London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 30 JANUARY 2018 AT 09:00-14:00 LONDON AMBULANCE SERVICE NHS TRUST HEADQUARTERS, 220 WATERLOO ROAD LONDON SE1 8SD

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.00	**1.**	**TB/17/144** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
09.05	**2.**	**TB/17/145** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	3.	**TB/17/146** Attachment	**Minutes of the meeting held in public on 28 November 2017** To approve the minutes of the meeting held on 28 November 2017.	HL	Decision
	4.	**TB/17/147** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
09.15	**5.**	**TB/17/148** Oral	**Staff Story** To understand the role of Advanced Paramedic Practitioner.	TB	Information
09.45	**6.**	**TB/17/149** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
10.00	**7.**	**TB/17/150** Attachment	**Report from Chief Executive** To receive a report from the Chief Executive (CEO).	GE	Information
10.15	**8.**	**TB/17/151** To follow	**STP Engagement Update** To receive updates in relation to STP engagement.	JoH	Information

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
10.30	**9.**	**TB/17/152** Attachment	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Discussion
11.30	**10.**	**TB/17/53** Attachment	**Quality Assurance Committee Assurance Report** To receive the report for the Quality Assurance Committee meeting on 09 January 2018.	RM	Assurance
11.35	**11.**	**TB/17/154** Attachment	**Finance & Investment Committee Assurance Report** To receive the report for the Finance & Investment Committee meeting on 16 January 2018.	FC	Assurance
11.40	**12.**	**TB/17/155** Attachment	**Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Review** To receive the results of the EPRR annual assurance review	PW	Assurance
11.55	**13.**	**TB/17/156** Attachment	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and Corporate Risk Register.	PH	Discussion
12.05	**14.**	**TB/17/157** Attachment	**Serious Incident Management** To note declared and closed Serious Incidents.	TB	Discussion
STRATEGY & PLANNING					
12.15	**15.**	**TB/17/158** To follow	**Business and Financial Planning Update** To receive a report on the business and financial planning process.	LB	Discussion
12.30	**16.**	**TB/17/159** To follow	**Connecting our Board with our Workforce** To approve the proposed approach to improving the connection between the Board and the LAS workforce.	JoH	Decision
GOVERNANCE					
12.50	**17.**	**TB/17/160** Attachment	**Quality Improvement Plan and CQC Preparation** To receive an update on the progress of the Quality Improvement Plan and the CQC Preparation Plan	TB/PH	Discussion
13.00	**18.**	**TB/17/161** Attachment	**Freedom to Speak Up Quarterly report** To receive the quarterly report on Freedom to Speak Up	PH	Discussion

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
13.10	**19.**	**TB/17/162** Attachment	**Report from the Trust Secretary** To receive a report from the Trust Secretary, including information about progress against the Trust's s.106 Undertakings.	PH	Information
13.20	**20.**	**TB/17/163** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
13.25	**21.**	**TB/17/164** Oral	**Questions from members of the public**	HL	Information
13.40	**22.**	**TB/17/165** Oral	**Any other business**	HL	Information
13.45	**23.**	**TB/17/166** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
14.00	**24.**		**Meeting close** The meeting of the Trust Board in public closes.	HL	
	Date and time of next meeting: The date of the next Trust Board meeting in public is on Tuesday 27 February 2018 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.				

Additional reports, circulated for information only:

TB/17/167 Update on Health and Safety Action Plan

TB/17/168 Quality Report

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 28 November 2017

DRAFT Minutes of the public meeting of the Board held at 9am in the Conference room – Headquarters, 220 Waterloo Road London SE1 8SD

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Director of Finance and Performance
Fergus Cass	FC	Non-Executive Director
Jessica Cecil	JC	Associate Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
Ross Fullerton	RF	Chief Information Officer
Patricia Grealish	PG	Director of People and Organisational Design
Philippa Harding	PH	Director of Corporate Governance
Jamie O'Hara	JO'H	Director of Strategy and Communications

1. Welcome and apologies (TB/17/118)

1.1. The Chair welcomed all to the meeting. No apologies had been received.

1.2. Jaime O'Hara, Director of Strategy and Communication, was welcomed to his first Board meeting, having joined the organisation the previous day.

