Level gained: RAG**
1) Subjective factors in employee motivation and long lead in time mean it is difficult to monitor 'cause and effect" for R&R initiatives 2) Performance reporting is not currently configured to report at Service Line level	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Monthly reporting of metrics 2) Task & finish group with key deliverables	1) Ongoing

Update by	JM 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.A.1 Failure to deliver income plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1601.1645,1491

Controls in place (to manage the risk)	**Gaps in Control**
1) Business Plans and budgets (activity and financial) savings / transformation plans. 2) Signed contracts with both main sets of commissioners (NHSE and CCGs). 3) Contract management process in place - clearer and better structure than last year. 4) Financial reporting, including forecast scenarios presented to Board Please note that the linked SRR risks refer to shortfall in elective income (1601), maternity pathway risk (1645) and (a non –finance risk) the level of emergency demand (1491)	1) A Chief Officer meeting has replaced the LTB but it is still establishing its structures – these are anticipated to be in place soon, but there is a question over the effectiveness of health system forums to manage emergency activity actions 2) No agreement over repayment of withheld marginal rate emergency tariff or completion of activity query process 3) CCG plans make significant assumptions on activity reductions that are not being adjusted by them in response to actual outturn and there is a widening gap between their plan and actuals – this is impacting elective activity as well as driving cost and providing the "wrong" income. 4) NHS England Contract is subject to a potentially wide-ranging contract variation around "national QIPP & national CQUIN" that has not been agreed;

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output and reporting from health system management (e.g.: System Resilience group) 5) Output of Contract Management Process - including the output from Activity Query Notice process.	Positive (+) 2013/14 activity and income met the Plan (+) Reconciliation process working with CCGs at the moment (avoiding delay to disputes) - that continues to be the case at M07 (+) settlement of 13/14 Surrey income dispute, also settlement of first 2014/15 dispute with NHS England. Negative (-) At M07 there continues to be adverse variance against plan in several areas – this includes the maternity pathway, radiology income and elective activity (-) From July to October emergency activity is higher than it has ever been, putting pressure on elective income, costs and providing the "wrong" income. (-) Too much non elective activity, not enough elective.

Gaps in assurance	**Assurance Level gained: Amber**
None as yet, but adverse variances within the actual value of income collected leaves this as amber.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Regular Contract monitoring meetings in place and working – payments being made by CCGs; 2) Ongoing internal review actions operating – income variances being tracked and fed into PMO discussions – specific detail being followed up in adverse areas (e.g.: radiology, maternity) 3) Trust has started action in respect of the 30% marginal rate tariff payment and asking for a contribution from the 70% withheld.	Actions proceeding to timetable – M07 shows delivery of actions in key areas (maternity & radiology – ICU resolved)

Update by	PS 20/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.A.2 Failure to stop divisional overspending against budget	**Current rating**	S5 x L3 = 15
		Target risk score	S3 x L2 = 6
		Linked to Risk	1602

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) Internal Performance Review (PMO) process and CEO review 4) Forecast scenarios presented to Board 5) M06 forecast process sees all Divisions working to clear targets	1) There are some areas in the Trust where variance from budget is significant and reduction of spend is not appropriate – these budgets need to be reviewed (and that will form part of 2015/16 budget setting)

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output in financial reporting describes improvement and risk mitigation. 5) Agency PMO.	Positive (+) Corporate budgets within tolerance. (+) budgets corrected for undeliverable savings and contingency found. (+) M07 variance from forecast OK Negative (-) Emergency activity pressures are greater than expected (-) At M07 all Divisions are overspent (please note comments on control through forecast process, and minimal variance at M07). (-) Overall agency cost remains high. Overall risk for BAF "red" – assurance rating also "red" noting position on overspend action planning.

Gaps in assurance	**Assurance Level gained: Red**
Please note comments above – budgets are overspent, but overspending levels have been agreed (nb: not as final control totals yet) and action is being linked to that work. M07 showed minor variance from expectations. The assurance level remains red, as some of the stretch actions present risk, and one month of expected performance doesn't make a summer.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) PMO/Performance structure continues - augmented by M06 CEO review 2) Controls are being exercised in divisions and centrally (vacancies are passed through Execs, procurement management etc.) 3) Contingency action around emergency and elective activity is now being considered.	Actions proceeding to timetable

Update by	PS 20/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.A.3 Unable to provide realistic medium term financial plan	**Current rating**	S4 x L3 = 12
		Target risk score	S4 x L2 = 8
		Linked to Risk	1603

