

Trust Board meeting 20 November 2008

TB2008.84

Subject	Annual Health Check			
Purpose of paper	<p>The Board is required to declare compliance on core standards each year and to meet a number of national indicators. In order to assure itself on its compliance and performance regular reports are prepared for its consideration.</p> <p>To give the current compliance/performance with all elements of the Annual Health Check - core standards, indicators (formerly existing and new national targets) and quality of financial management (formerly Use of Resources).</p>			
Board Lead(s)	Mrs Elaine Strachan-Hall, Director of Nursing & Clinical Leadership			
Background papers (if any)	<p>Annex A - ORH Performance report on 08/09 Annual Health Check (included)</p> <p>ALE Key lines of enquiry for 2008/09</p>			
Action/decision required	The Trust Board to review and note the current position and the actions underway to ensure the ORH receives a score of excellent for quality for the second year running and improves its position on the quality of financial management			
Key purpose	Strategy	<u>Assurance</u>	Policy	Performance
Strategic Goal(s)	<p>To be Hospitals of Choice (SG1)</p> <p>To be world-leading teaching hospitals and an AHSC (SG2)</p> <p>To achieve financial sustainability and long-term growth (SG3)</p> <p>To be an excellent employer (SG4)</p>			
Strategic Objective(s)	<p>All but specifically:</p> <p>SO2 - To provide high quality, efficient and innovative core services that meet the needs of local patients and the challenges of the local health community.</p> <p>SO6 - To provide demonstrably excellent clinical</p>			

	<p>outcomes and indicators of patient safety</p> <p>SO7 - To improve the overall patient experience by offering excellent customer care.</p> <p>SO10 - To become a strategic, high performing and agile organisation supported by efficient and patient focused clinical processes, modern systems and business processes.</p>
Links to: Board Assurance Framework/ Trust Key Risks/Annual Health Check element(s)	Yes - core standards are mapped to BAF and failure to sustain and/or improve current performance is included in Trust Key Risks
Also considered by	Executive Board members
Resource and financial impact	Not applicable
Consideration of legal/equality/diversity/engagement issues	Compliance with core standards covers all these areas; in addition, ALE domain value for money highlights engagement and equality and diversity issues
Acronyms and abbreviations used	BAF - Board Assurance Framework ALE - Audit Local Evaluation

Annual Health Check (AHC)

1. The ORH received a score of excellence for quality (the highest score) and a score of fair for the use of resources in the annual health check for 2007/08 published in October. The Board is seeking to maintain the score of excellent and to achieve a score of at least good for the quality of financial management for the year 2008/09. The report prepared by the Healthcare Commission summarising our performance is attached for information at **Annex A**.
2. The Board is asked to note the current compliance position on the following elements within the annual health check:
 - 2.1. Compliance with Core Standards (including the Hygiene Code)
 - 2.2. Compliance with Indicators (formerly the existing and new national targets)
 - 2.3. The ALE Action plan for 2008/09 to cover the quality of financial management (formerly known as the Use of Resources)
3. Internal quarterly reports are now prepared by the Healthcare Commission for its regional assessors and the ORH is responding to questions raised. These responses are reflected in the compliance report.
4. The Executive lead for each standard/element/indicator is responsible for highlighting any risks to performance/compliance and ensuring that action plans are put in place to manage any divergence. The Executive lead is be responsible for the regular validation and verification of data during the year and at the year end supported by staff in performance and information. The co-ordination of responses on compliance and the preparation of reports for the Trust Board and other bodies will be carried out by the Assistant Director of Governance.
5. The Board is reminded that the Healthcare Commission ceases to exist on 31 March 2009 and responsibility for the AHC (and other duties) will be assumed by the Care Quality Commission (CQC) from 1 April 2009, as the new regulatory body. The CQC will publish the outcome of the 2008/09 AHC in the autumn of 2009.
6. The first step in the regulation process will be the application for registration with the CQC in January/February 2009 in relation to healthcare associated infection and work is in hand to ensure that this proceeds smoothly. A paper outlining the process and including the proposed registration submission will be brought to the January Trust Board meeting for approval.
7. Further information on the registration process for all aspects of the ORH's activities (to be put into effect from 1 April 2010) and the duties of the CQC will be provided to the Board as they become available. Some information is already available from the CQC's interim website at www.cqc.org.uk/ ; the CQC has published its consultation document on its enforcement policy and is holding a number of events over the next few weeks on both this and the regulation for HCAI. These are being attended by the appropriate staff and updates will be included in future Board reports.

Annual health check 2007/08 - Performance of Oxford Radcliffe Hospitals NHS Trust

Summary







Based on our assessment for 2007/08, Oxford Radcliffe Hospitals NHS Trust provided an excellent quality of service to patients, having made significant improvements compared with the previous year. For 2005/06 the trust provided a good standard of performance. It has managed its finances adequately and has made improvements on its weak standard of the last two years.

The trust was not one of those chosen to receive an inspection over the summer.










In a recent survey of trusts in England, patients rated this organisation as 'satisfactory' in terms of their overall experience.

