London Ambulance Service NHS TRUST

Enclosure 11

TRUST BOARD 28th March 2006

Standards for Better Health
Assurance Framework 2005/6

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: To evidence full compliance

3. Summary

The Assurance Framework identifies which of the Trust's principal objectives are at risk because of inadequacies in the operation of controls or where the Trust has insufficient assurance. It also provides structured assurances about where risks are managed effectively and objectives being delivered. As advised by the Healthcare Commission each risk has been mapped to the seven domains of the 24 core standards.

This document therefore presents comprehensive evidence that the Trust is fully compliant with each standard in the form of controls and assurance. It has been agreed by the Senior Management Group and the Audit Committee as evidence to support full compliance to be recorded on the Final Declaration to be submitted to the Healthcare Commission in April 2006.

4. Recommendation

THAT the Trust Board note the framework as evidencing full compliance with the 24 core standards as part of the Annual Health check and agrees that the Final Declaration be submitted to the Healthcare Commission on that basis.

London Ambulance Services NHS Trust
Assurance Framework

The Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives. In the LAS NHS Trust this is based on an ongoing risk management process that identifies the principal risks to the organisation's objectives and evaluates the nature and extent of those risks, in order to manage them efficiently, effectively and economically. The Assurance Framework enables the Trust to do this and also may highlight significant issues. This will usually be a high priority risk that we are not managing adequately that threatens the achievement of a strategic objective.

- **The column headed *Compliance confirms the Trust is fully compliant with all 24 core standards based on the evidence summarised within the Framework***
- **Where the column *Principal Risks* states No Risks Identified - this means that there are currently no risks held on the Trust-wide Risk Register that relate to this core standard of the Annual Health Check**
- **The evidence held on this Framework is collated to provide the Board with assurance of compliance with the 24 core healthcare standards and sign off for the Final Declaration for the period 1 April 2005-31 March 2006**

LAS Service Plan Objectives	Standards for Better Health Domains
1) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, with particular attention to national priorities, including National Service Frameworks, risk and governance, NHS Plan and capacity planning, particularly winter, emergency preparedness and technology.	Safety Governance Patient Focus Accessible and Responsive Care
2) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, with particular attention to national performance targets e.g. Improving Working Lives, NHS Litigation Authority, complaints reduction /resolution with lessons learnt.	Clinical and Cost Effectiveness Governance Patient Focus Accessible and Responsive Care
3) To improve the delivery and outcomes of services for our patients and the public informed by their input by through the Patient and Public Involvement initiative, with particular attention to responding to recommendations of reviews that took place in 2004/5 by implementing them.	Governance Patient Focus
4) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, with particular attention to supporting partnership working with other organisations, to input and improve Urgent and out of hours care.	Patient Focus Accessible and Responsive Care Public Health

LAS Service Plan Objectives	**Standards for Better Health Domains**
5) To improve the delivery and outcomes of services for our patients and the public informed by their input through the Patient and Public Involvement initiative, with particular attention to providing more consistent training to existing members of staff.	Patient Focus
6) To ensure that change is sustainable through investment in organisational development following up on changes to LAS structure, including the new A&E operations structure, integration of the Patient Transport Service and the Emergency Bed Service, instituting the Urgent Control Room and embedding the Urgent Care Service.	Governance
7) To ensure that change is sustainable through investment in organisational development providing a high quality working and supportive environment for staff with good logistical support.	Governance Care Environment and Amenities
8) To ensure that change is sustainable through investment in organisational development developing a culture in which information is readily, openly shared and all staff are listened to and heard.	Governance
9) To ensure that change is sustainable through investment in organisational development ensuring behaviour is consistent with LAS values.	Governance

