Trust Board: Thursday 3 November 2011

TB2011.62

Title	**CQC Compliance review and Action Plan**

Purpose of paper	To update the Board on the current position in respect of compliance with CQC actions through consideration of the updated CQC Action Plan.
Board Lead(s)	Mrs Elaine Strachan-Hall, Chief Nurse

Key purpose	Strategy	**Assurance**	Policy	Performance
Strategic Objectives	All			
Links to Board Assurance Framework/Trust Key Risks/CQC Registration	To maintain compliance with all regulations and outcomes			

Resource and financial impact	N/a
Consideration of legal/ equality /diversity/engagement/risk issues	N/a

CQC Compliance review and Action Plan

Introduction

1. The three reports on the CQC's follow up visit on 18 July 2011 were published on 14 October 2011. As expected, the compliance position was confirmed as below.

Outcome	Outcome Number	JR	Churchill	Horton
Care and welfare of people who use services	4	Minor	Compliant	Minor
Staffing	13	Compliant	Compliant	Compliant
Supporting workers	14	Minor	Minor	Minor
Assessing and monitoring the quality of service provision	16	Minor	Minor	Minor

2. The action plan approved by the Board in February 2011 continues to be implemented and a full update was provided to the Trust Management Executive in October. The action plan prepared following the CQC's Dignity and Nutrition for older people visit (outcomes 1 and 5) has been incorporated so that a single action plan covering all outstanding outcomes requiring improvement action is in place. The national report on these outcomes was published on 13 October 2011. http://www.cqc.org.uk/public/reports-surveys-and-reviews/reviews-and-studies/dignity-and-nutrition-older-people

3. The updated action plan includes the necessary measures highlighted in the October 2011 reports, including the management of patients in escalation beds at the John Radcliffe Hospital, the delivery of targets in relation to discharge, the care of patients with dementia and staff training and resources, stroke care, dissemination of national guidance, sharing of learning and best practices and further improvements in the systems for clinical governance across the Divisions.

4. The actions being taken in response to the improvements sought to outcome 1 (respecting and involving people who use services) and outcome 7 (safeguarding people who use services from abuse) are also included together with the further improvement actions relating to outcome 1 arising from the DANI. Responsible leads have been identified for all actions and outcomes. All the improvement actions required for Outcome 7 have been completed apart from an audit of the implementation of the updated policies 12 months following their implementation.

5. It should be noted that the actions reported as completed to the Board in September have been listed in a schedule at the end of the Action Plan (highlighted in blue from page 10 onwards).

6. The CQC will continue to monitor compliance with all the above outcomes and work continues to ensure compliance across the Trust for all 16 outcomes and to assure the Board on the evidence and information that supports compliance. The inspection regime put in place earlier this year and now functioning as part of normal business is intended to support compliance.

7. The Trust Management Executive will receive regular updates on compliance which will also be reported on through the Divisional Quality Reports considered at each month's Clinical Governance Committee.

8. A full update on the evidence assuring on–going compliance will be provided to the Quality Committee at its December meeting and a further update will be provided to the Board in January 2012.

Recommendation

9. The Trust Board is asked to:

   9.1. note the judgements above and the actions underway to achieve and maintain compliance;

   9.2. to receive the updated action plan.

Mrs Elaine Strachan-Hall
Chief Nurse

COMBINED CQC ACTION PLAN[1] Update 30 September 2011

OUTCOME 1:Respecting and involving people who use services
Improvement actions: a) The Trust should ensure people are kept informed about the management of their care and treatment through the provision of appropriate patient information. b) The Trust should ensure there is good timely communication with a patient when a procedure is delayed or cancelled. c) The Trust should ensure patients and their relatives are always treated with respect. d) The Trust should ensure the Trust's policy to provide single sex accommodation is adhered to.

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due Date	Accountable Director
1.1	• Review the Framework for **Patient and Public Involvement** working with key stakeholders • Identify specific actions for 2011.12 to include review of patient information leaflets and the use of other media to engage and involve patients and the public • Patient and public engagement event to be held to cover items including NOC ORH engagement and Quality Account – are we measuring what matters to patients?	• Framework agreed by Trust Board following approval and sign off of detailed actions by each Division/corporate directorate • Agreed 'suite' of patient information leaflets for production through Patient information Group • Achievement of relevant NHLSA standard for patient information • Quality Account with the right content	Framework for Patient and Public Involvement been has reviewed and will be submitted via the Trust Management Executive to the Board (Quality Committee) for consideration. Progress continues with the development of the agreed 'suite' of patient information and the supporting strategy. Patient Information Group considered work to date at its meeting in September 2011. The Trust was assessed at Level 1 NHSLA standards in early September. The Trust scored 50/50 in the assessment. (Follow up) Patient and Public engagement event being held on 19 October 2011 – to include updates on plans in Quality Account published June 2011 (NOTE event postponed to January 2012)	**Deputy Chief Nurse (MF)**	**30.06.2011** (Stage 1 completed and stage 2 on-going) **30.09.2011** (In progress) **30.09.2011** Completed On-going work	**Chief Nurse**
1.3	Agree the Framework to improve **Patient Experience** and Customer Care identifying key areas for action during 2011 to cover (inter alia): • Maintenance of a strong Patient Services team to include PALs and related areas,	• Framework presented to Trust Board following approval and agreement on detailed actions by each Division/corporate directorate • Regular reporting through Divisions on actions taken to address concerns raised by patients and their families	The Quality Committee considered Patient Experience Framework in June. Work continues and update will be provided to Clinical Governance Committee November 2011 Quarterly review of complaints within Divisions on themes and by directorates Compliance and Quality Assurance process in	**Deputy Chief Nurse (MF)**	**31.07.2011** (stage 1 completed and stage 2 on-going – CGC Nov 2011)	**Chief Nurse** **Director of Clinical Services**