Overall performance

The overall performance rating is made up of two parts: 'use of resources', which looks at how effectively a trust manages its financial resources; and 'quality of services', which is an aggregated score of performance against national standards and targets. The below tables summarise the three years of the annual health check.

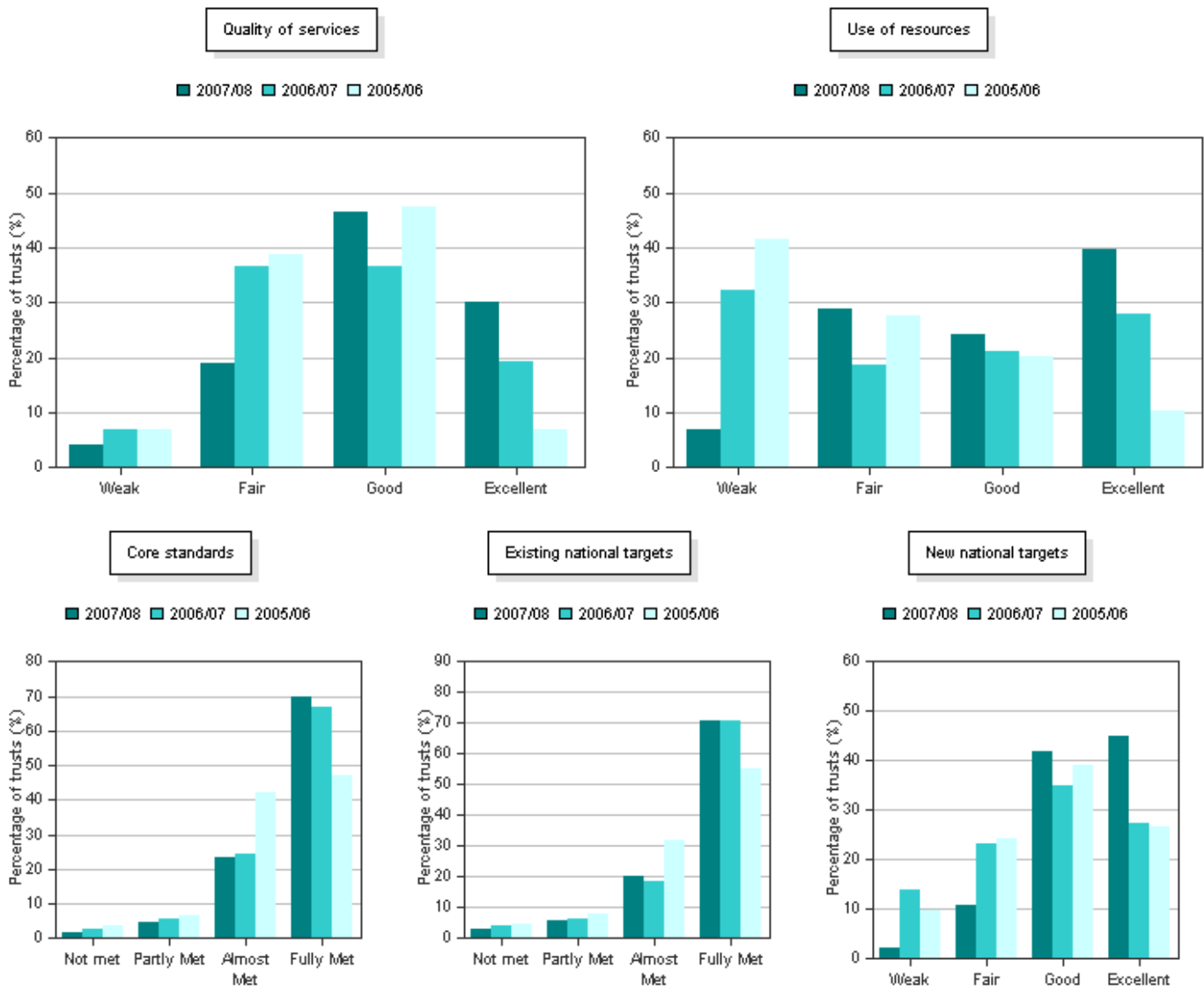
	2007/08	2006/07	2005/06
Quality of services			
Use of resources			

Components of quality of services

	2007/08	2006/07	2005/06
Core standards			
Existing national targets			
New national targets			

Overall performance of acute trusts

The graphs below show the overall performance of all acute and specialist trusts for the two parts of the overall performance ratings, as well as for the three components of quality of services, over the three years of the annual health check.



Core standards performance

Every NHS trust in England is responsible for ensuring that it is complying with the Department of Health's core standards. As part of the annual health check, we ask all trusts to assess their performance against the core standards and to publicly declare the information. The tables below present Oxford Radcliffe Hospitals NHS Trust's performance in the seven key areas of health and healthcare over the three years of the annual health check.

