Organisation Name:	
NHSLA Membership Number:	
NHS or Foundation trust	
Day 1 of Assessment:	
Day 2 of Assessment:	
Existing CNST/NHSLA Level:	
Level Applied For:	
Level Achieved:	
Assigned Assessor:	
Chief Executive: email address	
Organisation Contact: designation email address	

Evidence Template
for use with
NHSLA Risk Management Standards for Primary Care Trusts
2009/10 version

This evidence template has been produced to assist organisations in preparing for assessment and is based on the relevant NHSLA Standards.
In the event of any discrepancy between the text in this template and the NHSLA standards, the standards will take precedence.

Evidence Template Guidance to support organisations when using this template and preparing electronic evidence for an assessment can be downloaded from:
www.nhsla.com/Publications / Risk management publications / Evidence Templates

Data below will be populated automatically from information entered on subsequent worksheets.

	Standard 1		Standard 2		Standard 3		Standard 4		Standard 5		Total	
	Organisation	Assessor	Organisation	Assessor	Organisation	Assessor	Organisation	Assessor	Organisation	Assessor	Organisation	Assessor
1.1			2.1		3.1		4.1		5.1			
1.2			2.2		3.2		4.2		5.2			
1.3			2.3		3.3		4.3		5.3			
1.4			2.4		3.4		4.4		5.4			
1.5			2.5		3.5		4.5		5.5			
1.6			2.6		3.6		4.6		5.6			
1.7			2.7		3.7		4.7		5.7			
1.8			2.8		3.8		4.8		5.8			
1.9			2.9		3.9		4.9		5.9			
1.10			2.10		3.10		4.10		5.10			
Total	0	0	**Total**	0	0	**Total**	0	0	**Total**	0	0	0	0

Data above will be populated automatically from information entered on subsequent worksheets.

Cell: E1
Comment: Your first action should be to select your organisation's name here.

Related cells will be populated automatically.

Cell: E7
Comment: The navigation facility from the matrix below may function incorrectly until the appropriate assessment level is selected here.

Cell: E8
Comment: Assessor Use
post assessment

Cell: B20
Comment: Risk management strategy

Cell: G20
Comment: Corporate induction

Cell: L20
Comment: Secure environment

Cell: Q20
Comment: Patient identification

Cell: V20
Comment: Incident reporting

Cell: B21
Comment: Policy on procedural documents

Cell: G21
Comment: Local induction of permanent staff

Cell: L21
Comment: Sickness absence

Cell: Q21
Comment: Patient information

Cell: V21
Comment: Raising concerns

Cell: B22
Comment: Risk management committee(s)

Cell: G22
Comment: Local induction of temporary staff

Cell: L22
Comment: Safeguarding adults

Cell: Q22
Comment: Consent

Cell: V22
Comment: Complaints

Cell: B23
Comment: Risk management committee(s)

Cell: G23
Comment: Fitness to practice

Cell: L23
Comment: Moving & handling

Cell: Q23
Comment: Clinical record-keeping standards

Cell: V23
Comment: Claims

Cell: B24
Comment: Risk management committee(s)

Cell: G24
Comment: Risk management training

Cell: L24
Comment: Slips, trips & falls

Cell: Q24
Comment: Transfer of patients

Cell: V24
Comment: Investigations

Cell: B25
Comment: Risk management committee(s)

Cell: G25
Comment: Training needs analysis

Cell: L25
Comment: Inoculation incidents

Cell: Q25
Comment: Medicines management

Cell: V25
Comment: Analysis

Cell: B26
Comment: Responding to external recommendations specific to the organisation

Cell: G26
Comment: Medical devices training

Cell: L26
Comment: Maintenance of medical devices & equipment

Cell: Q26
Comment: Blood transfusion

Cell: V26
Comment: Improvement

Cell: B27
Comment: Clinical records management

Cell: G27
Comment: Hand hygiene training

Cell: L27
Comment: Harassment & bullying

Cell: Q27
Comment: Resuscitation

Cell: V27
Comment: Best practice - NICE

Cell: B28
Comment: Professional clinical registration

Cell: G28
Comment: Moving & handling training

Cell: L28
Comment: Violence & aggression

Cell: Q28
Comment: Infection control

Cell: V28
Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: B29
Comment: Employment checks

Cell: G29
Comment: Supporting staff involved in an incident, complaint or claim

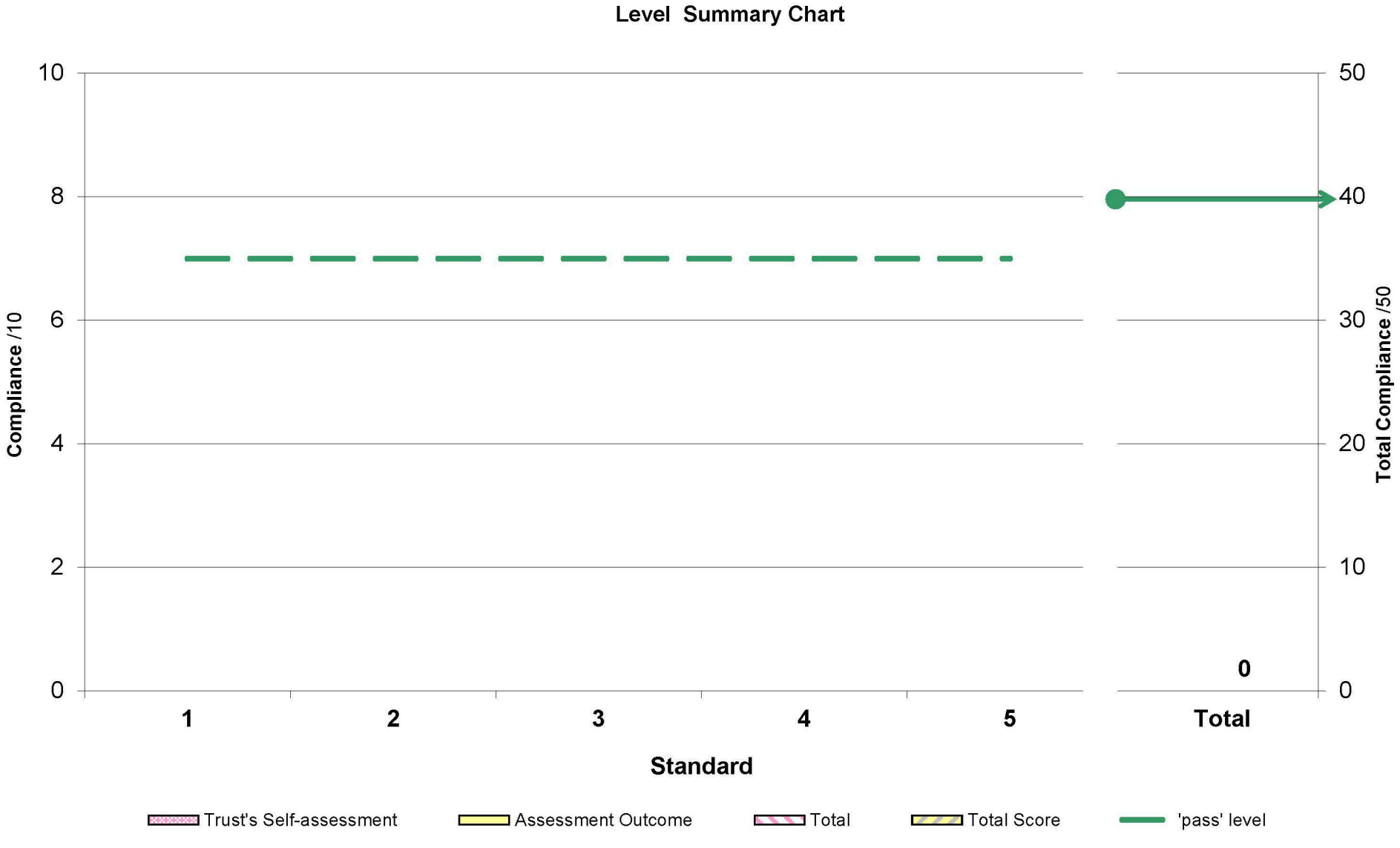
Cell: L29
Comment: Stress

Cell: Q29

Comment: Diagnostic testing and screening procedures

Cell: V29
Comment: Being open

NHSLA Risk Management Standards for Acute Trusts
Evidence Template



NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
Overview of Risk Areas

Standard ⇨	1	2	3	4	5
Criterion ⇩	Governance	Competent & Capable Workforce	Safe Environment	Clinical Care	Learning from Experience
1	Risk management strategy	Corporate induction	Secure environment	Patient identification	Incident reporting
2	Policy on procedural documents	Local induction of permanent staff	Sickness absence	Patient information	Raising concerns
3	Risk management committee(s)	Local induction of temporary staff	Safeguarding adults	Consent	Complaints
4	Risk awareness training for senior management	Fitness to practice	Moving & handling	Clinical record-keeping standards	Claims
5	Risk management process	Risk management training	Slips, trips & falls	Transfer of patients	Investigations
6	Risk register	Training needs analysis	Inoculation incidents	Medicines management	Analysis
7	Responding to external recommendations specific to the organisation	Medical devices training	Maintenance of medical devices & equipment	Blood transfusion	Improvement
8	Clinical records management	Hand hygiene training	Harassment & bullying	Resuscitation	Best practice - NICE
9	Professional clinical registration	Moving & handling training	Violence & aggression	Infection control	Best practice - NSFs, NCEs & High Level Enquiries
10	Employment checks	Supporting staff involved in an incident, complaint or claim	Stress	Diagnositc testing & screening procedures	Being open

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.1.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
1.1.1	1010	There is an organisation-wide risk management strategy which has been approved by the board.													
		As a minimum, the approved documentation must include a description of the:													
a	1011	organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk						No		Risk Management Strategy and Business Assurance Strategy need review and currently reflect PCT structure and arrangements before TCS/Kaleido					
b	1012	process for board or high level committee review of the organisation-wide risk register						No		Business Assurance Strategy needs review and currently reflect PCT structure and arrangements before TCS/Kaleido					
c	1013	**process for the management of risk locally, which reflects the organisation-wide risk management strategy**						No		Risk Management Strategy needs review, COR/010, COR/011 & COR/006 currently reflect PCT structure and arrangements before TCS/Kaleido					
d	1014	duties of the key individual(s) for risk management activities						No		Business Assurance & Risk Management Strategies need review, COR/010, COR/011 and COR/006 currently reflect PCT structure and arrangements before TCS/Kaleido					
e	1015	authority of all managers with regard to managing risk						No		Business Assurance & Risk Management Strategies need review, COR/010, COR/011 and COR/006 currently reflect PCT structure and arrangements before TCS/Kaleido					
f	1018	process for monitoring compliance with all of the above.						No		Business Assurance & Risk Management Strategies need review, COR/010, COR/011 and COR/006 currently reflect PCT structure and arrangements before TCS/Kaleido					
							Compliant	**No**		**Compliant**					
1.1.2	1020	The organisation has approved documentation which describes the process for developing organisation-wide procedural documents.													
		As a minimum, the approved documentation must include a description of the following requirements:													
a	1021	style and format						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009					
b	1022	an explanation of any terms used in documents developed						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009					
c	1023	consultation process						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009					

d	1024	**ratification process**						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
e	1025	review arrangements						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
f	1026	**control of documents, including archiving arrangements**						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
g	1027	associated documents						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
h	1027.1	supporting references						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
i	1028	the process for monitoring compliance with all of the above.						Yes		GOV/003 Provider Policy on Policies approved Provider Committee October 2009						
							Compliant	**Yes**		**Compliant**						
1.1.3	1030	The organisation has approved terms of reference for the high level committee(s) with overarching responsibility for risk.														
		As a minimum, the terms of reference must include a description of the:														
a	1031	duties						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
b	1032.1	**reporting arrangements to the board**						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
c	1033	membership, including nominated deputy where appropriate						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
d	1034	required frequency of attendance by members						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
e	1035	**reporting arrangements into the high level committee(s)**						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
f	1036	requirements for a quorum						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
g	1037	frequency of meetings						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
h	1038	process for monitoring compliance with all of the above.						No		Strategy must dictate which committee this is. ToR need to be prepared. Interim RM &Assurance Strategy 0910 to IGC in Jan'10						
							Compliant	**No**		**Compliant**						
1.1.4	1041	The organisation has approved documentation which describes the process for delivering risk management awareness training for all board members, executives and senior managers.														
		As a minimum, the approved documentation must include a description of the process for:														

a	1042	**ensuring that all board members, and senior managers receive relevant risk management awareness training**						No		Probably should be part of Risk Management Policy which needs to be updated to reflect TCS/Kaleido. TNA must also reflect this.						
b	1043	recording attendance						No		Probably should be part of Risk Management Policy which needs to be updated to reflect TCS/Kaleido. L&D Policy must state these arrangements.						
c	1044	**following up non-attendance**						No		Probably should be part of Risk Management Policy which needs to be updated to reflect TCS/Kaleido. L&D Policy must state these arrangements.						
d	1048	monitoring compliance with all of the above.						No		Probably should be part of Risk Management Policy which needs to be updated to reflect TCS/Kaleido. L&D Policy must also give information for this criterion.						
							Compliant	No		**Compliant**						
1.1.5	1051	The organisation has approved documentation which describes the organisation-wide systematic risk management process.														
		As a minimum, the approved documentation must include a description of the:														
a	1052	***process for assessing all types of risk***						No		Risk Management Strategy and possibly Business Assurance Strategy which need updating for TCS and Kaleido. Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 and Risk Assessment Pack. Possibly COR/012 and COR/045.						
b	1053	**process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation**						No		Risk Management Strategy and possibly Business Assurance Strategy which need updating for TCS and Kaleido. Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 and Risk Assessment Pack. Possibly COR/012 and COR/045.						
c	1054	assignment of management responsibility for different levels of risk within the organisation						No		Risk Management Strategy and possibly Business Assurance Strategy which need updating for TCS and Kaleido. Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 and Risk Assessment Pack. Possibly COR/012 and COR/045.						
d	1058	process for monitoring compliance with all of the above.						No		Risk Management Strategy and possibly Business Assurance Strategy which need updating for TCS and Kaleido. Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 and Risk Assessment Pack. Possibly COR/012 and COR/045.						
							Compliant	No		**Compliant**						
1.1.6	1061	The organisation has an approved organisation-wide risk register.														
		As a minimum, the approved organisation-wide risk register must include the:														

a	1062	***source of the risk (including, but not limited to, incident reports, risk assessment and directorate risk registers)***						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
b	1063	description of the risk						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
c	1064	risk score						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
d	1065	summary risk treatment plan						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
e	1066	date of review						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
f	1068	residual risk rating.						No		Risk Management Strategy and possibly Business Assurance Strategy, Draft amalgamated interim 0910 strategy going to IGC in Jan10. COR/006 which need updating for TCS and Kaleido.						
							Compliant	No		**Compliant**						
1.1.7	1070	The organisation has approved documentation which describes the process for preparing and responding to the recommendations and requirements arising from external agency visits, inspections and accreditations specific to the organisation.														
		As a minimum, the approved documentation must include a description of the process for:														
a	1071	nominating/appointing a suitable individual(s) to coordinate and report on any reviews carried out by external agencies						No		GOV/004 in place goes out of date in Jan 2010						
b	1072	maintaining a schedule of review dates						No		GOV/004 in place goes out of date in Jan 2010						
c	1073	**maintaining action plans to implement any recommendations made as a result of reviews**						No		GOV/004 in place goes out of date in Jan 2010						
d	1074	ensuring that the organisation-wide risk register is populated with risks identified from reviews						No		GOV/004 in place goes out of date in Jan 2010						
e	1078	monitoring compliance with all of the above.						No		GOV/004 in place goes out of date in Jan 2010						
							Compliant	No		**Compliant**						

