GOVERNANCE ANNUAL REPORT 2005/06

1. Purpose

1.1 The purpose of this report is to update the board regarding the activities undertaken in 2005-2006 to demonstrate that the Trust manages governance in an acceptable manner and to seek approval of plans for 2006/07. It does not cover areas of financial governance. This is dealt with via regular board reports and to Monitor, the independent regulator for Foundation Trusts.

2. Introduction

2.1 The overall responsibility for managing governance within the Trust rests with the chief executive. Operational responsibility for key components of the governance agenda is delegated to the medical director for clinical governance, the human resources director for health & safety and the finance director for financial governance.

2.2 2005/2006 has been a consolidation year in terms of governance. Directorate governance groups are now embedded into the organisation. As systems mature they will help improve the coordination and management of the Trust's approach to governance.

3. Report Breakdown

3.1 The report is broken down into a number of distinct areas designed to cover the full range of both the corporate and clinical governance agenda. These areas are the governance framework (including clinical and corporate governance), risk management (including health & safety) and governance support unit (including clinical audit). Where sections overlap, this is indicated in the report. Appendices offer further information on each section.

4. Governance Framework

4.1 Governance Committee

4.1.1 The Trust manages its governance activities through the governance committee. This committee is a sub-committee of the board of directors and met nine times during 2005-06. The committee covers both clinical and corporate governance activities across the Trust. The vice chairman chairs the committee and two other non-executive directors are also members. Representation is also drawn from the executive team and clinical specialities throughout the Trust.

4.1.2 Various specialist committees report their work to the governance committee. These committees all have agreed terms of reference and are chaired by senior members of staff. Appendix 1 illustrates the reporting committees.

4.2 The Assurance Framework and Risk Register

4.2.1 The assurance framework details the Trust's high-level objectives to ensure that there is adequate assurance at board level on its business processes. The governance committee is charged by the board to examine the process in detail.

4.2.2 Internal audit examines the assurance framework annually to ensure a positive sign off for the statement on internal control. The framework covers all areas of Trust business, which include the healthcare standards, Monitor, service development strategy and new & existing targets. Any area where a gap is identified is transferred onto the Trust risk register.

4.2.3 The Trust has continued to develop the corporate risk register over the year. Both the board and governance committee undertake a quarterly review of the register, which highlights the changes made within that quarter. Internal audit also assess the validity of the register in assessing the overall statement on internal control.

4.3 Directorate Governance Groups

4.3.1 The rationale behind the establishment of directorate governance groups in 2003-04 was to assist in embedding the governance and risk management framework into the organisation.

4.3.2 Directorate governance groups, chaired by the clinical director, cover all aspects of governance from a directorate perspective.

4.3.3 There has been a noticeable improvement in the workings of directorate governance groups during the last year and governance staff continue to attend all meetings to assist in their ongoing development.

4.4 Clinical Negligence Scheme for Trusts (CNST)

4.4.1 The Trust successfully met level 1 (acute) against the external criteria set down by the NHS Litigation Authority (NHSLA). The maternity service continues to operate at level 2.

5. The Healthcare standards and annual declaration

5.1 The Healthcare Commission was established in April 2004 as a successor to the Commission for Health Improvement. The Healthcare Commission is the statutory body responsible for performance managing the NHS on quality improvements for the benefit of patients. A major part of this activity is assuring compliance with the core national healthcare standards. These standards are broken down into the following seven domains:

Domain Number	Domain Name	Number of Core standards
1	Safety	9
2	Clinical & Cost Effectiveness	5
3	Governance	12
4	Patient Focus	9
5	Accessible & Responsive Care	3
6	Care Environment & Amenities	3
7	Public Health	5

5.2 Lead managers have been assigned to each of the standards with directors taking a lead on each of the domains.

5.3 The national standards, local strategy (NSLS) Committee, chaired by the operations director, oversees the implementation of action plans relating to the national standards. The NSLS committee reports to the governance committee.

5.4 During 2005/06, internal audit conducted a thorough review of the evidence relating to each of the core healthcare standards. The governance department also conducts reviews of evidence.

5.5 The Trust is also required to sign an annual declaration detailing the results of a self-assessment of how it thinks it has met the 44 core standards. Detailed reports have been presented to the board of directors in this area. The Trust self assessed itself as meeting 42 of the 44 standards and has developed action plans to ensure that it is meeting the all standards in 2006-07.

6. Risk Management (including health & safety)

6.1 Policy reviews

6.1.1 The cyclical task of reviewing and updating policies has continued throughout the year, as has the development of new policies that further enhance the safety of patients and staff. Of particular importance during 2005/06 was the implementation of the latex policy.

6.2 Learning from Errors

6.2.1 The Trust now electronically sends details of all patient incidents to the National Reporting and Learning System (NRLS). The NRLS is a central repository for all patient incidents that occur in the NHS and is administered by the National Patient Safety Agency. The National Patient Safety Agency analyses the information gathered by the NRLS and uses the data as a tool in developing national patient safety strategies.

6.2.2 Training in root cause analysis of serious incident was rolled out to a number of clinicians and matrons who now have the requisite skills needed to facilitate this in depth investigation. This team of investigators can be called upon as and when needed.

6.2.3 A more robust system has been developed for investigating incidents that are graded with an "actual impact" or "future potential" of moderate. Departmental/ward managers are now requested to investigate the incident and report back findings and recommended system changes.

6.3 Health & Safety Action Plan

6.3.1 The Trust has developed a health and safety action plan for 2005-06, in liaison with staff side representatives in order to ensure continual improvement in health and safety. An update of the plan progress can be seen in Appendix 2.

6.4 Incident Reporting

6.3.1 The incident reporting and investigation policy and procedure encourages all members of staff to report incidents, including near misses within 48 hours. Incidents are then graded with regard to the "actual impact" and also the "future potential" risk to the Trust, should the incident recur.

6.3.2 The rise in reported incidents from 800 to 1600 a quarter in a little over three years is viewed positively as it demonstrates a culture whereby staff feel empowered to report without fear of recrimination.

6.3.3 A risk matrix for the total number of patient, staff and other incidents is shown in appendix 3 as well as run charts for the top five patient and staff incidents. The total number of incidents reported in 2005/06 was 6383.

6.4 Manual handling

6.4.1 Analysis of moving and handling incidents identifies that approximately 50% were sustained lifting inanimate objects.

6.4.2 All new starters to the Trust receive an overview presentation from the moving and handling advisor on spinal awareness issues. This holistic induction session is

consolidated at ward/departmental level by "key trainers", who provide practical training commensurate with their work activity.

6.4.3 The manual handling advisor is responsible for training 'key trainers' who fulfil the role in addition to their normal duties. During 2005/06 the key trainers course was moved back to being provided in-house in order to increase the numbers of staff trained.

6.4.4 When a new member of staff starts in their ward/department, the key trainer provides specific manual handling training appropriate to the role e.g. patients or inanimate loads.

6.4.5 Key trainers are responsible for providing the annual manual handling update training for staff within their ward or department.

6.4.6 From the 1st April 2005 - 31st March 2006 there have been 162 moving and handling incidents. Of these, 12 were reported to the Health and Safety Executive (HSE).

6.5 Environmental monitoring

6.5.1 The Control of Substances Hazardous to Health Regulations 2002 specifies the circumstances where hazardous substances are used and environmental monitoring is required.

6.5.2 Following the successful use of an external specialist company during 2004/05 who completed a large part of the annual environmental air monitoring surveillance programme, monitoring returned in-house to be completed by the risk management department. No area sampled has shown over exposure to hazardous substances.

6.6 Violence and aggression

6.6.1 The Counter Fraud and Security Management Service (CFSMS) is a co-signatory to the concordat with the Health & Safety Executive (HSE) thus ensuring that violence and aggression remains high on the health and safety agenda.

6.6.2 Violence and aggression incidents are reported via the Trust incident reporting system. The security forum is the body charged with policy development in this area.

6.6.3 The CFSMS has required the Trust to have a nominated person responsible for security. As a result of this the Trust security manager is now fully accredited to give security advice.

6.6.4 Front line staff are now required to attend a 1-day training course on violence and aggression. The Trust is on target to meet the requirement of all staff to attend this training by April 2008.

6.7 Risk Management Training

6.7.1 Health and safety, including manual handling, is covered in the induction programme.

6.7.2 The Trust adopt a proactive approach to the management of risk and the foundations for this are risk officers who have completed the in-house three-day risk management training course.

6.7.3 The three-day package adopts a holistic approach to risk management and also incorporates the skills required to complete general risk, COSHH and display screen

equipment assessments. Completion of the course qualifies staff to be risk officers who are integral for not only ensuring that risk assessments are completed but also help ensure that risk management issues are being communicated through the directorate structure.

6.7.4 There are now 150 risk officers who have completed the three day course and a further 40 staff who have only day 3 to complete.

6.8 Health & Safety Committee

6.8.1 The Trust has a duty to consult with recognised safety representatives and the health and safety committee provides a forum for this to occur.

6.8.2 The committee meets on a quarterly basis and discusses health & safety issues, analyses staff incident data and ratifies health & safety policies. The director of human resources chairs the committee.

6.8.3 It is good practice that the committee has representation from staff side. To this end, 50% of the committee's membership is either trade union representation or appointed staff representatives.

6.9 Dealings with Health and Safety Executive

6.9.1 The Trust is required to report certain incidents to the HSE under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. In 2005/06, the Trust reported 24 incidents out of a total of 6383. The risk management department carries out an investigation on all incidents that are reportable under RIDDOR.

6.9.2 Regular contact has continued with the HSE During a routine visit in January, the HSE indicated that they were satisfied with the progress made by the Trust on health & safety and would therefore manage the Trust on specific issues only.

6.10 Safety Alert Broadcast System

6.10.1 The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health and is the primary method of distributing Medical Device Alerts (MDA) and Patient Safety Alerts to all NHS Trusts. Alerts are disseminated to SABS liaison officers in NHS Trusts. The liaison officer then ensures onward distribution of the alert and records the actions taken on SABS. This activity is undertaken in the risk management department. All alerts are also placed on the MHRA (Medicines and Healthcare Products Regulatory Agency) and NPSA (National Patient Safety Agency) websites. In 2005/06, there were 82 alerts issued.