Safety

	2007/08	2006/07	2005/06
C01a - incidents - reporting and learning	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C01b - safety alerts	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C02 - safeguarding children	● ● ● COMPLIANT	● COMPLIANT	○ INSUFFICIENT ASSURANCE
C03 - NICE interventional procedures	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C04a - infection control	● ● ● COMPLIANT	● NOT MET	● COMPLIANT
C04b - safe use of medical devices	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C04c - decontamination	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C04d - medicines management	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C04e - clinical waste	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT

Clinical and cost effectiveness

	2007/08	2006/07	2005/06
C05a - NICE technology appraisals	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C05b - clinical supervision	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C05c - updating clinical skills	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C05d - clinical audit and review	● ● ● COMPLIANT	● NOT MET	● COMPLIANT
C06 - partnership	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT







Governance

	2007/08	2006/07	2005/06
C07a and c - governance	● ● ● COMPLIANT	● NOT MET	● COMPLIANT
C07b - honesty, probity	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C07e - discrimination	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C08a - whistle-blowing	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C08b - personal development	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C09 - records management	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C10a - employment checks	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C10b - professional codes of conduct	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C11a - recruitment and training	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C11b - mandatory training	● ○ ● INSUFFICIENT ASSURANCE	● COMPLIANT	○ INSUFFICIENT ASSURANCE
C11c - professional development	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C12 - research governance	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT










Patient focus

	2007/08	2006/07	2005/06
C13a - dignity and respect	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C13b - consent	● ● ● COMPLIANT	○ INSUFFICIENT ASSURANCE	● COMPLIANT
C13c - confidentiality of information	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C14a - complaints procedure	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C14b - complainants discrimination	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C14c - complaints response	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C15a - food provision	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C15b - food needs	● ● ● COMPLIANT	● COMPLIANT	● COMPLIANT
C16 - accessible information	● ● ● COMPLIANT	● COMPLIANT	○ INSUFFICIENT ASSURANCE












Accessible and responsive care

	2007/08	2006/07	2005/06
C17 - patient and public involvement	 COMPLIANT	 COMPLIANT	 COMPLIANT
C18 - equity, choice	 COMPLIANT	 COMPLIANT	 COMPLIANT

Care environment and amenities

	2007/08	2006/07	2005/06
C20a - safe, secure environment	 COMPLIANT	 COMPLIANT	 COMPLIANT
C20b - privacy and confidentiality	 NOT MET	 NOT MET	 COMPLIANT
C21 - clean, well designed environment	 COMPLIANT	 COMPLIANT	 COMPLIANT

Public health

	2007/08	2006/07	2005/06
C22a and c - public health partnerships	 COMPLIANT	 COMPLIANT	 COMPLIANT
C22b - local health needs	NOT APPLICABLE	 COMPLIANT	 COMPLIANT
C23 - public health cycle	 COMPLIANT	 COMPLIANT	 COMPLIANT
C24 - emergency preparedness	 COMPLIANT	 COMPLIANT	 COMPLIANT

Existing national targets performance by indicator

Our assessment of existing national targets looks at whether this trust is maintaining the levels of service set through the Department of Health's 2003-2006 planning round. We use sets of performance indicators to measure the targets. In the 2007/08 annual health check we used a total of 36 indicators across the different trust types to measure performance against existing national targets. Most of those targets are measured by one performance indicator, with the remainder being measured by two indicators.

The levels of performance against the indicators for this trust are detailed below.

Indicators

	2007/08	2006/07	2005/06
Total time in A&E: four hours or less	UNDER ACHIEVED	ACHIEVED	ACHIEVED
All cancers: two week wait	ACHIEVED	ACHIEVED	ACHIEVED
Rapid access chest pain clinic: two week wait	ACHIEVED	ACHIEVED	ACHIEVED
Revascularisation: three month wait	ACHIEVED	ACHIEVED	ACHIEVED
Cancelled operations and those not admitted within 28 days	ACHIEVED	FAILED	FAILED
Thrombolysis - 60 minute call to needle time	UNDER ACHIEVED	UNDER ACHIEVED	ACHIEVED
Information in place to support choice	ACHIEVED	ACHIEVED	ACHIEVED
All cancers: one month diagnosis to treatment	ACHIEVED	ACHIEVED	ACHIEVED
All cancers: two month GP urgent referral to treatment	ACHIEVED	ACHIEVED	ACHIEVED
Inpatients waiting longer than 26 weeks	ACHIEVED	ACHIEVED	ACHIEVED
Outpatients waiting longer than 13 weeks	ACHIEVED	ACHIEVED	ACHIEVED

Note: Data from the last three years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

New national targets performance by indicator

Our new national targets assessment looks at the targets outlined in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 - 2007/08*. As for existing national targets we use sets of indicators to measure performance against the targets. In the 2007/08 annual health check we used a total of 59 indicators to measure performance against the new national targets. Some new national targets are measured by one performance indicator, with others being measured by up to four indicators.

Indicator level performance for this trust is detailed below.