Controls in place (to manage the risk)	**Gaps in Control**
1) Items referred to in 5.A.1 and 5.A.2 above 2) V3.0 long term financial model and integrated business plan completed (submitted to TDA in February 2014) V4.0 now approaching completion 3) TDA Plan submitted January 2014 4) Timetable for refreshed IBP and LTFM going forward is part of national planning guidance (next iteration due 20 June)	1) Items listed above (5.A.1, and 5.A.2) are applicable here 2) Elements of 2014/15 planning cannot yet be incorporated in Trust financial planning (e.g.: Better Care Fund implications) because of lack of detail. 3) Lack of alignment between CCG activity plans and actual performance. 4) Reliance on centrally determined rules for PbR, Better Care Fund and the wider NHS finance regime.

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 documentation, and delivery against them	Positive (+) Delivery of performance in 2013/14 (+) 4 versions of LTFM submitted – each has 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 proceed with FT timeline after Readiness Review. Negative (-) Performance in 2014/15 provides risk (-) alignment with CCG plans is not clear. There are significant differences between actual performance on activity and CCG plans. (-) Lack of clarity on significant changes from Better Care Fund. Overall, on basis of current assumptions and delivery of LTFM, RAG reduced to amber. Assurance RAG amber.

Gaps in assurance	**Assurance Level gained: Amber**
Revised LTFM (long term financial model) and IBP (Integrated Business Plan) currently being prepared but not yet complete	

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 20/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.A.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	1604

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 2013/14 - temporary borrowing needed in 2013/14, but reasons for that were delays in agreements (CCG and TDA) – temporary borrowing repaid in full by 31 March 2013 (+) 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 5.A.1 and 5.A.2 above. Overall rating “red” noting risk to forecast I&E. 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 20/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 - Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.B We are an organisation that is clinically led and managerially enabled	**Director responsible**	Medical Director
		Initial Risk	S4 x L2 = 8
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.B There is a risk that Clinical leadership efforts will not embed if staff do not feel empowered and supported in order to make positive changes regarding care pathways within specialties and directorates	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	No specific risk recorded on the operational risk register, 14 risk monitored by the Executive patient experience committee

Controls in place (to manage the risk)	**Gaps in Control**
1)JD and appointments to reflect importance of Chiefs and clinical leads 2)Joint work with Clinical leads and Exec Team undertaking the opportunity to work with GE 3)Work of Clinical leaders in many significant projects draws on and underlines the value of clinicians as leaders 4)Implementation of Trial appraisal using “talent mapping” methodology to promote succession planning	1)Variation in priorities of clinical leads 2)Some departments are small with no appropriate interest in clinical management.

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) 1:1 training 2) Board presentations SQC, Prescribing committee 3) HEKSS established dentistry school 4) GMC survey highlights no safety concerns (for the first time) 5) Talent review and achievement review at appraisal 6) Increased interest in clinicians wanting to lead and manage	Positive (+) CQC report and feedback (+) GE updates (+) Increasing buy in from clinical leads to leadership agenda (+) Overall staff survey (+) Deanery reports Negative (-) GMC survey training results , some areas report undermining

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)Ongoing work to embed Clinical Leads in activities to support strategic objectives 2)Delivery of outputs of SASH Plus (Appraisals)	1)Next phase commencing August 2014 2)September 14

Update by	DH 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 - Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.E Have appropriately qualified and competent staff always working to the highest standards of professionalism and ethics	**Director responsible**	Director of Human Resources
		Initial Risk	S3 x L3 = 9
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.E.1 There is a risk that staff do not take up opportunities to participate in developmental programmes which could further impact upon staff development and missed opportunities to improve quality of care	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	1170

Controls in place (to manage the risk)	**Gaps in Control**
1) Personal Development Plans as part of Appraisal identify development needs 2) Training Need's Analysis at Divisional level extrapolated to Trust level inform strategic planning of development priorities. 3) Analysis of education and training activity 4) Make available e learning packages as an alternate to face to face training implement new delivery model on yearly cycle (elearning one year face to face the next) 5) Pilot elearning and roll out across Trust 6) OLM configured to capture locally delivered MAST programmes	1) Reporting of development that is undertaken within Divisions

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) PDP's 2) Training needs analysis update to August 2014 Finance Investment and Workforce Committee 3) Monthly reporting against 10 Core Mandatory Training subjects at Divisional and Trust level at Finance Investment and Workforce Committee through ECQR&CC – Workforce Committee.	Positive (+)Trust utilises HEKSS central funding (+)TNA update to August 2014 Finance Investment and Workforce Committee Negative (-) Bursary funding being restructured under national 'costings' exercise (-) Compliance rates for MAST programme