[1] **Actions completed and reported on to the Board in September 2011 have been removed from the Action Plan (schedule at end of document highlighted in blue)**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due Date	Accountable Director
	• ORH complaints service that is robust and that local processes are strengthened to address and resolve issues and learn from the points raised, • Improved working and liaison between clinical teams, patient services, PALS, and patients and their families, • improvements in communications with patients about the course of their care and treatment • strengthened monitoring and reporting systems for delivering privacy and dignity and same sex accommodation	• Complaints service that meets ORH and patients requirements with clear accountability for actions within the Divisions and clinical teams (including communication with patients and their families) • Quarterly review of Divisional and Corporate patient experience plans through TME and performance review process • Assurance reports to Quality Committee on all aspects of patient experience including same sex accommodation	place for all CQC standards The Complaints Review has been completed and plans are in place for the implementation of recommendations Patient experience reports are provided on a regular basis to all Divisions and summaries of these are presented to the Trust Clinical Governance Committee for consideration. Plans under development to review patient experience and how best to use outcomes and ensure follow up of actions within Divisions. (include trial of use of iPads, local patient surveys and questionnaire, productive ward work and procurement of electronic system)			
1.6	Audit the implementation of the frameworks and action plan milestones following 12 months of implementation.	• Report to the Trust Board in line with agreed timetable	This will be taken forward as actions are implemented.	**Deputy Chief Nurse (MF)**	31.03.2012 (In progress)	**Chief Nurse**
Outcome 1: respecting and involving people who use services						
Improvement actions to maintain compliance following DANI review May 2011 • **Ensure that people who use services understand the care, treatment and support choices available to them by making sure that patients and those close to them receive adequate information about their treatment and care needs** • **Ensure people who use services have their privacy, dignity and independence respected by making sure that staff appropriately interacting with patients and respond to patient need in a timely and appropriate manner**						
Action ref.	**Action Required**	**Measurable Deliverable**	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead**	**Due Date**	**Accountable Director**
1.7	• Review the system and process for provision of patient information about treatment and care of emergency medical patients including ward specific information and notice board information • Develop and pilot the introduction of a standard for in-patient information assessment in which every medical patient and /or their next of kin is specifically visited by ward managers within 24 hours of admission to check understanding and information need • Incorporate checks of ward information, and patient information assessments in the programme of internal compliance	• Report on system and process to be presented to clinical governance committee and any changes arising from review to be implemented as soon as possible to a determined time frame. • Standard for information assessment developed and included in nursing standards • Standard implemented across medical wards • Compliance tool amended and reviewed and circulated to all Divisional Directors and Divisional Nurses	Dignity in Care campaign underway on Medical wards with Dignity champions and Red Peg initiatives Matrons Group have finalised template for information to be displayed in ward areas – all wards aware of standards Matrons in process of preparing final posters (through OMI) Inspection regime includes checks as outlined. Compliance tool being updated following comments from Divisional Nurses. Outcomes of inspections reported to Divisions	Deputy Chief Nurse (MF) Supported by Divisional Nurse (Medicine)	30.09.2011 (completed) 30.09.2011 31.10.2011 31.10.2011 30.09.2011 (Completed	**Chief Nurse**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due Date	Accountable Director
	inspections • Monitor compliance from internal compliance inspections and report through quality report	• Compliance with standard reported through to divisional meeting	by Divisional Nurses and summary of inspection visits and findings sent to Chief Nurse for review. Included within the Divisional Reports to the Clinical Governance Committee		and on-going)	
1.8	• Revise and launch revised nursing standards, emphasising the imperative of explaining what is about to happen before providing any aspect of care • Cascade of standards through Professional Nursing structure • Monitor compliance during internal compliance inspections • Strengthen induction process to explicitly cover expectations of standards • All Medical Ward Managers to attend specific Serious about 'Safety and Standards' refresher on Privacy and Dignity	• Copy of revised nursing standard and letter to each ward manager. • Confirmation of cascade & documented discussion from each medical ward/ department meetings • Revised induction process implemented for nursing staff members. • 'Serious about Standards' Programme and attendance record from Refresher session	The standards have been revised, shared with patient panel and matrons' group and will be launched in November with supporting cascade plans (including updates for specific nurse induction) and documentation. Implementation plans to be finalised with Matrons mid-October First of two Serious about Standards sessions delivered in September to ward sisters and charge nurses in EMTA covering all aspects of Outcomes 1 and 5 Attendance record supplied	Deputy Chief Nurse Supported by Divisional Nurses	31.10.2011 (elements completed and work on going) (all bullet points)	**Chief Nurse**
1.9	• As part of the Serious about 'Safety and Standards' refresher programme the practice of responding promptly to call bells will be re-emphasised • Re-launch the nursing standards with specific reference to responding to call bells immediately if nursing staff are not already giving direct care, and special needs are recognised and addressed	• Refresher Programme and attendance • Re-launched standards and evidence of dissemination to each ward • Compliance audits monitored at Divisional level and reported by exception through Quality report to the Board.	Included within work on nursing standards as above. Call bells included in Serious about Standards session above Compliance audits completed in Medicine	Deputy Chief Nurse Supported by Associate Chief Nurse	31.10.2011 (elements completed and work continues) 31.10.2011	**Chief Nurse**

OUTCOME 4: Care and welfare of people who use services

Compliance actions:

a) The Trust should ensure the standards are met for patient waiting times for treatments following referral and for waiting times for cancer treatment.

b) The Trust should ensure there is evidence of the actions being taken to reduce the high numbers of patients waiting to be discharged from hospital and monitor the impact of the delays

c) Standards for radiology turnaround times are met consistently and improvement is maintained.

d) The Trust should ensure best practice stroke care is routinely provided at the Horton General Hospital.

e) The Trust should ensure good bed management at the Horton General Hospital.

f) The Trust should evidence how NICE clinical guidelines are implemented and monitored for their impact on patient outcomes.