First Domain – Safety Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.						
C1 (a)	Healthcare organisations protect patients through systems that identify and learn from all patients' safety incidents and other reportable incidents, and make improvements in practice based on local and national experiences and information derived from the analysis of incidents.	Failure to reduce reported risks through incidents information not being systematically shared with all relevant department and committees etc. Thus limiting the scope of the investigation actions, not being implemented (2)	**Director of HR and OD**	• Implementation of LAS HSE action plan • Current CPD cycle in EOC includes a session on risk management that emphasises the Continuous Quality Improvement cycle and the importance of the Incident Report Form in the Process. • Integrated Risk Management database for recording and collecting data on incidents • Incident Reporting Procedure (references reporting to MHRA, reporting high priority risks to PSU and Procedure for the Rapid Follow up of serious Untoward Incidents). • Staff updated about the importance of investigations by ongoing H&S, Operations bulletins, RIb, The Pulse and LAS news as appropriate. • Quarterly Incidents Statistics are reviewed by the Corporate Health and Safety Group and Clinical Risk Group which feeds into the Risk Management Group. Local action is determined at complex meetings led by H&S representatives. • AOMs and Team Leaders are required to keep a portfolio of evidence demonstrating good investigation practice. • Incidents are graded according to severity of impact and likelihood of re-occurrence, determining the scope and depth of investigation required. This ensures a consistent approach to incident investigation • Incident procedure training provided to Managers (including grading)	HSE mini-audit (May-o5) – received positive assurance from the HSE and recognised as a good leader for H&S Incident Reporting Internal Audit (September 2004) Corporate Health & Safety Group monitor the completion of quarterly premise inspections (standard agenda item) GDU audit on Incident Reporting Procedures (postponed) SIP outcome 3-Reduction in staff incidents at work – traffic light status green (Jul-05) HSE met with LAS in march 2006 and confirmed their satisfaction with the LAS HSE planning progress and achievement to date	
		Inadequate analysis reports for Risk Management Group on reported incidents, which may lead to failure to spot trends and take action (30)	**HR and OD Director**	• Datix-Integrated Risk Management System used to record incidents • Incidents are reported externally to the NPSA. • Extra fields allowing analysis by complex (all similar sizes so can get direct comparison by locality) • Reports have been compared with other NHS organisations and have been forwarded to sectors in particular high risk areas e.g. Manual Handling • Incidents Reporting Procedures • Issuing of Bulletins & H&S Minutes • LA52's copied to Estates and fleet as appropriate. • Training and Clinical Updates produced by Management Information • Archives provide call records • Sector H&S meetings on a quarterly basis. • Use of LAS Intranet • Notification of Local Police	Incident Reporting internal Audit (September 04) Trend analysis to inform decision and evidence risks is presented at Corporate Health and Safety **Risk Information Report on claims incident, complaints and performance data trends is provided to Clinical Risk Group, This is used to identify new risks, make recommendations and report outcomes – need to make sure that medium and high graded incidents are investigated by PSU and reported to Clinical risk Group.** SIP Outcome 5- reduction in sickness absences levels – traffic light status –amber (Jul-o5) **Review of the effectiveness of Datix (August 2005) – User group to be established to take recommendations forward.**	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
				• Clinical audit reports plus Clinical Audit and Research Bulletins • Workplace Inspection Procedures • Complex based incident statistics distributed quarterly to evidence trends among individual staff • Industrial injury absence statistics produced on a quarterly basis		
C1 (b)	Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within agreed time-scales	Risk of not learning and changing practices, as appropriate, as a result of complaints (70)	**Chief Executive**	• Serious complaints are investigated by investigation Officers using root cause analysis techniques. Roundtables are then used to draw out lessons learned and generate recommendations to prevent similar incidents occurring in the future. • Datix Integrated Risk Management System – a database for complaints used to produce reports to allow trends to be analysed and acted upon. • Complaints are used in the Corporate Induction and EMT course for discussion regarding how the situation could have been dealt with better and to learn from • Complaints trend analysis • SIP outcome patients No's 18-20-Reduces all patient care related complaints • **SABs management reported to Trust Board ,included in the Medical Director's routine reports**	CHI-(Mar-04) Risk Management standard Internal Audit (Jul-04) NHSLA Risk Management Standard (May-05) – **Review Complaints and Claims Policies/Procedures in line with report recommendations** CHI Star-rating (July 2005) – Patient Focus Balanced Scorecard – medium **Complaints trend analysis – 5 days CPD course hoped to reduce attitude and behaviour complaints (Jun-05)** **SIP outcomes are routinely reported in the minutes of the Trust Board meetings.** patients care related complaints- Traffic Light status for CAC and PTS (green), A&E (amber) Jul -05	
C2	Healthcare organisations protect children by following national child protection guidance within their own activities and their dealings with other organisations	Risk of potential legal action and negative publicity due to staff being unaware of how to report suspected abuse of children and vulnerable adults through the appropriate channels which may lead to the continuation of abuse (99)	**Medical Director/ Director of Human Resources and Organisational Development**	Children Act 1989 Victoria Climbie Enquiry – adherence to recommendations Resource materials, booklets etc. Training-Trainers trained in the new procedures including PTS and a 3-hours session on adult/child protection has now been included in the Clinical Guidelines training, ECPs and Team Leaders also trained. Operational procedures have been agreed by the union, issued Nov-03, available on the Pulse, along with the reporting forms and guidance notes. All child and adult referrals are being followed up within 10 working days of the referral being made	**We undertake at recruitment, standard level CRB checks for staff with direct patient contact only. This includes POCA and POVA checks. There has been discussion but no decision, regarding moving to enhanced level checks. Guidance issued following the recommendations from the Climbie report has been implemented. Child and Adult Protection Internal Audit (Sep-04) Introduce CRB and recruitment** Number of referrals made (reported at CRG)	
C3	**Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) Interventional Procedures guidance**	**NO RISKS IDENTIFIED on the Trust Risk Register**	Medical Director	**The number of NICE Guidelines that affect Ambulance Services is low, however the Trust is following the 'How to put NICE Guidance into action' (published Dec 2005) A NICE Manager has been appointed and guidance will be monitored at the Clinical Risk Group**	Assurance needed - NHSLA have asked for procedures etc.	**Information presented to the Trust Board March 2006. New Guidance will be screened and decisions on relevance recorded on the risk register**
C4 (a)	Healthcare organisations	Risk of cross infection	**Medical**	Infection Control Manual	Clinical waste Audit- Jun – 02	Infection Control Annual Report

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
	keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year –on-year reductions in MRSA +B51	due to inability to replace supplies on a 24 hour basis (15)	**Director**	Awareness raising by senior managers Make-Ready-Scheme Each complex has a DSO with responsibility for risk	**Infection Control Internal Audit (November 05)** **Infection Control Policy** Board approved Nov 05 **Infection Control Audit (May 05)** **Store review being undertaken, roll out make-ready** Make-Ready KPIs to be progressed LA52 reports – **monthly** **Make Ready Scheme on every complex by end of this year**	Infection Control Programme Infection Control Steering Group
C4 (b)	Healthcare organisation keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised	Risk of injury and clinical equipment failure due to inadequate risk assessment prior to purchase of non – LAS issue equipment (28)	**Director of Operations**	Equipment and ergonomic issues are reviewed at regular A&E VEWG Manual Handling Sub Group meetings. Reports on the potential risks associated with any new equipment are scored as acceptable, low or high .The VEWG's terms of reference have been reviewed and is chaired by the Head of Operational Support. Safety and Risk Department are represented on the VEWG and contribute to all trials of new equipment (includes Ergonomics advisor). Defibrillator deployment policy agreed and implemented. Incident statistics discussed at bi monthly sector meetings led by ADOs	Quarterly Incident Statistics – account for 10% of reported clinical incidents **Medical Devices Internal Audit (Sep-03)-Annual Report produced for the Board and policy for the deployment, monitoring and control of medical devices to be developed.** Medical Devices Internal Audit – (Dec-05) See Carry chair evaluation below	
C4 (c)	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all re-usable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	Risk of cross infection to patients, staff and any area of the healthcare facility due to re-usable medical devices a) not being handled, collected and transported to the decontaminated area in an appropriate manner, b) not being subsequently cleaned or disinfected and c) being inadequately decontaminated prior to their return for servicing or repair (40)	**Director of Operations**	Alcohol rubs on vehicles Sluice upgrading programme on stations Reduction in use of re-usable devices Team leaders undertake ride outs on vehicles and challenge poor hygiene practice Infection Control Manual Annual Infection Control Programme produced FAQ's articles and material on hand hygiene have been provided Infection Control Steering Group, report quarterly to CRG. Equipment Exchange Scheme, Infection Control Group	**Medical Devices Internal Audit (Sep 03-) Annual Report for the deployment, monitoring and control of medical devices to be developed.** **Infection Control Internal Audit (Sep 04)-** **Infection Control Policy agreed at Board in Nov 05,** **Infection Control responsibility in Job Description of a senior manager.** Infection Control Audit – (May 05). Equipment Exchange Scheme KPis Medical Devices Internal Audit (Dec-05) Infection Control Annual Report to Board (05) approved by NHSLA	