1.1.8	1080	The organisation has approved documentation which describes the process for managing the risks associated with clinical records in all media.													
		As a minimum, the approved documentation must include a description of the:													
a	1081	duties						Yes		COR/022 has now been updated and approved at IGC Nov'09					
b	1082	legal obligations that apply to records						Yes		COR/022 has now been updated and approved at IGC Nov'09					
c	1083	**process for tracking records**						Yes		COR/022 has now been updated and approved at IGC Nov'09					
d	1084	process for creating records						Yes		COR/022 has now been updated and approved at IGC Nov'09					
e	1085	process for retrieving records						Yes		COR/022 has now been updated and approved at IGC Nov'09					
f	1086	**process for retaining and disposing of records**						Yes		COR/022 has now been updated and approved at IGC Nov'09					
g	1088	process for monitoring compliance with all of the above.						Yes		COR/022 has now been updated and approved at IGC Nov'09					
							Compliant	**Yes**		**Compliant**					
1.1.9	1090	The organisation has approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body.													
		As a minimum, the approved documentation must include a description of the:													
a	1091	duties, both on initial appointment and ongoing thereafter						No		PER/004, PER/019, PER/021, **PER/022**, may impact on this area and need review. Key policy out of date in Feb 2009. PER/004 ood Oct 09.					
b	1092	***process for ensuring registration checks are made directly with the relevant professional body, in accordance with their recommendations, in respect of all permanent clinical staff both on initial appointment and ongoing thereafter***						No		PER/004, PER/019, PER/021, **PER/022**, may impact on this area and need review. Key policy out of date in Feb 2009. PER/004 ood Oct 09.					
c	1093.1	***process for monitoring/receiving assurance that registration checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary clinical staff***						No		PER/004, PER/019, PER/021, **PER/022**, may impact on this area and need review. Key policy out of date in Feb 2009. PER/004 ood Oct 09.					
d	1094	process in place for following up those permanent clinical staff who fail to satisfy the validation of registration process						No		PER/004, PER/019, PER/021, **PER/022**, may impact on this area and need review. Key policy out of date in Feb 2009. PER/004 ood Oct 09.					
e	1098	process for monitoring compliance with all of the above.						No		PER/004, PER/019, PER/021, **PER/022**, may impact on this area and need review. Key policy out of date in Feb 2009. PER/004 ood Oct 09.					
							Compliant	**No**		**Compliant**					

1.1.10	1100	The organisation has approved documentation which describes the process for ensuring that all appropriate employment checks are undertaken for all staff (temporary and permanent).														
		As a minimum, the approved documentation must include a description of the:														
a	1101	duties						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
b	1102	**types of check required**						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
c	1103	checking procedures						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
d	1104	process for following up those who fail to satisfy the checking arrangements						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
e	1105	process for monitoring/receiving assurance that checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary staff						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
f	1108	process for monitoring compliance with all of the above.						No		PER/004, PER/006, PER/019, PER/021, **PER/022**, PER/036 may impact on this area and need review. PER/022 & PER/006 ood Feb 2009.PER/004 ood Oct 09.						
							Compliant	No		**Compliant**						

The following summary will be populated automatically from information entered on the worksheet.

1.1.1	No		0	
1.1.2	Yes		0	
1.1.3	No		0	
1.1.4	0		0	
1.1.5	No		0	
1.1.6	No		0	
1.1.7	No		0	
1.1.8	Yes		0	
1.1.9	No		0	
1.1.10	No		0	**All Standards Total**
Total	**2**		**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	

08/09 Not currently in strategy or TOR			
08/09 Need clearer description of reporting to and from Audit Comm and Board.			
08/09 Need clearer description of monitoring.			

COR/012 needs review to ensure cross-referencing to risk management policies and correct information in TNA. Needs to detail Proactive workplace risk assessment.	F.Regan	Jan'10 IGC													
COR/012 needs review to ensure cross-referencing to risk management policies and correct information in TNA. Needs to detail Proactive workplace risk assessment. COR/045 could benefit from clarity regarding the top level review of DSE assessments and whether this is reported in the H&S Annual report.	F.Regan	Jan'10 IGC ? Not ood until Aug'12													
COR/012 needs review to ensure cross-referencing to risk management policies and correct information in TNA. Needs to detail Proactive workplace risk assessment.	F.Regan	Jan'10 IGC													
COR/012 needs review to ensure cross-referencing to risk management policies and correct information in TNA. Needs to detail Proactive workplace risk assessment.	F.Regan	Jan'10 IGC													

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.1.

GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.	SM	Jan'10	
GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.	SM	Jan'10	
GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.	SM	Jan'10	
GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.	SM	Jan'10	
GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.	SM	Jan'10	

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.1.

08/09 Improved detail and cross-referencing between policies needed against all criteria.														

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H106
Comment: Risk management strategy

Cell: H107
Comment: Policy on procedural documents

Cell: H108
Comment: Risk management committee(s)

Cell: H109
Comment: Risk awareness training for senior management

Cell: H110
Comment: Risk management process

Cell: H111
Comment: Risk register

Cell: H112
Comment: Responding to external recommendations specific to the organisation

Cell: H113
Comment: Clinical records management

Cell: H114
Comment: Professional clinical registration

Cell: H115
Comment: Employment checks

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.2.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
1.2.1	2010	The organisation has approved documentation which describes the corporate induction arrangements for all new permanent staff.													
		As a minimum, the approved documentation must include a description of the:													
a	2011	duties						No		**PER/026** out of date, PER/037					
b	2012	minimum content of the corporate induction programme(s)						No		**PER/026** out of date, PER/037					
c	2013	process for ensuring that all new permanent staff are booked onto corporate induction						No		**PER/026** out of date, PER/037					
d	2014	**process for checking that all new permanent staff complete corporate induction**						No		**PER/026** out of date, PER/037					
e	2015	**process for following up those who fail to attend corporate induction**						No		**PER/026** out of date, PER/037					
f	2018	process for monitoring compliance with all of the above.						No		**PER/026** out of date, PER/037					
							Compliant	No		**Compliant**					
1.2.2	2020	The organisation has approved documentation which describes the local induction arrangements for all new permanent staff.													
		As a minimum, the approved documentation must include a description of the:													
a	2021	duties						No		**PER/026** out of date, PER/037					
b	2022	minimum content of local induction programme(s)						No		**PER/026** out of date, PER/037					
c	2023	**process for checking that all new permanent staff complete local induction**						No		**PER/026** out of date, PER/037					
d	2024	**process for following up those who fail to complete local induction**						No		**PER/026** out of date, PER/037					
e	2028	process for monitoring compliance with all of the above.						No		**PER/026** out of date, PER/037					
							Compliant	No		**Compliant**					
1.2.3	2030	The organisation has approved documentation which describes the local induction arrangements for all temporary staff.													
		As a minimum, the approved documentation must include a description of the:													
a	2031	duties						No		PER/004, PER/019, **PER/026** out of date, PER/037, PER/039					
b	2032	minimum content of local induction programme(s)						No		PER/004, PER/019, **PER/026** out of date, PER/037, PER/039					

c	2033	**process for checking that all temporary staff complete local induction**						No		PER/004, PER/019, **PER/026** out of date, PER/037, PER/039					
d	2034	**process for following up those who fail to complete local induction**						No		PER/004, PER/019, **PER/026** out of date, PER/037, PER/039					
e	2038	process for monitoring compliance with all of the above.						No		PER/004, PER/019, **PER/026** out of date, PER/037, PER/039					
							Compliant	**No**		**Compliant**					
1.2.4	2040	The organisation has approved documentation which describes the process for ensuring that the organisation undertakes the appropriate regulatory checks via the NHSLA Family Health Services Appeal Unit on all primary care performers (temporary and permanent).													
		As a minimum, the approved documentation must include a description of the:													
a	2041	duties						No		???? PER/004?					
b	2042	**process for ensuring checks are made**						No		???? PER/004?					
c	2043	process for following up those who fail to satisfy the checking arrangements						No		???? PER/004?					
d	2044	**procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern**						No		???? PER/004?					
e	2045	procedure for notification within the health community						No		???? PER/004?					
f	2048	process for monitoring compliance with all of the above.						No		???? PER/004?					
							Compliant	**No**		**Compliant**					
1.2.5	2050	The organisation has approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.													
		As a minimum, the approved documentation must include a description of the process for:													
a	2051	developing a training needs analysis which reflects the TNA Minimum Data Set						Yes		PER/037 and updated TNA					
b	2052	developing action plan(s) to deliver the training identified within the training needs analysis						Yes		PER/037 and updated TNA					
c	2053	developing a training prospectus to reflect the training needs analysis						Yes		PER/037 and updated TNA					
d	2054	**checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis**						Yes		PER/037 and updated TNA					
e	2055	**following up those who fail to attend relevant training programmes**						Yes		PER/037 and updated TNA					
f	2056	coordinating training records						Yes		PER/037 and updated TNA					
g	2058	monitoring compliance with all of the above.						No		PER/037 and updated TNA					
							Compliant	**No**		**Compliant**					

1.2.6	2060	The organisation has undertaken a training needs analysis to identify the risk management training requirements for all permanent staff and documented the results.													
		As a minimum, the approved documentation must include:													
a	2061	a list of topics defined as risk management training by the organisation (MUST include all those referred to in the NHSLA standards TNA Minimum Data Set)						Yes		PER/037 and updated TNA					
b	2062	evidence that the organisation has identified which staff groups are required to attend each type of training						Yes		PER/037 and updated TNA					
c	2063	evidence that the organisation has identified the frequency of updates required for each type of training.						Yes		PER/037 and updated TNA					
							Compliant	**Yes**		**Compliant**					
1.2.7	2070	The organisation has approved documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role.													
		As a minimum, the approved documentation must include a description of the:													
a	2071	duties						No		COR/009 ood Jan 2010					
b	2072	inventory (or links to an inventory) of diagnostic and therapeutic equipment used within the organisation						No		COR/009 ood Jan 2010					
c	2073	**process for identifying which permanent staff are authorised to use the equipment identified on the inventory**						No		COR/009 ood Jan 2010					
d	2074	**process for determining the training required to use the equipment identified on the inventory and the frequency of updates required**						No		COR/009 ood Jan 2010					
e	2075	**process for ensuring that the identified training needs of all permanent staff are met**						No		COR/009 ood Jan 2010					
f	2078	process for monitoring compliance with all of the above.						No		COR/009 ood Jan 2010					
							Compliant	**No**		**Compliant**					
1.2.8	2080	The organisation has approved documentation which describes the process for ensuring the delivery of effective hand hygiene training for all relevant permanent staff groups.													
		As a minimum, the approved documentation must include a description of the:													
a	2081	duties						Yes		INC/003					
b	2082	**process for checking that all relevant permanent staff groups, as identified in the training needs analysis, complete hand hygiene training**						Yes		INC/003, PER/037 and TNA					

c	2083	**process for following up those who fail to attend hand hygiene training**						Yes		INC/003, PER/037 and TNA					
d	2088	process for monitoring compliance with all of the above.						Yes		INC/003					
							Compliant	**Yes**		**Compliant**					
1.2.9	2090	The organisation has approved documentation which describes the process for ensuring the delivery of effective moving and handling training to all permanent staff.													
		As a minimum, the approved documentation must include a description of the:													
a	2091	duties						Yes		COR/042					
b	2092	**process for checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training**						Yes		COR/042, PER/037 and TNA					
c	2093	**process for following up those who fail to attend relevant moving and handling training**						Yes		COR/042, PER/037 and TNA					
d	2098	process for monitoring compliance with all of the above.						Yes		COR/042					
							Compliant	**Yes**		**Compliant**					
1.2.10	2100	The organisation has approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported.													
		As a minimum, the approved documentation must include a description of the:													
a	2101	duties						No		3.8.1 COR/011 ood Jan 2010, no actual staff support policy					
b	2102	**immediate support offered to staff (internally and, if necessary, externally)**						No		3.8.1 COR/011, no actual staff support policy					
c	2103	ongoing support offered to staff (internally and, if necessary, externally)						No		3.8.1 COR/011, no actual staff support policy					
d	2104	advice available to staff in the event of their being called as a witness (internally and, if necessary, externally)						No		3.8.1 COR/011, no actual staff support policy					
e	2105	**action for managers or individuals to take if the staff member is experiencing difficulties associated with the event**						No		3.8.1 COR/011, no actual staff support policy					

f	2108	process for monitoring compliance with all of the above.						No		3.8.1 COR/011, no actual staff support policy				
							Compliant	**No**		**Compliant**				
							The following summary will be populated automatically from information entered on the worksheet.							
							1.2.1	No			0			
							1.2.2	No			0			
							1.2.3	No			0			
							1.2.4	No			0			
							1.2.5	No			0			
							1.2.6	Yes			0			
							1.2.7	No			0			
							1.2.8	Yes			0			
							1.2.9	Yes			0			
							1.2.10	No			0		**All Standards Total**	
							Total	**3**			**0**		**0**	

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
08/09 Clarify duties and responsibilities			
08/09 Detail content of local induction in policy.			
08/09 Review arrangements for checking return of all local induction checklists including a monthly exception report			
08/09 Review arrangements for checking return of all local induction checklists including a monthly exception report			
08/09 Provide clarity on monitoring arrangements			
08/09 Improve cross-referencing to other policies, clarify duties for PER/019			
08/09 Detail local induction content for temporary workers			

NHSLA Risk Management Standards for Primary Care Trusts
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1.2.