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due date	Accountable Director
2.3	• Meet ORH specific requirements of the SHA action plan for Oxfordshire DTOC 2010/11 • Progress discussions to reach agreements on whole system approach	• Actions monitored by DTOC Programme Board • ORH members of Health Liaison Group	NOTE: Action completed and report to Board in previous update		**31.03.2011** (Actions completed but this is a dynamic issue which receives continuous action)	**Director of Clinical Services for ORH element of joint action plan**
2.5	• Continue to implement Horton stroke care action plan already in place	• As outlined in stroke plan being delivered and monitored through Emergency Medicine, Therapies and Ambulatory Division	Progress continues against action plan for Stroke Care at the Horton: consultant available 5 days week as required and training on swallow screening on track. Data on cognitive screening provided. Recruitment for Rehab assistants to support active therapy underway. In house continuing training in place for staff – face to face and on-line. MDT meetings in place. TIA target achieved and audit on carotid imaging underway for completion end November Stroke Nurse coordinator in place to ensure improvements in direct access to acute stroke beds continues and further work underway. Target for at least 90% stay in specialised unit achieved. Operational pressures on site impact on achievement of target in relation to direct admissions although improvements delivered in Q2 (c 70%) and plans in place to ring fence capacity for stroke.	**Divisional Director EMTA** **Divisional Nurse EMTA**	**31.05.2011 (and on-going)**	**Director of Clinical Services**
2.7	• Establish Trust Clinical Audit Committee and use as a forum for debate on implementation of NICE	• Divisions to monitor compliance with implementation of guidance and audits reporting to Clinical Audit Committee	The development of updated clinical audit plan will be completed by Clinical Audit Committee now in place (first meeting held in September	**Associate Medical Director**	**30.09.2011 (completed) (and on-**	**Medical Director**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due date	Accountable Director
	guidance		2011) The Clinical Audit Committee will assume responsibility for continuing to monitor the declarations of full compliance and auditing of NICE guidance in line with NICE compliance procedure. Clinical Risk Management Committee monitoring delivery of actions to ensure full compliance – continued compliance monitored through Clinical Audit Committee Compliance updates included in Board Quality reports and Divisions Quality Reports to Clinical Governance Committee	**Clinical Governance**	**going)**	
2.8	• Report to CQC on actions taken to deliver improvements as outlined in Horton report in relation to placement of patient	• Nursing staff have skills and knowledge to manage the care of all patients on medical wards • Training programme in place to provide knowledge and audit of knowledge levels	Patients cared for on this ward are general medical patients and the staff are recruited on this basis – it is not a specialist ward. Staff have access to education and training opportunities and two staff are undertaking course at OBU on deteriorating patients. Divisional team will address further with the ward to ensure clarity of ward purpose and function	**Divisional Nurse EMTA**	**30.11.011**	**Chief Nurse**
2.9	• Plans to deliver improvements in the identification, placement and care of patients with dementia/mental health disorders of patients on wards at the Horton • Report to CQC on actions taken to deliver improvements as outlined in Horton report (p9)	• Action plan (following National Audit) delivered for both Horton and JR	Plan in place and being completed as timetabled. Regular review through Divisions in all areas including surgery	**Deputy Chief Nurse** **Divisional Nurses**	**31.08.2011 (and on-going)** **As above**	**Chief Nurse**
2.10	• CQC to be informed on plans delivered to ensure sustained improvements in the JR escalation ward • Reorganisation of JR medical unit in place for the provision of facilities for the acutely ill and the less acutely ill	• Facilities (including cleanliness, equipment etc.) are fit for purpose – Matron's regular review (open and closed) • Nursing establishments meet requirements of both acute and post-acute units • Matrons' rounds and inspection regime in place with reporting on outcomes	Action card for the opening of escalation bed in place – plans for clear and swift decision making between operational/ward clinical teams. When escalation beds are not in use, facility to be maintained intact rather than stripped (new equipment available to ensure adequate facility) The medical unit has been reorganised and acutely ill patients are cohorted in a single area. The post-acute unit has been established (36 patients) to ensure provision of appropriate levels of care. A second post-acute unit to be established at the end of October. Nursing establishments reviewed to ensure appropriate skill mix for patient acuity in both	**Divisional Nurse EMTA**	**30.11.011**	**Chief Nurse** **Director of Clinical Services**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead	Due date	Accountable Director
			units.			

OUTCOME 5: Meeting nutritional needs

Improvement actions to maintain compliance following DANI review May 2011

- **Ensure provision of choice of food and drink to people with diverse needs including swallowing difficulty**
- **Ensure that people are supported to have adequate nutrition and hydration by assessment and support to people needing assistance with nutrition and hydration**

Action ref.	Action Required	Measurable Deliverable	Update on progress with actions as at 30th Sept 2011	Responsible Lead/	Due date	Accountable Director
5.1	• Improve reporting and follow up action from existing monitoring system of patients' views on the quality of food (see also 5.5.) • Formally evaluate the quality of the revised provision of pureed meals.	• Feedback on quality of food to be added to quality report received at Quality Committee • Report on soft moist menu provision to be provided to the Clinical Governance Committee including evidence of patient satisfaction scores and dietician acceptance	Ward feedback reports (quarterly across Divisions) on quality of food included in Divisional Quality Reports to Clinical Governance Committee. Contract Management team are preparing a report for submission to November's Clinical Governance Committee to feed back on the dietician's full acceptance of the soft moist meals and the outcome of the patient satisfaction surveys that have been undertaken and the actions that have resulted from the patient feedback to enhance the service.	Deputy Chief Nurse (MF) 31.10.2011	31.10.2011	**Chief Nurse**
5.2	• Review and revise the system of nutritional (and hydration) assessment for all emergency medical admissions including education and training • All clinical staff formally reminded that the assessment of patient's needs must include specific care needs, requirements and preferences which are documented and acted upon. • Monitor and audit that nutritional assessment tools are routinely used in	• Clear guidance on the system and process of nutritional and hydration assessment in emergency medicine drafted, approved and circulated • Dissemination evidence reminding staff of need for individual assessment for each patient • Audits of compliance will be monitored at Divisional level and reported to and remedial actions identified and completed where necessary	Nutrition and hydration assessment included within nursing assessment documentation in Emergency medicine Nursing standards recirculated and individual nurses have 'signed up' – nutrition and hydration specified within standards Nutritional assessments have been a specific focus for recent internal inspections in all areas and particularly emergency medical admissions. Outcomes included in nursing quality metrics	Deputy Chief Nurse (MF) Supported by Divisional Nurses	31.10.2011 (completed and on-going)	**Chief Nurse**

OUTCOME 5: Meeting nutritional needs

Improvement actions to maintain compliance following DANI review May 2011

- **Ensure provision of choice of food and drink to people with diverse needs including swallowing difficulty**
- **Ensure that people are supported to have adequate nutrition and hydration by assessment and support to people needing assistance with nutrition and hydration**