2. Declarations of interest (TB/17/119)

2.1. There were no declarations of interest.

3. Minutes of the meeting held in public on 31 October 2017 (TB/17/120)

3.1. The minutes of the Trust Board meeting held in public on 31 October 2017 were approved as a true and fair record of that meeting, subject to the following amendments:

3.1.1. The first sentence of minute reference TB/17/96, paragraph 8.6 should read "Board members welcomed the fact that the LAS had been able to increase its recruitment offers and pipeline in September but expressed concern that it was currently behind plan for paramedic, T/EAC and EMD recruitment".

3.1.2. The question set out in paragraph 20.1.5 of minute reference TB/17/108 should read "Can the Board confirm that there is an implementation plan for enhanced bariatric care?".

4. Matters arising (TB/17/121)

4.1. The actions arising from the previous meeting were noted.

4.2. Board members noted the recent circulation in correspondence of further information providing assurance about the London Ambulance Service NHS Trust's (LAS') winter planning. Non-Executive Directors asked about the additional actions that were being taken to ensure that any possible gaps in the provision of the Trust's services could be covered. It was confirmed that the situation was being closely monitored, with the Trust maintaining readiness to act dynamically, should such action be required. Consideration was being given to ensuring optimum capacity with regard to vehicles on the road as well as human resources, particularly those in the Emergency Operations Centre (EOC). It was noted that the Trust had more vehicles on the road that at the same point in 2016.

5. Patient Story (TB/17/122)

5.1. The Board received a presentation from Eulalee Valentine from the Merton Sickle Cell and Thalassaemia Group, which set out the priorities of the Sickle Cell patients receiving treatment from the LAS. These included joint care plans for patients in crisis; meeting the 18-minute target in the Ambulance Response Programme (ARP); training staff at the LAS Academy; and continued training of LAS front line staff. Board members were given information about the experiences of those Sickle Cell patients who had received care from the LAS whilst experiencing crisis. Generally, it was considered that Trust staff were friendly and positive in their treatment of Sickle Cell patients; however, there were always areas for improvement.

5.2. Board members were provided with an update on the progress implementing individual care plans. It was noted that mobile devices which would enable LAS staff to see care plans on a real time basis, were being rolled out across the Trust. These would enable staff to directly access "Co-ordinate My Care", which was a significant step forward for those patients who suffered from chronic conditions. As a result, the importance of ensuring that patient care plans were up-to-date was emphasised. This should be done in partnership with each patient, in order to ensure that patient care plans accurately reflected their experiences. As a result, it was anticipated that pain control would be better managed, whilst enabling better care that afforded patients greater dignity and respect.

5.3. Consideration was given to the relationship between local groups, such as the Merton Sickle Cell and Thalassaemia Group, and those national groups which provided support to Sickle Cell patients. The Chair of the Sickle Cell Society, a national organisation, was also present at the meeting and he provided the Board with key information about the incidence of Sickle Cell disease in London in comparison with the whole country.

5.4. It was noted that a patient referred to in the Group's presentation had not had a wholly positive experience at the hands of the LAS. Board members emphasised the importance of ensuring that she was contacted to receive an apology for this.

5.5. In response to a question about the measures that were in place to ensure that the LAS could be clear about how it was improving the quality of the service that it provided for Sickle Cell patients, it was noted that a CQUIN was in place relating to this. There had also been a recent clinical audit which indicated that the LAS had improved significantly in this area.

5.6. On behalf of the Board, the Chair thanked the representatives of the Merton Sickle Cell and Thalassaemia Group and the Chair of the Sickle Cell Society for their presentation to the meeting and broader engagement with the LAS.

6. Report from the Chair (TB/17/123)

6.1. In addition to the information set out in her report, the Chair provided a further oral update on the successful implementation of the new national performance standards associated with the ARP.