08/09 Clarify monitoring compliance arrangements			
08/09 Investigate this to understand requirements.			
TNA is currently being separated.Needs to cross ref Risk Man & H&S Policies	AA	?? Ood Mar'12	
TNA is currently being separated.	AA	?? Ood Mar'12	
Training calendar may need clear Prov/Comm split	AA	?? Ood Mar'12	
Managers/staff responsibility under PER/037, clarify?	AA	?? Ood Mar'12	
Ensure monitoring is auditable.	AA	?? Ood Mar'12	

TNA is currently being separated.Needs to cross ref Risk Man & H&S Policies	AA	?? Ood Mar'12	
COR/009 needs to be updated looking at suitable arrangements for local inventories and a central record. Needs to be reapproved.	BS/MT/SM/JH	Feb'10	
08/09 Clearer detail required in policy			
08/09 Clearer detail required in policy			

08/09 Clearer detail required in policy			
08/09 Clearer detail required in policy			
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.		?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.		?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.		?? Ood Jan'12	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09	

Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Dec'09												

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H98
Comment: Corporate induction

Cell: H99
Comment: Local induction of permanent staff

Cell: H100
Comment: Local induction of temporary staff

Cell: H101
Comment: Fitness to practice

Cell: H102
Comment: Risk management training

Cell: H103
Comment: Training needs analysis

Cell: H104
Comment: Medical devices training

Cell: H105
Comment: Hand hygiene training

Cell: H106
Comment: Moving & handling training

Cell: H107
Comment: Supporting staff involved in an incident, complaint or claim

NHSLA Risk Management Standards for Primary Care Trusts
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1.3.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
1.3.1	3010	The organisation has approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.													
		As a minimum, the approved documentation must include a description of the:													
a	3011	duties						No		COR/025 ood Jan 2010					
b	3012	requirement to undertake a lockdown risk profile for each organisational site or other specific building/area						No		COR/025 ood Jan 2010, no lockdown policy					
c	3013	**requirement to undertake appropriate risk assessments regarding the physical security of premises and assets**						No		COR/025 ood Jan 2010					
d	3014	**arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets**						No		COR/025 ood Jan 2010, COR/006					
e	3018	process for monitoring compliance with all of the above.						No		COR/025 ood Jan 2011, no lockdown policy					
							Compliant	**No**		**Compliant**					
1.3.2	3020	The organisation has approved documentation which describes the process for managing the risks associated with sickness absences.													
		As a minimum, the approved documentation must include a description of the:													
a	3021	duties						No		PER/009 ood, PER/027					
b	3022	process for maintaining contact with absent employees						No		PER/009 ood, PER/027					
c	3023	planning and facilitating return to work plans						No		PER/009 ood, PER/027					
d	3024	planning and undertaking workplace controls or adjustments						No		PER/009 ood, PER/027					
e	3025	**process for analysing sickness absence data**						No		PER/009 ood, PER/027					
f	3026	**arrangements for the organisational overview of sickness absence**						No		PER/009 ood, PER/027					
g	3028	process for monitoring compliance with all of the above.						No		PER/009 ood, PER/027					
							Compliant	**No**		**Compliant**					

1.3.3	3030	The organisation has approved documentation which describes the process for managing the risks associated with safeguarding adults.														
		As a minimum, the approved documentation must include a description of the:														
a	3031	duties						Yes		COR/033						
b	3032	**local arrangements for managing the risks associated with safeguarding adults**						Yes		COR/033						
c	3033	organisation's expectations in relation to staff training, as identified in the training needs analysis						Yes		COR/033, PER/037 and TNA						
d	3038	process for monitoring compliance with all of the above.						Yes		COR/033						
							Compliant	**Yes**		**Compliant**						
1.3.4	3040	The organisation has approved documentation which describes the process for managing the risks associated with moving and handling.														
		As a minimum, the approved documentation must include a description of the:														
a	3041	duties						Yes		COR/042						
b	3042	techniques to be used in the moving and handling of patients and objects, including the use of appropriate equipment						Yes		COR/042						
c	3043	arrangements for access to appropriate specialist advice						Yes		COR/042						
d	3044	**requirement to undertake appropriate risk assessments for the moving and handling of patients and objects**						Yes		COR/042						
e	3045	**arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects**						Yes		COR/042						
f	3048	process for monitoring compliance with all of the above.						Yes		COR/042						
							Compliant	**Yes**		**Compliant**						
1.3.5	3050	The organisation has approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others.														
		As a minimum, the approved documentation must include a description of the:														
a	3051	duties						No		COR/043 ood Jan 2010						
b	3052	**requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)**						No		COR/043 ood Jan 2010						

c	3053	**requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height)**						No		COR/043 ood Jan 2010					
d	3054	organisation's expectations in relation to staff training, as identified in the training needs analysis						No		COR/043 ood Jan 2010, PER/037 and TNA					
e	3055	process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients, staff and others						No		COR/043 ood Jan 2010					
f	3058	process for monitoring compliance with all of the above.						No		COR/043 ood Jan 2010					
							Compliant	**No**		**Compliant**					
1.3.6	3060	The organisation has approved documentation which describes the process for managing the risks associated with inoculation incidents.													
		As a minimum, the approved documentation must include a description of the:													
a	3061	duties						No		COR/041					
b	3062	reporting arrangements in relation to inoculation incidents						No		COR/041					
c	3063	**process for the management of an inoculation incident (including prophylaxis)**						Yes		COR/041					
d	3065	organisation's requirements in relation to staff training, as identified in the training needs analysis						Yes		COR/041, PER/037 and TNA					
e	3068	process for monitoring compliance with all of the above.						No		COR/041					
							Compliant	**No**		**Compliant**					
1.3.7	3070	The organisation has approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment.													
		As a minimum, the approved documentation must include a description of the:													
a	3071	duties						Yes		INC/009 & COR/009					
b	3072	requirement to have a systematic inventory of all reusable medical devices and equipment used within the organisation						Yes		INC/009 & COR/009					
c	3073	**process for ensuring that all reusable medical devices and equipment are properly maintained and repaired**						Yes		INC/009 & COR/009					
d	3074	process for checking that calibration of all reusable medical devices are completed within the specified time frames						Yes		INC/009 & COR/009					
e	3078	process for monitoring compliance with all of the above.						Yes		INC/009 & COR/009					

							Compliant	Yes		Compliant								
1.3.8	3080	The organisation has approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff.																
		As a minimum, the approved documentation must include a description of the:																
a	3081	duties						Yes		PER/010								
b	3082	statement by the organisation that harassment and/or bullying are not acceptable						Yes		PER/010								
c	3083	**process for raising concerns about harassment and/or bullying**						Yes		PER/010								
d	3084	**process to be followed once a concern has been raised**						Yes		PER/010								
e	3085	organisation's requirements in relation to staff training, as identified in the training needs analysis						Yes		PER/010, PER/037 and TNA								
f	3088	process for monitoring compliance with all of the above.						Yes		PER/010								
							Compliant	Yes		Compliant								
1.3.9	3090	The organisation has approved documentation which describes the process for managing the risks associated with the prevention and management of violence and aggression.																
		As a minimum, the approved documentation must include a description of the:																
a	3091	duties						Yes		PER/010								
b	3092	**requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression**						Yes		PER/010								
c	3093	**arrangements for ensuring the safety of lone workers**						Yes		PER/010								
d	3094	organisation's expectations in relation to staff training, as identified in the training needs analysis						Yes		PER/010, PER/037 and TNA								
e	3098	process for monitoring compliance with all of the above.						Yes		PER/010								
							Compliant	Yes		Compliant								
1.3.10	3100	The organisation has approved documentation which describes the process for managing the risks associated with work-related stress.																
		As a minimum, the approved documentation must include a description of the:																
a	3111	duties						Yes		PER/027 and PER/009 ood								
b	3112	process for accessing information on the management of work-related stress						Yes		PER/027 and PER/009 ood								
c	3113	**process for identifying workplace stressors**						Yes		PER/027 and PER/009 ood								
d	3114	**requirement to undertake appropriate risk assessments for the prevention and management of work-related stress**						Yes		PER/027 and PER/009 ood								
e	3118	process for monitoring compliance with all of the above.						Yes		PER/027 and PER/009 ood								
							Compliant	Yes		Compliant								

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.3.

The following summary will be populated automatically from information entered on the worksheet.

1.3.1	No	0	
1.3.2	No	0	
1.3.3	Yes	0	
1.3.4	Yes	0	
1.3.5	No	0	
1.3.6	No	0	
1.3.7	Yes	0	
1.3.8	Yes	0	
1.3.9	Yes	0	
1.3.10	Yes	0	**All Standards Total**
Total	**6**	**0**	**0**

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.3.

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.	SZ	Mar'10	
Lockdown policy currently being drafted.	SZ/JB	??	
COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.	SZ	Mar'10	
COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.	SZ	Mar'10	
COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.	SZ	Mar'10	

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.3.

COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
08/09 Improved detail COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
08/09 Improved detail COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
COR/042 need to fornalise the 'generic' M&H assessments for wards etc.	BS	?? Ood Jan'12	
08/09 Improved clarity COR/043 needs to be reapproved	BS	Jan'10	
08/09 Improved clarity COR/043 needs to be reapproved	BS	Jan'10	

08/09 Improved clarity COR/043 needs to be reapproved	BS	Jan'10	
08/09 Improved clarity COR/043 needs to be reapproved - need to check with M&H Advisor on training requirements	BS	Jan'10	
08/09 Improved clarity - particluarly for this criterion COR/043 needs to be reapproved	BS	Jan'10	
08/09 Improved clarity COR/043 needs to be reapproved	BS	Jan'10	
COR/041 roles and responsibilities should be clarified	FR/DW	?in date to Jan12	
COR/041 extra detail needed on non-medical incident reporting	FR/DW	?in date to Jan12	
Clarity needed	FR/DW	?in date to Jan12	
COR/009 needs to be updated looking at suitable arrangements for local inventories and a central record. Needs to be reapproved.	BS/MT/SM/JH	Feb'10	

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.3.

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.3.

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H100
Comment: Secure environment

Cell: H101
Comment: Sickness absence

Cell: H102
Comment: Safeguarding adults

Cell: H103
Comment: Moving & handling

Cell: H104
Comment: Slips, trips & falls

Cell: H105
Comment: Inoculation incidents

Cell: H106
Comment: Maintenance of medical devices & equipment

Cell: H107
Comment: Harassment & bullying

Cell: H108
Comment: Violence & aggression

Cell: H109
Comment: Stress

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.4.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
1.4.1	4010	The organisation has approved documentation which describes the process for managing the risks associated with the identification of all patients.													
		As a minimum, the approved documentation must include a description of the:													
a	4010.1	definition of all patients groups						No		CLN/018 ood Jan 2010					
b	4011	***process for identifying all patients***						No		CLN/018 ood Jan 2010					
c	4012	process for ongoing checks throughout the patient care episode						No		CLN/018 ood Jan 2010					
d	4013	**procedure to be followed in cases where patient misidentification occurs**						No		CLN/018 ood Jan 2010					
e	4018	process for monitoring compliance with all of the above.						No		CLN/018 ood Jan 2010					
							Compliant	**No**		**Compliant**					
1.4.2	4020	The organisation has approved documentation which describes the process for developing patient information associated with care, treatments and procedures.													
		As a minimum, the approved documentation must include a description of the:													
a	4022	process for the development of patient information						No		COR/040 ood Jan 2010					
b	4023	**list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate**						No		COR/040 ood Jan 2010					
c	4024	reviewing process, including review date						No		COR/040 ood Jan 2010					
d	4025	**archiving arrangements**						No		COR/040 ood Jan 2010					
e	4028	process for monitoring compliance with all of the above.						No		COR/040 ood Jan 2010					
							Compliant	**No**		**Compliant**					
1.4.3	4030	The organisation has approved documentation which describes the process for managing the risks associated with consent.													
		As a minimum, the approved documentation must include a description of the:													
a	4031	process for obtaining consent						Yes		CLN/002 approved at Provider Committee October 2009					
b	4032	process for recording consent						Yes		CLN/002 approved at Provider Committee October 2009					

c	4033	**process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure**						Yes		CLN/002 approved at Provider Committee October 2009						
d	4034	generic training on the consent process						Yes		CLN/002 approved at Provider Committee October 2009						
e	4035	**process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure**						No		CLN/002 approved at Provider Committee October 2009, staff who didn't take up training need to demonstrate compliance						
f	4038	process for monitoring compliance with all of the above.						No		CLN/002 approved at Provider Committee October 2009, might just need minor update for clarity.						
							Compliant	No		**Compliant**						
1.4.4	4040	The organisation has approved documentation which describes the process for managing the risks associated with the quality of clinical records in all media.														
		As a minimum, the approved documentation must include a description of the:														
a	4041	duties						Yes		COR/022 has now been updated and approved at IGC Nov'09						
b	4042	criteria against which the clinical records must be audited for all healthcare professionals						Yes		COR/022 has now been updated and approved at IGC Nov'09						
c	4043	frequency of audit of clinical records						Yes		COR/022 has now been updated and approved at IGC Nov'09						
d	4044	**format for all audit reports i.e. methodology, conclusions, action plans, etc.**						Yes		COR/022 has now been updated and approved at IGC Nov'09						
e	4045	**arrangements for the review of action plans**						Yes		COR/022 has now been updated and approved at IGC Nov'09						
f	4048	process for monitoring compliance with all of the above.						Yes		COR/022 has now been updated and approved at IGC Nov'09						
							Compliant	Yes		**Compliant**						
1.4.5	4050	The organisation has approved documentation which describes the process for managing the risks associated with the transfer of patients.														
		As a minimum, the approved documentation must include a description of the:														
a	4051	duties						Yes		CLN/020						
b	4052	**transfer requirements which are specific to each patient group**						Yes		CLN/020						
c	4053	**documentation to accompany the patient when being transferred**						Yes		CLN/020						
d	4054	process for transfer out of hours						Yes		CLN/020						
e	4058	process for monitoring compliance with all of the above.						Yes		CLN/020						
							Compliant	Yes		**Compliant**						
1.4.6	4060	The organisation has approved documentation which describes the process for managing the risks associated with medicines in all care environments.														
		As a minimum, the approved documentation must include a description of the:														

a	4061	process for prescribing medicines in all care environments						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
b	4061.1	**process for ensuring the accuracy of all prescription charts**						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
c	4062	process for the administration of medication in all care environments						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
d	4063	process for patient self administration						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
e	4064	procedure for the safe disposal of controlled drugs						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
f	4065	training requirements for all staff, as identified in the training needs analysis						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017, PER/037 and TNA						
g	4068	process for monitoring compliance with all of the above.						No		CLN/011(ood Jun 2010), CLN/016 & CLN/017						
							Compliant	**No**		**Compliant**						
1.4.7	4070	The organisation has approved documentation which describes the process for managing the risks associated with the blood transfusion process.														
		As a minimum, the approved documentation must include a description of the:														
a	4071	duties								Not Applicable						
b	4072	process for the request of blood samples for pre-transfusion compatibility testing														
c	4073	**process for the administration of blood and blood products**														
d	4074	**care of patient(s) receiving transfusion**														
e	4075	training requirements of all staff, as identified in the training needs analysis														
f	4076	requirements for the competency assessment of all staff involved in the blood transfusion process														
g	4078	process for monitoring compliance with all of the above.														
							Compliant	**Yes**		**Compliant**						
1.4.8	4080	The organisation has approved documentation which describes the process for managing the risks associated with resuscitation.														
		As a minimum, the approved documentation must include a description of the:														
a	4081	duties						No		CLN/006 ood Jun 2009						
b	4082	**early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest**						No		CLN/006 ood Jun 2009						
c	4083	post-resuscitation care						No		CLN/006 ood Jun 2009						
d	4084	**do not attempt resuscitation orders (DNAR)**						No		CLN/006 ood Jun 2009						
e	4085	process for ensuring the continual availability of resuscitation equipment						No		CLN/006 ood Jun 2009						
f	4086	training requirements for all staff, as identified in the training needs analysis						No		CLN/006 ood Jun 2009, PER/037 and TNA						
g	4088	process for monitoring compliance with all of the above.						No		CLN/006 ood Jun 2009						
							Compliant	**No**		**Compliant**						