Action ref.	Action Required	Measurable Deliverable	Update on progress with actions as at 30th Sept 2011	Responsible Lead/	Due date	Accountable Director
	practice		reported in Quality Report to the Board			
5.3	• Re-launch the red tray policy and with a strong emphasis on the roles and expectation of each member of staff including the role of Nurse in Charge at mealtimes • Monitor and audit that red tray policy is understood and routinely used in practice	• Re-launched red tray policy detailing roles and responsibilities of each member of staff • Audits of compliance demonstrate improved compliance • Internal compliance inspection reports and local audits discussed at Divisional meetings and remedial action taken where appropriate	Nutrition Group planning the relaunch of red trays and updated policy. Models for good practice have been identified locally from internal inspections Stroke Ward at JR has undertaken multidisciplinary assessment which has led to changes, e.g. the type of cups for patients to use	Deputy Chief Nurse **(MF)** Supported by Divisional Nurses	31.10.2011 30.09.2011 (part complete and work on-going)	**Chief Nurse**
5.4	• Review the protected mealtimes policy and clarify the role and expectation of each member of staff • Monitor and audit that protected mealtime s policy is adhered to routinely used in practice • Raise multi-professional awareness of protected mealtimes across the Trust	• Policy on protected mealtimes in emergency medicine reviewed, approved and circulated • Audits of compliance discussed at Divisional meetings and reported by exception through to quality report. • Meeting notes evidence that protected mealtimes have been discussed and any specific actions recorded	Protected meal time policy under review by Nutrition Group (see 1.8 above) Patient safety week campaign – focus on nurse support for patients. Included in Divisions Quality Reports to Clinical Governance Committee	Deputy Chief Nurse (MF)	31.10.2011	**Chief Nurse**
5.5	• All Medical Ward Managers participate in specific Serious about 'Safety and Standards' refresher on Nutrition and Hydration	• Programme developed and attendance recorded, individual actions identified where necessary and evidenced	Serious about Standards session delivered covering all aspects of Outcomes 1 and 5 to ward sisters and charge nurses in EMTA (see also	Deputy Chief Nurse (MF) Supported by Divisional Nurse (Medicine)	30.09.2011 (Completed)	**Chief Nurse**

OUTCOME 7: Safeguarding people who use services from abuse
Improvement actions: **a) The Trust should ensure staff are aware of how to identify and respond to safeguarding concerns by undertaking the relevant training.** **b) The Trust should ensure relevant safeguarding policies are reviewed and updated accordingly.**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible lead	Due date	Accountable Director
3.3	Audit the implementation of the revised policies following 12 months of implementation.	Annual report to include audit of policy compliance - the report will be presented to the Clinical Governance Committee (Divisions to contribute audits from their areas)	Audit will be undertaken after 12 months of implementation.	Associate Chief Nurse	within 12 months of implementation.	**Chief Nurse**

OUTCOME 14: Supporting workers
Compliance actions: **a) The Trust should ensure staff are competent to deliver care and treatment to people in the service because their learning and development needs have been met.** **b) The Trust should ensure staff have access to supervision that meets both their needs and the needs of the people who use the service.** **c) The Trust should ensure all staff receive an annual appraisal.**

Action ref.	Action Required	Measurable Deliverable (outcome)	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead(s)**	Due date	**Accountable Director**
5.1	• Ensure consistent and comprehensive systems are in place to ensure the recording and collation of a) data on statutory, mandatory and other training requirements and b) to support appraisal and the development of pdps • (see also actions for outcome 7 above)	• Agreed system in place for all areas with effective reports that support review and performance management	ORH has completed a comprehensive review of statutory and mandatory training. This has resulted in changes to the way training requirements are defined, delivered and recorded. An action plan is in place. Divisions have enhanced local systems for recording appraisals. These are being supplemented with central recording on the Electronic Staff Record (ESR)	**Deputy Chief Nurse (CC)**	**31.07.2011** (completed and on-going)	**Chief Nurse** **Director of Workforce**

Action ref.	Action Required	Measurable Deliverable (outcome)	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead(s)**	Due date	**Accountable Director**
5.5	• Review the supervision processes in place for clinical staff groups through annual appraisal and PDP process	• As above and ensure linked to revalidation process for medical staff. • Report to Quality Committee (through TME Committee structure) on supervision, mentoring, appraisals and performance	The Trust has launched a Modernising Nursing Careers programme which incorporates standardising knowledge, skills and competency framework with core portfolios which will support the development of a Trust-wide standard and guidelines for supervision of roles. Appraisal data are reported to TME and Quality Committee on a regular basis and included in quarterly Workforce Report to Trust Board.	**Deputy Chief Nurse (CC)**	**30.09.2011** (In progress)	**Chief Nurse Medical Director**
			Organisational revalidation self-assessment completed and lodged. Medical Revalidation Implementation Group established reporting to Workforce Committee. Full review and refresh of appraisal policies and procedures, and training and support for appraisers underway.	**Deputy Medical Director**	**30.11.2011 (for next update)**	

OUTCOME 16:Assessing and monitoring the quality of service provision

Compliance actions:

a) The Trust should continue to embed the new clinical governance systems and ensure appropriate assurance systems are in place.

b) The Trust should ensure there is a systematic process in place to demonstrate how actions are implemented, followed up and their impact monitored at key meetings.

Action ref.	**Action Required**	**Measurable Deliverable (outcome)**	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead**	**Due date**	**Accountable Director**
6.4	Ensure all divisions have same effective systems are in place to address all issues e.g. on complaints, incidents, patient feedback, SIRIs etc.	• Divisional Quality Reports are signed off by Clinical Governance Committee as having reached the required standards • Quality Committee received updates on progress through the minutes and in contents of Quality Reports to Committee and the Board	Divisional reports continue to improve and to ensure coverage of all required aspects Attention being paid to ensure minuting of learning and requirements for sharing of learning – divisions to review their minutes and reports	**Associate Medical Director Clinical Governance**	30.11.2011	**Medical Director**
6.5	Plans to be put in place for the delivery of VTE assessment rates across all divisions	• Audit shows required levels for VTE assessment have been reached	Real time data in relation to VTE risk assessment are now available electronically from trust level through to the individual consultant of admission. Additional ward-based spot checks are carried out to raise the profile of VTE and facilitate improvement at the ward level. Performance has improved from below 50% to approximately 80% and remains on an upwards trajectory.	**Associate Medical Director Clinical Governance**	31.01.2012	**Director of Clinical Services**