6.10.2 In a reciprocal arrangement, Trusts are also required to notify the MHRA should they be alerted to any actual or potential product failures. The MHRA investigates the incident with the manufacturer and takes any appropriate action necessary and informs the Trust of the outcome. In the year 2005/06, 36 reports were made to the Agency.

6.11 Departmental achievements

6.11.1 The following achievements by the department are worthy of note:

- The number of risk officers trained has increased by 50%
- Incident forms continue to rise and yet the total number of RIDDORs have dropped
- High number of reports of patient incidents to the National Patient Safety Agency's National Reporting & Learning System
- Improved information to both corporate and directorate departments
- Risk Manager awarded chartered status of the Institution of Occupational Safety and Health

7. Governance Support Unit

7.1 Introduction

7.1.1 During the past year the role of the governance support unit has become increasingly focused around national clinical audit and priorities, primarily driven by the Standards for Better Health. The national picture for clinical audit has evolved and outcomes from audit projects are of high importance.

7.1.2 The governance support unit leads on audit activity throughout the Trust and is committed to the provision of a high quality service. It provides a pivotal role in the co-ordination of clinical audit activity across the Trust in order to prevent duplication of effort and to ensure a harmonised approach. To ensure accurate documenting of all Trust activity, all known audit activity is recorded on a departmental database. Quarterly reports on audit activity are disseminated to directorates via their directorate governance groups and the quarterly review process.

7.1.3 Strong links have been maintained within directorates between governance support facilitators and directorate audit leads. Appendix 4 illustrates the number of projects reported to the department by directorates for this financial year.

7.2 Clinical Audit Committee

7.2.1 The clinical audit committee meet quarterly to co-ordinate, promote and oversee multi-disciplinary clinical audit activity throughout the Trust and provide strategic direction for the clinical audit programme. Audit Leads have been appointed within each directorate and attend clinical audit committee meetings to co-ordinate the directorate audit programme and provide evidence to confirm that change has been effective.

7.2.2 A highly successful training session for audit leads was held this year to inform leads of their role and responsibilities both within the Trust and specific to their directorate. Training packs for audit leads have also been introduced.

7.3 National Confidential Enquiries And National Audit Projects

7.3.1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

7.3.1.1 Reports produced by NCEPOD on each study do not contain comparative data. The reports contain a list of recommendations against which the Trust position is obtained from each directorate involved and action plans implemented to meet any shortfall. Reports from NCEPOD are released 18 months from the end of the study.

7.3.1.2 On 11th May 2005, NCEPOD launched its report ‘An Acute Problem’. This study reviewed the referral of adult medical patients into general intensive care units. The directorate governance group for medicine has taken recommendations from the report forward.

7.3.1.3 On 26th October 2005 NCEPOD launched its report ‘Abdominal Aortic Aneurysm: A service in need of surgery?’ This report contains the results of the study NCEPOD undertook last year looking at patients admitted to hospital following a diagnosis of abdominal aortic aneurysm. The self-assessment checklist to collate the Trust position with regard to the recommendations has been forwarded to the directorate governance groups for surgery and critical care for review and action planning.

7.3.1.4 The RD&E participated in the Severely Injured Patient pilot study in September 2005. It was not mandatory to participate in the pilot study but the Trust took the decision to do so as a marker for the forthcoming main study.

7.3.1.5 Coronial autopsies - this study assessed the quality of coronial autopsy reports. The report launch will be on Wednesday 18th October 2006 at the Royal College of Pathologists. Recommendations will be acted upon when released.

7.3.1.6 Sickle Cell Disease and Thalassaemia - This study is running from 1st January 2005 to 31st December 2006, and looks at all patients who die in hospital or in the community with sickle cell disease or thalassaemia. Recommendations will be acted upon when released.

7.3.1.7 Emergency Admissions Study - data was collected on two separate dates in February 2005. The report was due for publication in late 2006. However, due to the small number of cases included in the study, NCEPOD took the decision to collect additional data for the entire week of February 2nd – 8th 2006. From the information submitted to NCEPOD, patients have been selected for inclusion in the study. Questionnaires are being sent to both the admitting clinician and the clinician responsible for ongoing care. Recommendations will be acted upon when the report has been released.

7.3.1.8 Severely Injured Patient Study (main study) - data collection for this study ran from 1st February 2006 to 30th April 2006. The study aims to assess the pre-hospital and hospital care of severely injured patients at an organisational and clinical level. Casenotes of all patients identified as severely injured will be sent to NCEPOD. Each case will then be scored and those with an injury severity score >16 will be included in the study. A questionnaire will be sent to the A&E consultant and the admitting consultant. Recommendations will be acted upon when the report has been released.

7.3.2 Confidential Enquiry into Maternal and Child Health (CEMACH)

7.3.2.1 Work continues in the maternity department on this confidential enquiry. A six monthly report to the governance committee has highlighted good progress with the recommendations of this report and work continues.

7.3.3 Intensive Care National Audit and Research Centre (ICNARC)

7.3.3.1 Data from the RD&E has been submitted to the national database since January 1997 and reports compared with national performance. Eight cycles of data have reached the report stage and a further cycle is currently being validated. Once completed, performance based on 5149 admissions will be available. Based on this four-year period the RD&E case mix adjusted mortality based on APACHEII (severity scoring on how ill the patient is) is within the standardised norm and in addition, compares favourably with other units across the country.

7.3.3.2 The system is currently a source for identifying patients for a local follow up study of long-term outcomes of ITU. The study addresses patient and carers' experiences and remains ongoing.

7.3.3.3 The data has facilitated completion of National Audit Commission data forms and local audit and have also informed service decisions.

7.3.3.4 The minimum data set collected at the RD&E was reduced in July 1999 in line with the ICNARC validation programme. PRISM (paediatric severity scores) and APACHEII severity scores are now the only ones collected.

7.3.3.5 The ICNARC data collection dataset has been updated for 2006 so that calibration will be improved. The data set is being modified to the Critical Care Minimum Data Set (CCMDS), which will form the basis of PBR funding.

7.3.3.6 Benefits include accurate benchmarking against national performance, accurate data for supporting local activity such as mortality and morbidity meetings and provision of data for Paediatric Intensive Care Unit (PICU). Trust position is illustrated in Appendix 5.

7.3.4 National Trauma Audit Research Network (NTARN)

7.3.4.1 Inclusion Criteria - all trauma cases with a length of stay of 72 hours or more, admitted to ITU regardless of length of stay, that are transferred out or die within that period.

7.3.4.2 Over 690 eligible cases have been submitted to the national centre via a web based collection method.

7.3.4.3 Clinical case reports are produced on a monthly basis and identify the outcome of all patients submitted to TARN the previous month who have received emergency care and highlights suggested cases for review. The reports can be used for discussion at clinical audit meetings, which in the long term will improve patient care locally as well as contributing to staff development

7.3.4.4 Quarterly reports are produced with process and outcome measures for each site compared against the database. The report includes charts, which indicate overall hospital performance against other participating organisations (anonymised). Reports this year: thoracic injuries, orthopaedic injuries, abdominal & spinal Injuries and head injuries. Although the reports received compare the Trust with the national average for each individual injury site, they are however inaccurate in that there are anomalies between data collection periods for each organisation. Reports are forwarded to the trauma team leaders to ensure that outcomes are acted upon.

7.3.5 Myocardial Infarction National Audit Project (MINAP)

7.3.5.1This is a mandatory on-going national audit project to monitor the standards for the management of acute coronary syndromes as stated in the National Service Framework for Coronary Heart Disease.

7.3.5.2 Methods of treatment are changing, with ambulance crews being trained to administer thrombolysis and over the past year an increasing number of patients have received primary angioplasty. Primary angioplasty is the first line immediate treatment where blocked vessels are opened with a balloon or stent.

7.3.5.3 MINAP data is analysed locally on a monthly basis and as and when required by clinicians and managers to provide feedback on demographics and clinical care. The MINAP public report for 2005 showed the Trust to have a door to needle time of 71% (National target 75%), which is a 5% improvement on the previous year, and a call to needle time of 31% (previous year 13%). The Department of Health set NHS organisations a target of delivering a 10% improvement each year on a baseline of 38%, which was set in December 2002. The next MINAP public report is due out in

June 2006 and will reflect improvements to the service made over the past year, taking into account door to needle and call to needle times and the prescription of secondary prevention medication. The Trust scored 99.7% for data completeness in 2005 and participated in the data quality study where the target was participation.

7.3.5.4 The number of primary angioplasty patients is set to rise further with the selection of the RD&E as one of a number of pilot sites for the National Infarct Angioplasty Project, commencing April 2005, and requiring additional audit activity.

7.3.6 National Comparative Audit of Blood Transfusion

7.3.6.1 In April 2005 the Trust took part in the National Comparative Audit of Blood Transfusion. The report was published in September 2005. Recommendations from the report were fed back to the hospital transfusion committee, clinical audit committee and governance committee. The majority of recommendations made were around training and risk assessment. Actions have been undertaken against the recommendations. The recommendation that further audits be undertaken was discussed at the clinical audit committee and it was agreed that the forthcoming national platelet audit would incorporate this.

7.4 National Service Frameworks (NSF's)

7.4.1 National Service Frameworks (NSFs) set national standards and define service models for a specified service or care group, put in place strategies to support implementation and establish performance milestones against which progress within an agreed timescale will be measured. Working parties have been set up to implement the recommendations of the following National Service Frameworks: Coronary Heart Disease, Diabetes, Older People, Renal Services, Children and Long Term Conditions. Audits have been undertaken as part of the NSF action plans.

7.5 Cancer Services

7.5.1 The cancer projects team have a multi-faceted role within the Trust that incorporates audit activity for the twelve cancer site specialist teams. Information is collected on cancer care and the provision of data to support external quality assurance visits. In 2005-06 this included assisting with information collection for the preparatory submission for the national cancer peer review visit in September 2006.