1.4.9	4090	The organisation has approved documentation which describes the process for managing the risks associated with infection prevention and control.													
		As a minimum, the approved documentation must include a description of the:													
a	4092	**infection control assurance framework**						No		INC/001 ood Jan 2010					
b	4093	details of, or cross reference to, appropriate core policies						No		INC/001 ood Jan 2010					
c	4094	information available to patients and the public about the organisation's general processes and arrangements for preventing and controlling healthcare acquired infections						No		INC/001 ood Jan 2010					
d	4095	training requirements for all staff, as identified in the training needs analysis						No		INC/001 ood Jan 2010, PER/037 and TNA					
e	4098	process for monitoring compliance with all of the above.						No		INC/001 ood Jan 2010					
							Compliant	**No**		**Compliant**					
1.4.10	4100	The organisation has approved documentation which describes the organisation-wide process for developing local policies to manage the risks associated with the process of clinical diagnostic tests and screening procedures.													
		As a minimum, the approved documentation must include a description of the:													
a	4101	procedures for requesting clinical tests and screening						No		CLN/012					
b	4102	**process for taking action on clinical tests and screening results**						No		CLN/012					
c	4103	process for recording the actions taken						No		CLN/012					
d	4104	**process for the communication of test and screening results**						No		CLN/012					
e	4108	process for monitoring compliance with all of the above.						No		CLN/012					
							Compliant	**Yes**		**Compliant**					

The following summary will be populated automatically from information entered on the worksheet.

1.4.1	No	0
1.4.2	No	0
1.4.3	No	0
1.4.4	Yes	0
1.4.5	Yes	0
1.4.6	No	0
1.4.7	Yes	0
1.4.8	No	0
1.4.9	No	0
1.4.10	Yes	0
Total	**4**	**0**

All Standards Total
0

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.4.

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
Need to check on remedial action & AER process	SM	Feb'10	
Monitoring needs tightening up.	SM	Feb'10	
COR/040 needs to be checked for compliance, reviewed and reapproved	D.Barker	Mar'10	
COR/040 needs to be checked for compliance, reviewed and reapproved	D.Barker	Mar'10	
COR/040 needs to be checked for compliance, reviewed and reapproved	D.Barker	Mar'10	
COR/040 needs to be checked for compliance, reviewed and reapproved	D.Barker	Mar'10	
COR/040 needs to be checked for compliance, reviewed and reapproved	D.Barker	Mar'10	

CLN/002 needs to have minor amendment to Training/Monitoring to reflect this.	SM/JC	Mar'10	
CLN/002 needs to have minor amendment to Training/Monitoring to reflect this.	SM/JC	Mar'10	

Need dates to be rolled forward at committee	SM/AS	Jan'10	

08/09 Need to detail or cross reference to all core clinical care protocols. Should refer to the Health Act 2006 (revised Jan 2008). Need dates to be rolled forward at committee	DW/JC	Jan'10	
Needs disseminating	SL	Jan'10	

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H104
Comment: Patient identification

Cell: H105
Comment: Patient information

Cell: H106
Comment: Consent

Cell: H107
Comment: Clinical record-keeping standards

Cell: H108
Comment: Transfer of patients

Cell: H109
Comment: Medicines management

Cell: H110
Comment: Blood transfusion

Cell: H111
Comment: Resuscitation

Cell: H112
Comment: Infection control

Cell: H113
Comment: Diagnostic testing and screening procedures

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Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
1.5.1	5010	The organisation has approved documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable incidents.													
		As a minimum, the approved documentation must include a description of the:													
a	5011	duties						No		COR/010 ood Dec 2009					
b	5012	**process for reporting all incidents/near misses, involving staff, patients and others**						No		COR/010 ood Dec 2009					
c	5013	**process for reporting to external agencies**						No		COR/010 ood Dec 2009					
d	5014	reference to the processes for staff to raise concerns e.g. whistle blowing/open disclosure						No		COR/010 ood Dec 2009, PER/012 OOD Jun 2009					
e	5018	process for monitoring compliance with all of the above.						No		COR/010 ood Dec 2009					
							Compliant	**No**		**Compliant**					
1.5.2	5020	The organisation has approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to raise concerns informally.													
		As a minimum, the approved documentation must include a description of the:													
a	5021	duties						No		COR/001 ood Mar 09					
b	5022	**process for raising concerns (informal complaints/Patient Advice and Liaison Services)**						No		COR/001 ood Mar 09					
c	5023	process for ensuring that patients, relatives and their carers are not treated differently as a result of raising a concern						No		COR/001 ood Mar 09					
d	5024	**process by which the organisation aims to make changes as a result of concerns being raised**						No		COR/001 ood Mar 09					

e	5028	process for monitoring compliance with all of the above.						No		COR/001 ood Mar 09					
							Compliant	No		**Compliant**					
1.5.3	5030	The organisation has approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints.													
		As a minimum, the approved documentation must include a description of the:													
a	5031	duties						No		COR/001 ood Mar 09					
b	5032	**complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary**						No		COR/001 ood Mar 09					
c	5033	procedure to ensure that patients, relatives and their carers are not treated differently as a result of a complaint						No		COR/001 ood Mar 09					
d	5034	**process by which the organisation aims to make changes as a result of formal complaints**						No		COR/001 ood Mar 09					
e	5038	process for monitoring compliance with all of the above.						No		COR/001 ood Mar 09					
							Compliant	No		**Compliant**					
1.5.4	5040	The organisation has approved documentation which describes the process for managing all claims in accordance with NHSLA requirements.													
		As a minimum, the approved documentation must include a description of the:													
a	5041	duties						Yes		COR/023 may need update for changes to org					
b	5042	NHSLA schemes relevant to the organisation (i.e. CNST, LTPS and PES)						Yes		COR/023 may need update for changes to org					
c	5043	**action to be taken, including timescales**						No		COR/023 may need update for changes to org					
d	5044	**communication with relevant stakeholders**						Yes		COR/023 may need update for changes to org					
e	5048	process for monitoring compliance with all of the above.						Yes		COR/023 may need update for changes to org					
							Compliant	No		**Compliant**					
1.5.5	5050	The organisation has approved documentation which describes the process for investigating all incidents, complaints and claims.													
		As a minimum, the approved documentation must include a description of the:													
a	5051	duties						No		COR/011 ood Jan 2010					

b	5052	organisation's expectations in relation to staff training, as identified in the training needs analysis						No		COR/011 ood Jan 2010					
c	5053	**different levels of investigation appropriate to the severity of the event(s)**						No		COR/011 ood Jan 2010					
d	5054	process for involving and communicating with internal and external stakeholders to share safety lessons						No		COR/011 ood Jan 2010					
e	5055	**process for following up relevant action plans**						No		COR/011 ood Jan 2010					
f	5058	process for monitoring compliance with all of the above.						No		COR/011 ood Jan 2010					
						Compliant		No		**Compliant**					
1.5.6	5060	The organisation has approved documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis.													
		As a minimum, the approved documentation must include a description of the:													
a	5061	duties						No		COR/011 ood Jan 2010					
b	5062	**coordinated approach to the aggregation of incidents, complaints and claims**						No		COR/011 ood Jan 2010					
c	5063	frequency with which an aggregated analysis of incidents, complaints and claims is to be completed						No		COR/011 ood Jan 2010					
d	5064	**minimum content required within the analysis report, including qualitative and quantitative analysis**						No		COR/011 ood Jan 2010					
e	5065	process for communicating this information to relevant individuals or groups						No		COR/011 ood Jan 2010					
f	5068	process for monitoring compliance with all of the above.						No		COR/011 ood Jan 2010					
						Compliant		No		**Compliant**					

1.5.7	5070	The organisation has approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and claims.													
		As a minimum, the approved documentation must include a description of the:													
a	5071	process by which the organisation ensures both local and organisational learning from incidents, complaints and claims						No		COR/011 ood Jan 2010					
b	5072	opportunities for sharing lessons learnt from incidents, complaints and claims across the local health community						No		COR/011 ood Jan 2010					
c	5073	process by which the organisation ensures that lessons learnt from analysis result in a change in organisational culture and practice						No		COR/011 ood Jan 2010					
d	5074	**process for implementing risk reduction measures**						No		COR/011 ood Jan 2010					
e	5078	process for monitoring compliance with all of the above.						No		COR/011 ood Jan 2010					
							Compliant	No		**Compliant**					
1.5.8	5080	The organisation has approved documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidance (where appropriate), is taken into account in the context of the clinical services provided by the organisation.													
		As a minimum, the approved documentation must include a description of the:													
a	5081	duties including leadership for all stages of the process						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
b	5082	process for identifying relevant documents						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
c	5083	process for disseminating relevant documents						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
d	5084	process for conducting an organisational gap analysis						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
e	5085	**process for ensuring that recommendations are acted upon throughout the organisation**						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
f	5086	process for documenting any decision not to implement NICE recommendations						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
g	5088	process for monitoring compliance with all of the above.						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
							Compliant	No		**Compliant**					

1.5.9	5090	The organisation has approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation.													
		As a minimum, the approved documentation must include a description of the:													
a	5091	duties						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
b	5092	process for identifying relevant documents						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
c	5093	process for disseminating relevant documents						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
d	5094	process for conducting an organisational gap analysis						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
e	5095	**process for ensuring that recommendations are acted upon throughout the organisation**						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
f	5098	process for monitoring compliance with all of the above.						No		Partially covered by current Clinical Audit & Effectiveness Strategy					
							Compliant	**No**		**Compliant**					
1.5.10	5100	The organisation has approved documentation which describes the process for ensuring that all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.													
		As a minimum, the approved documentation must include a description of the:													
a	5101	**process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers**						No		COR/032 ood Dec 2009					
b	5102	process for acknowledging, apologising and explaining when things go wrong						No		COR/032 ood Dec 2009					
c	5103	requirements for truthfulness, timeliness and clarity of communication						No		COR/032 ood Dec 2009					
d	5104	provision of additional support as required						No		COR/032 ood Dec 2009					
e	5105	**requirements for documenting all communication**						No		COR/032 ood Dec 2009					
f	5108	process for monitoring compliance with all of the above.						No		COR/032 ood Dec 2009					
							Compliant	**No**		**Compliant**					

The following summary will be populated automatically from information entered on the worksheet.

1.5.1	No	0
1.5.2	No	0
1.5.3	No	0
1.5.4	No	0
1.5.5	No	0
1.5.6	No	0
1.5.7	No	0
1.5.8	No	0

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
1.5.

							1.5.9	No		0									
							1.5.10	No		0		**All Standards Total**							
							Total	**0**		**0**		**0**							

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	

COR/023 needs to detail how it will work with other organisations and who takes the lead.			
COR/023 needs to list the schemes of insurance and cross-reference 'Being Open'.			
COR/023 timescales need stating			
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	

Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10												

Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Possibly joining COR/010 and COR/011, drafts on T drive at T:\shared\Portsmouth City PCT\PCT Policies\Draft Policies\0910 IncidentPolicies	BS/SM/M-J	Mar'10	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	
Draft a NICE implementation policy	SM	??	

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1.5.

Draft a National Guidance implementation policy	SM	??	
Draft a National Guidance implementation policy	SM	??	
Draft a National Guidance implementation policy	SM	??	
Draft a National Guidance implementation policy	SM	??	
Draft a National Guidance implementation policy	SM	??	
Draft a National Guidance implementation policy	SM	??	
COR/032 appears to meet requirements but needs to be reviewed, reapproved and rolled out to staff	BS/SM	Feb'10	

NHSLA Risk Management Standards for Primary Care Trusts
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1.5.

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H102
Comment: Incident reporting

Cell: H103
Comment: Raising concerns

Cell: H104
Comment: Complaints

Cell: H105
Comment: Claims

Cell: H106
Comment: Investigations

Cell: H107
Comment: Analysis

Cell: H108
Comment: Improvement

Cell: H109
Comment: Best practice - NICE

Cell: H110
Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H111
Comment: Being open

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
2.1.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment for report?	Assessor's comments	Proposed Future Change	Rationale
2.1.1	1010	The organisation can demonstrate implementation of the approved organisation-wide risk management strategy.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1013	the management of risk locally, which reflects the organisation-wide risk management strategy.													
							Compliant			**Compliant**					
2.1.2	1020	The organisation can demonstrate implementation of the approved documentation which describes the process for developing organisation-wide procedural documents.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	1024	ratification process													
Level 1	1026	control of documents, including archiving arrangements.													
							Compliant			**Compliant**					
2.1.3	1030	The organisation can demonstrate that the high level committee(s) with overarching responsibility for risk is performing as described in the approved terms of reference.													
		The organisation can demonstrate compliance with the objectives set out within the terms of reference described at Level 1, in relation to the:													
Level 1	1032.1	reporting arrangements to the board													
Level 1	1035	reporting arrangements into the high level committee(s).													
							Compliant			**Compliant**					
2.1.4	1041	The organisation can demonstrate implementation of the approved documentation which describes the process for delivering risk management awareness training for all board members, executives and senior managers.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1042	ensuring that all board members and senior managers receive relevant risk management awareness training													

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
2.1.

Level 1	1044	following up non-attendance.													
							Compliant			**Compliant**					
2.1.5	1051	The organisation can demonstrate implementation of the approved documentation which describes the organisation-wide systematic risk management process.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1052	assessing **strategic risks**													
Level 1	1053	ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation													
							Compliant			**Compliant**					
2.1.6	1061	The organisation-wide risk register is populated from a diverse range of sources													
		The organisation can demonstrate that the approved organisation-wide risk register described at Level 1, is populated with significant risks from the following sources:													
Level 1	1062	incident reports													
Level 1	1062	risk assessments													
Level 1	1062	significant risks from directorate risk registers.													
							Compliant			**Compliant**					
2.1.7	1070	The organisation can demonstrate implementation of the approved documentation which describes the process for responding to the recommendations and requirements arising from external agency visits, inspections and accreditations specific to the organisation.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1073	maintaining action plans to implement any recommendations made as a result of reviews.													
							Compliant			**Compliant**					
2.1.8	1080	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with clinical records in all media.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1083	tracking records													
Level 1	1086	retaining and disposing of records.													
							Compliant			**Compliant**					

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
2.1.

