LIVERPOOL WOMEN'S HOSPITAL NHS TRUST

Liverpool Women's Hospital
in partnership with
The Aintree Centre for Women's Health

Corporate Governance
Annual Report 2002/03

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LIVERPOOL WOMEN'S HOSPITAL NHS TRUST

Corporate Governance Annual Report 2002/03

1. Purpose of the Report

The purpose of this report is to communicate;

- the Liverpool Women's Hospital NHS Trust organisational framework to enable delivery of robust governance arrangements.
- how the Trust performed in 2002/03 in its objective of developing a robust system of internal control
- key areas of progress

2. Introduction

Corporate Governance is about how organisations direct and control their functions to achieve their objectives. As much as it is concerned with structures, processes, or internal control mechanisms, it is also about culture, style and leadership; about what organisations want to do and how people make things work to achieve them. Consequently, it is about how effectively management boards work.

The term `governance` can be interpreted differently in different parts of the public sector. A number of frameworks and models of governance exist, not all of which address the same issues. An effective model however, is one which ultimately produces clear messages about good governance and one which drives organisational and service improvement and enhances public trust and confidence in public services.

Most organisations in the public sector are addressing the quality of governance arrangements and seeking how best to: interpret and apply the core principles of openness, integrity and accountability in conducting business; minimising the incidence of fraud (including the use of internal audit); and increasingly, how to include the perspective of users and the wider public in planning and decision making.

There are differences between the public sectors in how they approach this. In the NHS, interest in governance arrangements has been stimulated by new organisational structures and in particular, the role of non-executive directors in the overall functioning of NHS boards and in intra-NHS relationships between Primary Care Trusts, acute Trusts and Strategic Health Authorities.

The guidance and frameworks on corporate governance in the NHS emphasises effective controls assurance, with the requirement to publish an annual Statement of Internal Control and three sets of core standards relating to governance ie

- Governance
- Risk Management
- Financial Management

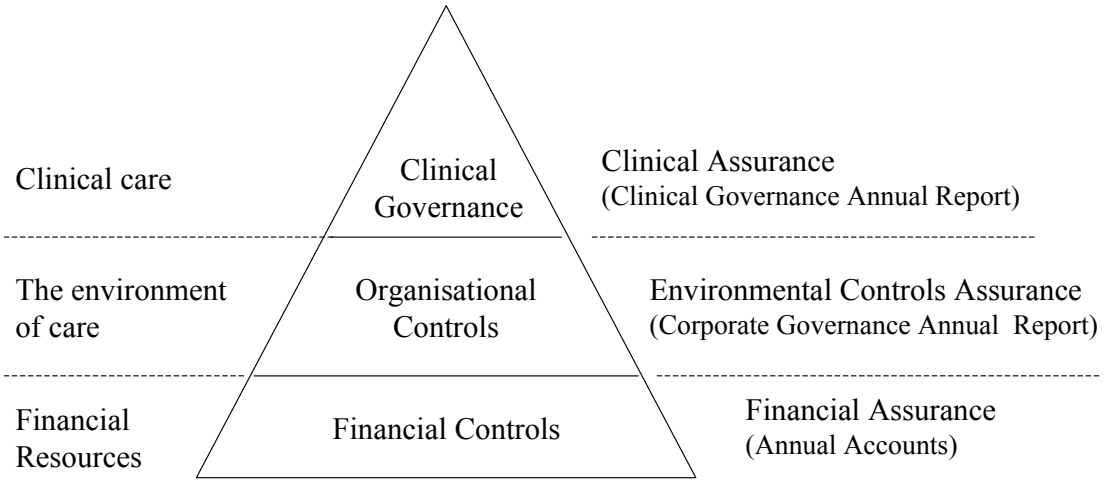
Also, what is perceived in local government to be at the heart of good corporate governance, is seen as the province of clinical governance in healthcare.

The three dimensions of

- organisational structure and process
- financial and performance reporting of internal controls
- and, standards of behaviour

are embodied in an holistic system of risk management and control which underpins the delivery of quality of care to patients.

The system is termed **Organisational Controls Assurance**. The system of internal control in the NHS comprises of three sub-systems; financial, organisational and clinical control.



Research suggests that public trust and engagement are either static or declining, what is not clear is whether there is a real decline or a reaction to negative medical coverage of high profile failures.

Governance must address how organisations communicate values and choices to the public and demonstrate openness, integrity and accountability for good as well as poor performance.

Organisational boards can only fulfil their responsibilities if there is a sound understanding of principal risks facing the organisation. This points to a need to debate and map the links between risks, effectiveness and assurance and develop a framework for delivering links to organisational objectives.

3. Corporate Governance Arrangements for Leadership, Accountability & Reporting

3.1 Leadership & Accountability

The framework for delivery is determined by the Trust Board which provides overall leadership for each of the sub-systems.

The Chief Executive is the accountable officer for the delivery of statutory responsibilities, the achievement of NHS performance targets and the delivery of services which underpin the quality of patient care.

Operational responsibilities and leadership enabling optimal performance in each of the sub-systems is delegated to other directors of the Trust Board as follows:

- Clinical - Director of Nursing & Midwifery
- Environmental/Organisational - Director of Corporate Services
- Financial - Director of Finance

Clinical

Leadership for development and activity is provided by the Clinical Lead for the Trust and Board accountability is delivered by the Director of Nursing and Midwifery. Additionally, there are nominated leads within each directorate, responsible for local delivery and arrangements.

Environmental/Organisational

Controls assurance development and activity against the 21 controls assurance standards is led by the Director of Corporate Services who is accountable at Board level. Each of the standards is operationally developed by a nominated service head who assumes responsibility for gauging performance against standards in the specialty and determining and delivering an annual development programme both locally and organisationally where appropriate.

Financial

Leadership for the delivery of financial performance targets, financial risk management and the development of a robust system for delivery is delegated to the Director of Finance who is accountable to the Trust Board.

3.2 Reporting

Each sub-system reports to the Trust Board via a framework of sub-committees.

Clinical

The annual programme of clinical governance development is co-ordinated and monitored by the Clinical Governance Committee (see Appendix A), and progress is reported quarterly to the Trust Board.

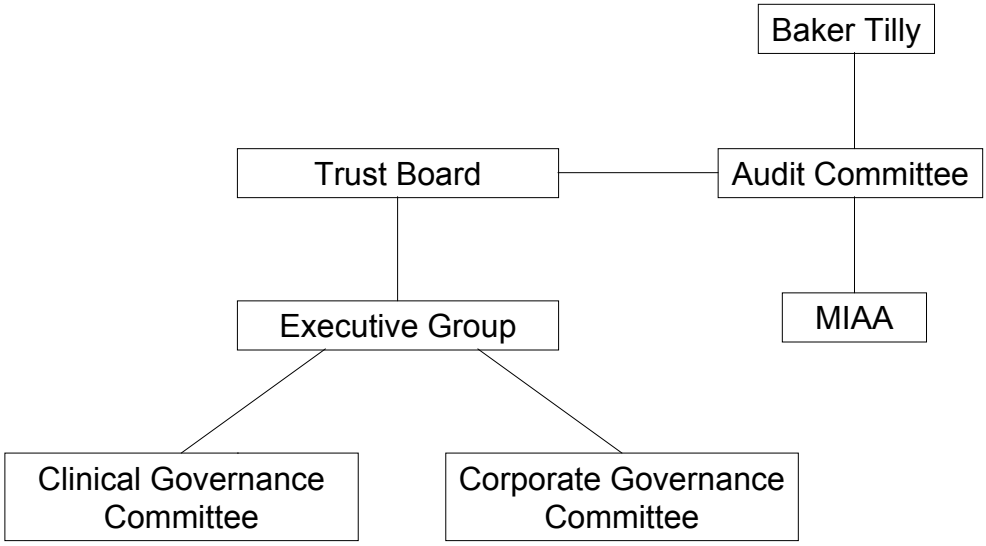
Environmental/Organisational

The annual programme for Controls Assurance development is co-ordinated and monitored by the Corporate Governance Committee (see Appendix B), and progress is reported quarterly to the Trust Board.

Financial

The Trust's financial activities continue to be monitored by the Mersey Internal Audit Agency (MIAA) who provide regular reports to the Audit Committee of the Trust Board.

Additionally, external auditors Baker Tilly, provide an annual report on accounting statements and financial activities to the Trust Board. The annual audit programme is approved by the Audit Committee.



4. Developments on Systems of Internal Control and Assurance 2002/03

4.1 Clinical

- Achievement of CNST Level 2

  In June 2002, the Trust was awarded Level 2 status for clinical standards set by the Clinical Negligence Scheme for Trusts.

  This achievement demonstrates the Trusts commitment to the delivery of high standards of patient care.