6.2. The Chair noted that Stella Franklin, LAS Inspection Lead, Care Quality Commission (CQC), was present to observe the meeting and provide a briefing on the CQC's new Well Led Inspection methodology.

6.3. Board members confirmed the roles of the Executive and Non-Executive Directors set out in the Chair's report, with the addition of the Director of Finance and Performance to the membership of the People and Organisational Development Committee.

6.4. The Chair reported that she was seeking to hold the January 2018 meeting of the Board in the Trust's Croydon office, from where its 111 service was provided. It was also anticipated that a staff story from an Advanced Paramedic Practitioner (APP) would be presented to that meeting of the Board.

ACTION: Next Board meeting be arranged to take place in Croydon, if possible, with an APP staff story to be included on the agenda.

7. Report from the Chief Executive Officer (TB/17/124)

7.1. The CEO reported on the Trust's successful transition on 31 October 2017 to the new ARP model of operational performance and the associated new time standards and measures associated with this. It was anticipated that the ARP would result in significant patient benefits.

7.2. Non-Executive Directors were provided with an update on the efforts that were being made to ensure that the Trust achieved a 50% response rate for its staff survey. The first headline results were due in December and these would be brought to the Board for consideration early in 2018. It was noted that the survey was being undertaken during a period of great change for the Trust and that this traditionally resulted in low response rates. This was particularly the case with regard to responses to the "Friends and Family Test". It was acknowledged that a significant amount of work would be required in order to improve upon previous years' results. The importance of tracking this progress was emphasised by Non-Executive Directors and its was requested that it should be reported regularly to the Board.

ACTION: Friends and Family Test results to be reported to the Board regularly.

ACTION: Staff survey headline results to be presented to the Board early in 2018.

8. Integrated Quality and Performance Report (TB/17/125)

8.1. LB provided an overview of the report, which provided an executive summary of the Trust's performance in relation to quality, operations, workforce and finance. Individual members of the Executive Leadership Team (ELT) also provided further oral updates and clarifications with regard to their areas of responsibility and the Chairs of the Board's Assurance Committees provided additional input with regard to pertinent issues discussed at recent meetings.

8.2. Consideration was given to the performance information available about delays in hospital handovers. Board members requested further information about these in future reports, at least during the winter period, if not during the whole year.

8.3. Non-Executive Directors requested further information about Job Cycle Times (JCTs). It was reported that these were not comparable with past figures, as a result of the implementation of the ARP. There were fewer multiple attendances as a result of the ARP, which suggested that JCTs had increased. The importance of remaining focussed on this issue was emphasised. Board members also asked about the information that would be available about the Trust's performance under the ARP. The importance of not waiting until April for this information was stressed. It was noted that work had begun with the national ARP group which would start to identify appropriate benchmark data. Until this information was available, which was not expected until the end of March 2018, it was likely that the Trust would have to rely on its exiting performance reporting; however, work was being undertaken to establish whether it was possible to expedite ARP performance reporting.

ACTION: ELT to advise the Board on proposed future performance reporting.

8.4. Board members were provided with an update on the Trust's performance in October. It was noted that it had been a busy month, with demand above forecast levels. The difference between performance expectations under ARP and the previous framework were explored in detail. It was reported that, overall, the LAS was performing in line with the levels set for each category; however, there were some issues relating to patient group determinants that required the consideration of the national ARP medical group. Three serious incidents had been reported as a result of these; however, following review, none of these were considered to have caused harm. It was noted that this had been discussed at the recent meeting of the Quality Assurance Committee and that the Committee had requested a Board briefing on the impact of the ARP by March 2018 at the latest.

ACTION: ARP briefing for the Board in March 2018.

8.5. With regard the Trust's performance on quality, it was reported that clinical performance indicators were receiving above 90% across the board. A new cohort of team leaders had recently been recruited and greater feedback was being provided throughout the performance management structures. Arrangements that would ensure greater levels of control during the challenging period of winter had also recently been put in place.

8.6. Non-Executive Directors noted that health and safety scorecard incorporated within the report and questioned the report that the Trust had not undertaken any fire drills. It was reported that these had been taking place but had yet to be reported. Work was being undertaken with operational teams to ensure appropriate reporting of health and safety activity. Board members welcomed this.