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C4 (d)	Health care organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely	Drug errors and adverse events not being reported (11)	**Medical Director**	Articles produced or the Patient Care News on reported drug administration errors for staff to learn from. Bulletin issued reported drug error, showing positive action, encouraging future reporting of similar incidents Operational training courses promote the reporting of drugs errors, adverse incidents. Team Leaders encourage the reporting of clinical incidents Incidents Reporting Procedure details when a report should be submitted. Patient Reporting Form documents the patient journey and provides evidence for subsequent investigations after the incident has been reported. Signing out procedures for drugs Drugs no longer held on ambulances Drug issue audits held on stations	**Drugs Control Internal Audit underway (March 06) of areas of concern identified last year to measure any improvements.** **NHSLA Risk Management Standard (January 2005) –** CHI- (March 2004) – no recommendation **Clinical Incidents are monitored through the Risk,** Risk Information Reported at Clinical Risk Group GDU audit on Incident Reporting Procedure (postponed) **Drug control Internal Audit (Feb 05).** Root and Branch review of DMS (Sep-05) **Drugs Management Scheme Review Group has designed a vehicle based trial of drug packs to improve areas of compliance**	
C4 (d)	Health care organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely	Drugs waste due to stock not being rotated (e.g. out of date) and loss of drugs due to not reconciling issues against stock (41)	**Director of Operations**	An article on Vehicle Based drugs featured in the LAS News, where drugs will be replenished centrally/ Drugs are procured centrally and ensure minimum stock holdings. POM's order (communication through RIB). Monitoring procedures from KPI's have been reviewed. Recruited staff have received training for implementation of the drug management system/ The vast majority of drugs will now be ordered and distributed centrally under the new DMS. Frimley Park contract agreed. Problems with re-sealing of Glucogen due to inadequate packaging have been reported. This has been resolved through adding a further seal, issuing a bulletin, contacting the manufacturer and the MHRA and re-iterating that sharps should be disposed of in the sharps bin. **RIB article advising staff against using drug bags for personal use.Green bags for patients' drugs being taken into hospital being introduced (Chris Vale to confirm). Drugs management scheme enhanced by new central warehouse facility, and use of Make Ready Scheme** **Reporting protocol agreed with Metropolitan Police to report any loss of morphine**	NHSLA Risk Management Standard (January 2005) CHI – (arch 2004) – no recommendations **Clinical incidents are monitored through the Risk Information Report at Clinical Risk Group** POMs audit (June 2002) **Drugs Controls Internal Audit (Feb-05) –Drug Management Scheme KPIs, management response to recommendations –** Root and Branch review of DMS (Sept-05).	
C4(e)	Health care organisations keep patients, staff and visitors safe by having systems in place to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to	Risk of cross infection due to clinical waste bags either not being used stored inappropriate (42)	**Director of Operations**	Infection Control Manual issued to all staff – operational bulletin has been issued as part of the new RIB system, to remain staff of their responsibility to read their copy of the infection control manual and where necessary, clarify any issues with their team leader, station officer or sector trainer, Clinical Waste removed by outside contractor. Out of hours clinical waste supplies – supported by SOM Ongoing Infection Control training Premises Inspection	Clinical Waste Audit – Jun 02 **Infection Control Audit (Sep -04) Infection Control Policy** Approved Nov 05 **Infection Control Audit (May -05) roll-out make – ready, ensure availability of lies for clinical waste bags** Premises Inspections monitored at Corporate Health and Safety LA52 reports – None reported	

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	minimise the risks to health and safety to the staff, patients, the public and the safety of the environment			**Clinical Waste contract has KPIs for contractors audited by staff –reports produced and acted upon at station level and reported to Health and Safety team**	(Apr – Jun 05) Review of the SOM – Final review due 11th May 05 –	

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Second Domain – Clinical and Cost Effectiveness Patient achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.						
C5 (a)	Health care organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and where it is available take in to account nationally agreed guidance when planning and delivering treatment and care	**NO RISKS IDENTIFIED on the Risk Register**	**Medical Director**	As above no risks are currently identified on the Risk Register properly because there are few technology appraisals that relate to Ambulance Services**. See entry under C4** **Manager appointed to review NICE guidelines and report to Clinical Risk Group**	Clinical Risk Group	Meidcal Director's report to the Board
C5 (b)	Health care organisations ensure that clinical care and treatment are carried out under supervision and leadership	**NO RISKS IDENTIFIED on the Risk Register**	**Medical Director**	There are no risks identified currently on the risk register but descriptions of controls might include team leaders roles, sector trainers, practice development managers jds and training courses i.e. 5day CPD course**. Support at complex level for clinical supervision -175 Team leaders in post to ensure work based supervision and training undertaken .Training managers appointed to each complex provide support to team leaders and additional supervision and training for staff.**	**Records of 'pre CPD' training package delivered locally . Ongoing checks of PRF completion. Paramedic Recert course attendance records. Attendance at 5 day CPD course. Medical Director's Bulletin on primacy of care being the responsibility of the most senior clinician at the scene**	Training Services Committee
C5 (c)	Health care organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work	Risks of paramedics falling to qualify for registration and not being able to practice due to the cancellation of, or non attendance at, recertification audits (65)	**Medical Director**	**Paramedics audit courses will now be held at local training centres to encourage regular attendance. AOM responsibility to check status of the professional registration of staff on the Health Professions Council website** **Policy for the professional registration of paramedics approved by the Board** **Team Leader Clinical supervision** **5 day Continuing Professional Development course introduced for all staff from April 2005. Records held of all training given to Trust operational staff** **Deputy Director of Operations authorised AOMs to conduct local audits of registration**	State registration ''Paramedic'' Inspection of training October 2003 (3-yearly) ASA CRG monitoring – **Training Services Committee addressing cancellation of recerts (Sep – 05)** SIP outcome 17 – Clinical supervision in place across the LAS (Jul-05) Status green **NHSLA Risk Management Standard (Jan -05)** **Proactively apply the Validation and Ongoing Registration for paramedics.**	
C5 (d)	Health care organisation ensure that clinicians participate in regular clinical audit and reviews of clinical services	Failure to fully complete the Patient Report Form (PRF) with details of drugs given, treatment provided and a detailed record of all LAS interventions offered (8)	**Medical Director**	Boxes provided on station for the storage of PRFs to ensure all forms are collected for recording purposes TP 017 Procedure for any Patient Identifiable Form Used, Generated or Stored by the LAS Trainees have a 2 hour training sessions at Ilford on PRF completion Training Supervisor role course Supervised Ops. Training All training courses discuss the importance of good documentation Team Leaders Procedure for the use of the PRF Reviewed– a revised procedure will be issued later on in 2005 to accompany the	NHSLA Risk management Standard (Jan 05**CHI – (March 2004)** **3 year plan to reach 100% compliance, re-launch in October at Team leader Development Day** SIP outcomes patients No 17 – Clinical supervision in place across the service (Team Leaders/Sectors Trainers) – Jil05 green status Risk Assessment of Team Leader programme **November 05 Board presentation on new electronic KPIs by Head of Clinical Audit and Research**	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
				new PRF. Treatment Protocols Medical Directors Bulletin emphasis the need of good documentation Statement of Duties		
C6	Health care organisations co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	**NO RISK IDENTIFIED on the Trust Risk Register**	**Medical Director**	**There are no risks identified currently on the risk register therefore it will be helpful to evidence what controls are in place. The reporting of suspected abuse of children and vulnerable adults by ambulance staff which is then referred on to Social Services initiating the process of securing the protection, safety and welfare of that individual. Patient specific protocols/information: Referrals regarding specific patients are accepted from other healthcare organisations and a protocol is drawn up with the input of the specialist healthcare professional to ensure the most appropriate care or most appropriate place of care for that individual. SE SHA handover form for patients with specialist palliative care needs: This process is similar to that of the patient specific protocols , the form is faxed over to the LAS form the Palliative Care Team, special needs and requirements for the patient are then put in place. ST elevation myocardial infarction patients being taken directly to a 'Heart Attack Centre'** **Examples of joint working included in the PALS update given to the Board in January 06** **Cardiac Care Strategy approved by the Board in November 05** **Concerns about other Healthcare Professionals reported by Staff and processed by PALS**	Assurance needed – might include Primary angioplasty arrangements London – wide, individual patient protocols, recent work by D Whitmore on living wills, memorandum of understanding with Police from recent board meeting. **LA279 and LA280 available on ' The Pulse' Anonymised patient specific protocol/information. Register held in EOC. Copy of the SE Handover Form. Evidence in peer reviewed literature. Regarded as best practice in Europe and Scandinavia. Case Conferences –PALS records available**	