- Improvements in complaint response times

  Work in year has seen response times improve from 40.5% to 77.5% being responded to in 20 working days

- Development of clinical policies

  The Clinical Governance Committee and Trust Board have ratified a number of polices in-year (see Table 1), providing statement and guidance to staff on a variety of work areas.

- Consent

  Considerable work has been undertaken to roll out the Department of Health consent form for taking patient consent prior to elective surgical procedure.

- Training

  In 02/03 the focus was on improving attendance at mandatory training. Arrangements for cardiopulmonary resuscitation were revised and an increased number of attenders achieved.

- Infection Control

  During 2002/03, the Trust established link workers in each directorate. This was with a view to making operational delivery of developments in the clinical areas a more manageable and robust arrangement.

Greater detail on these and other Clinical Governance developments are reported in the Clinical Governance Annual Report 2002/03.

Table 1

	POLICY NAME	NEW/ REVISED	DATE RATIFIED	RATIFIED BY	AUTHOR
1	Uniform Policy	New	April 02	Clinical Governance	Dir of Nursing & Midwifery
2	Major Incident Plan Policy	Revised	April 02	Clinical Governance	Dir of Nursing & Midwifery
3	Policy for the Disposal of Fetal Remains Guidelines	New	May 02	Clinical Governance	Dir of Nursing & Midwifery
4	Risk Management Strategy	New	June 02	Trust Board	Dir of Corporate Services
5	Medicines Management Strategy	New	June 02	Clinical Governance	Pharmacy Manager
6	Policy for the Identification of the Newborn	New	July 02	Clinical Governance	Dir of Nursing & Midwifery
7	Zero Tolerance Policy	New	Sep 02	Trust Board	Risk/H&S Manager
8	Fire Policy	Revised	Sep 02	Trust Board	Estates Manager
9	General Health & Safety Policy	Revised	Sep 02	Trust Board	Risk/H&S Manager
10	Lone Working Policy	Revised	Sep 02	Trust Board	Risk/H&S Manager
11	Chemical Spillage	New	Sep 02	Trust Board	Infection Control Manager
12	Policy for Reporting to External Regulators	New	Sep 02	Trust Board	Risk/H & S Manager
13	Policy for Receiving, Actioning & Filing Laboratory Reports	New	Nov 02	Clinical Governance	Dir of Nursing & Midwifery
14	Environmental Management Policy	New	Nov 02	Corporate Governance	Estates Manager
15	Incident Reporting Policy	Revised	Jan 03	Corporate Governance	Risk/H&S Manager
16	Policy for the Reporting, Recording and Treating Accidents & Incidents	Revised	Jan 03	Corporate Governance	Risk/H&S Manager
17	Estates Policy	New	Jan 03	Trust Board	Estates Manager
18	Electrical Safety Policy	New	Mar 03	Corporate Governance	Estates Manager

4.2. Organisational/Environmental

- RPST Level

In September 2002, the Trust was awarded Level 1 status for non-clinical standards and risk management arrangements by the Risk Pooling Scheme for Trusts (RPST). The table below highlights the scores attributed for compliance.

Table 2. ***RPST Risk management Criterion and Audit Compliance Score***

Criterion	No. Audit Questions	No. Yes	No. No	No. P	No. n/a	% Yes	% No	%P +n/a
Corporate Accountability	11	9	0	2	0	82	0	18
Risk Management Strategy	13	10	2	1	0	77	15	8
Risk Manager Organisational Structure	14	10	2	1	1	79	14	7
The reporting and management of incidents	34	27	4	3	0	79	12	9
Reporting and management of complaints and claims	28	24	2	2	0	86	7	7
Risk management process	23	17	3	2	1	78	13	9
Risk management training	14	11	1	2	0	79	7	14
Independent assurance	15	13	1	1	0	87	7	7
Overall Compliance score	**152**	**121**	**15**	**14**	**2**	**81**	**10**	**9**

P = Partial Compliance
N/A = not applicable

Trust Compliance Strengths

The Executive Summary of the RPST compliance audit report highlighted the following:

- "The excellent scores for each of the criteria highlight the commitment of the Trust to establishing good risk management systems across the organisation"
- "One of the strengths of the organisation is the well defined accountability arrangements for risk management"
- "The risk management strategy is an excellent document"
- "The organisation's high score on the incident reporting criterion is indicative of an excellent incident reporting procedure and staff's willingness to report incidents"
- "Complaints and claims appear to be well managed within the organisation"
- "The good score on criterion 7 demonstrates its obvious commitment towards provision of risk management training"

- "The organisation achieved an excellent score on criterion 8 demonstrating that it has given full consideration to the work of both internal audit and the Audit Committee and ensured they have an input on risk management processes".

This achievement is demonstrative of the organisation's commitment to providing an environment and arrangements in which quality patient care can be delivered.

A subsequent discount on next year's premiums will enable this resource to be channelled back into patient care.

A number of the Trust's documents were commended and requested for sharing with other organisations as examples of good practice (see Table 3).

Table 3

Title	Date
Risk Management Strategy	2001-2003
Incident Reporting Policy	July 2002
Procedure for Reporting, Recording and Treating Accidents & Incidents	July 2002
Procedure for the Root Cause Analysis of Accidents and Incidents,	July 2002
Adverse Clinical Event Reporting (ACE) Policy	February 2002

- 2 Star Status

  The Trust was awarded 2 star status in the national performance tables. Work in a number of areas is ongoing to enable the Trust to progress to 3 star status in 2003/04.

- Green Status for Patient Food

  An in-year assessment in the final quarter enabled the Trust to retain `green` status for patient food in the NHS Plan "Better Hospital Food" initiative. The Trust is one of four in the North West and 118 nationally to achieve this standard.

- Risk Register

  Risk registers are key to an organisation's management of risk. Work in-year has developed the register's capacity to approximately 1000 entries. Further development is planned.

- Patient Environment Action Team (PEAT) – 4 star status award

  The Trust was awarded the maximum 4 stars for the second year running in an external review of standards which cover the environment, privacy and dignity, hospital food, and cleanliness.

- Fire Safety

  In addition to planned developments, a full review of arrangements took place in response to a series of national fire service strikes.

  The system of internal control has benefited by

  - improving and increasing staff training arrangements and recording
  - a revision of the Fire Safety Policy
  - enhanced staff awareness
  - a programme of fire drills
  - monitoring of incidents and action by the Corporate Governance Committee

- Zero Tolerance

  The Trusty acknowledges the difficulties of delivering healthcare in the current social climate and the potential for physical and verbal abuse which staff are exposed to. A policy and procedure have been approved by the Trust Board mapping out the management and potential withdrawal of care from patients who are verbally or physically abusive.

- Risk Management Newsletter

  A bi-monthly newsletter was introduced in October 2002 with the objective of sharing lessons learned from incidents and communicating issues relating to all aspects of risk management.

- Training

  A review of provision led to increasing the number of courses for:-

  - cardiopulmonary resuscitation
  - first aid
  - manual handling
  - health and safety (IOSH and CIEH)
  - induction

  Management arrangements for the recording of training undertaken has also improved.

- Lone Worker System

  A "Multitone Staffguard" system was purchased to address the safety and security of staff working alone outside the safety of the hospital. Genetic directorate staff are operational on the system which will be rolled out further to other staff groups in due course.

- Decontamination of re-useable instruments

  In response to Department of Health guidance on traceability of surgical instruments, a system was introduced in 02/03.

  Local (departmental) decontamination of instruments has been greatly reduced and the Trust complies with the single use consumable directive from the Medical Device Agency.

  Progress has commenced on the transfer to disposable surgical gowns and drapes to replace cotton/calico stock which do not satisfy the forthcoming EU directive.

- Purchasing and Supply

  In August 2002, management of this function was contracted out to the Royal Liverpool Children's Hospital. Significant improvements in accountability have been seen early in the contract period.

  As a result, procedures have been reviewed, a purchasing strategy drafted and awareness of E.U. procurement regulations and Standing Financial Instructions drafted.

- Medicines Management

  Significant progress was made on strategy and policy development and approval and work on Patient Group Directions is on-going.

  Electronic prescribing which was first introduced into the gynaecology directorate in November 2001, was extended during 02/03 to the obstetric directorate.

- Improving Working Lives

  In March 2003 the Trust was recommended for, and subsequently awarded "Practice" status following an external assessment against the Improving Working Lives national standards. The next level "Practice Plus" will be worked towards in 2003/04.

- Patient and Public Involvement

  The Trust recognises the importance of involving patients and the public in a wide range of activities.

  Involvement has increased during 2002/03 and representation is now made on the following groups/committees.