2.1.9	1090	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1092	ensuring **ongoing** registration checks are made directly with the relevant professional body, in accordance with their recommendations, in respect of all permanent clinical staff.													
							Compliant				**Compliant**				
2.1.10	1100	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all appropriate employment checks are undertaken for all staff (temporary and permanent).													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:											The assessor will record below the two elements of the emmployment checks min. data set selected at random to test the implementation of the bullet points:		
Level 1	1102	types of check required.													
		The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess the organisation's compliance with the above minimum requirement.													
							Compliant				**Compliant**				

The following summary will be populated automatically from information entered on the worksheet.

2.1.1	0	0	
2.1.2	0	0	
2.1.3	0	0	
2.1.4	0	0	
2.1.5	0	0	
2.1.6	0	0	
2.1.7	0	0	
2.1.8	0	0	
2.1.9	0	0	
2.1.10	0	0	**All Standards Total**
Total	**0**	**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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2.1.

NHSLA Risk Management Standards for Primary Care Trusts
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NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
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Cell: H66
Comment: Risk management strategy

Cell: H67
Comment: Policy on procedural documents

Cell: H68
Comment: Risk management committee(s)

Cell: H69
Comment: Risk awareness training for senior management

Cell: H70
Comment: Risk management process

Cell: H71
Comment: Risk register

Cell: H72
Comment: Responding to external recommendations specific to the organisation

Cell: H73
Comment: Clinical records management

Cell: H74
Comment: Professional clinical registration

Cell: H75
Comment: Employment checks

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2.2.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
2.2.1	2010	The organisation can demonstrate implementation of the approved documentation which describes the corporate induction arrangements for all new permanent staff.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2014	checking that all new permanent staff complete corporate induction													
Level 1	2015	following up those who fail to attend corporate induction.													
							Compliant			**Compliant**					
2.2.2	2020	The organisation can demonstrate implementation of the approved documentation which describes the local induction arrangements for all new permanent staff.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2023	checking that all new permanent staff complete local induction													
Level 1	2024	following up those who fail to complete local induction.													
							Compliant			**Compliant**					
2.2.3	2030	The organisation can demonstrate implementation of the approved documentation which describes the local induction arrangements for all temporary staff.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2033	checking that all temporary staff complete local induction													
Level 1	2034	following up those who fail to complete local induction.													
							Compliant			**Compliant**					
2.2.4	2040	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that the organisation undertakes the appropriate regulatory checks via the NHSLA Family Health Service Appeal Unit on all primary care performers (temporary and permanent).													

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		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	2042	process for ensuring checks are made													
Level 1	2044	procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern.													
							Compliant			**Compliant**					
2.2.5	2050	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:											The assessor will record below the two elements of risk management training selected at random to test the implementation of the bullet points:		
	2057														
	2057														
Level 1	2054	checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis													
Level 1	2055	following up those who fail to attend relevant training programmes.													
		The assessor will select two elements of risk management training from the TNA Minimum Data Set at random to assess the organisation's compliance with the above minimum requirements.													
							Compliant			**Compliant**					
2.2.6	2060	The organisation can demonstrate the provision of the risk management training required by all permanent staff as identified in the training needs analysis at Level 1.													
		The organisation can demonstrate the provision of the risk management training required by all permanent staff as identified in the training needs analysis at Level 1 by:													
Level 1	2064	producing an annual training prospectus which reflects the training needs analysis.													
							Compliant			**Compliant**					
2.2.7	2070	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2073	identifying which permanent staff are authorised to use the equipment identified on the inventory													

Level 1	2074	determining the training required to use the equipment identified on the inventory and the frequency of updates required													
Level 1	2075	ensuring that the identified training needs of all permanent staff are met.													
							Compliant			**Compliant**					
2.2.8	2080	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring the delivery of effective hand hygiene training to all relevant permanent staff groups.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2082	checking that all relevant permanent staff groups, as identified in the training needs analysis, complete hand hygiene training													
Level 1	2083	following up those who fail to attend hand hygiene training.													
							Compliant			**Compliant**					
2.2.9	2090	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring the delivery of effective moving and handling training to all permanent staff.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2092	checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training													
Level 1	2093	following up those who fail to attend relevant moving and handling training.													
							Compliant			**Compliant**					
2.2.10	2100	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	2102	immediate support offered to staff (internally and, if necessary, externally)													
Level 1	2105	action for managers or individuals to take if the staff member is experiencing difficulties associated with the event.													
							Compliant			**Compliant**					

The following summary will be populated automatically from information entered on the worksheet.

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2.2.8	0	0	
2.2.9	0	0	
2.2.10	0	0	**All Standards Total**
Total	**0**	**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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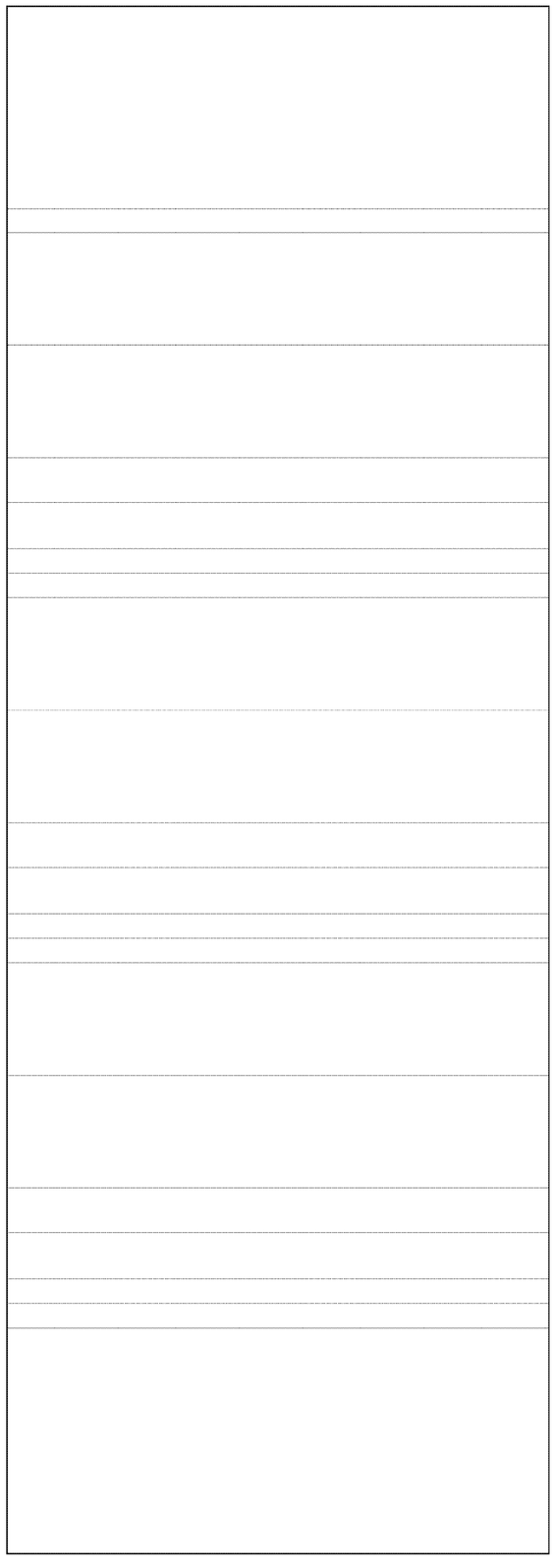

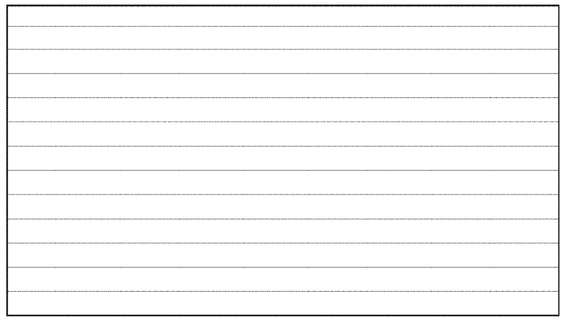

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Comment: Assessor Use Only

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Comment: Corporate induction

Cell: H70
Comment: Local induction of permanent staff

Cell: H71
Comment: Local induction of temporary staff

Cell: H72
Comment: Fitness to practice

Cell: H73
Comment: Risk management training

Cell: H74
Comment: Training needs analysis

Cell: H75
Comment: Medical devices training

Cell: H76
Comment: Hand hygiene training

Cell: H77
Comment: Moving & handling training

Cell: H78
Comment: Supporting staff involved in an incident, complaint or claim

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2.3.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale	Actions required to achieve compliance
2.3.1	3010	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3013	requirement to undertake appropriate risk assessments regarding the physical security of premises and assets														
Level 1	3014	arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets.														
							Compliant			**Compliant**						
2.3.2	3020	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with sickness absences.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3025	process for analysing sickness absence data														
Level 1	3026	arrangements for the organisational overview of sickness absence.														
							Compliant			**Compliant**						
2.3.3	3030	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with safeguarding adults.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3032	local arrangements for managing the risks associated with safeguarding adults.														
							Compliant			**Compliant**						
2.3.4	3040	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with moving and handling.														

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		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3044	requirement to undertake appropriate risk assessments for the moving and handling of patients and objects														
Level 1	3045	arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects.														
						Compliant			**Compliant**							
2.3.5	3050	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3052	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)														
Level 1	3053	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height).														
						Compliant			**Compliant**							
2.3.6	3060	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with inoculation incidents.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:														
Level 1	3063	the management of an inoculation incident (including prophylaxis).														
						Compliant			**Compliant**							
2.3.7	3070	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:														
Level 1	3073	ensuring that all reusable medical devices and equipment are properly maintained and repaired.														
						Compliant			**Compliant**							

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2.3.8	3080	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process:														
Level 1	3083	for raising concerns about harassment and/or bullying														
Level 1	3084	to be followed once a concern has been raised.														
							Compliant			**Compliant**						
2.3.9	3090	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the prevention and management of violence and aggression.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3092.1	requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression														
Level 1	3093	arrangements for ensuring the safety of lone workers.														
							Compliant			**Compliant**						
2.3.10	3100	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with work-related stress.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1	3113	process for identifying workplace stressors														
Level 1	3114	requirement to undertake appropriate risk assessments for the prevention and management of work-related stress.														
							Compliant			**Compliant**						

The following summary will be populated automatically from information entered on the worksheet.

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2.3.4	0	0	
2.3.5	0	0	
2.3.6	0	0	
2.3.7	0	0	
2.3.8	0	0	
2.3.9	0	0	
2.3.10	0	0	**All Standards Total**
Total	**0**	**0**	**0**

Person/ Committee responsible	Target Date	Associated Cost

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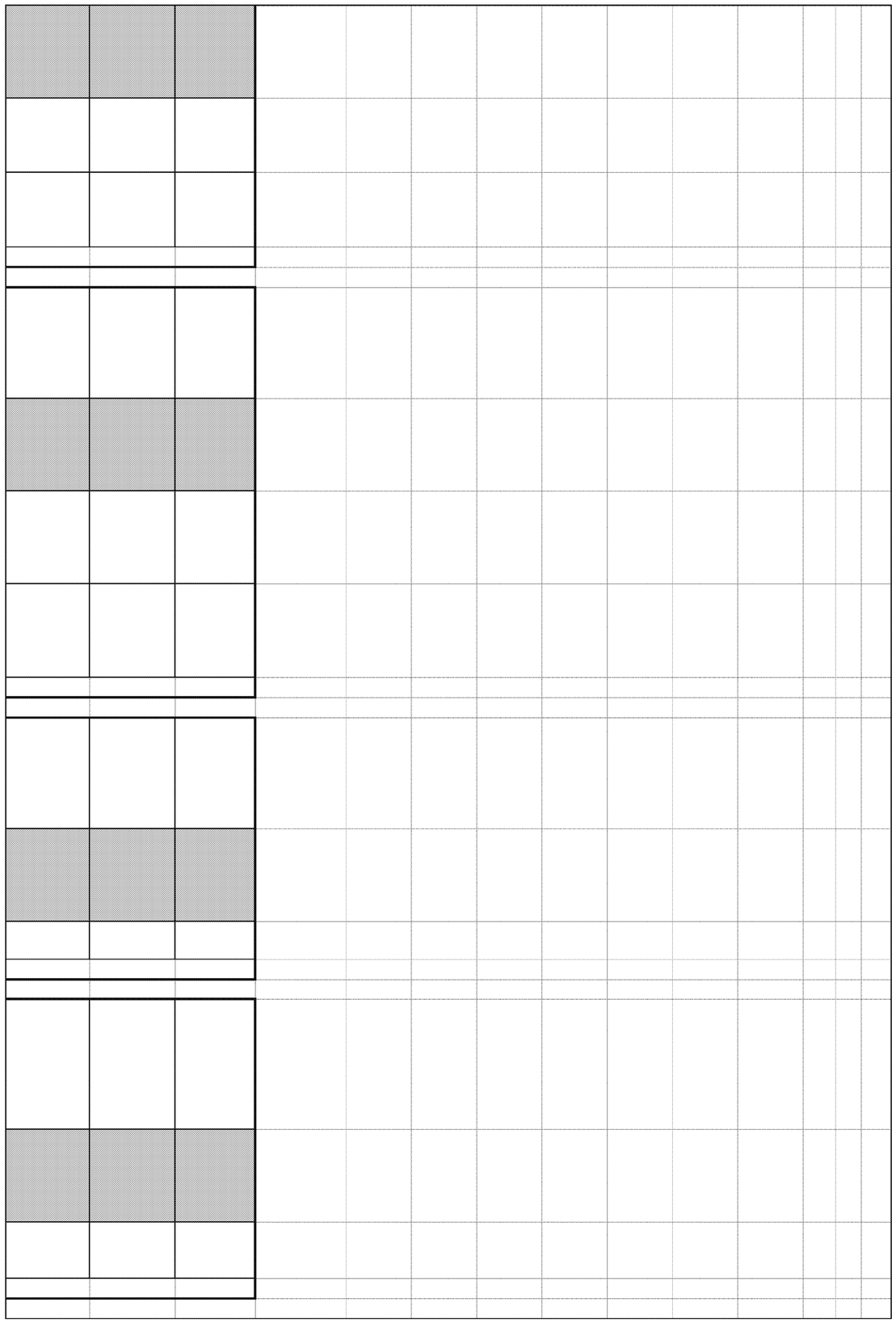