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Third Domain – Governance Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality assurance, quality improvement and patient safety are central competent of all activities of the healthcare organisation						
C7 (a)	Health care organisation apply the principles of sound clinical and corporate governance	**NO RISK IDENTIFIED on the Trust Risk Register**	Director Of Finance	Audit Committee/Governance review restructuring currently aligning systems and process to meet internal and external requirements. Risk Management Group reviews high priority risks. Annual Trust wide Risk Assessment identifies new risks. **(part of ALE-Auditors Local Evaluation co-ordinated by the Audit Commission)**	NHSLA Level 2, Risk Register, Assurance Framework, Risk Management Framework, Board reports including Assurance Framework, Annual Risk Management Report, Infection Control Report, Minutes from Audit Committee, Clinical Governance Committee Medical Director's reports.	
C7 (b)	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	**NO RISK IDENTIFIED on the Risk Register**	Director of Finance	Uses of Resources is monitored by a different mechanism (Audit commission) Audit Committee . **(part of ALE-Auditors Local Evaluation co-ordinated by the Audit Commission)**	Vision and Values, Whistle Blowing Policy, Governance arrangements routinely monitored by the Internal Audit Programme agreed by the Audit Committee	
C7 (c)	Healthcare organisations undertake systematic risk assessment and risk management	**NO RISK IDENTIFIED on the Risk Register**	Director of Finance	Risk Register, Risk Management Committee and other groups regularly review progress against risks on the Risk Register.	Annual Risk Management Report, Statement of Internal Control, Trust Annual Report	
C7 (d)	Healthcare organisations have systems in place to ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in uses or resources	**NO RISK IDENTIFIED on the Risk Register**	Director of Finance	There are no risks currently reported on the Risk register and compliances with this standard is audited separately by the Audit Commission **(part of ALE-Auditors Local Evaluation co-ordinated by the Audit Commission)**.	Audit Commission, External Auditors	
C7 (e)	Health care organisations challenge discrimination, promote equality and respect human rights	Failure to meet responsibilities under the Race Relations Act leading to further SUI's involving treatment of patients from minority backgrounds due to a failure to undertake training staff in working with diversity (118)	**HR and OD Director**	• Existing training (Corporate Induction Course, Community Awareness for Trainee EMT/EMD, Equal Ops) • **Diversity training programme/CPD One day session entitled Best Practice in the Workplace** • Language Line, Multi-lingual Phrasebook • PRF-**Ethnicity recording** • Monitoring/recording within EOC of 999 calls and radio communications • **Equality and Diversity Statement and Equality and Diversity Employment Policy.** • **Vision and Values** • **Equality and Diversity competency (KSF)** LAS Race Equality Scheme Strategic Steering Group, Race Equality and Implementation Programme, Diversity Team, Recruitment	**Commission for Racial Equality, South West London Strategic Health Authority review of Race Equality Schemes scored LAS Race Equality Scheme as Best in London, staff and patient surveys, external specialist reports e.g. 1990 trust**	

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				initiative		
		Failure to meet responsibilities under the Race Relations (Amendment) Act 2000 in the monitoring of patient ethnicity (119)		• New PRF introduced ethnicity data collected by staff and adherence to this included in the Team Leader PRF checks. MI collate the information for monitoring purposes	Commission for Racial Equality	
C7 (f)	Health care organisations meet the existing national operational performance requirements	**Lack of ambulance cover on weekend nights and ability to meet increasing demand (1)**	**Director of Operations**	Agreement of three flexibility proposals, of which crew splitting has now been agreed. **REAP Plan introduced including resourcing strategies to deal with increased demand at peak times** **Roster for on-duty senior managers (AOMs) to command night operation of service** **New relief rota introduced biased to support increased weekend working** **Sector support rotas covering nights and weekends** **Back up ambulance supply arrangements in place**	CHI Star Ratings (Jul-05) – 2 Stars – Achieving Cat A 8 minutes target but under-achieving for 14/19 minute target SIP Outcome 24 – Category A performance targets achieved (Jul 05) – status green SIP Outcome 25 – Category A 14 min performance targets achieved (Jul-05) status green SIP Outcome **26 – Category B 14 min performance targets achieved (Mar-05) –status red, maximising ambulance staffing and introduce a distribution regime which allows ambulances to respond more often from a mobile status. ACOAs and AOMs to focus on achieving this target. Emphasis to be given at PPGs & Complex Review workforce plan and install Urgent Care Control.** ORH review (Lo77) to	
C7 (f)		Delay in activating vehicles due to human error in EOC when call taking and allocating vehicles (9)	**ADO EOC**	• MDT system on all ambulances • EMD basic training modules 2&3 • AMPDS, a quality assured licensed Procedure • Incident Reporting Procedure • CTAK (Supervised) System • Rota System – Seeks to maximise number of call takers to alleviate pressure and reduce human error • Team briefs used to convey information, advice and instructions to staff e.g. learning from incidents, changed procedures etc.	Centre of Excellence accreditation (from National Institute of Accreditation for Emergency Dispatch) – 3 yearly (Submission of data for monitoring in between) CHI Star Rating (July 2005) – 2 Stars Achieving Cat A 8 minutes target but underachieving for 14/19 minute target Risk Information Report Sip Outcome 14 (Jul-05) – Status green	
C7 (f)		Delay in activating vehicles due to the unavailability of vehicles (12)	**Director of Operations**	AMPDS prioritisation Training bulletins Vehicle Replacement Strategy – the ongoing business case for the acquisition of vehicles OP 023 Procedure for Dispatch of Resources by EOC (which incorporates the section ‘’Communication of a Delay for Emergency, Urgent and Non – urgent Calls’’) has been distributed Resource Centre Procedure OP/019 – liaison with and assistance to other Ambulance and Emergency services / Agencies Fleet Management System DSOs and AOMs ensure and encourage that crews are	CHI Star Rating (July) 2 stars – Achieving Cat A 8 minute target but achieving for 14/19 minute target **Fleet and Transport Management Internal Audit (November 2003) – Management recommendations implemented** Risk Information Report Operational performance reports SIP Outcome 13 (Jul-05) – Status amber	