  - Corporate Governance Committee
  - Clinical Governance Committee
  - Patient Involvement Group
  - Patient Environment Steering Group
  - Research and Development Committee
  - Patient Information group
  - Labour Ward Forum

4.3. **Financial**

The Audit Committee met regularly throughout 2002/03. Business transacted included:

- Consideration of the 2001/02 Annual Accounts for the Trust and for Charitable Funds.
- Reports from the external and internal auditors
- 2001/02 Management Letter
- Review of waivers of standing orders
- Review of the hospitality and members interest registers
- Counter Fraud Annual Report 2001/02
- Controls Assurance Report 2001/02

The internal audit plan, covering all core financial systems, for 2002/03 was based on detailed audit risk assessment and incorporated mandatory requirements, traditional financial audit and value added risk-based reviews. Quarterly reports were made to the Audit Committee on the work undertaken against the plan together with a summary of recommendations arising from the audit.

In general the auditors found systems to be operating effectively, although in all cases there were opportunities for improvement. Detailed audit action plans were agreed with Trust managers to respond to the issues identified. Particular audit concerns were however identified in respect of systems for Budgetary Control and Reporting Finance and Corporate Information which led to detailed audit reports being received and monitored buy the Audit Committee. Action was taken in year to address the weaknesses identified and recover the financial deficit identified.

The management letter sets out the opinions of the external auditors on the financial affairs of the Trust and for 2001/02 (latest reporting period) gave an unqualified audit opinion for both NHS and Charitable Trust Funds. The letter noted achievement of all but one (Capital Cost Absorption Duty) of the four

statutory financial duties and concluded that the Trust's financial systems continue to be well controlled. The auditors reported that the Trust's overall arrangements to prevent and detect fraud and corruption are appropriate.

The External Auditors reported back findings on four performance reviews for which data was collected in 2001/02:

- Radiology
- Medicines Management
- Medical Staffing
- Supplies

Two further mandated studies were also undertaken relating to Data Quality and Implementation of the NHS Plan. Recommendations from these studies have been considered by the Committee.

The overall position on financial assurance for 2002/03 will be reported in the Annual Accounts for the Trust and for Charitable Funds.

5. Detailed Progress on Controls Assurance Standards 2002/03

A work programme is produced at the start of each financial year and follows a re-scoring exercise which audits the organisations positions in respect of performance against the 21 Controls Assurance standards.

Scores and proposed work are submitted to the Controls Assurance Support Unit (CASU) and the work programme is approved by the Trust Board.

Progress on the work plan to the year end is reported fully in Appendix C.

6. Controls Assurance Scores

As mentioned in the previous section, an annual scoring exercise is undertaken which informs the work programme for the following year.

Scores attained for each of the standards are detailed in Table 4.

Table 4

Controls Assurance Baseline Scores
(at commencement of each financial year)

Standard		% Score			
		00/01	01/02	02/03	03/04
1	Risk Management	50	58	71	83
2	Building, land, plant & non-medical equipment	21	35	52	60
3	Catering and Food Hygiene	90	78	81	84
4	Control of Contracts & Contractors (now called Management of Purchasing and Supply)	56	68	83	68*
5	Emergency Planning	50	35	35	38
6	Environmental Management	8	9	30	34
7	Fire Safety	68	72	82	90
8	Health & Safety	82	69	71	76
9	Human Resources	92	93	96	97
10	Information Management & Technology	60	66	70	84
11	Infection Control	71	76	83	88
12	Medical Devices Management	83	83	84	86
13	Medicines Management	67	69	73	73
14	Professional & Product Liability	90	96	99	95*
15	Records Management	52	57	69	86
16	Security Management	52	50	66	72
17	Waste Management	83	72	57	59
18	Transport	N/A	N/A	N/A	N/A
19	Decontamination of re-useable medical devices (new in 00/01)	N/A	36	59	72
20	Corporate Governance (new in 02/03)	N/A	N/A	93	91*
21	Financial Management (new in 02/03)	N/A	N/A	82	90

* These areas showed a decrease in score for the following reasons;

- Management of purchasing and supply

  Management arrangements changed in-year. A more critical and robust review of systems was undertaken which highlighted areas requiring update and modernisation. This work has commenced and will continue in 2003/04.

- Professional and product liability

  A review of contract terms and conditions pointed to a need for further work. Additionally, meetings with customers need to be arranged.

- Corporate Governance

  The agreed audit programme was subject to slippage in-year. The 5 year plan will be progressed with effect from 2003/04.

7. Audit Programme

An annual audit of the core standards of the Controls Assurance framework was undertaken as planned, ie:

- Governance
- Risk Management
- Financial Management

However, due to previously unforeseen audit requirements, the programme for 2002/03 approved by the Audit Committee was deferred.

Following a check on priorities to ensure that the proposed programme order was still current, it is proposed that this work will continue in 2003/04 (see Appendix D).

Appendix A

Clinical Governance Committee

Terms of Reference/Membership & Accountability

1. The Clinical Governance Committee of the Trust is a sub-committee of the Trust Board, and is multi-disciplinary, representative and inclusive.

2. The role of the Clinical Governance Committee is to monitor the quality of all aspects of clinical practice within the Trust, to include clinical effectiveness, professional development, continuous quality improvement and risk management.

3. Regular reports will be made on clinical quality to the Trust Board which will include information on:

   a) progress in achieving agreed objectives for clinical governance (action plan from baseline assessment)
   b) local and national audits
   c) complaints received and action taken
   d) clinical negligence claims received and action taken
   e) adverse clinical incidents reported and action taken
   f) medication and transfusion errors reported
   g) hospital infection reports
   h) staff development programs, participation in training programs and CPD
   i) staff appraisal
   j) progress with IT development

4. The Clinical Governance Committee will also, through directorate team representatives, ensure that each directorate team regularly reviews its clinical protocols, clinical incident reports, and new developments and clinical guidelines, and reports progress to the Committee.

5. The Clinical Governance Committee will prepare and submit an annual report on clinical governance activity to the Trust Board.

6. Action resulting from decisions taken at the Committee will be implemented via the clinical directorate management structure.

Membership

- Clinical lead for Clinical Governance - Chair
- Accountable Director - Director of Nursing & Midwifery
- Directorate Representatives
  - Neonatal
  - Obstetrics
  - Gynaecology
  - Theatres & Anaesthesia
  - Clinical Support Services
  - Genetics
- Control of Infection
- Supervisor of Midwives
- Public Representation - Member of Community Health Council
- Board Representatives
  - Executive Directors
    - Chief Executive
    - Medical Director
    - Director of Nursing & Midwifery
  - Non-Executive Director

Clinical Governance Committee

Membership – 2002/03

➢ Clinical Lead for Clinical Governance

- Chair – Professor R Cooke

➢ Director Accountable for Clinical Governance

- Director of Nursing & Midwifery – Mrs B Craig

➢ Directorate Representatives

- Neonatal – Dr N Subhedar
- Obstetrics – Dr H Scholefield
- Gynaecology – Mr J Herod
- Theatres & Anaesthesia – Dr P Barclay
- Clinical Support Services – Ms L Matthew
- Medical Genetics – Mrs A Douglas

➢ Control of Infection – Dr T Neal

➢ Supervisor of Midwives - Mrs C Casey-Hardman

➢ Public Representation

- Member of Community Health Council – Ms C Dersch

➢ Human Resources & Training – Mrs A M Stretch

➢ Board Representatives

- Executive Directors
  - Chief Executive
  - Medical Director – Mr D Richmond
- Non-Executive Director – Dr G Vince

Appendix B

Corporate Governance Committee

Terms of Reference/Membership & Accountability

1. **Role**

The role of this group is; to monitor activity, and to facilitate the development and associated compliance with controls assurance risk management system standards.

- Monitor compliance against standards
- Agree action plans
- To report progress to the Trust Board
- To co-ordinate activities and produce an annual plan
- To produce an annual report
- To co-ordinate a programme of audit

2. **Frequency of Meeting**

The Corporate Governance Committee will meet monthly or more frequently as determined by the prevailing agenda.

3. **Reporting**

The Group will provide reports to the Executive Group twice a year and will produce an annual report to the Trust Board. Minutes of each Committee meeting will be discussed at the Trust Board.

4. **Action**

In most circumstances, the accountable manager will have responsibility for formulating policies and procedures, and the Directorate/Departmental Manager will be responsible for their implementation.

5. **Membership**

Membership is configured to provide representation of the specialist controls assurance systems areas, directorates and departments, Trust Board representation by a non-executive director and a public representative.