Schedule of completed actions removed from CQC Action Plan at 30 September 2011

OUTCOME 1:Respecting and involving people who use services						
Improvement actions: a) The Trust should ensure people are kept informed about the management of their care and treatment through the provision of appropriate patient information. b) The Trust should ensure there is good timely communication with a patient when a procedure is delayed or cancelled. c) The Trust should ensure patients and their relatives are always treated with respect. d) The Trust should ensure the Trust's policy to provide single sex accommodation is adhered to.						
Action ref.	**Action Required**	**Measurable Deliverable (outcome)**	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead(s)**	**Due date**	**Accountable Director**
1.1	Patient and public engagement event to be held to cover items including NOC ORH engagement and Quality Account – are we measuring what matters to patients?	• Quality Account with the right content	The Trust Quality Accounts 2010/11 are published on 30th June 2011. The new Quality Accounts were developed by engaging with patients and public at a dedicated event on 11th April 2011. At the event the Trust invited attendees to comment on the issues that mattered to them. This feedback was collated into specific themes which in turn informed the development of the Quality Account priorities for 2011/12 which are reflected in the published document. NOTE: Follow up event being planned for 19 October 2011	**Deputy Chief Nurse**	**30.06.2011 (Completed)**	**Chief Nurse**
1.2	Review and update **stakeholder** lists each quarter	• Updated lists maintained by Communications and Media Team	The Trust has now implemented a structured process for reviewing and updating the lists of key stakeholders. The process involves monthly review which is maintained by the Communications & Media.	**Interim director of communic'ns**	**31.03.2011** **(Completed)**	**Director of Planning and Information**
1.4	• Follow up all incidents relating to delays in communication following or prior to delay or cancellation of procedure • Make sure that procedures are fit for purpose and that all such incidents are dealt with in a timely fashion	• Reduction in the number of reports (through PALS, patient questionnaires etc.) regarding communications of this nature • Regular monitoring through Divisional Reports to CGC and the Quality Report to the Board	The Trust continues to monitor incidents relating to communication about delays and cancellations. This analysis is monitored by the Incidents, Comments and Complaints Group. Incident reporting and management policy/procedures are currently being reviewed to assess their continued fitness for purpose.	**Deputy Chief Nurse**	**30.04.2011** On-going work with regular review	**Director of Clinical Services**
1.5	• Refresh senior clinicians feedback and reporting mechanisms – e.g. Matrons' rounds – to pick up comments and patient and relatives' feedback • Identify audit mechanisms to review trends and actions taken	• Regular discussion on patient experience on divisional and directorate team meetings • Inclusion in Matrons' reports • Themes and actions to be reported in divisional reports to CGC and Quality	All directorate meetings now feature a specific agenda item addressing feedback on patient experience. All matrons provide a report to directorate meetings on a monthly basis identifying areas of good practice and areas for improvement.	**Divisional Nurses and Divisional Directors**	**30.06.2011** **(completed)**	**Chief Nurse** **Director of Clinical Services**

		Committee				

OUTCOME 4: Care and welfare of people who use services

Compliance actions:

a) The Trust should ensure the standards are met for patient waiting times for treatments following referral and for waiting times for cancer treatment.

b) The Trust should ensure there is evidence of the actions being taken to reduce the high numbers of patients waiting to be discharged from hospital and monitor the impact of the delays

c) Standards for radiology turnaround times are met consistently and improvement is maintained.

d) The Trust should ensure best practice stroke care is routinely provided at the Horton General Hospital.

e) The Trust should ensure good bed management at the Horton General Hospital.

f) The Trust should evidence how NICE clinical guidelines are implemented and monitored for their impact on patient outcomes.

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
2.1	Progress agreed 18 week admitted plan	Target achieved by the required date	The Trust agreed a revised delivery plan with the Strategic Health Authority and PCT to support the Trust in achieving the required targets. This approved plan required the Trust to achieve specific targets by the end of Q1 2011/12. At the end of May 2011, 5 out of 6 targets of the complete set of 18 week targets were achieved with a plan in place to deliver the remaining target. The final data for Q1 is currently being validated. To support the continued achievement of the targets, The Trust implemented a process for bi-monthly performance review meetings with clinical divisions. Monthly operational performance reports are presented to the Trust Management Executive and Trust Board.		**30.06.2011 (completed)**	**Director of Clinical Services**
2.2	Progress the cancer action plan including tumour site specific action plans for colorectal, urology and gynaecology.	• **Achievement of 62 day and 2 week wait Trust performance across all specialties by March 2011 and on an on-going basis.** • **Routine reporting at Cancer Performance Board and discussion at TME** • **Achievement of radiotherapy standard from 1 June 2011**	The Trust agreed a revised delivery plan with the Strategic Health Authority and PCT to support the Trust in achieving the required targets. This approved plan required the Trust to achieve specific targets by the end of Q1 2011/12. The Trust is on target for achieving these plans by the end of Q1. The final data is currently being validated. To support the continued achievement of the targets, the Trust implemented an additional Cancer Performance Board to review cancer specific performance on a bimonthly basis.		**30.06.2011 (completed)** **30.06.2011 (Completed)**	**Director of Clinical Services**

			Monthly operational performance reports include cancer targets which are presented to the Trust Management Executive and Trust Board. Plans are in place to deliver the required performance against the radiotherapy standards. The final data is currently being validated. Draft data for May 2011 indicates that all 6 targets will potentially have been achieved.			
2.3	• Meet ORH specific requirements of the SHA action plan for Oxfordshire DTOC 2010/11 • Progress discussions to reach agreements on whole system approach	• Actions monitored by DTOC Programme Board • ORH members of Health Liaison Group	Regular discussions take place with PCT and Social Services to facilitate timely and appropriate discharge and unblock delayed discharge problems. Monthly operational performance reports include a specific reporting section for DTOC performance. These reports are presented to the Trust Management Executive and Trust Board. On a health economy level, ORH continues to participate in the systems-wide Chief Executives' DTOC Programme Board and others such as Planned Care Programme Board, Older People & Physical Disabilities Programme Board. These are undertaken with PCT and Social Services colleagues.		**31.03.2011** (Actions from this plan have been completed but this is a dynamic issue which receives continuous action.)	**Director of Clinical Services for ORH element of joint action plan**
2.4	• Monitor delivery of the action plan for radiology reporting turnaround times.	• 95% of all GP plain film and speciality imaging procedures are reported within 5 days (routine) and 48 hours (urgent) of the examination being performed	The Trust has consistently achieved the turnaround times for radiology reporting for February, March, April and May 2011. Feedback from GPs has been positive. Performance monitoring takes place on a daily and weekly basis with escalation if any issues with achieving deadlines could occur. Performance is also reported monthly to the Critical Care, Theatres, Diagnostics and Pharmacy (CCTDP) Divisional Board. Performance is reported externally in accordance with the Commissioner schedule 3.4.	**Divisional Director CCDP**	**30.04.2011** (Completed)	**Director of Clinical Services**
2.6	• Review bed management at Horton so that patients can be placed appropriately whilst flexibility is maintained	• Agreed improvements to operational management at the Horton	A review of operational management at the Horton by Horton Director and members of Operational management team was completed early 2011. Senior Operational Manager appointed to manage and lead HGH-based team	**Deputy Director of Operations and Service**	**31.05.2011 (completed)**	**Director of Clinical Services**