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				available for calls as quickly as possible after patient hand over		
C7 (f)		Delay in activating vehicles due to inability to answer calls promptly before the recorded messages is played (13)	**Director of Operations**	LAS standard to answer all calls within 10 seconds (National Standard 15 Seconds), achieved for over 80% of calls most of the time All delays in call answering are measured and monitored by the inbound Call Centre Managers Routinely monitored by EOC managers and reported on, also in conjunction with BT Procedure introduced to manage long delays in answering calls through assistance from Metpol and BT taking 999 calls. Trigger points for LA52 completion for a long delay agreed at CRG, allowing us to learn from situations All implementation of the Emergency Rule should be logged in the Occurrence Book EMD 1 Base Training Module 2 Call Taking system Access to language line Staff rotation Use of LAS Gazetteer, providing grid references for the location of call Automatic answering machine recorded	BT Monitored at CRG within the Risk Information Report (Performance and quality assurance information produced by MI and analysed by Senior Operations Officer – Planning and Risks) SIP Outcome 28 – 95% of 999 calls answered within 10 seconds (Jul-05) – status amber	
C7 (f)		Delay in activating vehicles due to difficulties from caller (14)	**Director of Operations**	Central Ambulances Control Training Department (CACTD) to provide training for all new recruits in handling difficulties involving different languages etc. Languages line is still used with EAC for callers Cable & Wireless have recently complied with the EU directive for Call Line identification EMD 1 Base Training Module 2 C TAK system Direct line to Language Line Balance call takers and dispatchers as appropriate to demand Automatic answering machine recorded message Uses of LAS Gazette MDT	Clinical Risk Group SIP Outcomes performance (Various) 24 – Category B 14 min performance targets achieving (Jul-05) – Status red, maximising ambulances staffing and introduce a distribution regime which allows ambulances to respond more often from a mobile status, ADAOs and AOMs to focus on achieving this target. Emphasis to be given at PPG's & Complex Review Meetings. Revise workforce plan and install Urgent Care Control	
C7 (f)		Delay in ambulance staff reaching the patient due to difficulties in locating the address (21)	**ADO EOC**	EOC Staff briefing Caller Line Identification Supervised ops training PTS course Tech. course – EOC talk Driving Course EMD training in Call Taking Driving & Care of Services Vehicles AMPDS, a quality assured licensed Procedure Crew radio back Allocation of other resources Duty Manager	CHI Star ratings (July) 2 Stars Achieving Cat A 8 minute target but underachieving for 14/19 minute target and poor performance for Cat B calls and GP Urgent Clinical Risk Group SIP Outcomes 24 – Category A performance targets achieved (Jul-05) status green SIP Outcome 25 – Category A 14 minute performance targets achieved (Jul-05) – Status amber SIP Outcome **26 – category B 14 min performance targets achieved (Jul-05) – status red, maximising**	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
				ARV Dirty Vehicles (assist only) Contact with the police if address cannot be located TAS telephone advice scheme Ring Back RRU's MRU's Management Information identifying ''hot spot'' Crew will seek help via Ops Liaison Desk CIU Daily Bulletin Language Line Stations obtain local estate maps from local government offices Local knowledge about road closure etc, is often relied upon Satellite Navigation System	**ambulance staffing and introduce a distribution regime which allows ambulances to respond more often from a mobile status..** **Revised workforce plan and installed Urgent Care control**	
C7 (f)		Delays are occurring in responding to urgent calls resulting in these calls becoming emergency calls (63)	**ADO EOC**	Protocol to provide prioritisation for calls from Doctors and Hospitals, resulting in EOC being able to prioritise urgent calls relatively alongside emergency calls so that the criteria for conveyance is clinical need for all patients A short term measure introduced to improve response to urgents requesting amber status 45 minutes to STA Dedicated call takers to AS2 lines EOC Urgent Care Service	CHI Star Ratings (July)-2 stars, GP Urgents (balanced scorecard-medium Urgent Calls are monitored through Risk Information Report presented at CRG **SIP Outcome 27 – AS2-Doctors urgent performance at 95% within 15 minutes of agreed arrival time (Jul-05) status red, immediate dispatch of call when one hour remaining on STA (Progressing) a system of AS2 triage, blue light response to one – hour AS2s.** **Operational recourses within the Urgent Care Services now has around 104 staff in post and some stations continue to support unfound AS2 vehicles** **SIP Outcomes 36 – 95% of Doctors calls answered in 30 seconds- status red , as above** Consider EBS Internal Audit 06/07	Please update assurance and existing control
C8 (a)	Health care organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	**NO RISK IDENTIFIED on the Risk Register**	**HR Director**	**25 trained support workers underpinning the LINC scheme** **Employee Assistance Programme (EAPS)** **Whistleblowing Policy** **Counselling Service** **Senior Management Review of Services by Head of Employment Services** **PALS support for staff reporting concerns raised by care provided by other Healthcare Professionals**	LINC Scheme, Consultation visit programme, development of new Services Plan with staff input	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
C8 (b)	Health care organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address where appropriate under-representation of minority groups	Staff expectation not met due to inability to sustain implementation of PDR service-wide (132)	**HR and OD Director**	Resource centre role in planning training using a formula that takes into context the relief factor, winter pressures, targets etc. Training Resources Group Training Services Committee Training Sub – group (with union) PTS Training Group Mechanisms to release staff for allocated training Monitoring roll- out to all staff of the PDR process**.** **Sponsored study budget. Breaking through programme. Positive statements on adverts. Support for staff networks** **Bursary applications Scheme**	IWL- Practice Plus status(Apr-05) SIP Outcome 2- Annual appraisals and personnel development plans in place for all staff (Jul-05) Amber status. **Monitoring and evaluation including impact assessments in line with Race and other Equalities legislation.** **80% KSF outlines in place**	
C9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	Risk of inconsistent treatment or records throughout the LAS and an uncoordinated approach due to the lack of a trust-wide records management plan and a senior manager responsible for implementing it which is endorsed the Board (35)	**IM & T Director**	Corporate Induction IM& T security policy Access to Health Records policy, Records Management Policy Information Governance panel Head of Records Management FoI Policy Two awareness training sessions attended by at least one representative from each department, 52 staff have received general & legal training, 32 staff process training. Publication scheme reviewed annually, annual assessment using the Information Governance Toolkit	CHI CG Review report – March 2004 **Board approved TP 017** **Internal Audit – June 2004 – Records Management Strategy been to Clinical Governance Committee and the Records Management policy approved by Board** FOI internal Audit (September 2004) Information Governance Toolkit (March 2005) – Rated 2 out of 3 **PRF Audits (Jun-05) – 30% completed services-wide, 3 years plan to reach 100% re-launch in October at Team Leader Development Days** FOI Policy Review (Trust Board July 2005)	
C 10 (a)	Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	Risk of employing staff with a criminal record due to not conducting Criminal Records Bureau checks (125)	**HR and OD Director**	90% of new staff are checked (A&E staff and intermediate tier) Compliance with CRB disclosures in the NHS (NHS Employers 2004)	NHSLA Risk management Standard Review (Jan-05) **We undertake at recruitment, standard level CRB checks for staff with direct patient contact only. This includes POCA and POVA checks. There has been discussion but no decision regarding moving to enhanced level checks**	
C 10 (b)	Health care organisations require that all employed professionals abide by relevant published codes of professional practice	Risk of staff not knowing their accountabilities for internal control and principles of the Code of Conduct	**Finance Director**	The induction process for new Directors has been expanded to include exec's as well as non-exec's Board members signed up to the Code of Conduct. Board reviewed compliance with Code of Conduct Key objectives agreed by the Board for Service Plan and used in the Assurance Framework Regular reports received by the Board about delivery of service objectives Work has been undertaken on resourcing and we now need to build on A&E Resources group and use operational research into deployment and staff survey result. Workforce planning has improved and the SIP and OD strategy have been reviewed.	Governance Standard Internal Audit (March -04) Develop an IM&T strategy governance Internal Audit (May 2005) – review Governance structure	