NHSLA Risk Management Standards for Primary Care Trusts
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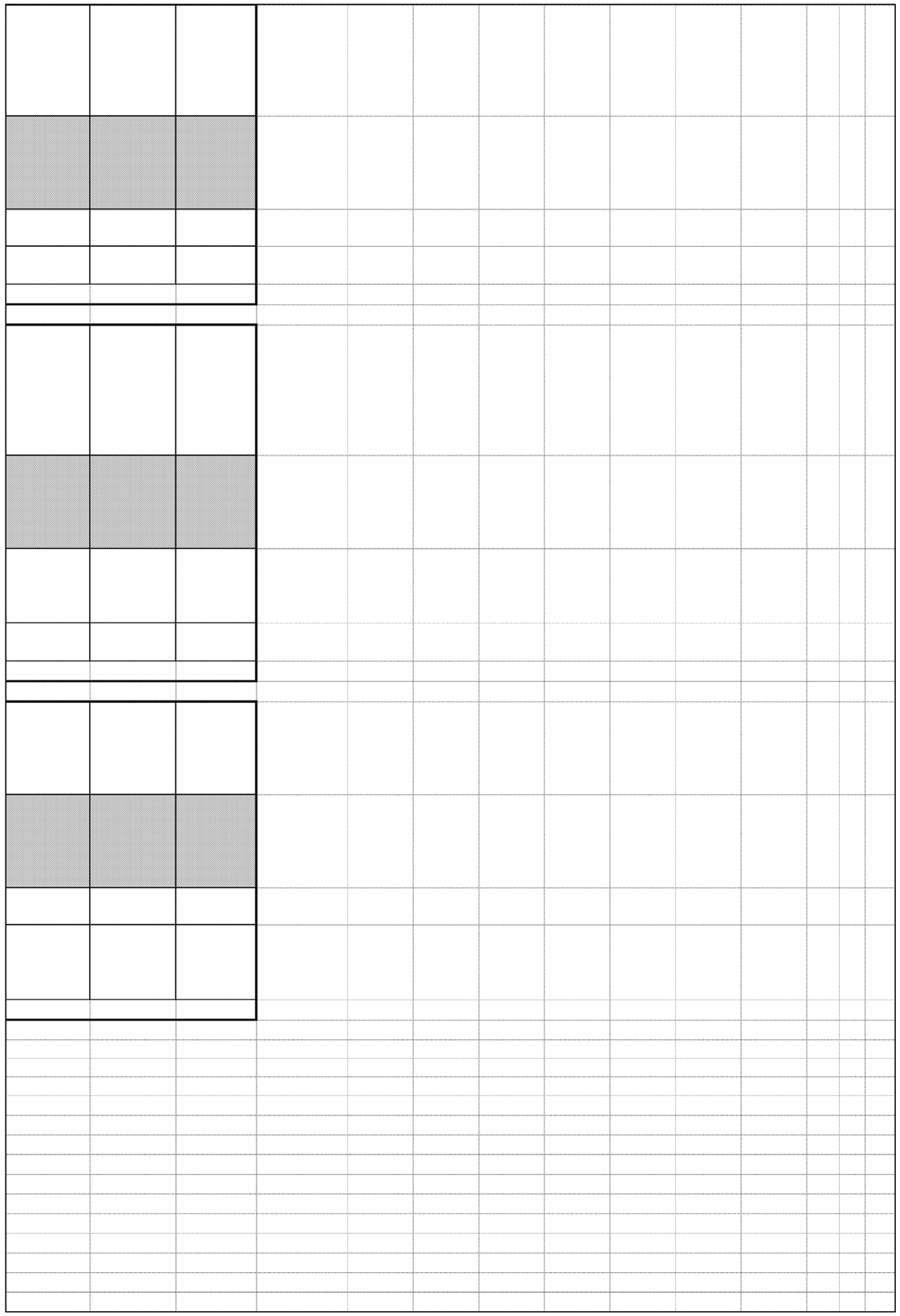

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Comment: Secure environment

Cell: H64
Comment: Sickness absence

Cell: H65
Comment: Safeguarding adults

Cell: H66
Comment: Moving & handling

Cell: H67
Comment: Slips, trips & falls

Cell: H68
Comment: Inoculation incidents

Cell: H69
Comment: Maintenance of medical devices & equipment

Cell: H70
Comment: Harassment & bullying

Cell: H71
Comment: Violence & aggression

Cell: H72
Comment: Stress

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2.4.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
2.4.1	4010	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the identification of **in**patients.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4011	process for identifying **in**patients													
Level 1	4013	procedure to be followed in cases where patient misidentification occurs.													
							Compliant			**Compliant**					
2.4.2	4020	The organisation can demonstrate implementation of the approved documentation which describes the process for developing patient information associated with care, treatments and procedures.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4023	list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate													
Level 1	4025	archiving arrangements.													
							Compliant			**Compliant**					
2.4.3	4030	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with consent.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4033	process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure													
Level 1	4035	process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure.													
							Compliant			**Compliant**					

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2.4.

2.4.4	4040	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the quality of clinical records in all media.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to:													
Level 1	4044	format for all audit reports i.e. methodology, conclusions, action plans, etc.													
Level 1	4045	arrangements for the review of action plans.													
							Compliant			**Compliant**					
2.4.5	4050	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the transfer of patients.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:											The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements.		
Level 1	4052	transfer requirements which are specific to each patient group													
Level 1	4053	documentation to accompany the patient when being transferred.													
		The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements.													
							Compliant			**Compliant**					
2.4.6	4060	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with medicines in all care environments.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4061.1	process for ensuring the accuracy of all prescription charts.													
							Compliant			**Compliant**					
2.4.7	4070	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the blood transfusion process.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4073	process for the administration of blood and blood products													

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2.4.

Level 1	4074	care of patient(s) receiving transfusion.													
							Compliant			Compliant					
2.4.8	4080	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with resuscitation.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4082	early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest													
Level 1	4084	do not attempt resuscitation orders (DNAR).													
							Compliant			Compliant					
2.4.9	4090	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with infection prevention and control.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	4092	infection control assurance framework.													
							Compliant			Compliant					
2.4.10	4100	The organisation can demonstrate implementation of the approved documentation which describes the organisation-wide process for developing local policies to manage the risks associated with the process of clinical diagnostic tests and screening procedures.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	4102	taking action on test and screening results													
Level 1	4104	the communication of clinical test and screening results.													
							Compliant			Compliant					

The following summary will be populated automatically from information entered on the worksheet.

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2.4.4	0		0	
2.4.5	0		0	
2.4.6	0		0	
2.4.7	0		0	
2.4.8	0		0	
2.4.9	0		0	
2.4.10	0		0	**All Standards Total**
Total	**0**		**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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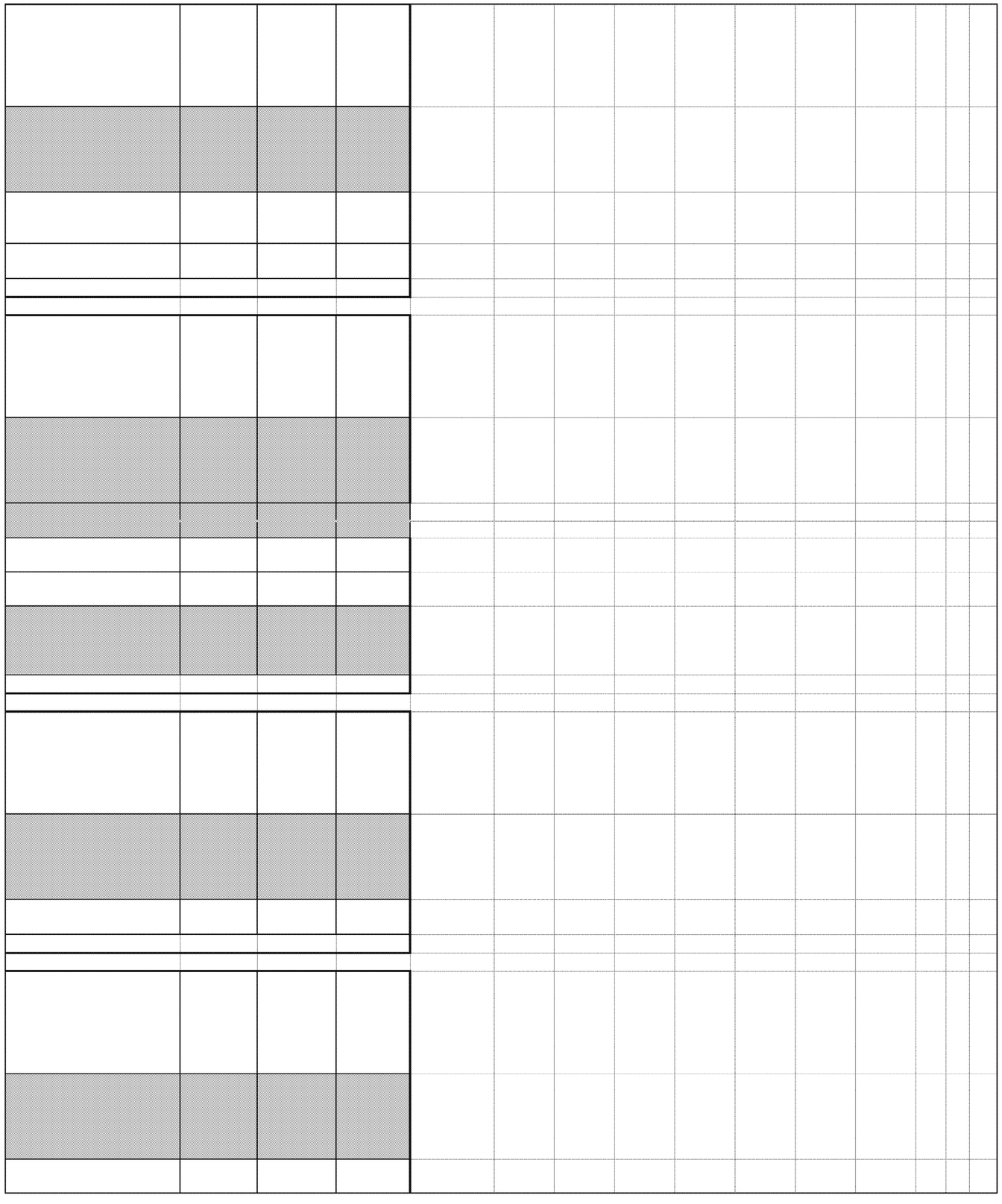
Evidence Template
2.4.



NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
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Comment: Patient information

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Comment: Consent

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Comment: Clinical record-keeping standards

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Comment: Transfer of patients

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Comment: Medicines management

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Comment: Blood transfusion

Cell: H74
Comment: Resuscitation

Cell: H75
Comment: Infection control

Cell: H76
Comment: Diagnostic testing and screening procedures

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Evidence Template
2.5.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
2.5.1	5010	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable incidents.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for reporting:													
Level 1	5012	all incidents/near misses, involving staff, patients and others													
Level 1	5013	to external agencies.													
							Compliant			**Compliant**					
2.5.2	5020	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to raise concerns informally.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process:													
Level 1	5022	for raising concerns (informal complaints/PALS)													
Level 1	5024	by which the organisation aims to make changes as a result of concerns being raised.													
							Compliant			**Compliant**					
2.5.3	5030	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	5032	complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary													

NHSLA Risk Management Standards for Primary Care Trusts
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2.5.

Level 1	5034	process by which the organisation aims to make changes as a result of formal complaints.													
							Compliant			**Compliant**					
2.5.4	5040	The organisation can demonstrate implementation of the approved documentation which describes the process for managing all claims in accordance with NHSLA requirements.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	5043	action to be taken, including timescales													
Level 1	5044	communication with relevant stakeholders.													
							Compliant			**Compliant**					
2.5.5	5050	The organisation can demonstrate implementation of the approved documentation which describes the process for investigating all incidents, complaints and claims.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	5053	different levels of investigation appropriate to the severity of the event(s)													
Level 1	5055	process for following up relevant action plans.													
							Compliant			**Compliant**					
2.5.6	5060	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1	5062	coordinated approach to the aggregation of incidents, complaints and claims													
Level 1	5064	minimum content required within the analysis report, including qualitative and quantitative analysis.													
							Compliant			**Compliant**					
2.5.7	5070	The organisation can demonstrate implementation of the approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and claims.													

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2.5.

		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process by which the organisation ensures:													
Level 1	5074	the implementation of risk reduction measures.													
							Compliant			**Compliant**					
2.5.8	5080	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidance is taken into account in the context of the clinical services provided by the organisation.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:											The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement.		
Level 1	5085	ensuring that recommendations are acted upon throughout the organisation.													
		The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement.													
							Compliant			**Compliant**					
2.5.9	5090	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:													
Level 1	5095	ensuring that recommendations are acted upon throughout the organisation.													
							Compliant			**Compliant**					
2.5.10	5100	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													

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2.5.

Level 1	5101	process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers													
Level 1	5105	requirements for documenting all communication.													
							Compliant			**Compliant**					
The following summary will be populated automatically from information entered on the worksheet.															
							2.5.1	0			0				
							2.5.2	0			0				
							2.5.3	0			0				
							2.5.4	0			0				
							2.5.5	0			0				
							2.5.6	0			0				
							2.5.7	0			0				
							2.5.8	0			0				
							2.5.9	0			0				
							2.5.10	0			0		**All Standards Total**		
							Total	**0**			**0**		**0**		

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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Evidence Template
2.5.

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Evidence Template
2.5.

NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
2.5.

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E for Electronic
P for Paper
N/A for not available

Cell: L1
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Comment: Assessor Use Only

Cell: H66
Comment: Incident reporting

Cell: H67
Comment: Raising concerns

Cell: H68
Comment: Complaints

Cell: H69
Comment: Claims

Cell: H70
Comment: Investigations

Cell: H71
Comment: Analysis

Cell: H72
Comment: Improvement

Cell: H73
Comment: Best practice - NICE

Cell: H74
Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H75
Comment: Being open

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Evidence Template
3.1.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
3.1.1	1010	The organisation can demonstrate that there are processes in place to monitor compliance with the approved organisation-wide risk management strategy.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1013	the management of risk locally, which reflects the organisation-wide risk management strategy.													
	1019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.2	1020	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for developing organisation-wide procedural documents.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	1024	ratification process													
Level 1	1026	control of documents, including archiving arrangements.													
	1029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.3	1030	The organisation can demonstrate that there are processes in place to monitor the performance of the high level committee(s) with overarching responsibility for risk.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	1032.1	reporting arrangements to the board													
Level 1	1035	reporting arrangements into the high level committee(s).													