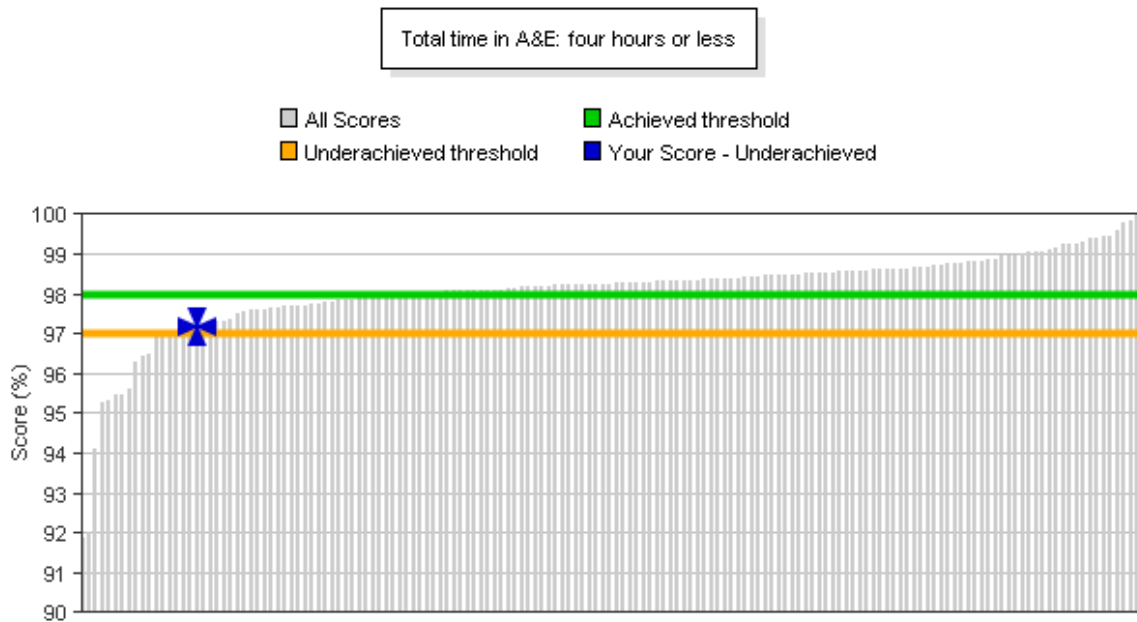
Indicators

	2007/08	2006/07	2005/06
Participation in audits	UNDER ACHIEVED	ACHIEVED	ACHIEVED
Smoking during pregnancy and breastfeeding initiation	ACHIEVED	ACHIEVED	ACHIEVED
Access to genito-urinary medicine clinics within 48 hours	ACHIEVED	ACHIEVED	ACHIEVED
Experience of patients	SATISFACTORY	SATISFACTORY	SATISFACTORY
Emergency bed days	UNDER ACHIEVED	ACHIEVED	ACHIEVED
Waiting times for diagnostic tests	ACHIEVED	ACHIEVED	ACHIEVED
Clostridium difficile data quality	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
MRSA bacteraemia	ACHIEVED	FAILED	UNDER ACHIEVED
Data quality on ethnic group	ACHIEVED	UNDER ACHIEVED	UNDER ACHIEVED
Compliance with guidelines concerning self harm	ACHIEVED	ACHIEVED	ACHIEVED
Information, screening and referral for drug misusers	ACHIEVED	ACHIEVED	ACHIEVED
Referral to treatment time milestones	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
Compliance with guidelines concerning obesity	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE

Note: Data from the last three years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

Focus on selected target indicator

The graph below shows how Oxford Radcliffe Hospitals NHS Trust has performed in comparison with all other acute trusts for the selected target indicator in 2007/08.



Summarised performance of other annual health check assessments

The following assessments have also been carried out during the first three years of the annual health check. Our reviews and studies look at whether NHS trusts are delivering high quality care and treatment, and achieving value for money.

	2007/08	2006/07	2005/06
Admissions management			
Diagnostic services			
Medicines management			
Services for children in hospital			
Maternity			

Useful links and glossary

The documents below provide further information on the annual health check:

- [Performance ratings 2007/08 - including links to national overview report and regional summaries](#)
- [More information on core standards](#)
- [More information on existing national targets](#)
- [More information on new national targets](#)
- [Annual health check 2007/08 frequently asked questions](#)
- [Information on NHS patient surveys](#)

Glossary of terms:

Core standards

Fully met: This score means that a trust met all of the core standards set by Government by the end of the assessment year. A trust can only receive this score if it declares no more than four failings during the year. These failings must have been corrected by the end of the year.

Almost met: This score means that a trust met almost all of the core standards set by Government.

Partly met: This score means that a trust met many of the core standards set by Government. However, it was not able to demonstrate that it had met a number of standards.

Not met: This score means that a trust did not meet several of the core standards set by Government.

Compliant: This score means that a trust's board determined that it had met a standard during the assessment year, without any significant lapses.

Insufficient assurance: This score means that a trust's board was unclear as to whether there had been one or more significant lapses during the assessment year in relation to a standard.

Not met: This score means that a trust's board was clear that there had been one or more significant lapses in relation to a standard during the assessment year.

Declaration adjusted / Qualification: This score means that a trust received a follow up inspection at the end of the assessment year and had its declared compliance level adjusted, or qualified, based on the findings of our inspection.

Existing and new national targets

Fully met: This score means that a trust performed consistently well for the existing national targets assessment.