Gaps in assurance	**Assurance Level gained: RAG**
Reporting of development that is undertaken within Divisions	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Reporting structure in ESR being reconfigured	1) Ongoing

Update by	JM 17/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 - Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.G.2 We are a well governed organisation	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.G.2 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 L1 = 4
		Linked to Risk	1531

Controls in place (to manage the risk)	**Gaps in Control**
1)BGAF assessment carried out and action plan in place 2)Corporate governance framework in place 3)Foundation Trust project board meeting 6 weekly 4) FT Task & Finish Group meeting monthly 5)Timeline agreed with TDA 6)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 completed 2)LTFM agreed by the Board 3)FT Project board 4)FT Project plan 5)Integrated Business Plan 6)Public Consultation completed 7)QGAF External completed with implementation of action plan 8)Speciality deep dives to inform Trust on readiness for assessments 9) TDA Readiness Review completed 10) Chief Inspector of Hospitals Inspection 11) Elections to Shadow Council of Governors due 12) TDA Board to Board 13) Implementation of Board Development Programme	Positive (+) Active FT Project Board (+) Draft IBP submitted to TDA 20.6.04 - updated & submitted 20.10.14 (+) LTFM submitted to TDA – 20.06.14 - updated & submitted 20.10.14 (+) FT membership strategy revised and being implemented – achieved 70% of target (+) External review of BGAF & QGAF undertaken (+) BGAF action plan being implemented - Amber/Green (+) Refresh of QGAF by Deloitte's – complete – score 3.5 action plan in place (+) Readiness Review held with TDA – March 14 (+) FT Timeline agreed with TDA (+) Mock board to board undertaken – Sept 14 (+) Date for Board to Board with TDA confirmed – 20.11.14 (+) Positive outcome of public and staff consultation (+) Patient & Public membership increasing with engagement of MES (+) Governor Awareness Sessions taking place with +70 expressions of interest (+) Engagement of ERS for Governor Election Services – Draft election timetable agreed

Gaps in assurance	**Assurance Level gained: RAG**
Historical Due Diligence yet to be confirmed by TDA	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Membership Strategy implementation with positive increase in membership 3) Re-fresh of QGAF external assessment - score of 3.5. Action plan in place	1) Ongoing 2) Plans are on track

Update by	GFM 13/11/14	**Date discussed at Board**	To be discussed at November Board

Objective 5 – Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.F. Ensure IT support/optimise patient experience by improving patient interface, sharing and capture of patient information and patient communication	**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	5.F. There is a risk that the Trust will not fully realise the benefits available from well embedded IT systems	**Current rating**	S5 x L3 = 15
		Target risk score	S5 x L2 = 10
		Linked to Risk	1605

Controls in place (to manage the risk)	**Gaps in Control**
1) IT Strategy aligned with Clinical Strategy and IBP and reviewed Oct 14 2) Clinical Informatics Group 3) Clinical IT leads 4) EPR User Group now well established 5) Various project group (EPMA etc.) 6) Internal Audit 7) EPR costs identified in LTM 8) CCIO and CNIO roles being implemented – greater clinical buy-in	1) Investment in Infrastructure needs to keep pace with organization requirements 2) Insufficient focus on change benefits realization due to financial constraints 3) Lack of operational involvement in identifying and delivering benefits 4) Insufficient focus on staff training

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
Efficiencies being delivered through IT enabled change	Positive (+) Improving infrastructure (e.g. Wi-Fi) (+) Development of existing EPR platform (e.g. EPMA) (+) EPR Procurement process Negative (-) Major IT transition approaching – 2015 (-) Technical issues resulting in organizational disruption from a recent major IT implementation, has led to concerns over future implementations

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. Procurement of replacement EPR as national contract ending November 2015 - preferred supplier now reached and OBC agreed by Board and TDA 2. Establishment of Clinical Lead IT Role 3. Clinical Cerner User Group now in place with strong leadership 4. Greater focus on IT in Capital Plan for 2014/15 and future years 5. Introduction of Business Continuity System for EPR (7/24)	EPR Contract to be awarded October 2014 – preferred supplier now selected. EPMA go-live November 2014. 724 Go-live November 2014. PC Upgrade plan in-place, funded and commenced. Network review first draft now complete and action plan being prepared.

Update by	IM 12/11/14	**Date discussed at Board**	To be discussed at November Board