			in May 2011. Daily bed management meetings are held at HGH to review 24 hours going forward taking account of available capacity, electives planned, ED position, outliers, the appropriate placement of patients (i.e. to manage SSA and HCAI), the patients needing repatriation from Oxford following procedure/investigation, etc. Team meetings are held which include Senior Ops Manager, Surgical Ops Manager, Matron and ward sisters as available. Outcomes of meetings are logged and emails exchanged with JR Ops team as required. The Horton Director acts as the escalation point for problems to be resolved by liaison with ops team in Oxford – e.g. any potential impact on elective admissions from emergency pressures or management of breaches.	**Improvement**		
2.7	• Widen programme for the audit of implemented NICE guidance and improve compliance rates • Facilitation working in support of guidance that requires cross-directorate cooperation. • Action plans to be put in place for areas not routinely audited their compliance	• Clinical Audit Committee established reporting to CGC • Audit Section in 2010/2011 Quality Account now in preparation • Presentation of Trust Clinical Audit Plan to CGC through the Clinical Audit Committee • Divisions to monitor compliance with implementation of guidance and audits reporting to Clinical Audit Committee	The Trust has approved a Terms of Reference to establish a new Clinical Audit Committee as a sub-committee of the Trust Clinical Governance Committee. The Clinical Audit Committee will be chaired by the newly appointed Associate Medical Director for Clinical Governance. The clinical audit component of the Trust's Quality Account has been developed and included in the published Quality Account on 30th June 2011.		**30.04.2011** (completed) **30.06.2011 (completed)**	**Medical Director**

OUTCOME 7: Safeguarding people who use services from abuse						
Improvement actions: **a) The Trust should ensure staff are aware of how to identify and respond to safeguarding concerns by undertaking the relevant training.** **b) The Trust should ensure relevant safeguarding policies are reviewed and updated accordingly.**						
Action ref.	**Action Required**	**Measurable Deliverable (outcome)**	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead(s)**	**Due date**	**Accountable Director**
3.1	• Review current training provision for Adult and Children's Safeguarding Training following Safe From Harm week and provide any additional training required • Review electronic training opportunities and if feasible pilot and	• Training programme on safeguarding reviewed and any changes needed implemented. • Programme of Level 2 multi-agency training Level 2 • Achievement of revised trajectory to March 2011 and production of trajectory	**The training programme was reviewed using a gap analysis against the three year plan for statutory & mandatory training.** The review identified the need for some additional training capacity which is now implemented. A new Education and Training committee was established as a formal sub-committee of the Trust Management Executive with terms of	Associate Chief Nurse	31.04.2011 (Completed)	**Chief Nurse**

	roll out by end of 2011 • Review all aspects of statutory and mandatory training through Education and Training Committee	for 2011/12 following detailed review • Education and Training Committee in place • Improved electronic access to training packages by end 2011	reference agreed by the TME. Work is on-going to continue to improve access by providing simple access guides for staff.			
3.2	Review and update the following Trust policies: Adult Safeguarding Policy, ORH Local Arrangements for Child Protection and Safe Restraint of Adult Patients.	• Revised policies approved by the appropriate body and implemented • Follow up of impact of policies and procedures post implementation	All three policies have been reviewed and updated. Work will be undertaken to monitor impact post implementation.	Associate Chief Nurse	31.03.2011 **(Completed)**	**Chief Nurse**

OUTCOME 13: Staffing
Compliance action: The Trust must ensure that there are sufficient staff numbers and types of staff working across the Trust at all times to meet the needs of the people who use the service.