Almost met: This score means that a trust performed well for many aspects of the existing national targets assessment.

Partly met: This score means that a trust performed poorly for some aspects of the existing national targets assessment.

Not met: This score means that a trust generally performed poorly for the existing national targets assessment.

Excellent: This score means that a trust performed well beyond the minimum requirements and the reasonable expectations for the new national targets assessment.

Good: This score means that a trust performed above the minimum requirements and the reasonable expectations for the new national targets assessment.

Fair: This score means that a trust performed in line with the minimum requirements and the reasonable expectations for the new national targets assessment.

Weak: This score means that a trust performed below the minimum requirements and the reasonable expectations for the new national targets assessment.

Achieved: This score means that a trust performed to a high level for this aspect of the targets assessment.

Underachieved: This score means that a trust performed below the required level for this aspect of the targets assessment.

Failed: This score means that a trust performed poorly for this aspect of the targets assessment.

Not applicable: This score means that this aspect of the targets assessment did not apply to this trust. As a result, this trust was not assessed against it.

Data not available: This score means that this aspect of the targets assessment did apply to this trust, but the relevant data were not available. This was not the fault of the trust, so it was not assessed against it.

Data not returned: This score means that this aspect of the targets assessment did apply to this trust, but the relevant data were either not returned or were of insufficient quality for the purpose of this assessment. As a result, this trust was awarded the lowest score, equivalent to a fail.

Target: This is an expectation of the NHS set by Government, which is to be achieved by a specific date.

Indicator: This is what we use to measure performance against a target. Often this will be a one-to-one relationship (in other words, one target is measured by one indicator), but sometimes we use more than one indicator to assess performance against a target.

Indicator construction: This is the detailed information that we publish about an indicator, which outlines the data and the method we will use to assess performance.

Scoring threshold: This is what we use to determine the required level of performance for an indicator. For each indicator, we use thresholds of performance to decide whether an organisation has 'achieved', 'underachieved' or 'failed'.

Quality of services assessment

Excellent: This score means that a trust received the highest score of either 'fully met' or 'excellent' for all applicable assessments that contribute to the overall quality of services score.

Good: This score means that a trust received at least the second highest score of either 'almost met' or 'good' for all applicable assessments that contribute to the overall quality of services score.

Fair: This score means that a trust has performed adequately, in that it has not received the lowest score of 'not met' for either core standards or existing national targets. However, it has not performed sufficiently well across the applicable assessments that contribute to the overall quality of services score to score any higher.

Weak: This score means that a trust received the lowest score of 'not met' for either core standards or existing national targets.

Use of resources assessment

Excellent: This score means that a trust performed very well. Management arrangements operated effectively, and financial targets were met for at least the last two years.

Good: This score means that a trust performed well in regard to its financial arrangements, and met its financial targets for at least the last two years.

Fair: This score means that a trust performed adequately in regard to its financial arrangements.

Weak: This score means that a trust performed poorly in regard to its financial arrangements.

8. The Board should note that these reports are supported by detailed work within the directorates and divisions and regular consideration of performance by the Executive Board and other Board Committees including the Governance Committee and the Finance and Performance Committee.
9. The Board is asked to receive the report and to note the current position in relation to core standards and indicators.

Megan Turmezei
Assistant Director of Governance
November 2008

Oxford Radcliffe Hospitals

Annex B Compliance report at November 2008 on core standards and indicators

Core Standard	Key focus of standard	Executive Board Lead	Non compliant	Work required & in progress	Compliant
C1a	Patient safety & incidents; learning & analysis	Director of Nursing & Clinical Leadership Directors of Operations	Compliant - Awaiting CEAC report on Incident management Cancer centre wash hand basin taps are being replaced to ensure patient safety (ref HSE prosecution)		
C1b	Acting on patient safety notices etc - SABs	Director of Nursing & Clinical Leadership Directors of Operations	Compliant - new process put in place by DH for reporting		
C2	Child protection & safeguarding	Director of Nursing & Clinical Leadership & Director of Operations (C)	Compliant - update report considered at Governance Committee in September 2008. Full report to March 2009 Committee		
C3	NICE interventional procedures	Medical Director & Director of Nursing & Clinical Leadership	Compliant - detailed report to December Governance Committee		
C4a	Infection control systems and processes (link to Hygiene Code)	Medical Director (DIPC) to lead across all areas	Compliant - work in hand to address outcome of Hygiene Code inspection 07/08 and to prepare for 08/09 visit due between 1.1.09 and 31.3.09. Updated action plan in preparation. Visit 11.11.08 from DH and PM's delivery unit Continued work being done as follow up to action plan from 2007 patient and staff surveys (reported on in 2008) - staff survey 2008 includes questions on training issues (see below). Preparation work for registration with CQC underway		
C4b	Medical Devices acquisition & use	Medical Director	Compliant		
C4c	Decontamination (link to Hygiene Code)	Director of Estates & Facilities Directors of Operation B	Compliant - Decontamination policy under review (by end November 08) work in hand to address outcome of Hygiene Code inspection 07/08 and to prepare for 08/09 visit due between 1.1.09 and 31.3.09. Updated action plan in preparation.		