8.7. Concern was expressed with regard to the reported number of assaults experienced by LAS staff members in the course of their work. It was reported that action was being taken to ensure prosecutions wherever appropriate.

8.8. On the information provided with regard to compliance with mandatory and statutory training, it was noted that this had improved significantly, assisted by the roll out of the ESR project. Work was now being undertaken to focus upon improving sickness reporting, particularly after feedback that had been received during the CEO's roadshows in September and October, about the LAS's occupational health provider. A diagnostic report had been commissioned to determine the appropriate action to be taken. Focus was also shifting to ensuring that members of staff across the LAS receive an annual performance appraisal.

8.9. Consideration was given to the success of the Trust's recruitment activities, particularly of Emergency Medical Despatchers (EMDs). It was reported that work was being undertaken to review the process that were being used to support recruitment activities, including how the organisation attracted candidates, assessed and engaged them when they joined the organisation. Of concern was the reported pay disparity in relation to EMDs within the LAS and those within the Metropolitan Police Service or London Fire Brigade. As the LAS was bound by NHS pay rules, consideration was being given to what action might be taken.

8.10. Board members asked about the trajectory for bringing individuals into the organisation to fill vacant EMD positions, particularly when an additional 73 posts had been added to the establishment of the EOC. It was considered that a much more strategic discussion was required in relation to these issues, including the location and staffing required by the EOC. The importance of having clarity regarding these questions by the end of the 2017/18 financial year was emphasised.

ACTION: recruitment plan, with a focus on the EOC, to be brought to the Board in Spring 2018

9. Audit Committee Assurance Report (TB/17/126)

9.1. The report was noted; JJ had provided an overview of the meeting of the Audit Committee on 6 November 2017 during the Board's consideration of the integrated quality and performance report.

9.2. Board members noted that the Risk Management Framework approved by the Audit Committee according to the authority delegated to it had not been included in the report. It was confirmed that this would be circulated in correspondence after the meeting. The Board would also be reviewing the organisation's risk appetite at the Board development session that was due to take place on 12 December 2017.

10. Quality Assurance Committee Assurance Report (TB/17/127)

10.1. The report was noted; RM had provided an overview of the meeting of the Quality Assurance Committee on 14 November 2017 during the Board's consideration of the integrated quality and performance report.

11. People & Organisational Development Committee Assurance Report (TB/17/128)

11.1. The report was noted; JM had provided an overview of the meeting of the People and Organisational Development Committee on 20 November 2017 during the Board's consideration of the integrated quality and performance report.

12. Finance and Investment Committee Assurance Report (TB/17/129)

12.1. The report was tabled and noted; FC had provided an overview of the meeting of the Finance and Investment Committee on 24 November 2017 during the Board's consideration of the integrated quality and performance report.

13. Board Assurance Framework (TB/17/130)

13.1. Board members noted the Board Assurance Framework (BAF).

13.2. In line with the recommendations of the Finance and Investment Committee, Board members considered it appropriate that BAF risks 41 (The current Personal Digital Assistants in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed) and 42 (The Trust may not receive the full £7.8m attached to the contractual CQUINs) should be de-escalated and no longer required inclusion on the BAF. It was noted that further though needed to be given to the articulation of BAF risk 07 (patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability).

13.3. With regard to BAF risk 48 (the capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational managers having out of hours access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities which has resulted in increased personal cost to managers for having access to vehicles with emergency response capabilities), Non-Executive Directors questioned the extent to which this was a real or perceived risk. It was noted that the national implications of the changes articulated within the risk were being considered by the Association of Ambulance Chief Executives. Further consideration would be given to the significance of the risk.

13.4. Board members emphasised the importance of ensuring that BAF risks and their controls continued to be updated on a regular basis. It was proposed that further work be undertaken to achieve this ahead of further consideration of the BAF by the Board at its development session on 12 December 2017.