Action ref.	**Action Required**	**Measurable Deliverable (outcome)**	**Update on progress with actions as at 30th Sept 2011**	**Responsible Lead(s)**	**Due date**	**Accountable Director**
4.1	• A workforce plan linked to budgets for 2011.12 and local delivery plan and quality and safety requirements to be developed and agreed. • Agree the metrics to be used to monitor the scope available for managers to ensure staffing levels meet requirements – balance between establishment and temporary staff use to be determined (see also below)	• Financial plan including workforce plans in place agreed by the Trust Board • Agreed metrics in place for workforce management and authorisation for use of temporary staff	Following the implementation of a new organisational structure in November 2010, comprehensive workforce planning has been completed. Work is on-going to align financial and workforce plans. These plans are approval at Divisional Boards, and scrutinised within the context of the performance management meetings with the Executive Directors. Agreed metrics are in place for workforce management. These are reviewed at Divisional Board meetings and a range of Trust committees including Workforce Committee, Trust Management Executive and Trust Board. The Trust has implemented strict controls for the authorisation and use of temporary staff. Metrics have been implemented to monitor temporary staff usage.	Deputy Chief Nurse	30.04.2011 (Completed)	**Director of Clinical Services and individual Executive Directors**
4.2	• Review monthly available staffing numbers at divisional level with associated action plans via dashboards • Identify and agree revised skill mix for nursing workforce at ward and department level (including escalation areas) and display in staff areas as part of the agreed workforce plans • Monitor workforce including temporary workforce against agreed workforce	• Twice-monthly reports to TME with agreed actions to address exceptions through escalation processes • Nursing establishment can be monitored and tracked through Roster Central which presents historical data pictorially to show trends • Monthly reports to Workforce and Performance Committees highlighting actions taken to resolve staffing	During the period October 2010 to March 2011, weekly workforce numbers were reviewed by Trust Management Executive. This data identified staffing levels at both directorate and divisional level and tracked the use of substantive and temporary staff. Following the development and implementation of new divisional workforce plans at the end of April 2011, the review of this data and agreement of appropriate actions	**Deputy chief Nurse**	**30.04.2011** **(action plan completed but monitoring is on-going)**	**Chief Nurse Medical Director** **Director of Clinical Services**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
	plan levels • Provide clear and universally understood escalation processes to identify and mitigate risk where shortfalls occur.	shortages and meet workforce plans • Reports to each TME meeting • Reports contribute to Quality Reports for the Trust Board and Quality Committee	now takes place at Divisional Boards and in the context of the performance meetings with Executives and Divisional Teams. Performance against workforce plans is also reviewed by the Workforce Committee and Trust Board. Nurse staffing establishments and skill mix have been reviewed. Staff numbers and grade of staff have been considered on a 'shift by shift' basis. This process has been facilitated by the on-going implementation of electronic rostering referred to as Roster Central. In additional to the overall workforce reports, specific information about nursing levels, based on the 'safer care matrix', is reviewed at the Quality Committee and at Trust Board. The Trust plans to implement a new tool to monitor nurse staffing levels across the organisation from July 2011. This tool, in addition to providing live information about the current and predicted nurse staffing levels, will act as risk assessment framework. Information from this will be incorporated into the quality scorecard from August 2011 onwards. Clear escalation processes are in place and are managed within Divisions by the Divisional Nurse. Where escalation requires nursing staff flexing to work across Divisions the daily operational management meetings are used as the forum for identifying and allocating staff to escalation areas.			
4.3	• Review current bank, agency and locum staff usage and ensure fast redeployment where possible and recruitment where necessary • Reduce bank and agency demand to enable better fill rates and greater continuity of staff	• Levels of available staff addressed monthly • Monthly meeting with NHSP to identify and address usage	A system is in place to manage use of agency, locum and NHSP staff ensuring effective use of resources. Monthly meeting takes place with NHSP to review and address usage.	Deputy Chief Nurse	31.05.2011 (Completed)	**Director of Clinical Services** **Chief Nurse**
4.4	• Continue to recruit to or redeploy to Band 5 and Band 2 nursing vacancies across all areas in line with agreed workforce plans	Vacancy levels reducing and reductions in turnover and sickness absence	On-going recruitment of band 2 and Band 5 nurses and planned redeployment is underway through the Divisions in line with agreed workforce plans. Review systems are in place.	Deputy Chief Nurse	Completed but monitoring on-going	**Director of Clinical Services**
4.5	• Train divisional nurses and matrons on e-rostering to enable use of 'roster central' to move staff from area to	Implementation across all areas with regular reporting	Training programme completed.	Deputy Chief Nurse	30.04.2011 (Completed)	**Chief Nurse**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
	area to safeguard quality and address risk.					
4.6	• Implement revised HR policies including absence management, appraisals and performance, to support accountability of managers • Provide training on use of policies and procedures and on the development of key metrics – e.g. sickness absence	• Divisional data - report to Board • Workforce report to workforce committee will include overall vacancy and recruitment levels by staff group and division • Improvements seen in sickness absence rates and appraisal rates	Revised HR Policies have been developed and implemented following consultation with unions and agreement at Workforce Committee and Trust Management Executive meetings. Training in respect of new policies has been provided to Divisional teams via HR staff and materials are available for additional and refresher training. Monitoring of sickness absence and appraisal rates, within a broader workforce metrics report are in place with regular reports to Divisional Boards, Workforce Committee and Trust Board. Sick absence levels are sustained (at below Trust and SHA target) and appraisal rates improved during the period.	Deputy Chief Nurse	31.03.2011 (Completed)	**Director of Human Resources**
4.7	• Develop system for review of medical staffing requirements for obstetrics • Trust Management Executive to agreed terms of reference for Maternity services review and other service reviews as agreed (e.g. surgical and trauma services at the HGH)	• Staffing levels agreed for maternity services together with implementation plan • Plans agreed for review of other clinical services by TME	Terms of reference for maternity review agreed and action plan being finalised following external review of obstetric outcomes A discussion paper with proposals for increased resources was presented to TME and Trust Board in June. It was agreed to invest in additional consultant medical staff support and to support the plans to achieve NHSLA Level 2.	Deputy Chief Nurse	30.06.2011 (Completed)	**Director of Clinical Services**

OUTCOME 14: Supporting workers

Compliance actions:

a) The Trust should ensure staff are competent to deliver care and treatment to people in the service because their learning and development needs have been met.

b) The Trust should ensure staff have access to supervision that meets both their needs and the needs of the people who use the service.

c) The Trust should ensure all staff receive an annual appraisal.