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Core Standard	Key focus of standard	Executive Board Lead	Non compliant	Work required & in progress	Compliant
			Preparation work for registration with CQC underway		
C4d	Medicines management	Medical Director/Director of Nursing & Clinical Leadership	Compliant		
C4e	Waste management	Director of Estates & Facilities	Compliant		
C5a	NICE technology appraisals	Medical Director/Director of Nursing & Clinical Leadership	Compliant - detailed report to December Governance Committee		
C5b	Supervision & leadership of clinical care & treatment	Medical Director/Director of Nursing & Clinical Leadership	Compliant		
C5c	Continuous updating of skills for clinicians	Medical Director/Director of Nursing & Clinical Leadership	Compliant		
C5d	Clinical audit & clinical reviews	Medical Director	Compliant - awaiting CEAC report Clinical audit and effectiveness team in place and supporting the existing work done within directorates and across the Trust as a whole		
C6	Whole system working for individual patient needs	Director of Operations A	Compliant		
C7a & 7c	Governance & risk	Director of Nursing & Clinical Leadership	Compliant - updated BAF considered by Governance Committee in September and Trust Board to consider in January 09 Updated Trust Key Risks to Trust Board in November 08		
C7b	Probity & Honesty	Director of Nursing & Clinical Leadership	Compliant		
C7e	Human rights, diversity, equality	Director of HR and OD	Compliant		
C8a	Whistle blowing	Director of HR and OD	Compliant - Whistle blowing included in induction		

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Core Standard	Key focus of standard	Executive Board Lead	Non compliant	Work required & in progress	Compliant
			Fraud awareness (including how to raise concerns) events held during year and risk-based study underway on all aspects of fraud		
C8b	Organisational development & minority groups	Director of HR and OD	Compliant - with the introduction of the Oracle Learning Module (OLM) linked to the Electronic Staff Record (ESR), further analysis to be undertaken on BME appraisal uptake and access to training.		
C9	Records management (& training)	Director of Nursing and Clinical Leadership Director of Finance	Compliant		
C10a & b	Employment checks & professional codes of practice	Director of HR and OD	Compliant - complete overhaul of immigration process following introduction of new legislation using advice provided by external audit team. Handcheck audit of all personnel files to ensure immigration status and work permits in order.		
C11 a	Appropriate recruitment, training & qualifications	Director of HR and OD	Compliant		
C11b	Mandatory training	Director of HR and OD	Compliant - all mandatory training now recorded on OLM, linked to the ESR so more accurate and timely reporting and analysis available. ORH chosen as a pilot for SC SHA to use the OLM and seen as a model of good practice. Infection control training - 'continuing vigilance' identified in the 2007 staff survey action plan. The Improved training during 2008 highlighted as one of the benefits of taking part in the 2008 staff survey. Diversity, racial and religious awareness training - further training provided for Board and senior managers.		
C11c	Professional & occupational development	Director of HR and OD	Compliant - further update of e-learning platform for staff to access learning and development modules at their desktop. Greater number of appraisals during 2007/8, monitored monthly.		
C12	Research governance	Medical Director	Compliant		
C13 a	Privacy & Dignity	Director of Nursing & Clinical Leadership	Compliant - CEAC report provided significant assurance in relation to privacy and dignity and work continues to improve quality of patient		

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Core Standard	Key focus of standard	Executive Board Lead	Non compliant	Work required & in progress	Compliant
			<p>experience in all areas</p> <p>Continued work being done as follow up to action plan from 2007 patient survey (reported on in 2008)</p> <p>Matrons' reports cover privacy and dignity</p>		
C13b	Consent & use of information	Director of Nursing and Clinical Leadership	Compliant		
C13c	Confidentiality of Information	Director of Nursing and Clinical Leadership	<p>Working to ensure that compliance is maintained in line with national guidance on confidentiality.</p> <p>Work continuing through Information governance group (includes corporate and divisional members)</p>		
C14a, b, c	Information re complaints & proper processes No discrimination, Learning & service improvement	Director of Nursing & Clinical Leadership	<p>Compliant - Annual report on complaints to Trust Board in July 2008. Report is also submitted to HCC and SHA</p> <p>Continued work being done as follow up to action plan from 2007 patient survey (reported on in 2008)</p>		
C15 a, b	Food choice & 24 hours	Director of Estates & Facilities	<p>Compliant</p> <p>Continued work being done as follow up to action plan from 2007 patient survey (reported on in 2008)</p>		
C16	Patient & corporate information	Director of Communications	<p>Compliant - to be developed as part of FT work and through continued work of the Patient Information Group - significant number of patient leaflets amended to date</p> <p>Work continuing through year</p>		
C17	View of patients & carers, designing, delivering, planning & improving healthcare	Director of Nursing & Clinical Leadership	<p>Compliant - to be developed as part of FT work - membership recruitment and engagement - workshops held in October and more to be held in December and January. Membership target for November exceeded</p> <p>Full engagement in PCT-led process for services in the north of the</p>		