Controls Assurance System		Representative on Committee (Management lead in brackets if different)
• Medicines Management	-	Pharmacy Manager (Director of Corporate Services)
• Medical Devices	-	Head of Biomedical Engineering (Director of Corporate Services)
• Security • Catering & Food Hygiene • Waste Management	} } }	Operational Services Manager
• Health & Safety	-	Health & Safety/Risk Manager
• Risk Management	-	Health & Safety/Risk Manager (Director of Corporate Services)
• Human Resources	-	Director of Human Resources
• Fire Safety • Environment Management • Building, land, plant & non-medical equipment	} } }	Estates Manager
• Emergency Planning	-	Estates Manager (Director of Nursing & Midwifery)
• Records Management • Information Management & Technology	} }	Head of IM&T
• Infection Control	-	Infection Control Manager (Director of Nursing & Midwifery)
• Professional & Product Liability • Finance • Contracts & Contractor Control • Governance	} } } }	Deputy Director of Finance (Director of Finance)
• Decontamination	-	Sterile Services Manager (Directorate Manager – Theatres)

Others		Representative
• Directorates	-	Directorate Managers
• Trust Board	-	Non Executive Director
• Public representation	-	CHC
• Mersey Internal Audit Agency		

CONTROLS ASSURANCE WORK PLAN 2002/03

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
Building, Land & Plant & Non-medical Equipment							
3	Have an approved Estates policy and strategy in place	16	RW	Oct 2002	£0	£0	**COMPLETED.**
4	Register of all equipment and maintenance requirements need to be finalised. Operational policies and procedures to be completed. Medical gas & LV policies to be prioritised	16	RW	Aug 2002	£0	£0	Medical gas policy & LV Policy completed – to Corp Gov Ctee in Jan 03. Asset register of plant & equipment 75% complete. Delays due to arrangements for fire taking priority Roll over to 2003/04
5	Database management system to be developed and utilised. Annual review and gap analysis to be completed	9	RW	Oct 2002	£0	£0	Database management system is installed on PC & in process of being developed. Trust rooms, plant rooms and locations are in the process of being installed on the database. Roll over to 2003/04
6	Asset register, estates inventory and maintenance plans to be developed and installed on database management system. PPM for fire and Legionellae to be prioritised. Estates helpdesk established.	12	RW	Nov 2002	£0	£0	Asset register, maintenance plans & log books for major plant & equipment have been developed. Roll over to 2003/04
7	Property management issues to be evaluated. Documented surveys of user satisfaction and documented expenditure related to utilisation to be created. Patient and user satisfaction surveys to be prioritised.	6	RW	Mar 2003	£0	£0	Patient and user satisfaction survey forms need to be devised. Roll over to 2003/04
8	Risk Register and risk treatment plans are to be completed. Estates staff training and information logs to be expanded.	16	RW	Nov 2002	£0	£0	Risk register is being developed Roll over to 2003/04
12	Performance targets need to be established and agreed with the Board, monitoring performance is to be established with regular updates to all staff	9	RW	Dec 2002	£0	£0	Performance targets are incorporated within the Estates strategy & ERIC returns. Roll over to 2003/04
13	Statistical benchmarking to be used to identify best practice and opportunities	6	RW	Jan 2003	£0	£0	ERIC – returns can be used for statistical benchmarking. Roll over to 2003/04

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
14	A quality control system to monitor and review estates needs to be established, quality initiatives to be agreed.	4	RW	Dec 2002	£0	£0	Meetings with share holders need to be implemented & recorded. Roll over to 2003/04
15	Internal audit function needs to be established	9	RW	Dec 2002	£0	£0	**COMPLETED June 2002**
Catering & Food Hygiene							
1	Nutritional policy to be reviewed	9	Dietician	Sept 2002	£0	£0	**COMPLETED March 2003.** For approval at April 2003 CGC
8	Basic food hygiene training for non-Sodexho staff	16	BP	July 2002	£0	£0	Proposal drafted and accepted, training in progress. **COMPLETED Nov 2002**
9	Translation of menus to other languages	4	BP	Mar 2003	£1,200	£0	Current options available fall out with budget allocated. Discussions held, agreement reached, to be revisited Feb 03. Carry forward agreed by LAM. Action not completed as menus were being revised for implementation in May 03. Roll over to 2003/04
14	Monitoring of wastage and patient satisfaction questionnaire re adequate provision of meal service	4	BP	Aug 2002	£0	£0	A rolling programme of patient satisfaction and food wastage monitoring is in place. This will be reported to the Operational Services meeting on a regular basis. **COMPLETED Aug 2002**
15	Implementation of reporting procedure to Board	9	BP	Aug 2002	£0	£0	Reporting undertaken via the Corp Gov Ctee and completion of the controls assurance work plan. **COMPLETED Aug 2002**
15	Nutritional assessment procedures to be established	9	BP/Dietician	Dec 2002	£0	£0	Meeting with Dietician and Sodexho arranged for November did not take place, attempting to rearrange for Feb 03. Action not completed due to insufficient time to complete and a lack of understanding of what was required by myself. Roll over to 2003/04
16	Regular set of dates for Catering meetings	4	BP	July 2002	£0	£0	In place via new Operational Services meetings. **COMPLETED Aug 2002**
16	Schedule planned reviews on the "Inovise" system	4	BP	Aug 2002	£0	£0	Quarterly review matrix agreed and to be effective from Nov 02. **COMPLETED Oct 02**
16	Review arrangements for the auditing and monitoring of ACWH - adherence to meeting standards required by controls assurance	4	BP	Oct 2002	£0	£0	Meeting held with ACWH and quarterly report to be provided. Arrangements **COMPLETED Oct 2002**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
Corporate Governance							
1	Review standing orders and scheme of delegation for decision making	4	SJK	Dec 2002	£0	£0	**COMPLETED March 2003**
1	Review Board compliance with Code of Accountability	4	SJK	Dec 2002	£0	£0	**COMPLETED March 2003**
2	Ensure communication of objectives to staff	6	SJK	May 2002	£0	£0	Objectives shared with Management Group. **COMPLETED**
3	Development of robust system of risk indicators	9	LAM	Mar 2003	£0	£0	Some progress. Roll over to 2003/04
4	Develop a programme of information audits	9	PY	Sept 2002	£0	£0	An NHS-wide data accreditation programme is underway. LWH is due for an external assessment of its data quality (and therefore its information provision capabilities) before the end of March 2003. **COMPLETED**
4	Progress the information audit plan	9	PY	Mar 2003	£0	£0	As above. **COMPLETED**
5	Ensure a system of follow up action resulting from incident reporting	12	LAM/BEC	Sept 2002	£0	£0	A mechanism for ensuring follow-up action is included in the procedure for clinical and non-clinical incident reporting. **COMPLETED Sept 2002**
5	Identify and progress opportunities for benchmarking	6	LAM/BEC	Mar 2003	£0	£0	**COMPLETED** for 2002/03 but rolled into 2003/04 plan. Areas identified include: all national confidential enquiries, National patient survey which included clinical & non-clinical areas, HFEA pregnancy success rates. Roll over to 2003/04
Emergency Planning							
1	Manager to be appointed to lead planning team	20	RW	Aug 2002	£0	£0	Estates manager identified as the appointed person. Roles and responsibilities in process of being drafted. **COMPLETED Aug 2002**
1	Corporate internal plan to be produced where clear roles and responsibilities are defined. Training sessions and update sessions to be documented.	20	RW	Feb 2003	£0	£0	Completion/review deferred due to Fire Strike arrangements taking priority. Roll over to 2003/04
2	Major incident plan for both internal and external needs to be produced. A control room to be identified and equipped with recommended items and equipment	20	RW	Feb 2003	£0	£0	Major incident plan is in the process of being produced as part of the NHS initiative. Roll over to 2003/04