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				Monitoring and follow up of delivery of outcomes e.g. SIP outcomes Patient and Public Involvement Department Plan has begun to address the information gathered by stakeholders Counter fraud Services		
C11 (a)	**Healthcare organisations require that all employed professionals are appropriately recruited, trained and qualified for the work that they undertake**	**NO RISKS IDENTIFIED on the Risk Register**	**HR and OD Director**	Cause for concern addressed via additional training / capability policy **Disciplinary policy and other related HR Policies and Procedures**	Recruitment policy, workforce recruitment and turnover plans routinely reported to the Board	
C11 (b)	Healthcare organisations ensure that staff concerned with all aspects of healthcare participate in mandatory training programmes	Risk of technicians falling to meet requirements for mandatory refresher and update elements of Risk Management Training (66)	**Medical Director**	Discrete packages to update skills are delivered to EMTs on a continuous rolling basis Training Records **. All operational staff will attend a 5 day CPD course over the next two years (from April 2005). Any EMT3 who wishes to progress to EMT 4 is required to have the evidence of having attended all mandatory training** **Training Services Committee Minutes**	IHCD Inspection of training October 2003 (3-yearly) Training Services Committee A full review on the education and development department (Jan-05**) will be completed by summer 2006. Processes now in place to ensure that staff who do not attend mandatory training are re-booked and that an audit will take place to ensure that they attend and that their managers are informed.** **Successful IHCD inspection of Education and Development completed in February 06.**	
C11 (c)	Healthcare organisations ensure that all staff concerned with all aspects healthcare participate in further professional and occupational development commensurate with their work throughout their working lives	**NO RISK IDENTIFIED on the Risk Register**	**HR and OD Director**	Well Person Medicals available, IWL standards compliant, KSF rollout underway **5 Day CPD courseEMT4 course** **Initial HEMS course for Paramedics** **ECP programme.** **Use of New Resuscitation guidelines** **DSO training programme** **AOM development programme** **AMPDS course for EOC staff** **PSIOM training**	KSF implemented IWL Practice Plus. **Managers have been attending PDR/KSF workshops since June 05 in preparation of the PDR/PDP process roll out scheduled for the coming year.**	
C12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the Research Governance framework are consistently applied	Risk of research being stopped due to falling to conform to Research Governance Framework (85)	**Medical Director**	Research Surgeries Research Handbooks Supervisor Handbook Seminar Presentation Implementation plan External framework with targets (risk scored) Publicity Communications with University CARSG Research Governance targets met (2004) **Research governance targets met (2005)**	Research Governance policy board approved. Research Governance targets to benchmark LAS progress**. DH rating 2005 'good'**	
		Risk to patient and to the viability of research projects, with financial, ethnical and	**Medical Director**	Research Protocols Research Governance framework Research Strategy Responsibility contained in Paramedics and EMT job	Internal audit on Research Governance – Planned 05/06	

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		reputational impacts due to poor/no documentations kept by staff (137)		description		

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Fourth Domain – Patient Focus Healthcare is provided in partnership with patients, their carers and relatives and designed around decisions which respected their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing						
C13 (a)	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect	**NO RISKS IDENTIFIED on the Risk Register**	**HR and OD Director**	**Vision and Values. HR Policies and Procedures. Operational Policies and Procedures. Training for operational staff specifically diversity CPD training. RIB article on not photographing patients receiving care** Complaints Policy. Race Equality Scheme and Race Equality Scheme Implementation plan currently monitored by the Strategic Race Equality Scheme Steering Group	SWLHA review of scheme v positive. **Monitoring of complaints handling including matters aggravated by bias factors. KSF competencies**	
C13 (b)	Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	**NO RISKS IDENTIFIED on the Risk Register**	**Medical Director / Director of IMT**	Consent Policy has been issued trust -wide, consent forms printed Freedom of Information Act requirements in place and served by trust PALS team. Data Protection Policy (TP012) Procedure for Patient Identifiable form used, generated or stored by LAS (TP017) Policy for Access to Medical Records , disclosure of Patient Information, .Protection and use of Patient Information (TP009)	Consent policy board approved November 05	
C13 (c)	Healthcare organisations have systems in place to ensure staff treat patient information confidentially, except where authorised by legislation to the contrary	**NO RISKS IDENTIFIED on the Risk Register**	**As above**	**As above Data Protection Policy in place. Access to patient data strictly controlled. Written requests required on official LAS form to facilitate release of such information to specific authorities. Locally, database views are employed to restrict access to specific fields of patient data on a per individual/role basis. Policy for Access to Health Records --TP009 Feed into staff induction: re patient confidentiality/legislative requirements through presentation and handouts –to go live April 2006. DPA policy already in place documenting access to patient data . Further ongoing training to be incorporated into current staff training to equip staff handling such data with (at least) yearly best practice advice/guidance through training. Localised training yet to be approved. Go Live date estimated mid-2006. Regular communication channels (newsletters/intranet) to be opened up (as per 2005 audit requirements**	**Information Governance panel and management of IGT to set future IG initiatives and strategy**	
C14 (a)	Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about and clear access to procedures to register formal complaints and feedback on the quality of services	**NO RISK IDENTIFIED on the Risk Register**	**CEO**	PALS team in place with separate arrangements for Freedom of information Act.	**trust website about to be updated** **PSU Review for trust board**	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
C14 (b)	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made	**NO RISK IDENTIFIED**		Race Equality Scheme and related policy documents embedded trust wide.	Complaints policy, Diversity team reports **.1990 Trust Report to Board. Patient Surveys**	
C14 ©	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and where appropriate make changes to ensure improvements in service delivery	Risk of not learning and changing practice, as a result of complaints (70).	**Chief Executive**	Serious complaints are investigated by Investigation Officers using Root Analysis techniques. Roundtables are then used to draw out lessons learned and generate recommendations to prevent similar incidents occurring in the future. Datix Integrated Risk Management System – a database for complaints used to produce reports to allow trend to be analysed and acted upon. Complaints are used in the Corporate Induction, DSO and EMT course for discussion regarding how the situation could have been dealt with better and to learn from Complaints Review Panel Complaints Procedure with revised flow chart Local outcome reports As part of CPD complaints will be included in the training for all operational staff	CHI – (March 2004) Complaints Internal Audit (Feb-05) **NHSLA Risk Management Standard (Jan-05) – Added Statement and Summary Writing Guidance to the Complaints procedure as an appendix, actioned through the Complaints Review Panel.** CHI Star – rating (Jul-04) – Patient Focus, balanced scorecard – medium **Complaints trend analysis – CPD course to address trend in attitude and behaviour complaints** SIP outcomes patients No's 18-20 – Reduce all patient care related complaints (Jul-05) – PTS and CAC green, A&E amber.	PALS Reports to the Board
C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and where appropriate, inform patients on what to expect during treatment, care and after – care	Patients and Public Involvement plan resulting in staff being unaware of responsibilities and service delivery not being responsive to Patient and Public need (91)	**Director of Communications**	PALs Team Patients Forum monitors the effectiveness of local PALS PPI Strategy A formal protocol has been drawn up between PALs and PSU	PALS enquiries trend monitoring SIP outcomes 22 – Regular comprehensive information about user views/levels of satisfaction (Jul-05) – Status amber Patient Forum minutes	