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Core Standard	Key focus of standard	Executive Board Lead	Non compliant	Work required & in progress	Compliant
			county Continued work being done as follow up to action plan from 2007 patient survey (reported on in 2008)		
C18	Equality of Access	Directors of Operations	Compliant		
C20a	Safe & secure environment	Director of Estates & Facilities	Compliant		
C20b	Care environment privacy & confidentiality	Director of Estates & Facilities Director of Nursing & Clinical Leadership	Compliant - see also C13a above Continued work being done as follow up to action plan from 2007 patient survey (reported on in 2008)		
C21	Environment, maintenance & cleaning link to Hygiene Code	Director of Estates & Facilities	Compliant - work in hand to address outcome of Hygiene Code inspection 07/08 and to prepare for 08/09 visit due between 1.1.09 and 31.3.09. Updated action plan in preparation Preparation work for registration with CQC underway		
C22 a & c	Health promotion in local community	Medical Director	Compliant		
C23	Health promotion to meet NSFs etc on obesity, smoking, substance misuse etc	Medical Director	Compliant - ORH completed web-based survey on public health in November 2008		
C24	Emergency planning	Director of Operations (A)	Compliant		

Annex C Compliance report at November 2008 on acute indicators

2008/2009 acute indicator	NP ¹	EC ²	Executive lead	Not being met	Work required & in progress	Compliant against 07/08 measures
Health and wellbeing						
Infant health and inequalities: smoking during pregnancy and breastfeeding initiation		√	Director of Operations, Div C	Compliant (data reviewed monthly by Directorate) Smoking -first quarter 2008/9 = 7.7% Breast Feeding initiation - first quarter = 77%		
Access to genitourinary medicine (GUM)	√		Director of Operations, Div C	Q1 Numerator (% appointments offered within 48 hours)= 100% Denominator (% patients seen within 48 hours) = 82% Work continuing to achieve denominator		
Data quality in ethnic group	√		Director of Planning and Information	Compliant		
Experience of patients - from health and wellbeing domain(s)		√	Director of Nursing and Clinical Leadership	Work continuing to ensure good and positive engagement with patients and their families. Customer care and patient engagement strategies approved by the Board		
Clinical Quality						
Participation in heart disease audits		√	Director of Operations, Div A	Compliant		
Time to reperfusion for patients following a heart attack	√		Director of Operations, Div A	new structure to indicator and low numbers rule applies		

¹ EC - Existing commitment

² NP - national priority

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2008/2009 acute indicator	NP ¹	EC ²	Executive lead	Not being met	Work required & in progress	Compliant against 07/08 measures
				part 1 still 60 mins call to needle. part 2 data completeness @80%		
Engagement in clinical audits		√	Medical Director	Compliant		
Stroke care		√	Director of Operations, Div A	Organisational part received this week and being reviewed by service; clinical return due autumn - issues re % of patients who get onto unit		
Experience of patients - clinical quality domain(s)		√	Director of Nursing and Clinical Leadership	Customer care and patient engagement strategies approved by the Board		
Maternity Hospital Episode Statistics - data quality indicator		√	Director of Operations, Div C	Compliant		
Safety						
Incidence of MRSA		√	Medical Director	Compliant (see also core standard C4a) Performance in line with trajectory		
Experience of patients - safety domain(s)		√	Director of Nursing and Clinical Leadership	Patient safety framework approved and Safety Action Groups in place Customer care, patient engagement and patient safety strategies approved by the Board		
Incidence of <i>Clostridium difficile</i>		√	Medical Director	Compliant (see also core standard C4a) Performance below trajectory		
Patient focus and access						
Delayed transfers of care	√		Director of Operations, Div A	Metric for assessment not declared for 2007/08 position not yet clear for 2008/09		

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2008/2009 acute indicator	NP ¹	EC ²	Executive lead	Not being met	Work required & in progress	Compliant against 07/08 measures
						Oxon Chief Execs programme in place - meeting November 2008
18 week referral to treatment times		√	Director of Performance Improvement			Compliant - but possible risk of not achieving in each speciality highlighted to both Oxon PCT and SHA (Oxon instruction to extend waiting times)
All cancers: two-week wait		√	Director of Operations, Div B			Compliant - Work progressing to implement revised tracking tools (published September'08) required for new targets
All cancers: one month diagnosis to treatment (including new cancer strategy commitment)		√	Director of Operations, Div B			Compliant - Work in progress to implement revised tracking tools (published September'08) required for new targets
All cancers: two-month GP urgent referral to treatment (including new cancer strategy commitment)		√	Director of Operations, Div B			Compliant
Total time in A&E	√		Director of Performance Improvement			Compliant
Experience of patients - patient focus and access domains		√	Director of Nursing and Clinical Leadership			Work continuing to ensure good and positive engagement with patients and their families - opportunities taken through FT membership recruitment and the Members' Council training events Customer care and patient engagement strategies approved by the Board
Outpatients waiting longer than the 13-week standards	√		Director of Performance Improvement			Compliant
Inpatients waiting longer than the 26-week standards	√		Director of Performance Improvement			Compliant