7.5.2 Retrospective patient information is collected on the Dendrite system, which allows the Trust to maintain cancer registries covering each tumour site. This data is compiled into a report and is sent to the regional cancer register (Southwest Public Health Observatory SWPHO) and the data is currently complete to within guidelines. The dataset also provides information for local clinicians, other healthcare professionals and the public on the pathway, treatments and outcomes for cancer patients treated in the Trust, for example the 2005 Dr Foster breast cancer services enquiry. The Cancer Projects Team have collected data from Dendrite and other sources for SWPHO & Peninsula cancer network audits, such as the colorectal 'lymph node harvest and staging' audit and the lung 'Timing if CT scan and bronchoscopy' audit.

7.5.3 The Facilitators provide monthly, tumour specific information on treatment cancer waiting times in an accurate and timely manner in accordance with mandatory agreed definitions and targets. Monitoring of the two-week wait targets is also provided using Dendrite. Cancer waiting times went live in January 2006 and the data provided forms the basis for Connecting for Health quarterly reports; part of the Trust's performance targets. The cancer projects team is responsible for the communication with other

Trusts in the exchange of cancer waiting times information. The team are actively involved in the development of the information collection procedures for cancer services and waiting times.

7.5.4 The Team collects data for participation in the National Clinical Audit Support Programme (NCASP) projects including LUCADA (Lung), BASO (Breast), DAHNO (Head and Neck), ACP (Colorectal), and AUGIS (Upper GI).

7.6 Integrated Care Pathways (ICPs)

7.6.1 The development of ICPs in the Trust has increased following a one day ICP Conference that was organised by the Trust's ICP Forum. The conference was held in November 2005 and was extremely successful. A second conference is planned for early 2007.

7.6.2 The Trust is committed to introduce a Single Assessment Process (SAP). A new form of documentation in the form of a generic admissions ICP that incorporates SAP assessments has been developed and early trials of the new documentation is currently taking place in 3 sites across the Trust. The ICP will:

- Improved documentation and record keeping
- Achievement of new healthcare standard and performance indicators
- More equitable service for patients
- Evidence based best practice being delivered
- Improved communication with the multidisciplinary team and with staff across the community

7.6.3 If the trials are successful a programme will be developed to introduce the ICP Trust wide.

7.7 Multidisciplinary Audit

7.7.1 Multidisciplinary clinical audit meetings take place within specialties. Each team select audit projects to be undertaken and topics are audited using national standards. Audits using standards from guidance issued by the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs) were incorporated within the clinical audit programme for 2005/06. NICE is responsible for the provision of guidance for the NHS and patients on medicines, medical equipment and clinical procedures based on evidence of both clinical and cost effectiveness.

7.7.2 The membership of the clinical audit committee also reflects the Trust's recognition of the importance of multidisciplinary clinical audit.

7.8 User Involvement

7.8.1 The user involvement monitoring policy has been working effectively over the last year. There has been a marked increase in the number of surveys submitted for approval, demonstrating an increased awareness of the policy. The department's questionnaire design and advisory service for patient and staff satisfaction surveys has been well utilised within the last year.

7.8.2 The department continues to promote the importance of involving users in audit and appendix 6 illustrates the number of audits involving users undertaken within the

Trust in 2005/06, together with the number of user involvement projects reviewed by and notified to the user involvement group during that period. Reports on user involvement activity are regularly reported to the patient and public involvement steering group and directorates through the quarterly review process and directorate governance groups.

7.8.3 The governance support unit manager sits as a member of the patient and public involvement steering group.

7.9 Evidence Based Practice

7.9.1 The evidence based practice group, chaired by the medical director, has continued to meet throughout the year. A database has been set up to monitor the dissemination and implementation of guidance from the National Institute of Clinical Excellence (NICE). A pathway for dissemination and feedback on activity around implementation of the guidance has been introduced and is working effectively. The Trust has an identified NICE guidance manager and NICE guidance co-ordinator roles. Audits of NICE guidance being implemented within the Trust are incorporated into directorate audit programmes. Appendix 7 illustrates the number of audit projects undertaken.

7.10 Random Note Review

7.10.1 A six monthly programme of case note review, examining the quality of record keeping and consent was rolled out across the Trust to ensure compliance with standards set by the Clinical Negligence Scheme for Trusts and Royal Colleges. Directorates are being encouraged to facilitate the process within their areas. Reports on activity are included in the Trust's quarterly review reporting.

7.11 Informed Consent

7.11.1 The governance support unit manager continues to be the Trust lead for the development of procedure-specific consent forms. Consent forms have been devised within the specialities of Anaesthetics; Breast Care; General Surgery; Oncology; Ophthalmology; Orthopaedics and Urology. A Trust-wide audit of informed consent is currently being undertaken. Specialist Subject Lessons (SSLs) on informed consent are provided to Peninsula Medical School students each term.

7.12 Research Governance

7.12.1 Links have been forged with the research and development directorate and audits of research sites have been undertaken to ensure compliance with the research governance framework.

7.13 Education and Training

7.13.1 Training sessions on clinical audit have been provided to junior doctors and allied health professionals across the Trust. This has lead to a greater understanding of clinical audit, raised the profile of the department and brought about an increase in the number of audit outcomes reported. Junior doctors are being requested to undertake meaningful audit projects as part of teams, which could lead to improvements in care. Audits of NICE guidance currently being implemented within the Trust have been given to junior doctors to audit as part of their training.

7.14 Department of Research Ethics and Medical Affairs

7.14.1 The department provides administrative support for the Trust's drug and therapeutics committee, medical staff committee and clinical ethics reference group. It also provides extensive administrative support for the North and East Devon Research Ethics Committee. The committee is responsible for approving all research conducted within north and east Devon involving patients, staff and users of the NHS. The central office funds the committee for research ethics committees in London.

7.15 North and East Devon Research Ethics Committee

7.15.1 2005-06 has seen many events in the research ethics committee calendar for the whole of the UK, which has, and will continue to impact upon the current and future service provided by research ethics committees. The events have included:

- Central office for research ethics committees joined the National Patient Safety Agency in April 2005
- Publication of Lord Warner's report in June 2005 (The report of the ad hoc advisory group on the operations of NHS research ethics committees - now referred to as the DH report), which made nine recommendations for improving consistency, efficiency and effectiveness of the ethics review through stronger support for committees.
- July 2005 - a change advisory group set up to address the recommendations of the DH report, chaired by Prof Sir John Lilleyman, medical director of the NPSA.
- September 2005 - change advisory group implementation plan presented to the NPSA board and received ministerial approval in October 2005.
- January 2006 - publication of the implementation plan for consultation

7.15.2 Whilst some changes have already taken effect throughout the UK with a reduction in the number of committees, the South West committees from Cornwall to Poole are expected to reduce from 7 to 5 over the summer of 2006. Although the North & East Devon REC has been unaffected by any changes so far, a proposed merger between our committee (North & East Devon REC) and Torbay (South Devon REC) has been recommended. The forthcoming year brings further changes as a result of the implementation plans.

7.15.3 The electronic application form continues to improve with every new version released and the online database maintained by committee co-ordinators and overseen by the central office, provides useful management information that was previously unavailable.

7.15.4 Whilst there is a decline in research applications across the UK, another busy year concludes for the committee. Membership has increased from 11 to 13, the review of 59 studies (a reduction of 5 from the previous year) was carried out over 11 meetings (18 student studies, 4 clinical trials of a medicinal product and the remainder 'other' research) and with the exception of 3 studies, all were given a favourable opinion from the committee.

8. Developments for 2006/07

8.1 Whilst much work has been has been completed in 2005/06, the Trust is committed to continually improving its services, year on year. To this end, a number of plans have been developed. These are detailed below.

8.2 Healthcare Commission Standards

8.2.1 The Trust will be annually assessed by the Healthcare Commission against the core HC standards as part of the annual healthcheck. The NSLS committee will monitor compliance against these standards and internal audit will provide an independent verification against the standards. Work will continue within 2006-07 to ensure that robust information is available, should the Healthcare Commission choose to audit the Trust.

8.3 Health & Safety action plan

8.3.1 The Trust has developed a health and safety action plan for 2006-07, in liaison with staff side representatives. This can be seen in appendix 8.

8.4 Governance Support Unit

8.4.1 With the introduction of the Healthcare Standards and an increase in national audit projects the role of the department will continue to be driven by national priorities. To support local clinician-driven audit the governance support unit ComEx site will be further developed to provide a comprehensive resource for audit for staff within the Trust. Governance support facilitators will continue to link with directorate audit leads to ensure an advisory service is provided within directorates.

8.4.2 The system for monitoring actions taken against the recommendations made on projects undertaken by the National Patient Enquiry into Patient Outcome and Death has been revised in line with the Healthcare Standards and is shortly to be introduced.