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
3	Identify risks and failures from individual department plans. A corporate consideration is also required	16	RW	Feb 2003	£0	£0	As above. Roll over to 2003/04
4	Liaison with stakeholders needs to be established and their input taken into account in the development of the plan. An internal emergency planning group is to be established with representatives from all relevant departments.	20	RW	Aug 2002	£0	£0	Emergency-planning group has been set up and will incorporate relevant departments. Roll over to 2003/04
5	All emergency plans should be tested, in exercises, to ensure their effectiveness. Records to be kept for evidence. Identify risk and failures from individual departments.	16	RW	Mar 2003	£0	£0	This forms part of the emergency planning team and will be tested within the next 6 months. Roll over to 2003/04
6	An annual independent audit of the major incident plan needs to be implemented. Also evidence of review and amendment of the plan is required.	9	RW	Mar 2003	£0	£0	An independent audit will be organised within a 6 month period. Roll over to 2003/04
7	Capital and revenue costs related to emergency planning are identified and included within business planning and budgetary arrangements	16	RW	Mar 2003	£0	£0	Costs associated with the emergency planning are to be produced. Roll over to 2003/04
8	The Trust has access to up to date guidance	16	RW	Mar 2003	£0	£0	**COMPLETED**
9	Implement in-house training courses for staff who have a role in major incident response training	16	RW	Mar 2003	£0	£0	To be organised. Roll over to 2003/04
10	Develop key indicators which demonstrate the performance of the system in place for emergency planning	6	RW	Mar 2003	£0	£0	Key indicators yet to be developed. Roll over to 2003/04
11	An emergency planning committee needs to be organised to carry out detailed reviews	12	RW	Mar 2003	£0	£0	The Corp Gov Ctte will play a significant role in monitoring & reviewing all aspects of the system. As above. Roll over to 2003/04
12	An internal audit function is required to give an opinion to the Board on the adequacy and effectiveness of the overall system of internal control	12	RW	June 2002	£0	£0	**COMPLETED June 2002**
Environmental Management							
2	Environmental Policy completed, requires Board approval	20	RW	Sept 2002	£0	£0	Board approval obtained. **COMPLETED Sept 2002**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
3	Structure for environmental review to be prioritised.	6	RW	Sept 2002	£0	£0	Structure for environmental review is finalised. Sections of structure need to be actioned. **COMPLETED Sept 2002.**
3	Structure for environmental management system	6	RW	Sept 2002	£0	£0	Structure for environmental management system is finalised. Sections of structure need to be actioned. **COMPLETED Sept 2002**
4	Environmental management programme to identify the means and time frame by which objectives and targets are to be achieved and developed	20	RW	Oct 2002	£0	£0	E M programmed to be organised within the next 6 months. Roll over to 2003/04
5	Environmental risk register to be developed	6	RW	Nov 2002	£0	£0	Work in progress. Roll over to 2003/04
5	Environmental treatment plans to be developed	6	RW	Feb 2003	£0	£0	Work in progress. Roll over to 2003/04
6	The Trust has access to up to date information for legislation and guidance	16	RW	Sept 2002	£0	£0	**COMPLETED Sept 2002**
7	Education and training programmes are to be developed, training staff in environmental awareness. An analysis of staff training needs to be carried out with appropriate records kept	6	RW	Mar 2003	£0	£0	Deferred due to strike arrangements. Roll over to 2003/04.
10	Internal audit should verify that suitable and effective system of internal controls exist with respect to environmental management.	12	RW	June 2002	£0	£0	**COMPLETED June 2002**
Financial Management							
1	Review standing orders	4	SJK	Dec 2002	£0	£0	**COMPLETED March 2003**
2	Review SFI's	12	Financial Acct	Dec 2002	£0	£0	**COMPLETED March 2003**
3	Introduce performance management framework	16	SJK	May 2002	£0	£0	Draft framework shared with managers. First run in progress July 2002. **COMPLETED July 2002.**
4	Review role and function of Audit Committee	4	Audit Ctee/SJK	June 2002	£0	£0	Review undertaken and finance sub-committee established**. COMPLETED January 2003**
5	Provide finance training for non-finance staff	9	SJK/DR	Ongoing	£1,000	£1,000	NED programme commenced. Other training programmes have been drafted.
6	Review financial risk and record in risk register	6	DR	Sept 2002	£0	£0	Not completed. Roll over to 2003/04.
7	Complete finance department accreditation	4	DR	Mar 2003	£0	£0	Roll over to 2003/04.

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
Fire Safety							
2	**Review** Fire Safety Policy and obtain Board approval	12	RW	Sept 2002	£0	£0	Copy to Trust Board Sept 02. **COMPLETED.**
10	Risk register and treatment plans need to be finalised	15	RW	Aug 2002	£0	£0	Fire audit pro-forma approved by Corp Gov Ctee. **COMPLETED**. Risk register and treatment plans need to be completed.
11	Fire safety risk assessments for all occupied areas need to be completed and documented. Fire risk assessments to be undertaken in accordance with HTM 86. Programme to be organised	15	RW	July 2002	£0	£0	Fire safety risk assessment documentation **COMPLETED** and being actioned in the majority of areas. Remainder will be finalised early 2003/04.
12	Physical inspections and treatment plans need to be completed for the Trust to adhere to the fundamental requirements of fire precautions work place regulations. Programme to be organised	15	RW	July 2002	£0	£0	Physical inspections are being undertaken and treatment plans developed. **COMPLETED** in majority of areas. Remainder will be finalised early in 2003/04.
13	The review of fire evacuation plans need to be finalised. Some ward/dept procedures outstanding	15	RW	July 2002	£0	£0	**COMPLETED July 2002.**
16	Review the provision of mandatory fire training and maintenance of records	16	RW	June 2002	£0	£0	**COMPLETED June 2002**
17	Fire safety indicators need to be developed.	12	RW	Aug 2002	£0	£0	ERIC returns fire safety data is being used as an indicator. **COMPLETED Sept 2002**
19	Establish an internal audit system with respect to fire safety	12	RW	June 2002	£0	£0	**COMPLETED June 2002**
Health & Safety							
1	Complete the development of regular health and safety reports to the Board	12	AJ	Sept 2002	£0	£0	Statistics being produced. **COMPLETED Sept 2002**
4	General health and safety policies to be translated into local directorate based policies	12	AJ/Dir Mgrs	Mar 2003	£0	£0	**ONGOING** as part of a programme to ensure embedding of H&S & Risk Management at all levels of the organisation during 2003/04 required for RPST Level 2 compliance. Clinical Directorates and most non-clinical depts developed local risk management strategies the majority including H&S issues. Directorates/depts requested to produce action plans and local H&S policies. Progress to be reported to and monitored by Corp Gov Ctte.

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
5	Ensure procedures for verification for staff having read health and safety related policies are in place in directorates and departments	12	AJ/Dir Mgrs	Oct 2002	£0	£0	**ONGOING** As part of HS4 above verification procedures/processes will form part of the action plan
7	Review of health and safety audit form required. Need to combine with Clinical Risk Assessment form.	8	AJ	Sept 2002	£0	£0	**REVIEW COMPLETED** not deemed necessary at this time. To be reviewed following the completion of the risk assessment review programme
7	Establish formal audit programme for different levels of management. Develop relevant audit forms.	16	AJ	Oct 2002	£0	£0	Audit programme issued. Audit programme underway. Departmental audits being carried out by managers. **COMPLETED Oct 2002**
8	Review incident policy and procedure and re-issue	12	AJ	Oct 2002	£0	£0	**COMPLETED.** Approved at Jan 03 Board
10	Estates contractors, service engineers etc to possess the `Passport` induction certificate or to receive a certified Trust induction programme	16	AJ/RW	Oct 2002	£0	£0	Formal induction programme for contractors not deemed necessary. Contractors logged on via new database control system and to be given local rules by manager controlling work. **COMPLETED Oct 2002**
10	Review Permit To Work system and ensure formal application of in all areas	12	AJ/RW/Dir Mgrs	Oct 2002	£0	£0	**COMPLETED Jan 2003** Permit to Work (PTW) already in place for Hot Work, HV & LV electrical work, confined space entry. New Estates policy requires risk assessments/method statements for all work as part of the contracting/tendering process. Current Trust general PTW not required for most jobs but will be used for works where more control is required
10	Review the tendering process to ensure that they are consistent with health and safety obligations	12	AJ/RW/GC	Aug 2002	£0	£0	**REVIEW COMPLETE** The general purchasing contractual requirements all require contractors to meet Trust H&S requirements. For contractors not on the NHS general approved list the precursor to approval at local level will be the provision of the company's approved H&S policy and statement to the trust. This will be incorporated into a review by estates in 2003/04 of the policies and procedures relating to control of contractors.

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
12	Review with HR the status of managerial and other job descriptions to ensure that they reflect H&S obligations	12	AJ/MS	Sept 2002	£0	£0	**REVIEW COMPLETE** HR revising Job Description Guidance. Existing job descriptions to be updated as part of PDR process
12	Review with HR the status of managerial and other PDR's to ensure they reflect H&S obligations	12	AJ/MS	Oct 2002	£0	£0	**REVIEW COMPLETE.** HR revising PDR form to take RM & H&S objectives into account
14	Review the status of all risk assessments	9	AJ	July 2002	£0	£0	**ONGOING** Action programme by Directorate managers. Programme requires bi-monthly updates on progress. These are correlated and discussed at the Corporate Governance Committee. Roll over to 2003/04
14	Review the risk assessment and other assessments policies and procedures and re-issue.	6	AJ	Oct 2002	£0	£0	**ONGOING** carried over delayed to take account of the RPST audit RPST level 2 & 3 require the Trust to demonstrate the embedding of Risk and H&S culture at all levels of the organisation. RPST Level 1 also requires the development of comprehensive policy and procedure to encompass the identification, assessment, treatment, monitoring, auditing and recording of risk (including H&S). Following the RPST audit the review/amendment of the risk assessment policies and procedures has been incorporated into the RPST action plan covering 2002-2004. Roll over to 2003/04
15	Audit and monitor the overall health and safety action plan based on the action required from individual departmental audits	12	AJ	Mar 2003	£0	£0	**ONGOING** see comments under HS 14. Roll over to 2003/04.
18	Develop a policy and procedure for consulting and communicating with stakeholders	9	AJ	Dec 2002	£0	£0	**ONGOING** carried over as part of the RPST audit. The Trust had identified a list of stakeholders to whom the Risk Management strategy was circulated. Consideration needs to be given to expansion of the list and development of the policy. Roll over to 2003/04