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Fifth Domain – Accessible and Responsive Care Patient receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.						
C17	Views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving heath care services	**NO RISKS IDENTIFIED on the Risk Register**	**Director of Service Development /Director of Communication**	PPI Strategy Delivery plan, PPI Committee, Patient Forum member on CARSAG Patient representation on clinical audits	Membership of Patients Forum on senior governance committees. Informal approval of compliance for this standard given by Healthcare Commission during recent visit	**Assurance to be taken from Evidence shown to the Healthcare Commission informal review fo 5 Healthcare Standards in February 06**
C18	Health care organisations enable all members of the population to access services equally and offer choice in access and treatment equitably	**NO RISKS IDENTIFIED on the Risk Register**	**Director of Service Development**	Urgent Calls Centre, 2 Star rating, Emergency plan, MINAP database **Equality of Access programme in the Strategic Seven Year Plan including milestones/targets** **Strategic Plan includes options for patients to identify and contribute to the development of the new operational model. Patient Specific Protocols**	Reports to SDC/Board on overall performance	
C19	Health care organisation ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	Falling to appreciate the significant and urgency of psychiatric illnesses, and to provide the appropriate response/assistance/treatment (102)	**Service Development Director**	In EOC – AMPDS provides a call prioritisation far all calls including those where the patient has a mental illness. In addition there are procedures in place to deal with non – emergency requests and their management and subsequent requests for upgrading the prioritisation of a call. Operational Staff – Psychiatric illness is covered in basic training and Treatment Protocol TP/053 Mental Problems provides generic guidance and gives a basic background. Coverage on National Clinical Guidelines is not extensive. Addressed on EMT course and intermediate tier course. Also part of ECP training. Diversity Officer has delivered a session for CTA staff **Mental Health Strategy approved by the Board November 05, Paramedic Recert course, CEO consultation meetings** **Training for all operational staff in managing children and vulnerable adults** **Reporting procedure for patients wh are assessed as being "at risk"**	As above	
		Delay in treatment and potential adverse outcome for patient when police attendance has been requested but there are no available units to respond due to their operational pressures and no dynamic risk assessment is undertaken (138)	**Director of Operations**	In instances where there is an unavailability of police crews to attend a call crews can request a DSO or Team Leader (see below) Part of the AOM (Ambulance Operation Manager) remit to forge local links with the police to resolve such issues Memoranda of understanding MI ask AOMs to review High Risk Addresses monthly	High Risk Address register Audit – Jul – 2001 DPA Audit - 2004	