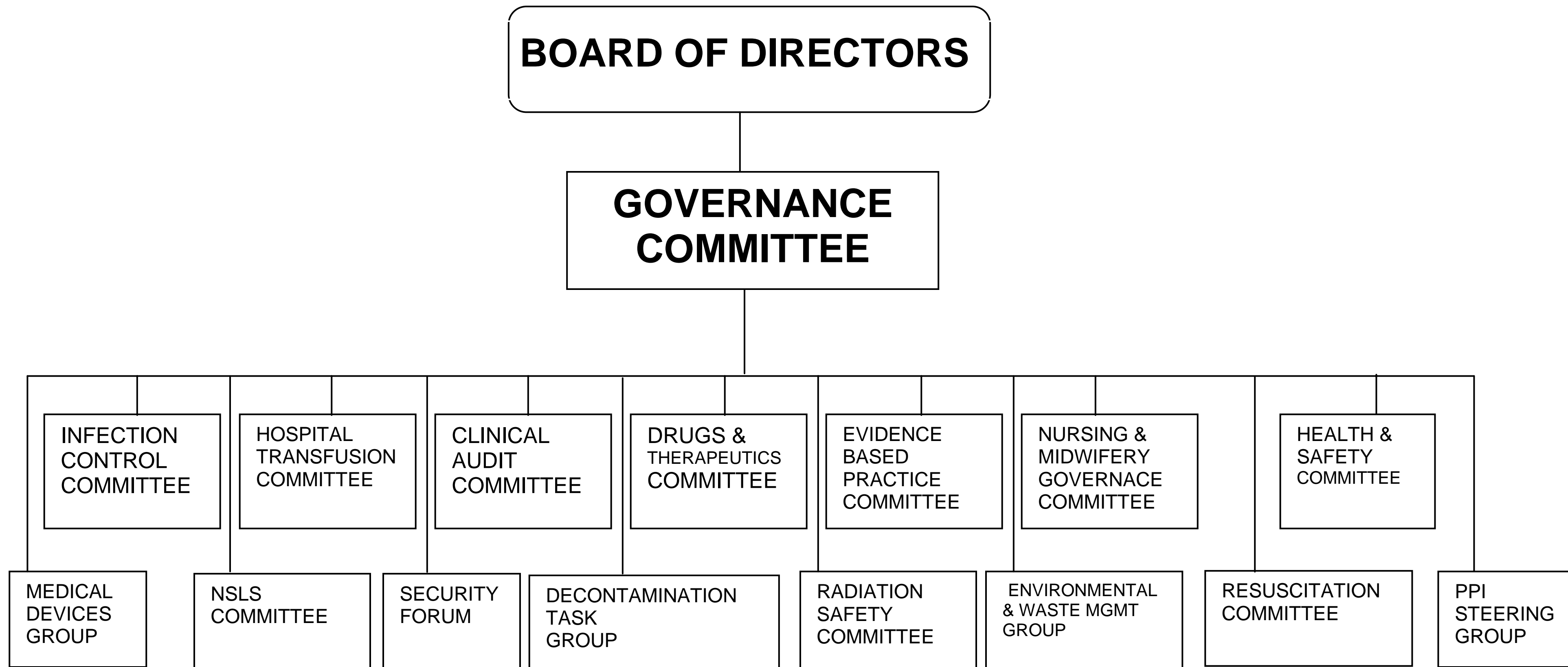
8.4.3 Further work is to be undertaken to ensure that the system of dissemination, implementation and monitoring of NICE guidance is robust, in line with the requirements of the Healthcare Standards.

8.4.4 A Trust policy for clinical audit is currently being devised and is to be implemented Trust-wide to raise awareness, increase reporting of audit activity and promote standardisation.

9.0 Recommendations

9.1 The board of directors is asked to receive this report, note the progress made to date and approve the plans set out to ensure that governance continues to be managed effectively in the current year.

APPENDIX 1



Health and Safety
Action Plan 2005 - 06

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
1.	Moving & Handling	❑ Complete pilot study for the new patient handling assessment plan is to be completed. ❑ Analyse feedback. ❑ Identified improvements included on form. ❑ The form will then be submitted to the Medical Records Sub-Committee for approval. ❑ Process policy through the following Trust ratification process, Operations Management Group and Governance committee. ❑ A briefing paper will be circulated to managers advising them of the new form. ❑ Training will be given to moving & handling key trainers who will disseminate the information throughout their teams.	A patient handling assessment plan, which is used throughout primary care will be implemented, if assessed as right for the organisation.	Moving & Handling Advisor	March 2006	Amber

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
2.	Moving & Handling	❑ Evaluate present system for recording who has attended moving & handling training. ❑ Identify improvements. ❑ Implement a more robust system of recording.	A new system for recording will be implemented.	Moving and Handling Advisor	March 2006	Amber
3.	Moving & Handling	Carry out an inventory audit of moving and handling equipment across the Trust. Establish a system for recording the results of the audit. Make recommendations as a result of the audit.	An inventory will be established on the level of moving & handling equipment. Identified deficiencies will be forwarded to the appropriate manager.	Moving and Handling Advisor	June 2005	Complete
4.	Moving and Handling Advisor	Establish a system for conducting moving and handling audits of wards and departments. Record findings and make appropriate recommendations.	A moving & handling profile of each ward/department will be established, which can be used to identify where improvements could be made.	Moving and Handling Advisor	May 2005	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
5.	Moving & Handling	As agreed with the HSE during their visit to the Trust, on the 6 Jan 05, carry out a review of how we provide our moving & handling service. Identify whether 1Moving & Handling is sufficient for a Trust of our size.	An evaluation of the current M&H's role will be undertaken to identify here improvements to the service can be made.	Director of HR	March 2006	Complete
6.	Policy de-velopm't	Review and update the following policies & procedures: ❑ Health and Safety Policy.	The Trust will be working with new policies, which reflect up to date legislation.	Risk Manager	Jun 2005	Complete
7.	Training	❑ Promote the 3day-risk management in-house training course, across the Trust. ❑ This qualifies staff to be known as 'Risk Officers.'	Aim to teach between 125 - 150 Risk Officers by the end of the second year training.	Risk Manager & Leaning and Development Service	Mar 2006	Complete
8.	Training	Develop a one-day refresher course for Risk Officer's who have been qualified for 2 years.	Aim to run 2/3 refresher courses to update Risk Officer's on any changes.	Risk Manager & Leaning and Development Service	Mar 2006	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
9.	Training	❑ Promote the importance of organisational leaning through the process of incident investigation. ❑ Encourage staff who may be involved in incident investigation to attend the 1-day incident investigation course.	Aim to teach 40 staff in the principles of incident investigation by the end of the second year of training.	Risk Manager	Mar 2006	Amber
10.	Training	❑ Develop an in-house Root Cause Analysis (RCA) course. ❑ The eight-trained RCA staff will conduct in-houses training.	The aim is to run 2 in-house RCA courses, which will include Consultants.	Risk Manager	Nov 2005	Complete
11.	Training	Front line staff are to have first allocation of conflict resolution training places. (This is a requirement of the Counter Fraud and Security Management Service (CFSMS)).	Those most at risk will be trained first in conflict resolution.	Learning and Development	Apr 2005	Complete
12.	Training	Complete and deliver "Conflict resolution training" programme for all other staff.	All Trust employees to have conflict resolution training.	Learning and Development	Apr 2008	Amber
13.	Training	Security awareness training and information to all new staff at corporate induction will continue.	All staff will receive security training.	Trust Security Manager D&C Police Partnership	Ongoing	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
14.	Security	There will be ongoing work throughout the year looking at the management and development of the following technical security measures: ❑ Access control ❑ CCTV ❑ Staff identity / access control I.D. badges.	Stricter access/egress control will be achieved, thus improving security.	Trust Security Manager	Ongoing	Complete
15.	Security	Continue to promote the "in-house" Security Service, including: ❑ Security Officer training and updates ❑ Implementation of statutes and directives ❑ Expansion of staffing levels ❑ Awareness of service by staff, visitors and public.	The newly formed in-house security service will assume a higher profile.	Trust Security Manager	Ongoing	Complete
16.	Estates Dept	❑ Urban Environments Ltd will carry out a Legionella risk assessment review on all Trust properties. ❑ The findings of this assessment will be reported on. ❑ The report will be discussed. ❑ Recommendations implemented	The risk of Legionella continues to be assessed and controlled.	Estates Manager	Annually	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
17.	Estates Dept	Scheduled testing of portable electrical appliances continues.	Risk of electrocution and fire will be reduced.	Estates Manager	On going	Complete
18.	Estates Dept	❑ The proactive regular inspection of the car parks and road surfaces to assess their condition continues all year round. ❑ Any identified problems will be rectified.	Road surfaces will have identified problems resolved.	Estates Manager	On going	Complete
19.	Estates Dept	❑ A Trust wide risk assessment of radiator surface temperature and water temperature to be completed. ❑ Any supply or radiator found to be exceeding recommended temperatures will have remedial action.	Potential for burns or scalds will be reduced.	Estates Manager / Risk Manager	Mar 2006	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
20.	Estates Dept	Conduct a Trust wide risk assessment of roads, pavements and anywhere where pedestrians and vehicles have the potential to come into contact with one another e.g. laundry vehicles reversing Make appropriate recommendations as necessary.	Identification & remedial action taken as necessary where there is a risk of vehicles & pedestrians coming into contact.	Estates Manager	March 2006	Amber
21.	COSHH	Conduct a Trust wide environmental air monitoring assessment of high-risk areas such as theatres. Consideration will be given to using independent accredited consultants.	Baseline data will be provided for substances, which need to be monitored.	Risk Manager	June 2006	Complete
22.	Risk M'gment	Review the current audit tool used during routine H&S inspections of ward/departments. Ensure the inspection information is then - transferred onto a database.	The form will ensure a consistent approach is applied to an inspection programme, which is electronically recorded.	Risk Manager	Sept 2005	Complete

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date	Traffic light
23.	Risk M'gment	Develop an innovative approach for the recruitment of staff to the H&S Committee.	Membership of the H&S Committee will be improved and there will be broader discussions.	Risk Manager	July 2005	Complete
24.	Risk M'gment	Re-draft the current Latex Policy, which at present only covers patients. The new policy will combine patients & staff.	A single policy will be produced that covers both patients and staff.	Risk Manager	July 2005	Complete
25	Infection Control	The feasibility of introducing safer needle systems will be investigated.	If the introduction is feasible and goes ahead then there should be a reduction in inoculation injuries.	Occupational Health Manager/ Director of Infection Control.	March 2006	Amber

Health and Safety Action Plan 2005/06
Exception Report

1.0 Incomplete

1.1 The following points of the H&S Action Pan 2005/06 remain incomplete:

1 The assessment form has still not been finalised. It needs to go before the nursing a midwifery governance committee and the information governance committee. As the document is four pages long and space is a premium in the medical notes, it is still uncertain at this stage whether the document will be ratified.

2 The present system was evaluated however no improvements could be identified.

9 The incident investigation course has been subsumed into the risk officer's review day. However, during the course of the year 18 people were trained to be route cause analysis facilitators.

12 Conflict resolution training continues to be carried out and has a target date of April 2008.

20 Although routine assessment of the roads and pavements is carried out with regards to maintenance upkeep, a documented risk assessment has not been completed.

25 Following a successful review of the present systems on the market it is hoped that needle-free systems may well be implemented in the near future.

2.0 Recommendations

2.1 In order to make the management of forthcoming action plans easier, it is recommended that individuals with a lead responsibility for a task, report back to this committee themselves, or where the lead person is not a member of the committee, then their report will be fed back via the Risk Manager.