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
21	Continue training of directorate and other managers on IOSH managing safely course. (£20,000– in H&S training budget for H&S training)	12	AJ	Ongoing	£0	£0	H&S training programme for 2002/03 developed. IOSH course scheduled for Nov 2002. **COMPLETED Oct 2002**
22	Develop and establish further relevant performance indicators	16	AJ	Dec 2002	£0	£0	**COMPLETED**
24	Establish in association with MIAA a formal internal audit programme.	9	AJ	June 2002	£0	£0	**COMPLETED June 2002**
Human Resources							
10	Produce a corporate counselling policy	1	AMS	Sept 2002	£0	£0	Counselling service reviewed and extended. 6 monthly report in place. Policy not required at this stage. **COMPLETED**
12	Produce an induction policy	4	MS	June 2002	£0	£0	**COMPLETED Nov 2002**
13	Produce a staff involvement policy	1	AMS	Sept 2002	£0	£0	**COMPLETED Feb 2003**
15	Additional training resources identified	3	AMS	May 2002	£0	£0	In place. **COMPLETED May 2002**
Infection Control							
3	Consider whether to distinguish IC from the general microbiological service in the contracting process	5	BEC/Finance	Mar 2003	£0	£0	Sessions identified. **COMPLETED March 2003**
3	The budget for IC should be defined in discussion with the ICT	5	BEC/Finance	Mar 2003	£0	£0	**COMPLETED March 2003**
4	Evidence of agreement (IC involvement in service development) required from clinical directors and estates department	9	Chair ICC/CDs/ Estates	Mar 2003	£0	£0	In addition to previous correspondence with Clinical Directors, letters have been sent to Directorate Managers. Reports will be a standing item at ICC. **COMPLETED Oct 02**
6	Verification of occupational health policies	9	ICT/HR/ Occ Health	Ongoing	£0	£0	Mrs Craig will address this issue with Human Resources Director. **COMPLETED March 03**
8	Address problem of no direct access for ICN to microbiology results (microbiology service split between different laboratories)	8	Contracting Services CS/TJN	Ongoing	£0	£0	Access by ICN to microbiology results actioned by IT. Awaiting installation by Estates. Agreement obtained. Hardware installed Feb 03.

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
12	The ICT should be involved in training in infection control and antimicrobial prescribing for medical staff	9	TJN/Postgrad Education	Mar 2003	£0	£0	TJN now has regular slot in SHO educational/ induction programme. Agreement with consultant body for updates in IC. Contribution by ICT to induction packs & days for SHOs & SpRs. **COMPLETED Oct 2002**
13	An indicator/monitoring system should be developed – awaiting National Progress on this topic	9	ICT/National Groups	Ongoing	£0	£0	No Change – no National programme developed to date – March 03.
15	Internal auditors should periodically assess compliance	6	Board & Internal Auditors	June 2002	£0	£0	**COMPLETED June 2002**
Information Management and Technology							
1	Document the IM&T procurement process, in liaison with purchasing manager	2	PY/GC	Mar 2003	£0	£0	An NHS-wide IM&T procurement process exists. The POISE (Procurement of Information Solutions Effectively) handbook is held in the office of the Head of IM&T. This process is followed for IM&T procurements. **COMPLETED Oct 2002**
2	Document, publicise and distribute data validation procedures	6	PY/Info Mgr	Mar 2003	£0	£0	Data validation procedures have been drafted as part of the NHS-wide Data Accreditation process. **COMPLETED.**
3	Achieve compliance with IT security standard BS7799	9	IT Services Mgr	Dec 2002	£0	£0	This objective has not been completed within the timescale originally set, due to scoping the exercise too wide. We are now working with the Mersey Internal Audit Agency on the recovery action plan. Roll over to 2003/04.
4	Continue with the Confidentiality, Data Protection & Human Rights training	4	PY	Mar 2003	£0	£0	Training is now incorporated into the Trust training programme. **COMPLETED.**
5	Incorporate IM&T into risk management strategy	4	PY	Mar 2003	£0	£0	IM&T Risk Management strategy document drafted. **COMPLETED.**
7	Provide "information" training and ensure that it is recorded in personnel training records	6	PY	Mar 2003	£0	£0	Training in the use of the Hospital Information Support System is provided in a systematic and scheduled way for new users, staff who require refresher training and where a system change or change in individual responsibility mitigates additional training. **COMPLETED.**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
8	Develop local IM&T key indicators	6	PY	Sept 2002	£0	£0	Draft IM&T key indicators produced, nd approved by the HISS Board. **COMPLETED August 2002**
9	Develop a Board reporting mechanism utilising the key indicators	6	PY	Sept 2002	£0	£0	**COMPLETED**
10	Incorporate IM&T into the internal audit schedule	4	PY	Mar 2003	£0	£0	**COMPLETED June 2002**
Medical Devices Management							
2	Implement actions from medical devices policy Trust wide	6	MCP/GD	Nov 2002	£0	£0	Policy implemented. **COMPLETED.**
2	Review policy and processes and amend if necessary	4	MCP/GD	Mar 2003	£0	£0	**COMPLETED Jan 2003**
3	Implement devices policy	6	MAP/GD	Nov 2002	£0	£0	Policy agreed and distributed in directorates. **COMPLETED Oct 2002**
5	Discuss trial/development of medical devices with chair of research group and CGC to establish a way forward	6	MCP/GD	June 2002	£0	£0	The National NHS R&D Forum is currently developing a framework Agreement of best practice for NHS/University Collaborations which should encompass a specific statement pertaining to medical device developments, modifications & trials. Once available it will be presented for approval by the Trust. **Rollover to 2003/04.**
11	Carry out a Trust wide review of storage of devices	6	GD/DRC	Nov 2002	£0	£0	**REVIEW COMPLETED**. Report written. Action to be implemented in 2003/04
12	Request confirmation from directorates and departments that single use devices are not reused	8	GD/DRC	Nov 2002	£0	£0	**COMPLETED March 2003**
12	Produce document clarifying symbols used on device packaging	8	GD/DRC	Nov 2002	£0	£0	Laminated document produced. To be distributed and kept in visible place in wards and departments. **COMPLETED March 2003**
22	Clarify medical device risk management arrangements	4	MCP/GD	Jan 2003	£0	£0	**COMPLETED**
27	Clarify and confirm training arrangements and records	6	MCP/GD/AJ	Nov 2003	£0	£0	**COMPLETED**
Medicines Management							
2	Audit controls in place against Duthie	9	ER	Mar 2003	£0	£0	Approval of the Storage of Medicines Policy is imminent. Audit tool under consultation. Roll over to 2003/04

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
3	Extend and review existing policies re the handling and storage of medicines	9	ER	Mar 2003	£0	£0	Currently working on Controlled Drugs Policy. Use of Patient's Own Medicine Policy. Roll over to 2003/04
6	Activate Patient Group directions	9	ER	Mar 2003	£0	£0	Patient Group Directions for SCBU have been written. Medication datasheets are currently being reviewed prior to release of PGD for approval by CGC. Roll over to 2003/04
11	Build up a training portfolio for unqualified staff	9	ER	Mar 2003	£0	£0	Training sessions currently on hold due to staff shortages and vacancy at senior technician grade. Training manual has been reviewed and updated. Roll over to 2003/04
12	Review risk assessments and action plans	9	ER	Oct 2002	£0	£0	Pharmacy receiving ACE report forms from clinical directorates on medicine management issues. Database is being upgraded to ease collection data at Clinical Support directorate level. **COMPLETED**
13	Review training requirements for healthcare staff and formalise training sessions	9	ER	Mar 2003	£0	£0	Poor response to questionnaire. Work now on hold due to staff shortages. Roll over 2003/04.
17	Report all audit results back to the Board via the CGC	6	ER	June 2002	£0	£0	**COMPLETED June 2002.**
Records Management							
1	Report on document imaging as an alternative to storage	9	PY	July 02	£0	£0	Initial draft of report completed, 2nd draft due early September. An outline Business Case which develops these drafts will be put to the Board in the next Financial Year. **COMPLETED Oct 2002**
2	Raise awareness of good practice in records handling through internal publicity	6	PY	Sept 02	£0	£0	Records Management Policy / Strategy widely distributed, also included in the staff Induction Day. **COMPLETED.**
3	Apply the BS7799 principles to paper records	4	IT Service Mgr	Dec 02	£0	£0	A comprehensive Records Management Strategy/Policy has been produced covering issues such as access, usage, retention and destruction. The same principles are applied to IM&T systems, and incorporated in the IT Security policies either available now, or under construction. **COMPLETED.**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
4	Record on the job training in individual training records	4	PY	Sept 02	£0	£0	Discussions with the Training manager have identified that this is a problematic area. Training is now provided on the Induction day, and supported by a handout which is an excerpt from the strategy. **COMPLETED**
5	Implement records handling key indicators	4	PY	Sept 02	£0	£0	Audit process has been developed and actioned. **COMPLETED.**
6	Incorporate Records Management into the internal audit process	4	PY	June 02	£0	£0	Audit process has been developed and actioned. **COMPLETED.**
Risk Management							
3	Review the RM strategy document	12	LAM	July 2002	£0	£0	**COMPLETED July 2002**
4	Review the current procedures for communicating the RM strategy to stakeholders	12	LAM	July 2002	£0	£0	Distribution list revised July 02. Distribution undertaken. **COMPLETED July 2002**
6	Review the current status of local RM strategies and policies, and implement as required	16	AJ	Mar 2003	£0	£0	**REVIEW COMPLETE** Production of Directorate and Department local RM strategies under way. Actioned by LAM. **ONGOING** carried over - Part of process to embed H&S and Risk management culture at all levels of the organisation in preparation for going for RPST Level 2 accreditation
7	Ensure directorates draw together their individual RM plans and these are compiled into a single plan	9	AJ	Nov 2002	£0	£0	**ONGOING** as part of RI 6 above and HS 4 through the RPST audit action plan
12	Review the hazard identification process to ensure there is a comprehensive chain from identification through to re-mediation and ongoing monitoring	16	AJ	Oct 2002	£0	£0	**ONGOING** comments as under HS 14 above and the RPST action plan
17	Review the co-ordination of complaints, litigation, sickness, incidents etc to ensure trend patterns etc are being discovered	12	AJ	Sept 2002	£0	£0	Complaints and Claims personnel trained. LWH user group established. **COMPLETED**
21	Review the use of the Ulysses database for claims management	9	SF/AJ	Sept 2002	£0	£0	**COMPLETED.** Reload/update of Ulysses Litigation module achieved. Claims data being put on Ulysses, but slow due to LWH problems with access speed.