14. Serious Incidents Update (TB/17/131)

14.1. TB presented the report which provided an update on the current status of Serious Incident (SI) investigation compliance across the Trust and updated the Board on the current projects and improvements that were being made within the Quality, Governance and Assurance Team.

14.2. Board members noted the report.

15. LAS Strategy Update (TB/17/132)

Angela Flaherty (Deputy Director of Strategy) joined the meeting for the consideration of this item.

15.1. Angela Flaherty introduced the report which provided an update on the engagement activities being undertaken with regard to the LAS document "Our Strategic Intent". Further sessions were planned to take place until the end of 2017 and feedback from those which had already taken place had been largely positive about the vision and proposals outlined in the document.

15.2. Board members noted the progress that had already been made with regard to the engagement of key stakeholders. This was particularly important as LAS was the only pan-London healthcare provider. The feedback that had been received from Strategic Transformation Partnerships (STPs) was very encouraging. In response to questions about how the LAS was planning to manage the challenge of growing demand in the context of limited resources, it was confirmed that additional work was also being undertaken to develop this, including the broader issues of technology and pay.

15.3. Board members emphasised the importance of embracing technological opportunities and engaging with disruptors to achieve this. Similarly, consideration should be given to engaging with other organisations that would be able to provide different perspectives, such as voluntary organisations and healthcare companies.

15.4. It was noted that next steps in the development of the LAS strategy included working with the business intelligence and finance teams in order to build a target operating model, which had to be developed with assumptions for wider system.

ACTION: share draft information about strategy development with Board members as early as possible.

16. Quality Improvement and Learning Framework (TB/17/133)

16.1. TB introduced the report which proposed a framework for the development of supporting infrastructure, methods, and principles to build capacity and capability in relation to quality improvement, a learning culture and strong assurance mechanisms in relation to the quality and safety priorities.

16.2. Consideration was given to the improvement methodology set out in the Framework. The principle of "Plan, Do, Study, Act" was discussed. Board members welcomed the proposals, noting the importance of the Framework, which had been required by the Trust for some time. The Quality Assurance Committee had also considered the proposed Framework in detail and supported it.

16.3. Non-Executive Directors noted the level of activity required in order to achieve phase one of the Framework. Consideration was given to the available bandwidth required to achieve this. It was noted, however, that many individuals across the Trust had already been trained in the proposed methodology and so could assist in driving the required improvements throughout the organisation. With regard to the Framework's application in corporate directorates, Board members noted that it provided a model for improvement across any service, with clear criteria to determine its success. This would also be assisted by the introduction of Health Assure.

Resolved:

16.4. The Board resolved to approve the adoption of the proposed Quality Improvement and Learning Framework.

17. Draft Health and Safety Strategy and action plan update (TB/17/134)

17.1. TB presented the report which set out the proposed strategy setting out the aims and objectives of the LAS for health and safety over a five year period.

17.2. Board members welcomed the proposed strategy, noting its quality.

Resolved:

17.3. The Board resolved to approve the adoption of the proposed Health and Safety Strategy.

18. Quality Improvement Plan and CQC Preparation (TB/17/135)

18.1. Board members noted the update on the current actions in the Quality Improvement Plan and Care Quality Commission (CQC) action plan for the next Well Led inspection.

19. CQC Briefing (TB/17/136)

19.1. Stella Franklin, LAS Inspection Lead, CQC, provided the Board with an oral briefing on the CQC's recently updated methodology for Well Led inspections. It was noted that the methodology included a lot more engagement throughout the whole year, than previously had been undertaken.

19.2. With regard to the LAS' forthcoming Well Led inspection, the Board was informed that inspectors would be creating a regulatory plan – collecting all the information that they had gathered, including the information provided by the Trust in its Provider Information Request (PIR), reviewing this information and then determining the level of

risk that they considered to be present in the service provided by the Trust. This plan would then be tested by an internal CQC panel and an inspection approach determined.

19.3. The value of being able to facilitate CQC observation of discussions was noted. Board members requested ELT members to consider the events that CQC inspectors might be invited to observe and the development of a plan of appropriate activities throughout the year.