Incident Reporting

Risk Matrix – ALL Incidents 01/04/05 - 31/03/06

Actual Impact - Patient incidents

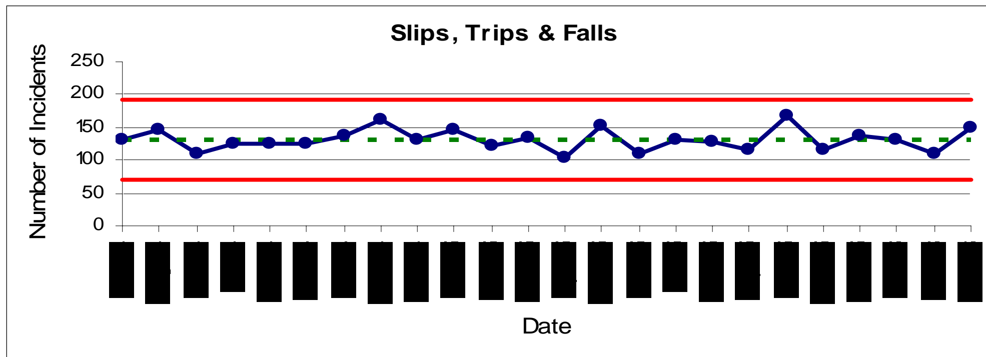
None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
3474	981	53	5	2

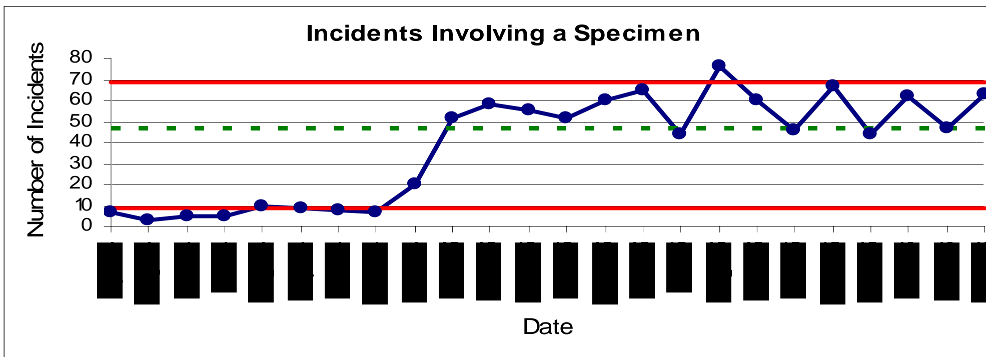
Future potential impact to the organisation

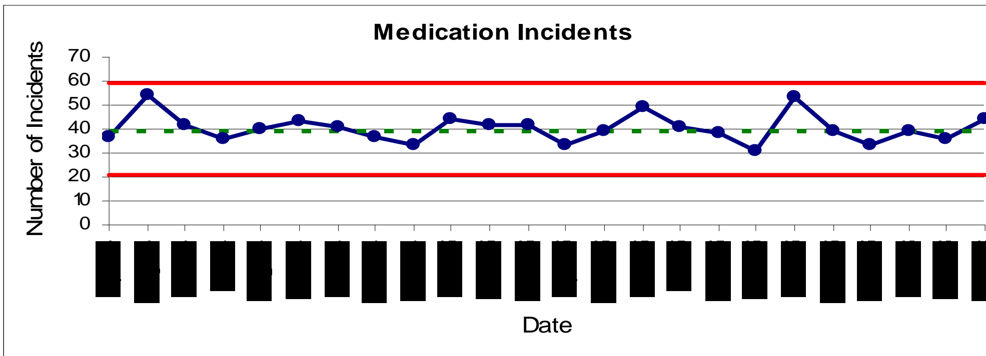
Patient Incidents 2005 - 06

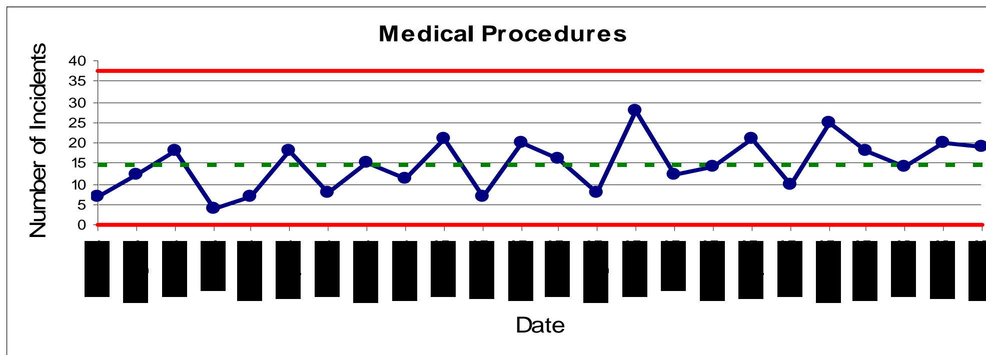
LIKELIHOOD of hazard being realised	**CONSEQUENCE**				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	350	184	36	6	1
Unlikely (2)	615	339	42	0	1
Possible (3)	1039	615	20	5	1
Likely (4)	1139	119	119	0	0
Almost Certain (5)	0	0	0	0	0

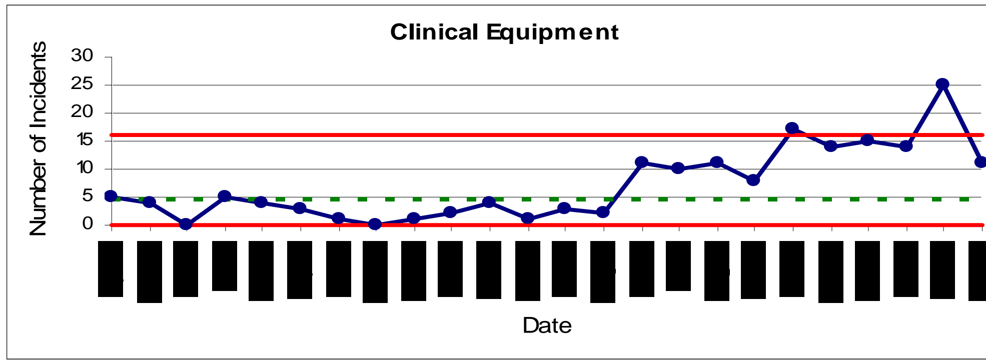
Trustwide Top 5 Patient Incidents Apr 2004 to Mar 2006
Statistical Process Control Charts











Actual Impact - Staff incidents

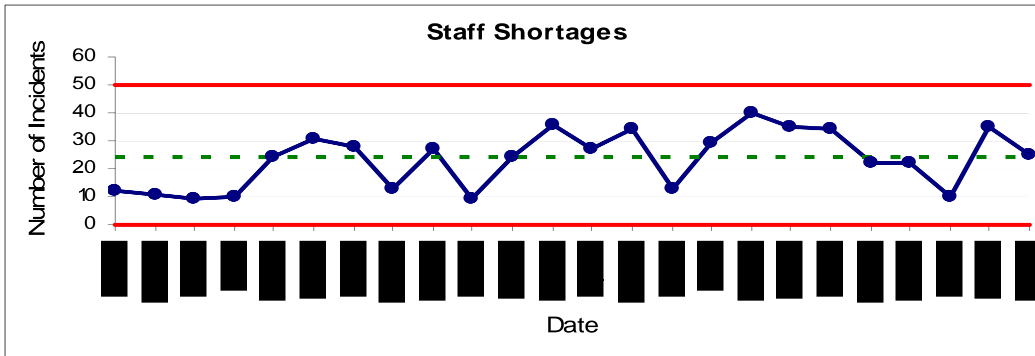
None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
1050	705	26	0	0

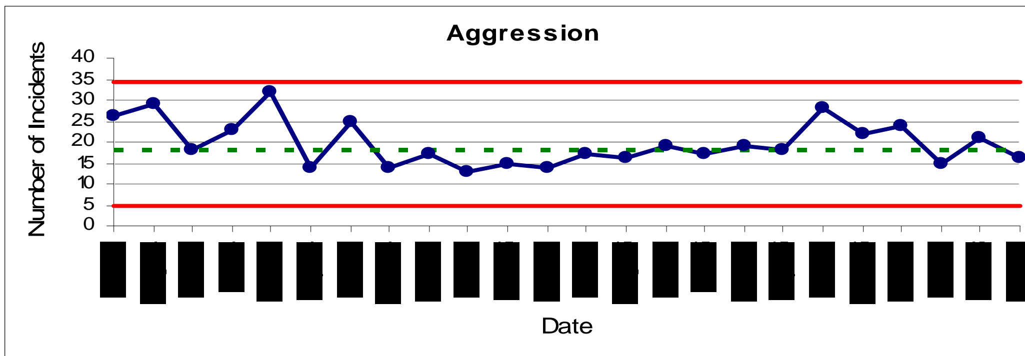
Future potential impact to the organisation

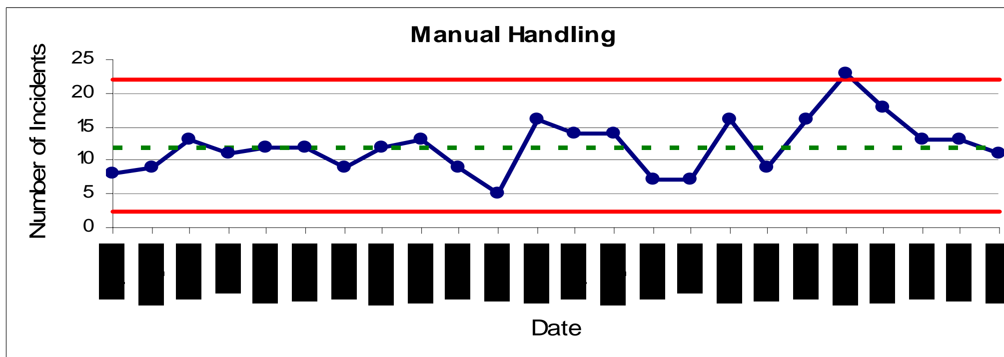
Staff Incidents 2004 - 05

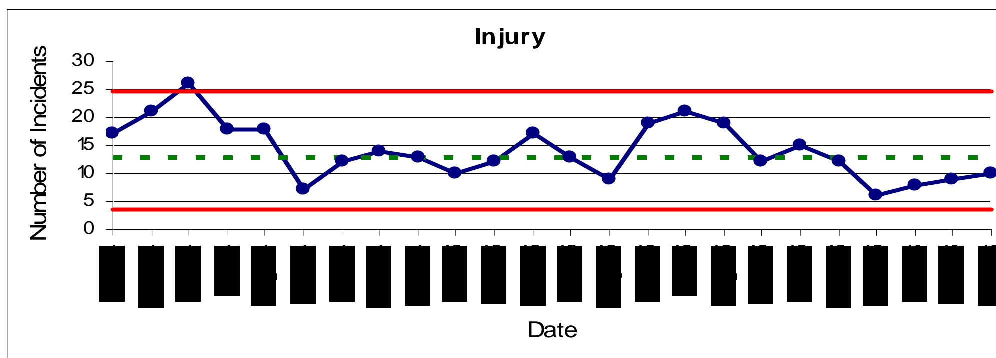
LIKELIHOOD of hazard being realised	**CONSEQUENCE**				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	148	53	5	4	0
Unlikely (2)	324	226	11	0	0
Possible (3)	703	244	8	0	0
Likely (4)	43	11	0	0	0
Almost Certain (5)	0	1	0	0	0