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
22	Review the distribution of clinical and non-clinical claims information to raise management awareness	12	SF/AJ	Sept 2002	£0	£0	**ONGOING** Discussed within user group and to be incorporated into the review of the Claims policy under RPST 2002-2004 action plan
23	Continue the development of the risk register and its electronic version	12	AJ	Mar 2003	£0	£0	Being entered onto Ulysses and ongoing
24	Review the current system and procedures for risk assessment	16	AJ	Nov 2002	£0	£0	**ONGOING** see comments under HS 14
25	Review the current system for risk rating	16	AJ	Nov 2002	£0	£0	**COMPLETED** Risk grading now part of the revised incident procedure following RPST. Approved at Jan 2003 Board. Future review to follow clarification on NPSA requirements
26	Review the current methods for prioritising risk treatments including cost benefit analysis, and develop a treatment plan	16	AJ	Jan 2003	£0	£0	**ONGOING** see comments under HS 14
29	Identify current stakeholders, review the current policies and procedures for stakeholder consultation	12	LAM/AJ	Oct 2002	£0	£0	Stakeholders identified. System for the review of policies is agreed. **COMPLETED Oct 02**
31	Review the need to develop a system for assessing and prioritising risk for the purposes of funding	16	LAM/AJ	Sept 2002	£0	£0	A risk grading system was introduced in May 02. **COMPLETED May 2002**
32	Review the need to develop a RM training matrix	16	AJ/CS	Sept 2002	£0	£0	**REVIEW COMPLETE** Development of matrix identified. **ONGOING** Directorates as part of their RPST evidence have developed Risk Training matrices. These need to be amalgamated and form a programme of work towards RPST Level 2. A draft risk management training matrix was presented to the March Corporate Governance Committee for comment and addition
33	Develop a system of performance indicators	9	AJ/Dir Mgrs	Mar 2003	£0	£0	**ONGOING** H&S indicators developed. Indicators in operational services dependent on progressive review of service contracts. Key performance targets/indicators identified as under development as part of the other controls assurance standards. These need to be amalgamated into a single set of indicators. Draft document presented to March Corp Gov for comment and addition. Roll over to 2003/04

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
34	Review the need to establish a system audit programme	16	AJ	Sept 2002	£0	£0	**COMPLETED June 2002**
35	Need to agree and establish a system of internal audit	16	LAM/AJ	Oct 2002	£0	£0	**COMPLETED June 2002**
Professional & Product Liability							
1	Compile register of customers	4	SJK	June 2002	£0	£0	**COMPLETED July 2002**
2	Review CSQA Ref Centre SLA	4	Directorate Acct	May 2002	£0	£0	**COMPLETED May 2002**
3	Review Helpdesk SLA's	4	PY	Mar 2003	£0	£0	Review undertaken. **COMPLETED March 03**
4	Review Loan Equipment Policy	9	LAM	Mar 2003	£0	£0	**COMPLETED Mar 2003** Policy incorporated into the Medical Equipment. Policy approved at PAG in April 03
5	Remind staff of responsibilities	3	SJK	May 2002	£0	£0	Revised policy re-circulated to relevant departments. **COMPLETED May 2002**
6	Ensure all SLA's are monitored and plan review meetings with customers	9	SJK	Mar 2003	£0	£0	In progress – ongoing. Roll over to 2003/04
Management of Purchasing & Supply							
1	Review procurement strategy	9	SJK/SB	Mar 2003	£0	£0	A new Supply Strategy is currently being drafted. This will cover the period April 2003 to March 2006.
2	Draw up workplan for 2002/03	9	SB	May 2002	£0	£0	An Operational Workplan was drafted for 2002/03 and submitted to the Product Advisory Group in October 2002 for comment. **COMPLETED**
3	Include purchasing in operational plan 2002/03	3	SJK/SB	June 2002	£0	£0	Information provided to Head of IM&T in October 2002. **COMPLETED**
4	Review PI's for procurement and monitor performance	4	SJK/SB	Ongoing	£0	£0	Key performance indicators will be reviewed as part of the exercise related to the drafting of the 2003-06 Supply Strategy. Roll over to 2003/04
5	Include procurement rules/quotes/tender procedure in training for non-financial managers	6	SJK/SB	Ongoing	£0	£0	The Purchasing department has been actively raising awareness of the EU Procurement Regulations and the Trust's Standing Orders / Standing Financial Instructions obligations. There has been a marked increase in the number of tender exercises undertaken as a result. **COMPLETED**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
6	Review procedures manual	6	SB	Dec 2002	£0	£0	A new Trust Operational Purchasing Procedures Manual is currently in draft form. **COMPLETED**
7	Review scheme of delegation	6	SJK	Dec 2002	£0	£0	The Finance department is currently updating the Trust's delegated Authorities List. Once finalised, the details will be input on Meditech by the Purchasing department. Roll over to 2003/04
8	Record phone calls/meetings with tenderers	6	SB	Ongoing	£0	£0	A more formal system for recording and logging details of supplier discussions has been implemented. **COMPLETED**
9	Introduce satisfaction surveys	4	SB	Ongoing	£0	£0	No action yet. Roll over to 2003/04
10	Establish criteria for inclusion in purchasing procedures manual	9	SB	Sept 2002	£0	£0	Detailed supplier selection and vendor assessment criteria is included in the new draft Operational Purchasing Procedures Manual. **COMPLETED**
11	Complete contract register, plan review timetable and implement	9	Product Advisory Group	Ongoing	£0	£0	The Purchasing department is currently devising a Contracts Database to assist with the logging and control of all Trust contracts. Roll over to 2003/04
Security Management							
1	Establish a system for a regular report of security management issues to Corporate Governance Cttee	4	BP	Dec 2002	£0	£0	Weekly meetings are held with the provider.. Security incidents are reported via Corp Gov Cttee and a general security report will be made to Corp Gov Cttee on a quarterly basis commencing Nov 02. **COMPLETED Sept 02**
2	Review the need for overall security plan to be written incorporating all aspects of security management. To be approved by the Board	9	BP	Mar 2003	£0	£0	Security Policy approved at Corporate Governance March 03. **COMPLETED March 2003**
6	Review the need to incorporate updated information on security matters into existing team briefing structure within the Trust	12	BP	July 2002	£0	£0	Discussed and agreed with Dir of HR. **COMPLETED July 2002**
9	Review the need for introducing a sampling system to check `Chrymark` vetting procedures and supervisor visit records	6	BP	Sept 2002	£0	£0	CRB registration granted. A rolling programme of vetting is in place. **COMPLETED Sept 2002**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
9	Review the need for security staff to be given infection control training and Hepatitis B injections	15	Occ Health/ CS/MJ	July 2002	£0	£0	Discussed with Occupational Health dept. To be incorporated into the tender document for security services. **COMPLETED July 2002**
10	Appropriate key performance indicators to be put in place to give an accurate reflection at all levels within the organisation	6	BP	Dec 2002	£0	£0	Proposed KPIs part of security services specification to be tabled at Jan 03 meeting for implementation when new contract begins 01.04.03. **COMPLETED Feb 2003**
11	Review the need of re-establishment of specialist security committee/group meetings	4	BP	Oct 2002	£0	£0	To be a standing agenda item on the Operational Services meetings. **COMPLETED Sept 2002**
11	Audit and monitor ACWH adherence to meeting standards as required by controls assurance	6	BP/MJ	Oct 2002	£0	£0	Roll over to 2003/04
Waste Management							
1	Accountability chart to be completed	16	BP	May 2002	£0	£0	**COMPLETED May 2002**
1	Waste management policy to be completed	12	BP	Aug 2002	£0	£0	Approved at March 03 Corporate Governance. **COMPLETED March 2003**
2	Policy and strategy to be completed and Board approved	12	BP	Jan 2003	£0	£0	**COMPLETED March 2003**
3	Documented procedures for categorising waste needs to be established	16	BP	Mar 2003	£0	£0	Procedure has proved to be more detailed than first thought to be. To be tabled at May Corporate Governance. Roll over to 2003/04
4	Waste segregation management policy is required	12	BP	Apr 2003	£0	£0	Procedure has proved to be more detailed than first thought to be. To be tabled at May Corporate Governance. Roll over to 2003/04
6	Waste management policy and strategy to be established. Documented procedures to be completed	6	BP	July 2002	£0	£0	**COMPLETED March 2003**
7	Risk/COSHH assessments to be completed. Training records to be updated	12	BP	Apr 2003	£0	£0	Not completed due to volume of work and late acquisition of standard. Roll over to 2003/04
8	Certificate of registration from waste carrier to be copied and filed. Also waste management license for ultimate disposal site, including ACWH	8	BP	Apr 2002	£0	£0	**COMPLETED April 2002**
10	Incident reporting procedures to be established in accordance with the processes contained in the Risk Management System Standard and HSAC	12	BP	July 2002	£0	£0	Incidents currently reported via standard reporting procedures. Further work needed to assess other regulatory requirements. **COMPLETED.**