ACTION: ELT to develop a plan of meetings to which the CQC should be invited to observe.

20. Unaudited Charitable Funds Annual Report & Financial Statements for 2016/17 independently examined by Ernst & Young LLP (TB/17/137)

20.1. The Board considered the report which set out the annual report and financial statements (including the annual report, primary financial statements and notes, a statement on the trustee's responsibilities and an independent examination report) for the London Ambulance Service Charitable Fund in 2016/17.

RESOLVED:

20.2. The Board resolved to approve the unaudited annual report and financial statement of the London Ambulance Service Charitable Fund for 2016/17, which had been independently examined by Ernst & Young LLP and the attached letter of representation.

21. Trust Board Forward Planner (TB/17/138)

21.1. Board members noted the report which set out the forward plan for Board meetings until the end of 2018/19.

21.2. It was noted that the Board meeting in May 2018 had been moved to accommodate the earlier submission of the Trust's Annual Report and Accounts to NHS Improvement.

22. Questions from members of the public (TB/17/139)

22.1. The Patients' Forum had raised the following questions in advance of the meeting:

22.1.1. Could the Board please explain their arrangements to ensure that all LAS Strategies and Policies are assessed prior to publication using the LA035 Equality Analysis Tool?

22.1.2. Will the Board ensure that its papers are distributed and placed on the LAS website 7 days in advance of Board meetings?

22.1.3. Will Board members consider attending at least one annual observation shift in EOCs in Waterloo and Bow, to be better informed about the centrality of the work of EOC and to show support for EOC staff?

22.2. It did not prove possible to provide the answers to these questions at the meeting, however the following answers were provided following the meeting:

22.2.1. An equality analysis paper and Quality Impact Assessment review would be considered by the ELT by the end of January 2018. A review was also being undertaken of the processes used by the Trust for policy approval more broadly, which would address this as well.

22.2.2. Board papers would be made available on the public website as they were made available to Board members. Wherever possible this would be seven calendar days in advance of Board meetings.

22.2.3. Board members, including Non-Executive Directors, undertook various observational visits as part of the Quality Assessment (QA) process and Mock Inspections. The process will continue as part of the Trust's QA business as usual and the extended engagement with staff strategy that is also being developed. Executive Directors have recently visited Bow EOC and discussed the issues raised at a recent ELT meeting. The ELT, working with EOC and Bow colleagues have an intensive support programme in place, since December 2017, with actions reviewed by the ELT every week.

23. Any other business (TB/17/140)

23.1. Non-Executive Directors provided the Board with information about the events and Quality Assurance visits that they had attended in the last month.

24. Review of the meeting (TB/17/141)

24.1. Board members welcomed the open and constructive challenge between executives that had taken place during the meeting. It was generally considered that the level of challenge at Board meetings was continuing to improve; however, there was still a lot of information to be considered which could result in a less wide ranging discussion than was required.

24.2. Ongoing improvement of the standard of papers was noted. Non-Executive Directors considered that the quality of the BAF was improving and that it was becoming a useful guide for discussion. The value of being able to move away from discussions about process to discussions about content was noted.

24.3. Board members confirmed that they considered valuable the consideration of the reports from the Board Assurance Committees alongside the integrated quality and performance report and that they wished to continue to follow this approach.