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Sixth Domain – Care Environment and Amenities Care is provided in environments that promote patient and staff wellbeing and respect for patients and preferences in that they are designed for the effective and safe delivery of treatment. Care of a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.						
C20a	Health care services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects, patients, staff, visitors and their property, and the physical assets of the organisation	Risk in injury to operational staff and/or patient through issues relating to manual handling This can occur when using equipment, including trolley beds and carry chairs, or when lifting or assisting patients without equipment. Staff can also incur injury when lifting inanimate heavy loads (4)	**HR and OD Director**	One day patient moving and handling update training introduced in summer 05. Training in line with current best practice Ergonomics study commissioned for design of specialist vehicles to move heavy incubators ITU and balloon pumps patients. Specification to be finalised in the coming year Some staff trained to be accredited assessors and trainers (Instructors , Fleet staff and Archivist) Mangar Elk cushions introduced into the workplace to manage lifts from floor and lifting heavy patients VEWG evaluate all procurement of equipment Manual Handling steering group chaired by Director of Operations. All new vehicles have tail lifts and gas assisted trolley beds Ergonomics consideration given to vehicle equipment and design Generic tasks risk assessed and updated in line with equipment provision Links made with other stakeholders (North East area) to address patient handling issues and developing protocols for managing bariatric patients	HSE mini – audit (Mar-05) – positive assurance IHCD (3 yearly, last one October 2003) CHI – (March 2004) Health & Safety Internal Audit (August 2004) Quarterly Incident statistics - Monitoring of personal injury claims – general downward for staff claims Monitoring of industrial injury Sickness – Quarterly monitoring of Premises Manual Handling Policy ratified and implementation group set up Ergonomics and Back care adviser developing KPIs and monitoring application and impact of MH policy Evaluation of carry chairs phase 1 complete	
C20 (a)	Health care services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects, patients, staff, visitors and their property, and the physical assets of the organisation	Risk of injury to staff, patients or third party travelling in an LAS vehicle or involved in an RTA with an LAS vehicle (17)	**Director of Operations**	• Mandatory LAS policy to wear vehicle seatbelts • 24 hour vehicle fitters provide vehicle maintenance • Fleet Co-ordinator appointed in EOC • FRU training • Driver training/assessment on PTS,EMT,DSO and paramedic courses, including remedial training • Various Operational Procedures • Incident Reporting procedures • Statutory requirements • IHCD Driving Manual • Incident investigation course • Off road driving course for 4x4's • EEV driving course • Continuous Professional Development involves a ride- out with Team leaders where driving skills will be monitored • Disciplinary Procedure • Complaints Procedure • Vehicle Inventories & Checking Procedures • LA400 Defect sheet and LA1	IHCD (3 yearly, last undertaken October 2003) HSE mini-audit – positive assurance received. NHSLA Risk Management Standard (January 2005) Local Authority Transport Management Internal Audit (November 2003)	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
				• Scheduled maintenance programme and full record • Monitoring of staff injury • Vehicle Defect allegation investigation • Vehicle design specification • Resource(s) allocated as appropriate • Police • Routine checks on Driving Llicences monthly • Garage layout and parking arrangements • RTA investigation reporting process • Quarterly reports on RTAs to AOMs to define		
		Risk of LAS staff being physically assaulted (118)	**HR and OD Director**	Staff Safety Group meet on a 2 monthly basis 7x2 – day manager's personal safety / post incident support training undertaken Identified issues from Safety Audit Stab vests issued to all A & E Operational staff Close liaison with CPS and Met Police established At Risk Register of known violent addresses held and updated by EOC, reviewed on a yearly basis Violent Incidents reported on LA 277 EMT course Health & Safety for Managers EMD Basic training course PTS Training Incident Reporting Procedure Staff Safety Policy Referred to OHD Anti – violence warning signs (in ambulance) PRF quality assurance Lone – worker policy (draft) Posters 'No Excuse' Panic button on personal radios Analysis undertaken to highlight particularly 'at risk areas' so that preventative action can be taken locally AMPDS call taking protocol Dispatcher protocol. Direct emergency number into EOC via mobile phones Post Violence Support Training in Development for Team Leaders	CFSMS (Counter Fraud and Security Management Services. **Security Management Internal Audit (Jun-04) Security Policy and Strategy** **Training Needs Analysis in Risk Management approved by NHSLA at level 2 assessment** Quarterly Incident Statistic issued Trust Wide and include reported violence, allowing monitoring – Audit of the effectiveness of Personal Safety training undertaken in March 2006 Nominated Security Management Specialist to attend CFSMS Training in August 2006 GDU Re-Audit on the High Risk Address Register (postponed SIP people outcomes No.4 – Reduction of assaults on staff (Jul-05) – green status Staff Safety Audit (Nov -02)	
C20 (b)	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patients privacy and confidentiality	**NO RISKS IDENTIFIED on the Trust Risk Register**	**Director of Operations**	Make Ready Scheme, New Vehicle Specification with compliances achieved with BSN 1789:2000 Tinted windows and shutters on vehicles Patient Assessment sign on back of vehicles Operational Policy on use of courtesy blankets	Vehicles and Equipment Working Group Board reports on Make Ready	
C21	Healthcare services are provided in environments which promote effective	Risk to patients and staff due to contamination of	**Director of Operations**	Infection Control Manual and the pre-learning material for new recruits now contains a large section on Infection Control.	Clinical Waste Audit – June-02 **Infection Control Internal Audit (Sept-04) – finalised Infection Control Policy. (approved by Board Nov 05)**	As Ambulances are our environments this is covered by Make Ready Scheme

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	care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	equipment and vehicle (48)		Changing bags before they become very full has been communicated to Sector management teams. Established members of PTS staff will be trained through the new programme of Work Based trainer activity. The concept involves the introduction of themed training activity at local level, which will subsequently change on a monthly basis (to include Infection Control). Ongoing promotion of Infection Control Manual.	**Implementation of organisation- wide annual audit. Clinical theme for Work Based Training to be set, roll-out Make-Ready, one off deep clean for all vehicles, LAS News Article.** Premises Inspections monitored at Corporate Health and Safety Committee –LA52 reports – None reported (Apr-June-05). Review of the SOM –	

Ref No	Standard	Principal Risks	SMG Lead	Existing Controls	Trust Assurance	Compliance
Seventh Domain – Public Health Healthcare organisations provided leadership and collaborate with relevant local organisations and communities to ensure the design and delivery of programmes and services which promote, protect and improve the health of the population and reduce health inequalities between different population groups and areas						
C22 (a)	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by co-operating with each other and with local authorities and other organisations	**NO RISKS IDENTIFIED on the Risk Register**	**Directors: Medical ,Operations, and Service Development**	Bromley Community Responder Scheme Community relationships developed using borough profiles by AOMS Cardiac Care Schemes Public education scheme provides training in CPR School visits Defibrillators in public places scheme London wide Primary Angioplasty arrangements First responder CPR scheme	PPI Policy PPI Committee PALS reports Race Equality Scheme and Development Plan quality assured with Strategic Health Authority who gave it best practice status	
C22 (b)	Healthcare organisations promote, protect and improve the health of the community served, and narrow health and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices	**NO RISK IDENTIFIED on the Risk Register**	**Medical Director**	Cardiac Arrest DVD, Community Resus team work, Project Harmony etc. **Cardiac Care Strategy approved by the Board in November O5 .**	See 22a above	
C22 (c)	Healthcare organisations promote, protect and improve the health of the community served, and narrow health inequalities by making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction partnerships	**NO RISKS IDENTIFIED on the Risk Register**	Director of HR	Evidence provided for Healthcare Commission recent visit Patient Specific Protocols LAS Protocol for use of Whitechapel WIC Stakeholder goals from NHS Partners workshop to develop 7 year strategic plan	PPI strategy LESLEP NICE Manager identified and reporting in to Clinical Risk Group Mental Health Strategy	
C23	Healthcare organisation have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national	**NO RISKS IDENTIFIED on the Risk Register**	**Director of Service Development**	NSFs, Patient education programmes see above Compliance with new national target indicators for ambulance trusts NICE Guidelines applicable to Ambulance Trusts (NICE Guideline 16) and application of JRCALC guidelines will be assessed for compliance using an audit co-ordinated by the Clinical Effectiveness dept Make Ready Scheme NICE Manager identified and reporting in to Clinical Risk	Mental Health Strategy approved by Board November 2005 Annual Clinical Audit Programme Infection Control Annual Report	

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	plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections			Group		
C24	Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	No being able to instigate an effective response in the event of either an internal or external incident that affected the infrastructure of the service due to a lack of a comprehensive, fully integrated Contingency	**Director of Operations** **IM&T Director**	**Exercises with operational mangers and crews** Major Incident Plan, EPU, Business Continuity Plan London Emergency Services Liaison panel membership Major incident management training annually for senior managers Secondments of senior managers to London Resilience Team International Emergency Planning Exercise London wide Police Fire and Ambulance Services rehearsal exercise	Catastrophic Incident plan Mass Casualty Plan Heatwave plan Mutual Aid Agreements with other emergency services Agreements with private sector ambulance services Business Continuity Planning internal Audit – 06/07	