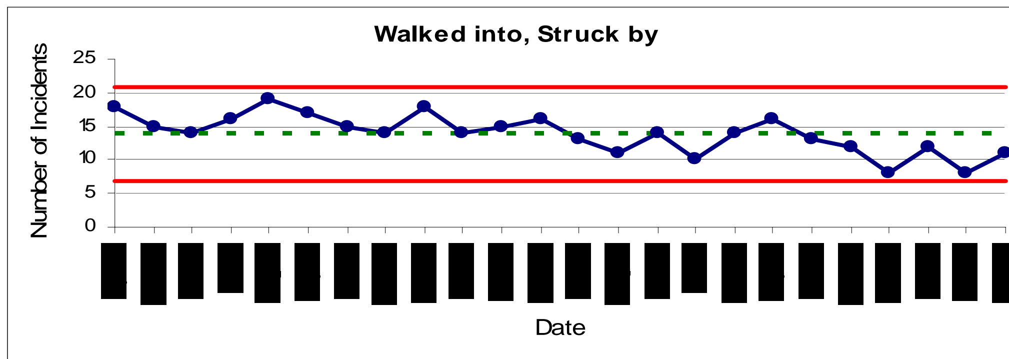
Trustwide Top 5 Employee Incidents Apr 2004 to Mar 2006
Statistical Process Control Charts











Actual Impact - Visitor/others incidents

None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
55	32	0	0	0

Future potential impact to the organisation

Visitor/others Incidents 2004 - 05

LIKELIHOOD of hazard being realised	**CONSEQUENCE**				
	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	10	3	0	0	0
Unlikely (2)	22	17	0	0	0
Possible (3)	31	2	0	0	0
Likely (4)	2	0	0	0	0
Almost Certain (5)	0	0	0	0	0

Risk Matrix – Definition of likelihood

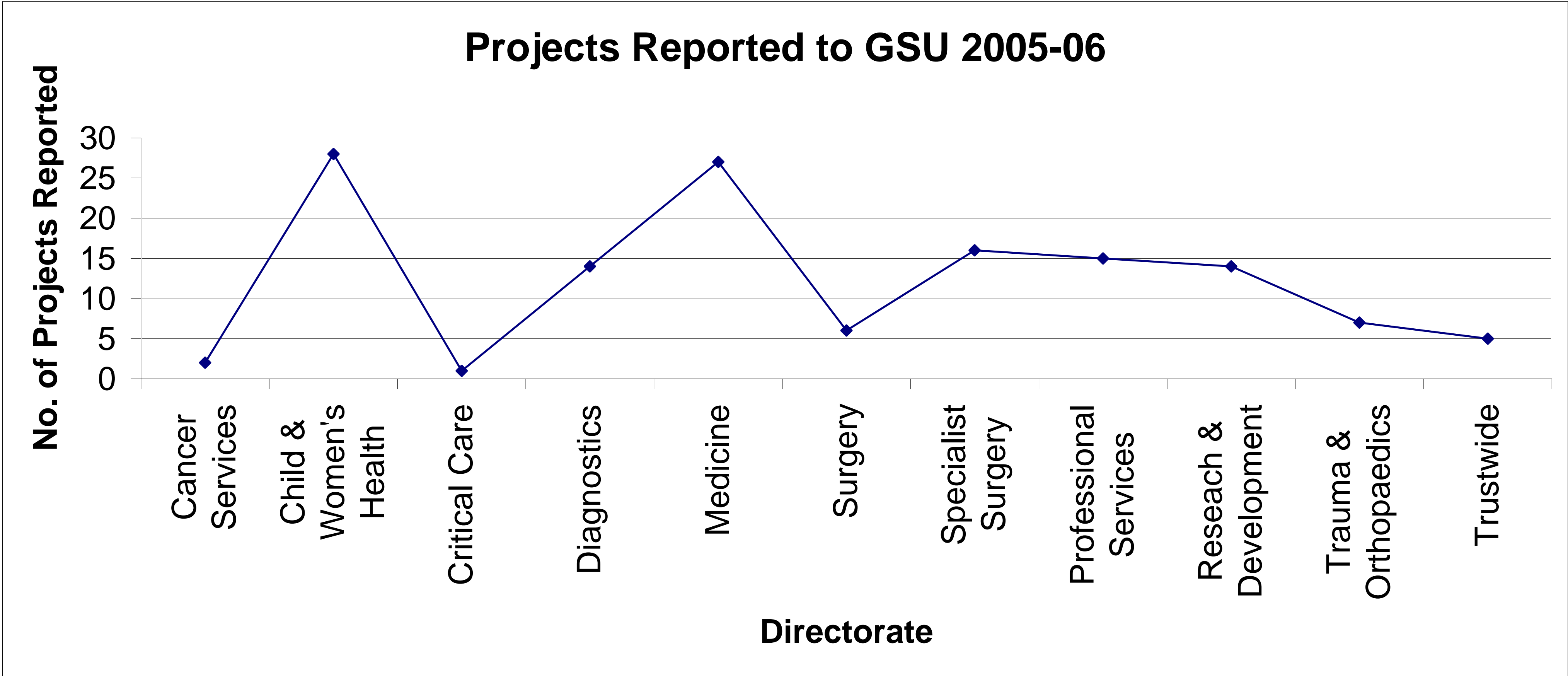
LIKELIHOOD	DESCRIPTION
ALMOST CERTAIN	Will undoubtedly occur on a regular basis (daily)
LIKELY	Will probably occur (weekly)
POSSIBLE	May occur (monthly)
UNLIKELY	Do not expect it to happen but it is possible (once per year)
RARE	Cannot believe that this will ever happen (< once per year)

Risk Matrix – Definitions for consequence of incident (actual or potential)

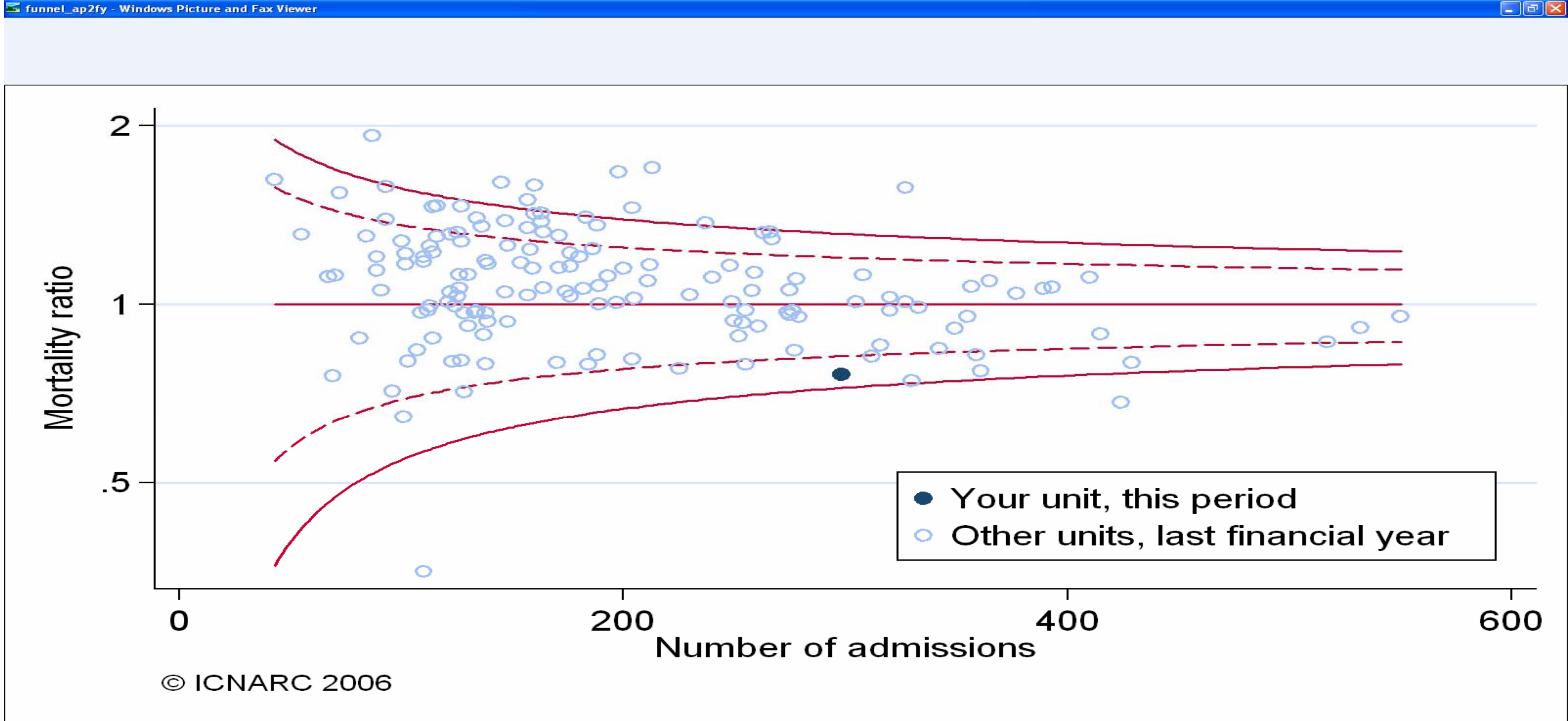
DESCRIPTION	ACTUAL OR POTENTIAL IMPACT	NUMBER OF PERSONS AFFECTED	ACTUAL OR POTENTIAL IMPACT ON THE ORGANISATION
CATASTROPHIC	Death	Many (>50) e.g. cervical screening concerns, vaccination error etc.	• International adverse publicity, loss of confidence in the organisation • Extended service closure • Litigation >£1million
MAJOR	Major permanent harm	16-50	• National adverse publicity/major loss of confidence in the service • Temporary service closure • Litigation >£500,000 • Increased length of stay >15 days
MODERATE	Semi-permanent harm (up to 1 year)	3-15	• Local adverse publicity/moderate loss of confidence • Litigation £50k-£500k • Increased length of stay 8-15 days
MINOR	Non-permanent harm (up to 1 month)	1-2	• Litigation <£50k • Increased length of stay 1-7 days
NONE	No obvious harm	N/A	• Minimal impact, no service disruption

Audit Projects Reported to the Governance support unit in 2005/06

The following is a breakdown, by directorate, of the number of audit projects reported to the Governance support unit in 2005/06.