	1039	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.4	1040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for delivering risk management awareness training for board members, executives and senior managers.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1042	ensuring that all board members and senior managers receive relevant risk management awareness training													
Level 1	1044	following up non-attendance.													
	1049	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.5	1050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the organisation-wide systematic risk management process.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1055	assessing strategic risks													
Level 1	1053	ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.													
	1059	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.6	1060	The organisation can demonstrate that the organisation-wide risk register is a dynamic document.													
Level 1	1067	The organisation can demonstrate that it is monitoring the approved organisation-wide risk register.													
	1069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					

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3.1.7	1070	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for responding to the recommendations and requirements arising from external agency visits, inspections and accreditations specific to the organisation.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1073	maintaining action plans to implement any recommendations made as a result of reviews.													
	1079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.8	1080	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with clinical records in all media.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1083	tracking records													
Level 1	1086	retaining and disposing of records.													
	1089	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.9	1090	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	1092	ensuring registration checks are made directly with the relevant professional body, in accordance with their recommendations in respect of all permanent clinical staff both on initial appointment and ongoing thereafter													

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Level 1	1093.1	monitoring/receiving assurance that registration checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary clinical staff.													
	1099	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.1.10	1100	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all appropriate employment checks are undertaken for all staff (temporary and permanent).													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:										The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess the organisation's compliance with the above minimum requirement.			
	1107														
	1107														
Level 1	1102	types of check required.													
	1109	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
		The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess the organisation's compliance with the above minimum requirement.													
							Compliant			**Compliant**					

The following summary will be populated automatically from information entered on the worksheet.

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3.1.6	0	0	
3.1.7	0	0	
3.1.8	0	0	
3.1.9	0	0	
3.1.10	0	0	**All Standards Total**
Total	**0**	**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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3.1.

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NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
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Comment: Assessor Use Only

Cell: H74
Comment: Risk management strategy

Cell: H75
Comment: Policy on procedural documents

Cell: H76
Comment: Risk management committee(s)

Cell: H77
Comment: Risk awareness training for senior management

Cell: H78
Comment: Risk management process

Cell: H79
Comment: Risk register

Cell: H80
Comment: Responding to external recommendations specific to the organisation

Cell: H81
Comment: Clinical records management

Cell: H82
Comment: Professional clinical registration

Cell: H83
Comment: Employment checks

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Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
3.2.1	2010	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the corporate induction arrangements for all new permanent staff.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2014	checking that all new permanent staff complete corporate induction													
Level 1	2015	following up those who fail to attend corporate induction.													
	2019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.2	2020	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the local induction arrangements for all new permanent staff.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2023	checking that all new permanent staff complete local induction													
Level 1	2024	following up those who fail to complete local induction.													
	2029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.3	2030	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the local induction arrangements for all temporary staff.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													

Level 1	2033	checking that all temporary staff complete local induction													
Level 1	2034	following up those who fail to complete local induction.													
	2039	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.4	2040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that the organisation undertakes the appropriate regulatory checks via the NHSLA Family Health Service Appeal Unit on all primary care performers (temporary and permanent).													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	2042	process for ensuring checks are made													
Level 1	2044	procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern.													
	2049	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.5	2050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:											The assessor will select two elements of risk management training from the TNA Minimum Data Set at random to assess the organisation's compliance with the above minimum requirements.		
	2057														
	2057														
Level 1	2054	checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis													
Level 1	2055	following up those who fail to attend relevant training programmes.													
	2059	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													

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		The assessor will select two elements of risk management training from the TNA Minimum Data Set at random to assess the organisation's compliance with the above minimum requirements.													
							Compliant			**Compliant**					
3.2.6	2060	The organisation can demonstrate that there are processes in place to monitor the risk management training needs analysis identified at Level 1 for all permanent staff.													
		The organisation can demonstrate the risk management training needs analysis for all permanent staff by:													
Level 1	2065	producing an annual training report covering all the topics identified within the TNA Minimum Data Set.													
	2069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.7	2070	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2073	identifying which permanent staff are authorised to use the equipment identified on the inventory													
Level 1	2074	determining the training required to use the equipment identified on the inventory and the frequency of updates required													
Level 1	2075	ensuring that the identified training needs of all permanent staff are met.													
	2079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.2.8	2080	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring the delivery of effective hand hygiene training to all relevant permanent staff groups.													

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		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2082	checking that all relevant permanent staff groups, as identified in the training needs analysis, complete hand hygiene training													
Level 1	2083	following up those who fail to attend hand hygiene training.													
	2089	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						
3.2.9	2090	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring the delivery of effective moving and handling training to all permanent staff.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	2092	checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training													
Level 1	2093	following up those who fail to attend relevant moving and handling training.													
	2099	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						
3.2.10	2100	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	2102	immediate support offered to staff (internally and, if necessary, externally)													
Level 1	2105	action for managers or individuals to take if the staff member is experiencing difficulties associated with the event.													

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3.2.

	2109	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						
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						3.2.7	0			0					
						3.2.8	0			0					
						3.2.9	0			0					
						3.2.10	0			0		**All Standards Total**			
						Total	**0**			**0**		**0**			

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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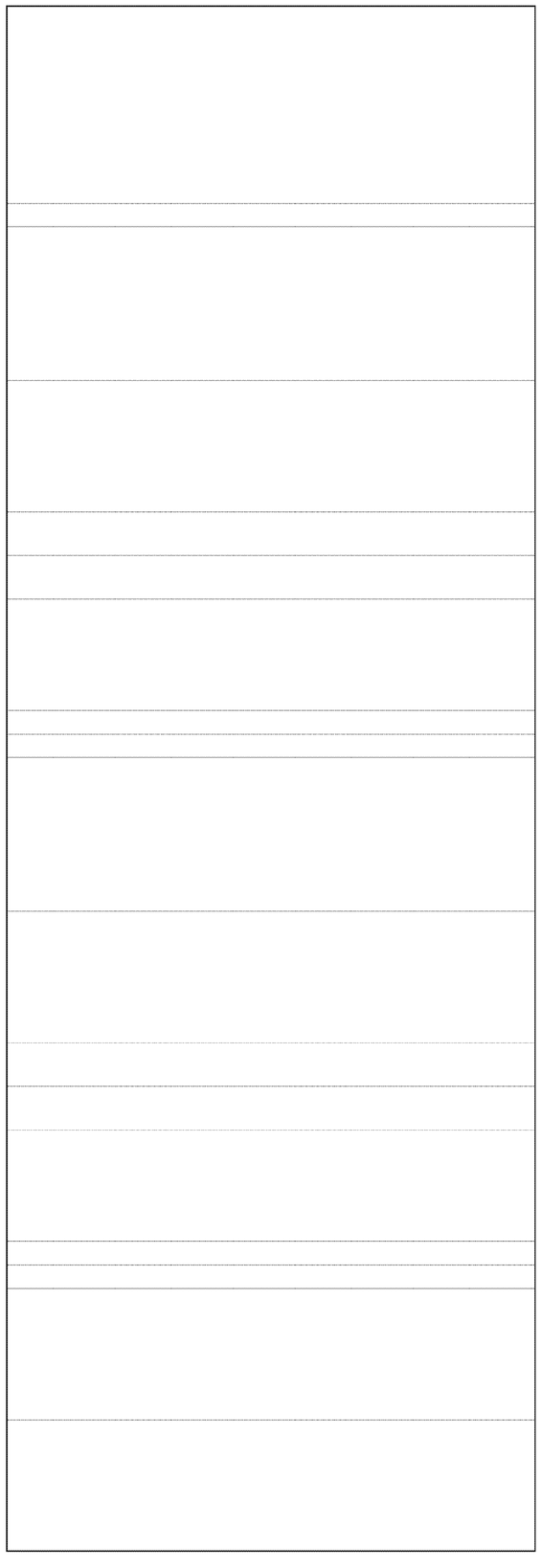

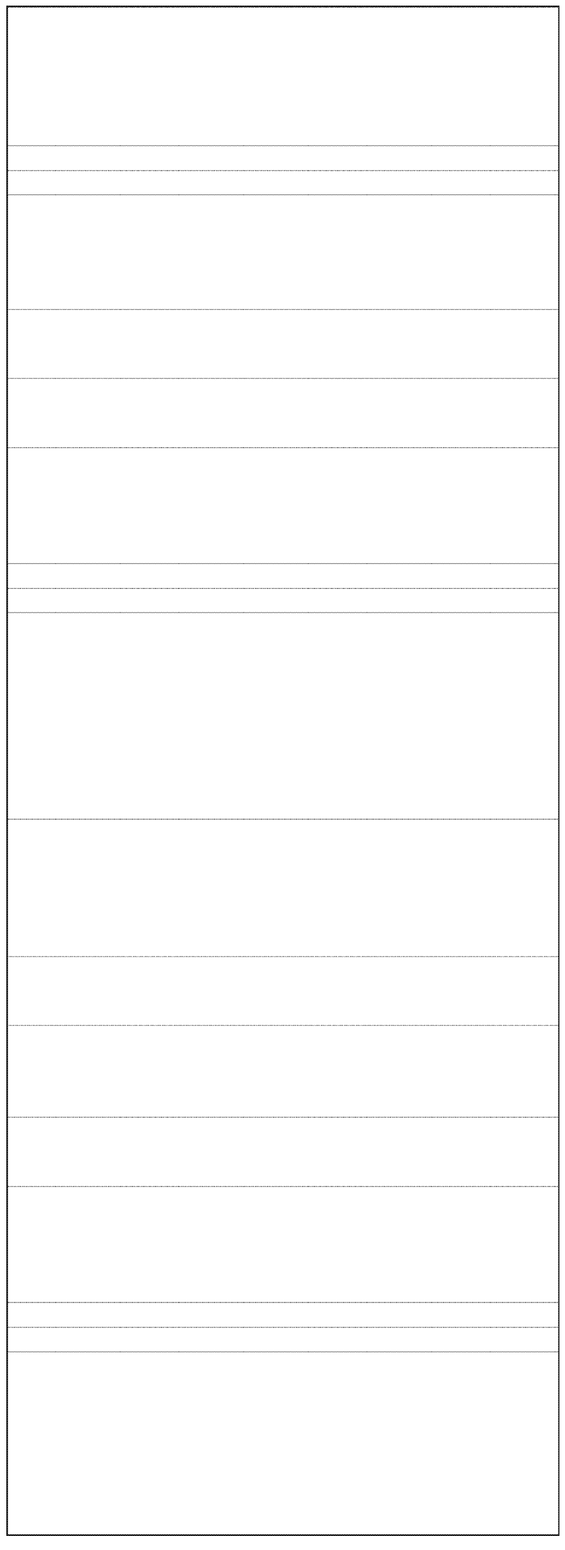

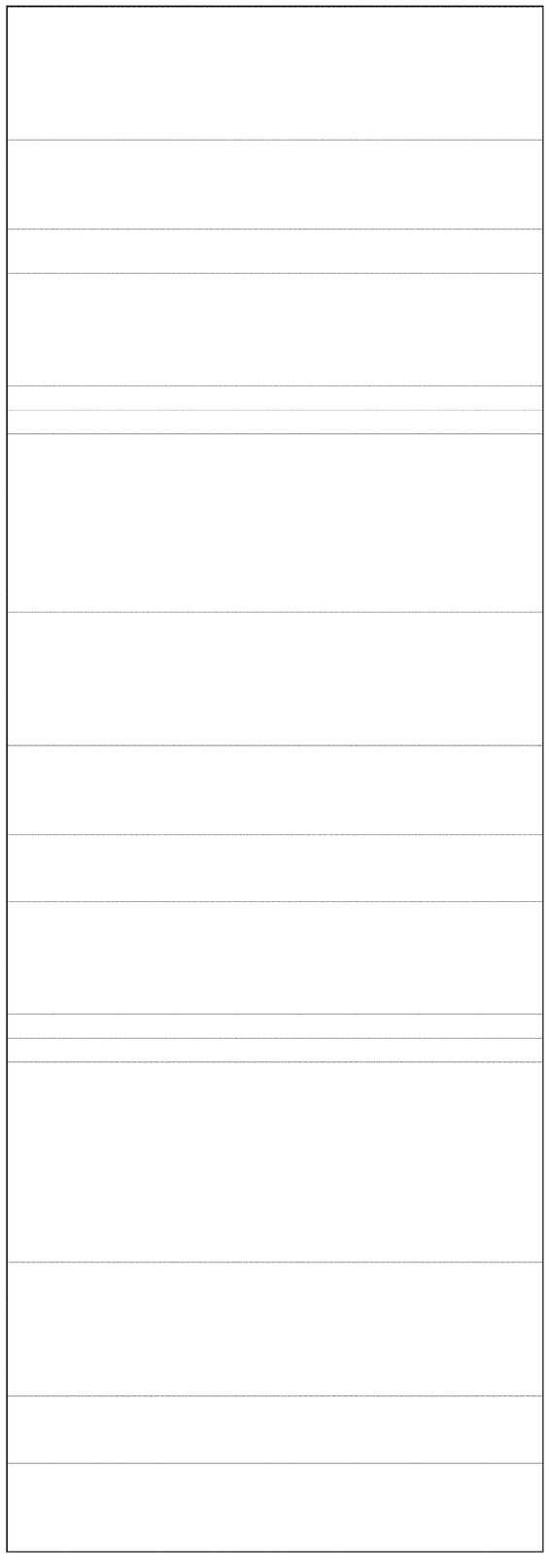

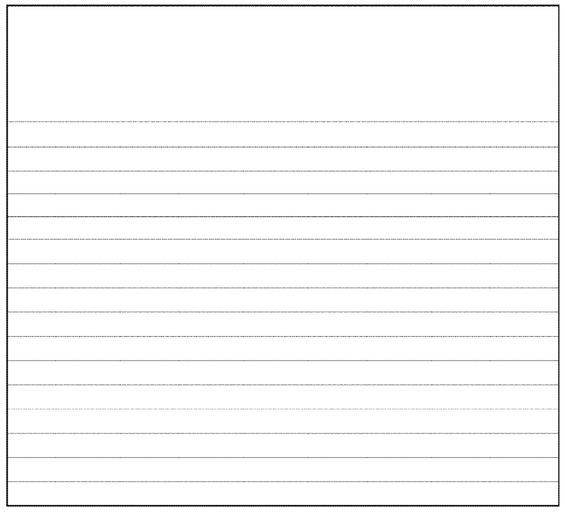

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P for Paper
N/A for not available

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Comment: Assessor Use Only

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Comment: Assessor Use Only

Cell: H79
Comment: Corporate induction

Cell: H80
Comment: Local induction of permanent staff

Cell: H81
Comment: Local induction of temporary staff

Cell: H82
Comment: Fitness to practice

Cell: H83
Comment: Risk management training

Cell: H84
Comment: Training needs analysis

Cell: H85
Comment: Medical devices training

Cell: H86
Comment: Hand hygiene training

Cell: H87
Comment: Moving & handling training

Cell: H88
Comment: Supporting staff involved in an incident, complaint or claim

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3.3.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale	Actions required to achieve compliance
3.3.1	3010	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3013	requirement to undertake appropriate risk assessments regarding the physical security of premises and assets														
Level 1	3014	arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets.														
	3019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.2	3020	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with sickness absences.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3025	process for analysing sickness absence data														
Level 1	3026	arrangements for the organisational overview of sickness absence.														
	3029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.3	3030	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with safeguarding adults.														