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
11	Risk register and treatment plans for both sites to be completed. Staff training to be extended and recorded	12	BP	Mar 2003	£0	£0	Not completed due to volume of work and late acquisition of standard. Roll over to 2003/04
14	Waste management indicators to be established	6	BP	Mar 2003	£0	£0	Not completed due to volume of work and late acquisition of standard. Roll over to 2003/04
16	Management to consider the range of independent internal and external assurance available. An internal audit function needs to be established	6	BP	June 2002	£0	£0	**COMPLETED June 2002**
	Total Cost (excluding Decontamination)				**£2,200**	**£1,000**	

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
Decontamination							
2	Complete the rollout of the purchasing system forms to be used prior to purchasing equipment	9	GD/DC/GC	Oct 2002	£0		Forms part of Medical Devices Policy. **COMPLETED Nov 2002**
3	Training for new system of traceability (HSC 2000/32)	20	GD/Altrax	Aug 2002	£0		Problems still encountered with hardware and software. Purchasing involved to help resolve problems. All HSSU staff trained & competent **COMPLETED**
5	Write policy for use of closed containers	8	GD	June 2002	£0		In draft cannot be finalised until we know which containers we are purchasing. Purchase request of container trolleys. Roll over to 03/04
	Total Cost				**£0**		
Decontamination Capital Reserve							
3	Order additional equipment to allow for introduction of computerised traceability. (HSC 2000/32 requirement)	20	GD	July 2002	£5,500		Purchase **COMPLETED July 2002**
4	Implement traceability throughout the Trust (HSC 2000/32)	20	GD/DM/DH	Dec 2002	£5,000		See point 3 in section above – problem with scanners will delay rollout through the Trust. Deadline of February being given to company. Spiked electricity supply still gives problems with equipment. Training for staff to commence May 2003 a few departments have already introduced the system. An audit to be undertaken later in year. Roll over to 2003/04
6	Await business plan response for endoscopic washer/ disinfector	20	GD/DWY/JW	Apr 2002	£28,000		Purchase **COMPLETED March 2003**
7	Quarterly and annual validation of Sterilisers as per HTM 2010	16	GD/Audere Medical	Mar 2003	£11,100	£11,100	Contract in place to undertake validations as required. **COMPLETED**
13	To further reduce the amount of local decontamination eg laryngoscope blades and handles by autoclavable equipment purchase	8	GD	Nov 2002	£8,000		Not proceeding with purchase due to cost and view of the anaesthetists that they wish to continue as they are. **COMPLETED**
17	Enable staff to undertake training (TVQ)	9	GD	Mar 2003	£3,200		ILA's applied for April 2003 to fund training. **COMPLETED**
	Total Cost				**£60,800**	**£11,100**	2002/03 funding in place from Capital programme

CRITERION REF NO.	ACTION REQUIRED	RISK #	RESPONSIBILITY	ACTION BY	£ 02/03	£ FUTURE YEARS	PROGRESS YEAR END POSITION
Modernisation Bid							
5	Purchase 8 numbered closed containers for collection and delivery of equipment etc	8	GD	June 2002	£18,300		Bid submitted. Awaiting outcome. No money available this financial year and unlikely next year. **Bid not successful 2002/03.**
7	Need endotoxin free water plant	8	GD/RW/JAK	June 2002	£40,000		Bid submitted. Awaiting outcome. No money available this financial year and unlikely next year. **Bid not successful 2002/03 Submitted request for funding Trust B/Plan 2003/04.**
11	Provision of new ultrasonic and heat sealer, shelving, tables etc	12	GD/JAK	June 2002	£35,000		Bid submitted. Awaiting outcome. No money available this financial year and unlikely next year. **Bid not successful 2002/03 Submitted request for funding Trust B/Plan 2003/04.**
15	Air conditioning/segregation equipment required	20	GD	June 2002	£75,000		Bid submitted. Awaiting outcome. No money available this financial year and unlikely next year. **Bid not successful 2002/03 Estates reviewing situation as what can be achieved within budget.**
	Total **Plus capital for building work & equipment – Total =**				**£168,300** **£338,000**		
Future Revenue Requirement of Modernisation Bid							
	Secure future annual Trust revenue funding if allowed to stay in-house until 2007, ie if Modernisation bid successful	20	GD	June 2002	67,500	67,500	Bid submitted. Awaiting outcome. No money available this financial year and unlikely next year. **Bid not successful 2002/03Revenue costs will need to reassessed depending on capital expenditure.**
	Total				**£67,500**	**£67,500**	

Appendix D

Controls Assurance – Audit Plan

A four year rolling programme is proposed which will incorporate

i) Annual desktop audit of:

Governance	}
Risk Management	} Core standards
Financial Management	}

Plus workshops providing a deeper audit of:

Year 1 **(Approved by Audit Committee June 2002 revised in April 2003)**

Fire Safety
Building, land, plant and non-medical equipment
Decontamination of re-usable medical devices

Year 2 **(Draft)**

Records Management
Health & Safety
Emergency Planning
Security Management
Management of Purchasing and Supply

Year 3 **(Draft)**

Catering & Food Hygiene
Environmental Management
Waste Management
Infection Control
Human Resources

Year 4 **(Draft)**

Professional and product liability
Medical Devices Management
Medicines Management
Information Management & Technology

The above draft proposals will be considered by the Audit Committee annually.

Appendix E

STATEMENT ON INTERNAL CONTROL 2002/2003

The Board is accountable for internal control. As Accountable Officer, and Chief Executive Officer of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically. The system of internal control is underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management

As Accountable Officer, I also have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the organisation who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken account of comments made by external auditors and other review bodies in their reports.

The assurance framework is still being finalised and will be fully embedded during 2003/04 to provide the necessary evidence of an effective system of internal control.

The actions taken so far include:

- The organisation has undertaken a self-assessment exercise against the core Controls Assurance standards (Governance, Financial Management and Risk Management). An action plan has been developed and implemented to meet any gaps.
- The organisation has in place arrangements to monitor, as part of its risk identification and management processes, compliance with other key standards, including relevant Controls Assurance standards covering areas of potentially significant organisational risk.
- Established governance arrangements by developing an appropriate infrastructure within the organisation.
- The Trust is developing the risk management framework ensuring that risks are identified on an ongoing basis.

In addition to the actions outlined above, in the coming year it is planned to:

- The development of a Board Assurance framework linking objectives to risks and controls.
  Implementation: Quarter 4 2003/4

- Cascading training and awareness of risk management requirements to all levels within the organisation.
  Implementation: Quarter 3 2003/4

- Deriving audit plans from the organisation's risk register.
  Implementation: Quarter 4 2003/4

- Structured risk identification at Board level linked to objectives.
  Implementation: Quarter 4 2003/4

- Ongoing Board monitoring of the effectiveness of the resulting Assurance framework.
  Implementation: Quarter 4 2003/4

Signed:	Terry Windle	Chief Executive Officer (Acting)
Date:	13th May 2003	(on behalf of the board)