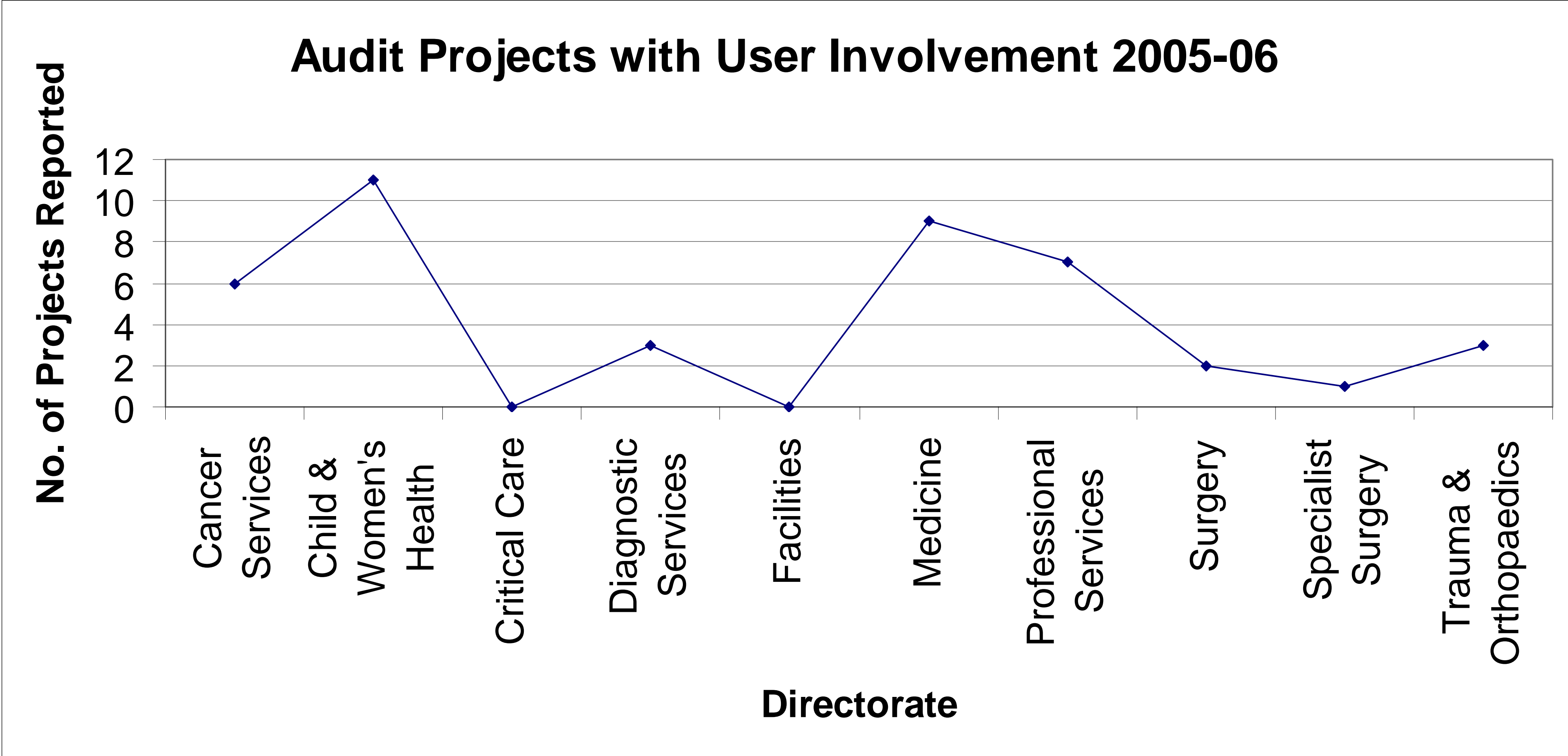


Intensive Care National Audit and Research Centre Project



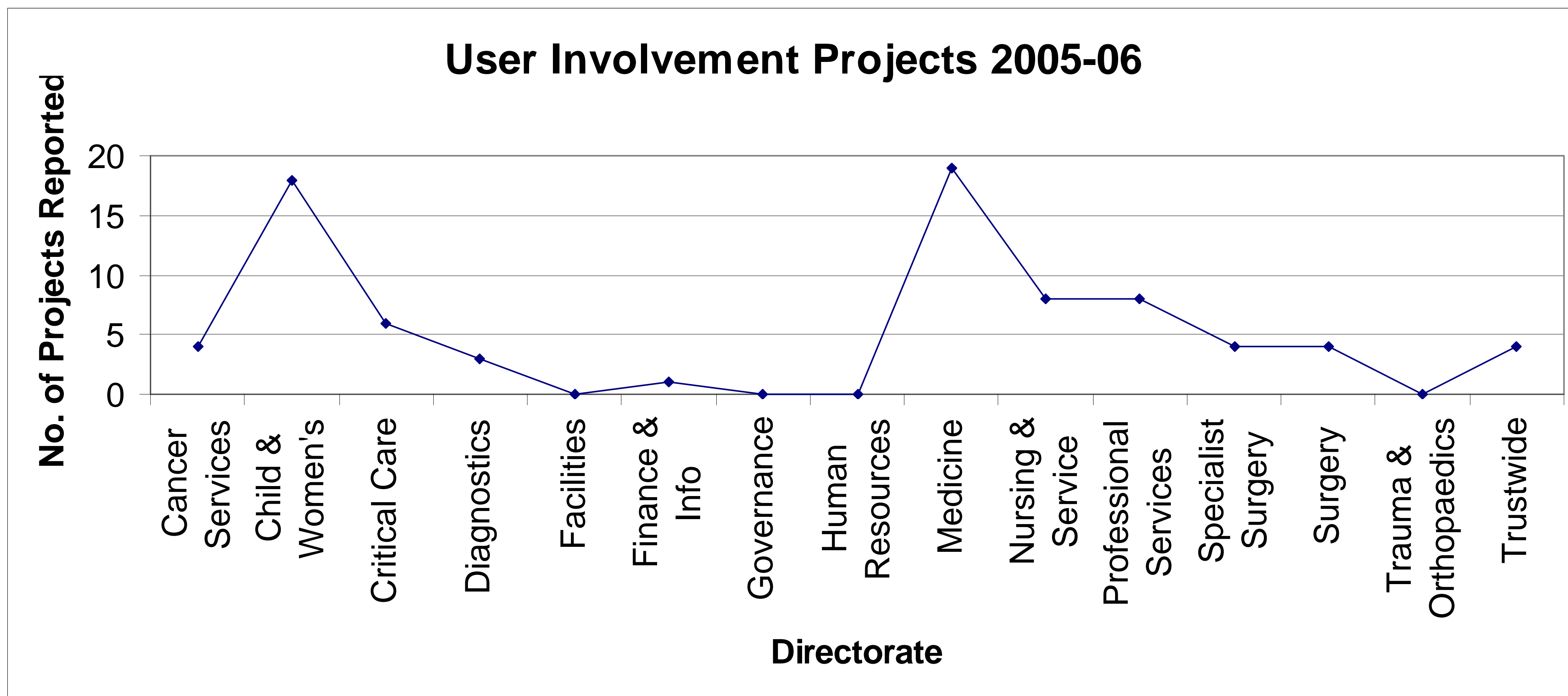
Audit Projects Involving Users in 2005/06

This graph demonstrates the number of audit projects, by directorate, undertaken in 2005/06 involving users.