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		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3032	local arrangements for managing the risks associated with safeguarding adults.														
	3039	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
						Compliant			**Compliant**							
3.3.4	3040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with moving and handling.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3044	requirement to undertake appropriate risk assessments for the moving and handling of patients and objects														
Level 1	3045	arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects.														
	3049	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
						Compliant			**Compliant**							
3.3.5	3050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3052	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)														
Level 1	3053	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height).														

	3059	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.6	3060	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with inoculation incidents.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:														
Level 1	3063	the management of an inoculation incident (including prophylaxis).														
	3069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.7	3070	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:														
Level 1	3073	ensuring that all reusable medical devices and equipment are properly maintained and repaired.														
	3079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.8	3080	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process:														
Level 1	3083	for raising concerns about harassment and/or bullying														
Level 1	3084	to be followed once a concern has been raised.														

	3089	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.9	3090	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the prevention and management of violence and aggression.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3092.1	requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression														
Level 1	3093	arrangements for ensuring the safety of lone workers.														
	3099	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						
3.3.10	3100	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with work-related stress.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	3113	process for identifying workplace stressors														
Level 1	3114	requirement to undertake appropriate risk assessments for the prevention and management of work-related stress.														
	3119	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			**Compliant**						

The following summary will be populated automatically from information entered on the worksheet.

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3.3.5	0		0
3.3.6	0		0
3.3.7	0		0

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							3.3.8	0		0							
							3.3.9	0		0							
							3.3.10	0		0		**All Standards Total**					
							Total	**0**		**0**		**0**					

Person/ Committee responsible	Target Date	Associated Cost

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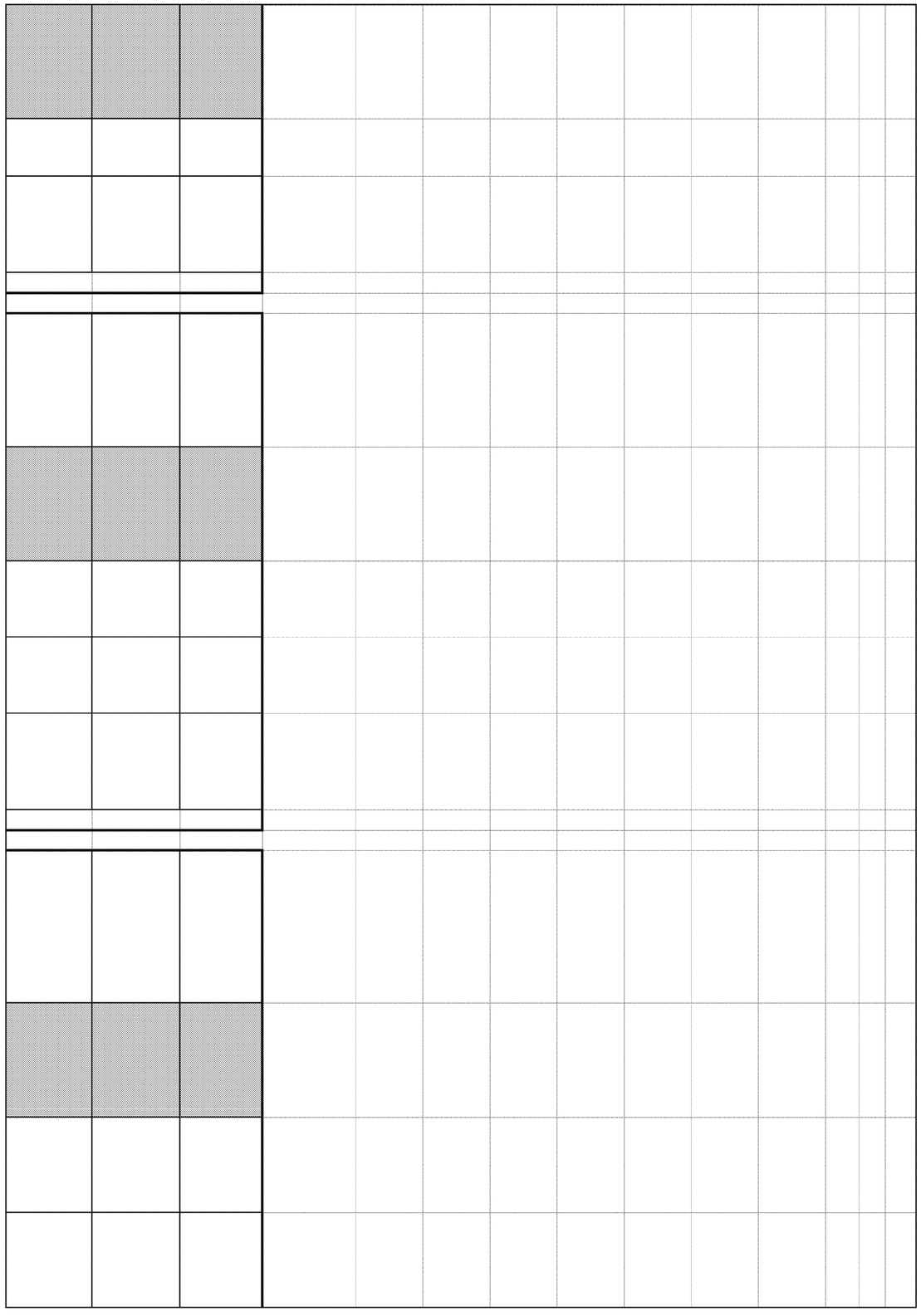
3.3.



NHSLA Risk Management Standards for Primary Care Trusts
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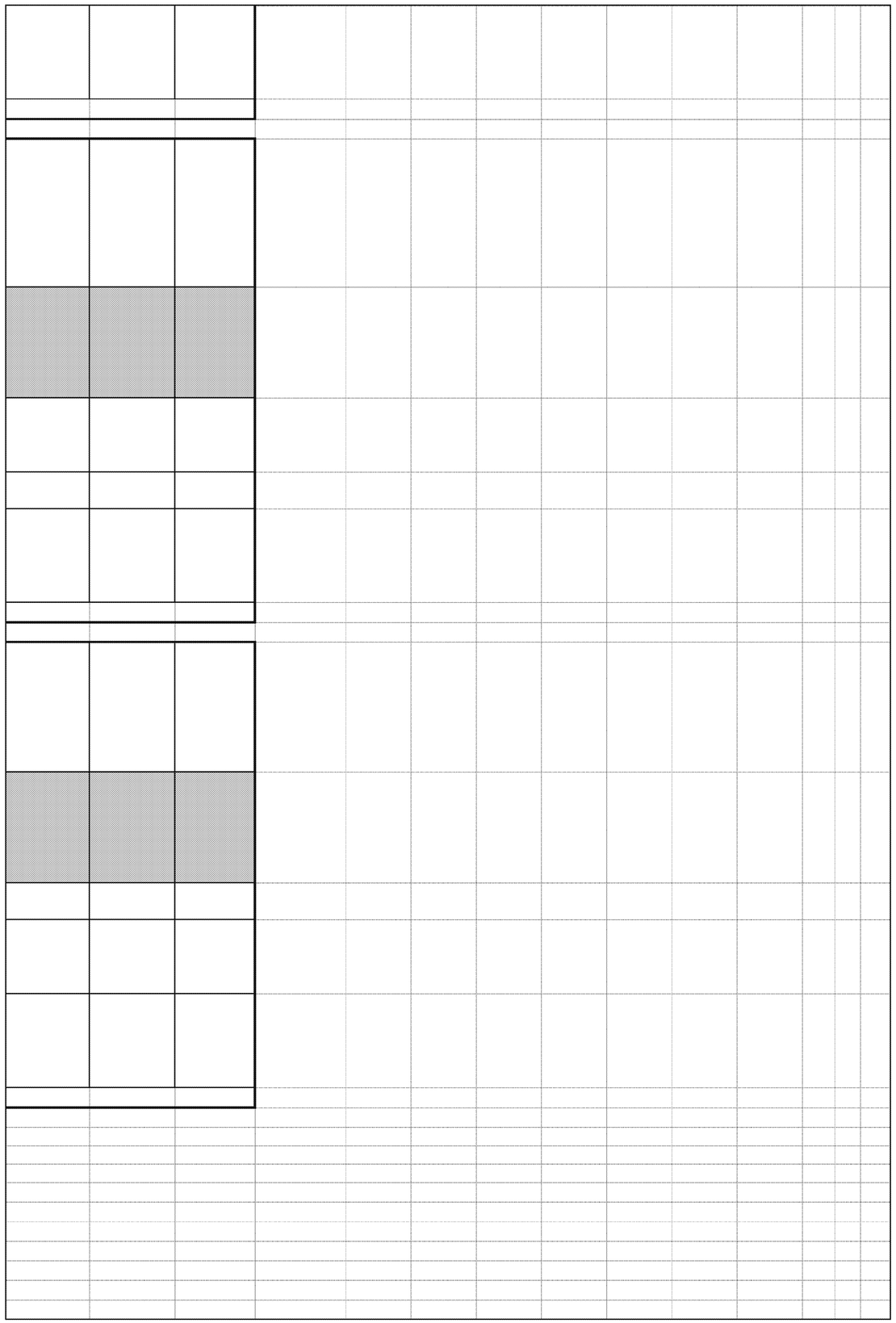
NHSLA Risk Management Standards for Primary Care Trusts
Evidence Template
3.3.



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E for Electronic
P for Paper
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Comment: Assessor Use Only

Cell: H73
Comment: Secure environment

Cell: H74
Comment: Sickness absence

Cell: H75
Comment: Safeguarding adults

Cell: H76
Comment: Moving & handling

Cell: H77
Comment: Slips, trips & falls

Cell: H78
Comment: Inoculation incidents

Cell: H79
Comment: Maintenance of medical devices & equipment

Cell: H80
Comment: Harassment & bullying

Cell: H81
Comment: Violence & aggression

Cell: H82
Comment: Stress

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3.4.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
3.4.1	4010	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the identification of **in**patients.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4012	process for identifying **in**patients													
Level 1	4014	procedure to be followed in cases where patient misidentification occurs.													
	4019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.2	4020	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for developing patient information associated with care, treatments and procedure.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4022	list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate													
Level 1	4024	archiving arrangements.													
	4029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.3	4030	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with consent.													

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		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4033	process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure													
Level 1	4035	process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure.													
	4039	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.4	4040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the quality of clinical records in all media.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4044	format for all audit reports i.e. methodology, conclusions, action plans, etc.													
Level 1	4045	arrangements for the review of action plans.													
	4049	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.5	4050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the transfer of patients.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:											The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements.		
	4057														
	4057														
Level 1	4052	transfer requirements which are specific to each patient group													
Level 1	4053	documentation to accompany the patient when being transferred.													

	4059	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
		The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements.													
							Compliant			**Compliant**					
3.4.6	4060	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with medicines in all care environments.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4061.1	process for ensuring the accuracy of all prescription charts.													
	4069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.7	4070	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the blood transfusion process.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4073	process for the administration of blood and blood products													
Level 1	4074	care of patient(s) receiving transfusion.													
	4079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.8	4080	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with resuscitation.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													

Level 1	4082	early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest													
Level 1	4084	do not attempt resuscitation orders (DNAR).													
	4089	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.9	4090	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with infection prevention and control.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	4092	infection control assurance framework.													
	4099	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.4.10	4100	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the organisation-wide process for developing local policies to manage the risks associated with the process of clinical diagnostic test and screening procedures.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	4102	taking action on test and screening results													
Level 1	4104	the communication of clinical tests and screening results.													
	4109	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					

The following summary will be populated automatically from information entered on the worksheet.

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3.4.7	0		0

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Evidence Template
3.4.

							3.4.8	0		0					
							3.4.9	0		0					
							3.4.10	0		0		**All Standards Total**			
							Total	**0**		**0**		**0**			

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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Evidence Template
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Evidence Template
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E for Electronic
P for Paper
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Comment: Assessor Use Only

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Comment: Assessor Use Only

Cell: H77
Comment: Patient identification

Cell: H78
Comment: Patient information

Cell: H79
Comment: Consent

Cell: H80
Comment: Clinical record-keeping standards

Cell: H81
Comment: Transfer of patients

Cell: H82
Comment: Medicines management

Cell: H83
Comment: Blood transfusion

Cell: H84
Comment: Resuscitation

Cell: H85
Comment: Infection control

Cell: H86
Comment: Diagnostic testing and screening procedures

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3.5.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
3.5.1	5010	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable incidents.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for reporting:													
Level 1	5012	all incidents/near misses, involving staff, patients and others													
Level 1	5013	to external agencies.													
	5019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.5.2	5020	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to raise concerns informally.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process:													
Level 1	5022	for raising concerns (informal complaints/PALS)													
Level 1	5024	by which the organisation aims to make changes as a result of concerns being raised.													
	5029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					

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3.5.3	5030	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	5032	complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary													
Level 1	5034	process by which the organisation aims to make changes as a result of formal complaints.													
	5039	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						
3.5.4	5040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing all claims in accordance with NHSLA requirements.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	5043	action to be taken, including timescales													
Level 1	5044	communication with relevant stakeholders.													
	5049	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						
3.5.5	5050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for investigating all incidents, complaints and claims.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													

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Level 1	5053	different levels of investigation appropriate to the severity of the event(s)													
Level 1	5055	process for following up relevant action plans.													
	5059	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.5.6	5060	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring a systematic approach to the analysis of incidents, complaints and claims on an aggregated basis.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:													
Level 1	5062	coordinated approach to aggregation of incidents, complaints and claims													
Level 1	5064	minimum content required within the analysis report, including qualitative and quantitative analysis.													
	5069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					
3.5.7	5070	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and claims.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process by which the organisation ensures:													
Level 1	5074	the implementation of risk reduction measures.													
	5079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			**Compliant**					

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3.5.

3.5.8	5080	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidance is taken into account in the context of the clinical services provided by the organisation.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:											The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement.		
	5087														
	5087														
Level 1	5085	ensuring that recommendations are acted upon throughout the organisation.													
	5089	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
		The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement.													
						Compliant			**Compliant**						
3.5.9	5090	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation.													
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for:													
Level 1	5095	ensuring that recommendations are acted upon throughout the organisation.													
	5099	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
						Compliant			**Compliant**						

3.5.10	5100	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.														
		The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:														
Level 1	5101	process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers														
Level 1	5105	requirements for documenting all communication.														
	5109	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
						Compliant			**Compliant**							

The following summary will be populated automatically from information entered on the worksheet.

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3.5.7	0	0	
3.5.8	0	0	
3.5.9	0	0	
3.5.10	0	0	**All Standards Total**
Total	**0**	**0**	**0**

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost

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Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: H76
Comment: Incident reporting

Cell: H77
Comment: Raising concerns

Cell: H78
Comment: Complaints

Cell: H79
Comment: Claims

Cell: H80
Comment: Investigations

Cell: H81
Comment: Analysis

Cell: H82
Comment: Improvement

Cell: H83
Comment: Best practice - NICE

Cell: H84
Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H85
Comment: Being open