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
5.2	• Development and agreement of clear and prioritised plan for training and education for 2011.2012 (to include trajectory of delivery of agreed statutory and mandatory training)	• Regular reports provided by Divisions and Directorates on agreed actions to appropriate Committees • Quarterly reports to Education and	Clear prioritised plan and trajectory for Statutory and Mandatory training has been agreed and implemented. Performance against plan is reviewed at Trust Management Executive, Workforce Committee	**Deputy Chief Nurse**	**31.07.2011** (completed)	**Chief Nurse** **Medical Director**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
	• Agreed monitoring mechanisms for delivery of agreed plans through Education and Training Committee, Performance Committee and Workforce Committee	Training Committee • Twice-yearly reports to Quality Committee	and in the context of performance meetings between the Divisional teams and Executives. Regular reports will be provided to the new Education and Training Committee and will be reported to Quality Committee on a twice yearly basis.			
5.3	• Develop and implement a formal clinical supervision and mentorship policy for all new consultant staff. • Implement the revised consultant recruitment process that includes the requirement to confirm mentorship arrangements as part of the appointment process. • Ensure feedback on delivery of agreed appointment conditions Develop monthly mandatory study day programme for consultants to be delivered in support of induction	• Approved arrangements for the allocation of mentors for all new consultants in place and reported on • Approved arrangements for the delivery of agreed appointment conditions in place and reported on	A new Trust policy was agreed by Trust Board. Mentors are allocated as part of the revised consultant appointment process and induction programme. Personal development programmes put in place as required. Induction programmes are in place and are personalised as appropriate. The first detailed report was presented to the Trust Board in February 2011 and further reports are continuing for each public Trust Board meeting	**Deputy Chief Nurse**	**31.07.2011** (Completed)	**Medical Director**
5.4	• Review suitability and fitness of current mentoring arrangements and procedures for other health professional groups including nurses, midwives, AHPs and healthcare scientists and identify gaps	• Approved arrangements in place for clinical staff with agreed monitoring. Performance review processes linked to individual appraisal	Clear mentoring arrangements are in place for student nurses, allied health professionals and clinical scientists, aligned to national standards. A register of qualified mentors is in place and reviewed jointly by Oxford Brookes University (OBU) and the Trust. The outcome of the mentoring process is also reviewed jointly by OBU and the Trust. Performance of mentors is picked up as part of the review with OBU and linked, where appropriate, to individual appraisal.	**Deputy Chief Nurse**	**31.07.2011** (Completed)	**Chief Nurse**
5.6	• Ensure that sufficient consultant appraisers are available to meet the demands, particularly in delivering to agreed numbers by end of financial year. • All staff to receive annual appraisal	• Sufficient appraisers in place to ensure 100% appraisal of consultant body to support ORH and revalidation requirements • Circulation requirements for annual appraisals	Additional training capacity has been provided to ensure the Trust has adequate levels of trained appraisers to support the revalidation process. Guidance has been developed and circulated to consultants detailing the requirements for annual appraisals.	**Deputy Chief Nurse**	**31.07.2011 (completed but training continues)**	**Medical Director** **Director of Workforce** **Director of Clinical Services**
5.7	• Review outcome of annual CQC staff survey (due March 2011) and agreed programme to address areas of concern as integral part of staff engagement programme	• Programme approved by the Board • Staff engagement programme in place and impact reviewed	Review of CQC staff survey completed and priorities for Staff Engagement Programme to address areas of concern agreed in March 2011 at Workforce Committee and Trust Board. Clear ownership of actions signed off at Divisional Boards.	**Deputy Chief Nurse**	30.06.2011 (Completed)	**Director of Workforce**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
			More detailed Staff Engagement Programme developed and agreed with Trust Board in June 2011 and will be subject to six monthly reviews.			
5.8	• Finalise approval of Raising Concerns policy	• Agreed policy endorsed by the Trust Board with formal launch attended by Board members	The Raising Concerns Policy was approved by the Trust Board at its meeting in April and launched with comprehensive communication throughout Trust.	Deputy Director of Workforce	30.05.2011 (Completed)	**Director of Workforce**

OUTCOME 16:Assessing and monitoring the quality of service provision

Compliance actions:

a) The Trust should continue to embed the new clinical governance systems and ensure appropriate assurance systems are in place.

b) The Trust should ensure there is a systematic process in place to demonstrate how actions are implemented, followed up and their impact monitored at key meetings.

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
6.1	Board to finalise arrangements for governance and assurance structures, including those for clinical governance	• Committee structure in place with agreed terms of reference • Terms of reference reviewed in line with Board requirements • Assurance arrangements in place (see below)	At the November 2010 Board meeting, the Trust Board formally agreed revised Terms of Reference (TORS) for the Trust Board, Board-in-Committee, Quality Committee and Audit & Finance Committee. These new TORs were implemented in January 2011 with a forward schedule of dates agreed for 2011 and 2012. In February 2011, revised Terms of Reference were approved for the Trust Management Executive (TME) and its associated sub-committees. These revised TORS were implemented for TME and its sub-committees by 30th April 2011. A new Clinical Governance Committee was established as a sub-committee of the TME (and replaced the previous Care Quality Board). It meets monthly with a comprehensive membership consisting of senior clinical and managerial staff from clinical divisions and specialist corporate areas.	**Associate Medical Director clinical Governance**	**30.04.2011** (Completed)	**Medical Director**
6.2	Divisional clinical governance arrangements to be finalised with reporting mechanisms in place to TME and to the	• Guidance for Divisional Report content for Clinical Governance committee	Clinical Divisions were provided with advice on content for their Clinical Governance Reports. Whilst supporting each division to develop their		30.04.2011 (Completed)	**Medical Director**

Action ref.	Action Required	Measurable Deliverable (outcome)	Update on progress with actions as at 30th Sept 2011	Responsible Lead(s)	Due date	Accountable Director
	Board (through CGC and QC).	issued to Divisional Directors to include all aspects of safety, quality and risk • Divisional Quality Reports regularly presented to Clinical Governance Committee with assurance then provided to the Quality Committee. • Process in place for the monitoring of the delivery of agreed actions (from clinical teams	specific approach, a template format was promoted to reflect the CQC standards and outcomes. Reports from Divisions were presented to the Trust Clinical Governance Committee in April and May 2011. A new process for monitoring performance has been agreed and implemented in Quarter 1 of Year 2011/12. New integrated performance reports are being developed to reflect a full range of measures for Quality, Finance, Workforce and Activity. These reports are monitored via the new Performance Compact meetings held on a quarterly basis with Divisional Teams and Executive Directors. Management issues arising from these performance meetings will be reported to TME. Assurance on compliance and outcomes will be provided to the Quality Committee.			
6.3	• Development of clinical governance systems to be aligned with development of assurance strategy and systems, with particular reference to risk management systems and processes • Assurance systems, processes and strategy to support evidence of outcomes	• Assurance strategy in place which defines the processes in place across the ORH • Strategy provides clear risk management strategy and actions required from all areas (in line with NHSLA requirements) • Clear links to clinical governance systems • Compliance monitoring system in place with regular reports providing evidence of compliance and/or appropriate actions • CGC and QC receiving reports from Divisions and directorates (including corporate directorates) to evidence compliance	At a meeting of the Quality Committee on 21st June 2011, the Committee reviewed the appropriateness of this action and agreed that the development of an Assurance Strategy was a long term objective. It was decided that this action would be removed from the overall action plan until a later date. However progress has been made with the development of proposals to strengthen the systems for monitoring compliance. The Trust has procured the Allocate software system to support the development of assurance processes and implementation is underway as at 30th June 2011. The actions relating to the development of Divisional reports on CQC compliance and outcomes were achieved in April and May 2011.		**31.07.2011** Partially deferred in relation to Assurance Strategy but otherwise actions completed.	**Medical Director** **Director of Assurance**