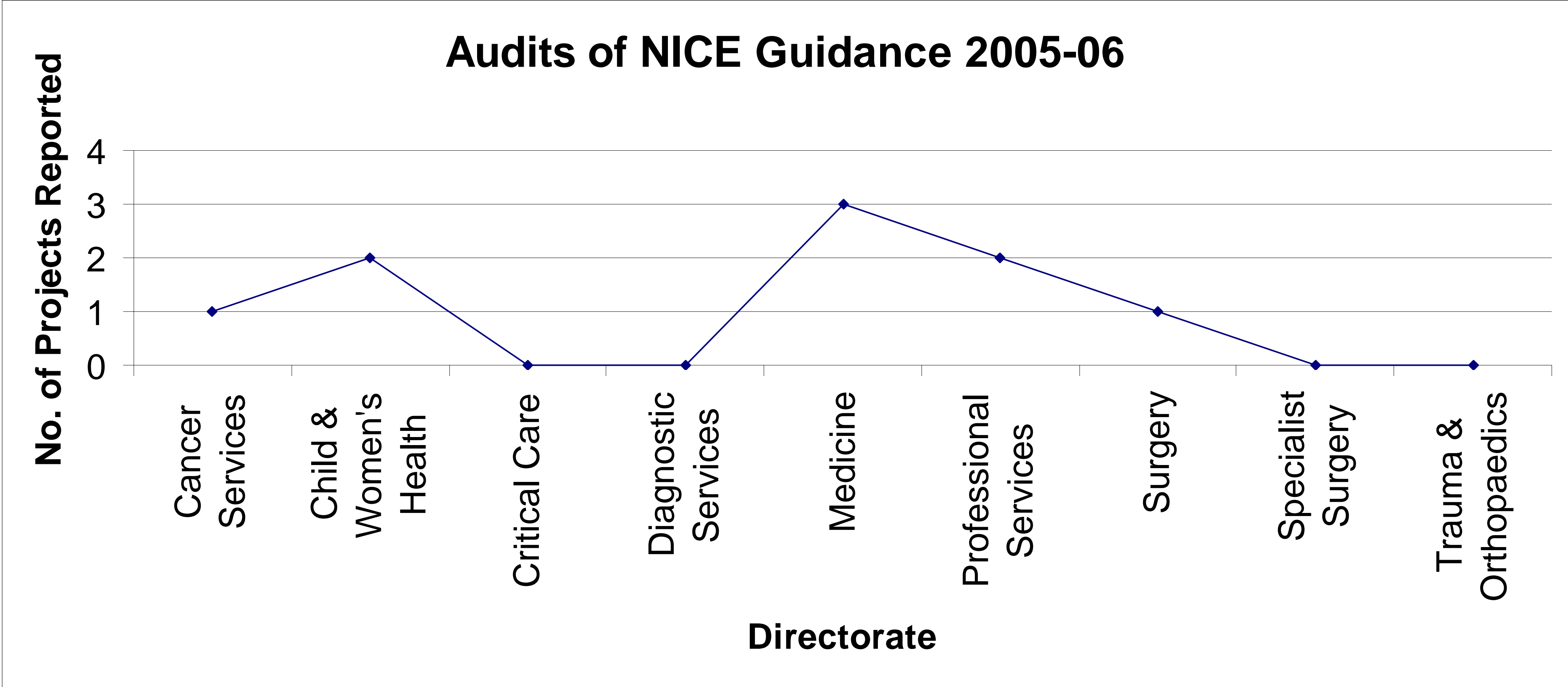
User Involvement Projects/Initiatives in 2005/06

The following is a breakdown, by directorate, of the number of user involvement projects and initiatives reviewed by or notified to the Trust's Patient, User and Staff Involvement Group in 2005/06.



Audits of NICE Guidance in 2005/06

The following is a breakdown, by directorate, of the number of audits of NICE Guidance undertaken in 2005/06.



Health and Safety
Action Plan 2006 - 07

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
1.	Trustwide	Introduce a complete ban on smoking, both inside and outside of the hospital for all staff and patients.	Create a complete smoke free environment.	Director of Nursing	Nov 2006
2.	Estates	Review the current Snow and Ice Policy and advise staff of any changes.	Will update current policy and raise staff awareness.	Head of Estates	Nov 2006
3.	Moving & Handling	Prepare a business case for the purchase of bariatric equipment.	If the business case is successful the Trust will then have a suitable and sufficient supply of bariatric equipment.	Moving and Handling Advisor	Sep 2006

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
4.	Risk Managm'nt	Initiate an H&S awareness raising campaign regarding slips and trips in the workplace through: • Investigation of all employees who slip or trip • Use of HSE posters • Presentations to staff • Assessment of roughness of floors in elderly care wards to assess if floor covering is appropriate	A reduction in employee slip and trips	Risk Manager	March 2007
5.	Estates	Conduct a risk assessment through the physical examination of every window that can be opened above ground level or ground level window where the ground outside the window falls significantly away. Ensure any opening restrictor devices already fitted to the above windows are operating correctly and fit restrictors to all other windows.	Remove the risk of people falling from first floor and above from windows that can be opened	Head of Estates	March 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
6.	Risk Managm'nt	Update all risk management policies & procedures, which are scheduled for review and amend accordingly to reflect any legislative changes.	The Trust will be working with new policies, which reflect up to date legislation.	Risk Manager	March 2007
7.	Training	Promote the 3day-risk management in-house training course, across the Trust. This qualifies staff to be known as 'Risk Officers.'	Aim to have between 160 - 190 Risk Officers across the Trust	Risk Manager & Leaning and Development Service	Mar 2007
8.	Training	Promote the one-day refresher course, which will incorporate the previous incident investigation course, for Risk Officer's who have been qualified for 2 years.	Aim to run 3 refresher courses to update Risk Officer's on any risk management changes.	Risk Manager & Leaning and Development Service	Mar 2007
9.	Training	Conduct one further Root Cause Analysis (RCA) course.	Aim to have enough appropriately qualified staff capable of facilitating a RCA.	Risk Manager	Mar 2007

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
10.	House keeping	All staff that are engaged permanently or temporarily in the deep cleaning of clinical areas, such as wards, must receive appropriate information, instruction, training (IITS) and supervision before commencement of the task. There must be a record kept of which members of staff have received the training.	Only appropriately trained staff will engage in deep cleaning duties.	Hotel Services Manager	Ongoing
11.	House keeping	The purchase of any machinery e.g. steam cleaners or chemicals, which are to be used for deep cleaning should be made in consultation with the Hotel Services Manager. The Hotel Services Manager should centrally store machinery used for deep cleaning and only issue them to appropriately trained staff.	The competent person regarding the cleaning throughout the Trust is responsible or the control of hazardous cleaning chemicals and machinery.	Hotel Services Manager	Ongoing
12.	Training	Front line staff are to have first allocation of conflict resolution training places. (This is a requirement of the Counter Fraud and Security Management Service (CFSMS)).	Those most at risk will be trained first in conflict resolution.	Learning and Development	Apr 2005
13.	Training	Complete and deliver "Conflict resolution training" programme for all other staff.	All Trust employees to have conflict resolution training.	Learning and Development	Apr 2008

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
14.	Training	Security awareness training and information to all new staff at corporate induction will continue.	All staff will receive security training.	Trust Security Manager D&C Police Partnership	Ongoing
15.	Security	There will be ongoing work throughout the year looking at the management and development of the following technical security measures: ❑ Access control ❑ CCTV ❑ Staff identity / access control I.D. badges.	Stricter access/egress control will be achieved, thus improving security.	Trust Security Manager	Ongoing
16.	Security	Continue to promote the "in-house" Security Service, including: ❑ Security Officer training and updates ❑ Implementation of statutes and directives ❑ Expansion of staffing levels ❑ Awareness of service by staff, visitors and public.	The newly formed in-house security service will assume a higher profile.	Trust Security Manager	Ongoing

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
17.	Estates Dept	Urban Environments Ltd will carry out a Legionella risk assessment review on all Trust properties. ❑ The findings of this assessment will be reported on. ❑ The report will be discussed. ❑ Recommendations implemented	The risk of Legionella continues to be assessed and controlled.	Estates Manager	Annually
18.	Estates Dept	Scheduled testing of portable electrical appliances continues.	Risk of electrocution and fire will be reduced.	Estates Manager	On going
19.	Estates Dept	The proactive regular inspection of the car parks and road surfaces to assess their condition continues all year round. Any identified problems will be rectified.	Road surfaces will have identified problems resolved.	Estates Manager	On going

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
20.	Estates Dept	To ensure that all staff who are engaged in the handling of food are trained commensurate with their work activity.	Compliance with Food Safety and Hygiene regulations	Head Chef and Catering Manager	Ongoing
21.	COSHH	Complete a Capital bid application for the purchase of an environmental air monitor.	Will allow the Trust comply with its statutory requirement to monitor chemicals hazardous to health	Risk Manager	August 2006
22.	Estates	Conduct a Trustwide risk assessment to identify areas where persons might fall from a height e.g. flat roofs and implement control measures accordingly.	Reduce the possibility of anyone falling from a height	Head of Estates	March 2006

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
23	Estates	Ensure the close supervision of the contractors carrying out the demolition of the old incinerator chimneystack, with particular attention paid to dust suppression and noise pollution.	A safe controlled removal of the stack with no nuisance complaints.	Head of Estates	Oct 2006
24.	Facilities	Conduct a workplace noise assessment within the laundry.	To ensure that the latest 'action levels' laid down in the Noise at Work Regulations are not being breached.	Risk Manager	March 2007
25.	Trust wide	Pandemic Flu will pose health risks for staff caring for sick patients and will put severe strain on services and therefore a Trust wide Action Plan is being developed to control an outbreak.	A reduction in the likelihood of infection and serious ill health in staff.	Director of Operations	Sep 06

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
26.	Trust wide	Extend the enquiry about health, health and safety and wellbeing at appraisal, to include doctors.	This will fulfil HSE's requirement for health surveillance for such things as latex and stress.	Consultant Occupational Physician	March 07
27.	Risk M'gement	Identify and convert a room to provide a risk management/moving and handling (M&H) training facility. The room should be fitted out with a hospital bed, hoist and any other M&H equipment required to demonstrate and practice M&H techniques.	Provide a facility which can be utilized by Directorate M&H Key trainers.	Risk Manager	Oct 06
28.	Human Resources	Ratify Management of Sickness Absence and Return to Work Policy. Implement above policy and develop training awareness sessions for managers.	Closer monitoring of sickness trends will assist in early identification of potential problems, thus allowing timely and expedient implementation of remedial measures.	Head of Human Resources	Dec 06

No.	Area	Action to be taken	Outcome	Lead responsibility	Delivery date
29.	Estates Dept	❑ The proactive regular inspection of the car parks and road surfaces to assess their condition continues all year round. ❑ Any identified problems will be rectified.	Road surfaces will have identified problems resolved.	Estates Manager	On going
30.	Estates Dept	Conduct a Trust wide risk assessment of roads, pavements and anywhere where pedestrians and vehicles have the potential to come into contact with one another e.g. road between PEOC and ED Make appropriate recommendations as necessary.	Identification & remedial action taken as necessary where there is a risk of vehicles & pedestrians coming into contact.	Estates Manager	Oct 06
31.	Infection Control	The feasibility of introducing safer needle systems will be investigated.	If the introduction is feasible and goes ahead then there should be a reduction in inoculation injuries.	Occupational Health Manager/ Deputy Director of Infection Control.	Mar 07