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2008/2009 acute indicator	NP ¹	EC ²	Executive lead	Not being met	Work required & in progress	Compliant against 07/08 measures
Patients waiting longer than three months for revascularisation	√		Director of Operations, Div A	Compliant		
Waiting times for rapid access chest pain clinic	√		Director of Operations, Div A	Compliant		
Cancelled operations and those not admitted within 28 days	√		Director of Performance Improvement	Compliant		
NHS Staff satisfaction		√	Director of HR	Continued focus on staff survey undertaken annually - 2008 survey underway with additional focus on areas highlight in 2007 survey		
Total	10	16				

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Annex D Quality of Financial Management ALE Action Plan 2008/09

Domain	KLOE	Score 07/08	Action required	Lead	Date
Financial Reporting (3 overall)	1.1 The trust produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers	3	Potential for 4 is under evaluation but may not be achievable given shortened NHS timetable for closure and submission of accounts	Philip Bonnier	Nov 30
	1.2 The trust promotes external accountability	3	Potential for 4 is under evaluation	Helen Peggs	Nov 30
Financial Management (3 overall)	2.1 The trust's medium-term financial strategy/plan, budgets and capital programme are soundly based and designed to deliver its strategic priorities	2 (fell in 07/08)	2009/10 capital budget to be considered and approved by Trust Board in March 2009	Ian Humphries	Feb 28 for Mar 09 TB
	2.2 The trust manages performance against budgets	3	Sustain at 3 – not yet able to achieve Level 4	Chris Hurst	Ongoing
	2.3 The trust manages its asset base	3	Sustain at 3 performance – not yet able to achieve Level 4 Updated Estates Strategy to be considered and approved at Dec 08 Trust Board	Ian Humphries	Nov 30 for Dec 08 TB
Financial Standing (2 overall)	3.1 The trust manages its spending within the available resources	2	Improve to 3 – to be achieved by: The trust to break-even in 2008/09 – target surplus £4.3m The trust has met its capital resource limit in each of the last two years – ensure CRL is achieved in 2008/09 The going concern confirmation is supported by a strong audit trail to show the basis of considerations – to be demonstrated by achievement of surplus for second consecutive year (third year with underlying surplus) and year-end analytical review	Chris Hurst Chris Hurst Nuala Donnelly	Mar 31 Mar 31 Apr 30 for May 09 TB
Internal Control (3 overall)	4.1 The trust manages its significant business risks	3	Potential for 4 under evaluation – Board workshop on risk to be timetabled before end February 2009	Megan Turmezei	Nov 30
	4.2 The trust has arrangements in place to maintain a sound system of internal control	3	Sustain at 3	Richard Sonley	Ongoing
	4.3 The trust has arrangements in place that are designed to promote and ensure probity and propriety in the conduct of its business	3	Sustain at 3	FT Board Secretary (appointment pending)	Ongoing
Value for Money	5.1 The trust has put in place proper arrangements for	2	Improve to 3 – to be achieved by:		

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Domain	KLOE	Score 07/08	Action required	Lead	Date
(2 overall)	securing strategic and operational objectives		Board papers to make explicit reference overall purpose and strategic objectives Integrated FT action plan (HDD and Governance Review) and FT project plan to be reviewed at monthly Board meetings Stakeholder analysis to be prepared and mapped to Trust objectives and plans Trust objectives to be reviewed by Board with traffic light assessment of progress to date [Note – number of improvements have been made since the 2007/08 assessment including: IBP & LTFM produced and being updated, the bi-annual accountability reviews now embedded]	Megan Turmezei Andrew Stevens Helen Peggs Andrew Stevens	From Nov 08 TB From Nov 08 TB Nov 30 Nov 08 TB
	5.2 The trust has put in place proper arrangements to ensure that services meet the needs of patients and taxpayers, and for engaging with the wider community	3	Potential for 4 – to be achieved by: Regular patient feedback to Trust Board from Jan 09 Demonstrating that the feedback from FT consultation has impacted on the Board's plans/proposals – summary feedback to be considered at Nov 08 Board with detailed consideration in January 09 Membership database to be used to add to evidence that Trust is communicating with hard to reach groups	Elaine Strachan Hall Elaine Strachan Hall Elaine Strachan Hall	Nov 08 TB/Jan 09 TB Dec 31
	5.3 The trust has put in place proper arrangements for monitoring and reviewing performance, including arrangements to ensure data quality	3	Sustain at 3		
	5.4 The trust has established arrangements for managing its financial and other resources which demonstrate value for money is being managed and achieved	2 (fell in 07/08)	Improve to 3 – to be achieved by: PICRP to be mapped to the NHS Operating Framework 2008/09 and improvements being delivered in this year mapped back to Reference Costs 2007 to demonstrate links to areas targeted Compile plans to improve efficiency of back office functions (drawing on IBP Chapter 8 and PICRP plans) – report to Finance & Performance Committee for review in Dec 08 Analysis of outcome of Reference Costs 2008 to be reported to Executive Board and Finance & Performance Committee with action plan (note – DH publication date not yet established)	Don West/ Fiona Barnes Sue Donaldson/ Andrew Murphy Chris Hurst	Nov 30 Nov 30 By Jan 09