Meeting close

The meeting closed at 2.30pm. The next Trust Board meeting in public will take place at 9am on Tuesday 30 January 2018.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/68	Paper to be presented to the November Board meeting setting out the arrangements in place for senior engagement with STPs and how feedback from this activity will be presented to the Board in the future	Philippa Harding, Angela Flaherty	03/10/17	28/11/17	**CLOSED**	See item on agenda
TB/17/70	Bring a paper on Trust-wide activity and planning in relation to training to the Board in the near future	Patricia Grealish	03/10/17		**CLOSED**	Superseded by action ref: TB/17/125 para 8.10
TB/17/80	Arrange Board seminar on the evolving staffing issues expected to be faced by the LAS in the future	Patricia Grealish, Philippa Harding	03/10/17		**CLOSED**	Discussed at the Board development session on 12 December 2018
TB/17/95 para 7.1	Next staff story to the Board to focus on the APP (Urgent Care) role	Fenella Wrigley, Philippa Harding	31/10/17	30/01/18	**CLOSED**	See item on agenda
TB/17/95 para 7.2	A full report on the impact of the new rest break policy to be brought to the Board at its meeting in July 2018, with an interim report to be brought to the Board in March 2018	Paul Woodrow	31/10/17	31/07/18	**On track**	Scheduled for Board meetings on 27/03/18 and 21/07/18
TB/17/95 para 7.5	Provide the Board with an update on recruitment to the Hazardous Area Response Team and other recruitment activities in line with bolstering the LAS' ability to respond to major terrorist incidents	Paul Woodrow, Patricia Grealish	31/10/17		**CLOSED**	Oral update provided at the Board meeting on 31 October 2017.
TB/17/123	Next Board meeting be arranged to take place in Croydon, if possible, with an APP staff story to be included on the agenda	Philippa Harding	28/11/17	30/01/18	**CLOSED**	APP staff story on agenda, but there was insufficient space available for a Board meeting in Croydon. Further work is being done to establish alternative Board meeting venues.
TB/17/124a	Friends and Family Test results to be reported to the Board regularly	Patricia Grealish	28/11/17	30/01/18	**On track**	See performance reporting
TB/17/124b	Staff survey headline results to be presented to the Board early in 2018	Patricia Grealish	28/11/17	30/01/18	**CLOSED**	See item on agenda for Private Board meeting.
TB/17/125 para 8.3	ELT to advise the Board on proposed future performance reporting	Lorraine Bewes	28/11/17	27/03/18	**On track**	To be incorporated into Business Planning work.
TB/17/125 para 8.4	ARP briefing for the Board in March 2018	Paul Woodrow	28/11/17	27/03/18	**On track**	Scheduled for Board meeting on 27/03/18

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/125 para 8.10	Recruitment plan, with a focus on the EOC, to be brought to the Board in Spring 2018	Patricia Grealish	28/11/17	24/04/18	**On track**	Dependent on skills mix work being undertaken through Business Planning activity.
TB/17/132	Share draft information about strategy development with Board members as early as possible	Angela Flaherty	28/11/17	30/01/18	**CLOSED**	See item on Board Private meeting agenda
TB/17/136	ELT to develop a plan of meetings to which the CQC should be invited to observe	Trisha Bain	28/11/17	30/01/18	**CLOSED**	A list of meetings has been provided.

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Report from the Chair			
Agenda item:	06			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information

Background / Purpose:

The Chair's report provides an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Chair

Executive Leadership Team

1. I'm pleased to be able to say that we now have our full Executive Leadership Team in place. The last outstanding member, our Director of Strategic Assets and Property, Benita Mehra joined the Trust on 15 January 2018. We have a vast fleet and property portfolio - one of the largest in London. Benita's role will bring together all of this including the equipment management functions, and will develop our asset management capabilities and investment plans to support a long term strategy. She has significant experience in this field, most recently at the Surrey and Borders Foundation Trust as Director of Property and Project Management Office (PMO) and is currently the President of the Women's Engineering Society. Prior to that she also held various senior Assets and Projects posts during 12 years at the British Airports Authority. I'm delighted she's joining us. I think that it's important that she joins the Logistics and Infrastructure Committee and ask the Board's agreement to this.

Care Quality Commission (CQC)

2. The re-inspection date for the Trust's Well Led review has been confirmed as 21-22 March 2018. Those required for interview will have be advised of the timing of these as soon as possible. There will also be a series of unannounced visits across Service in the weeks prior to the re-inspection.

3. Sir David Beehan, Chief Executive Officer (CEO) of the CQC has announced that he is to step down in the summer, after a five year period in the role where he has overseen major change on the inspection process and will be missed.

National Paramedic re-banding

4. In December I received a letter from Miles Scott, Improvement Director at NHS Improvement (NHSI) and Jonathan Benger, National Clinical Director for Urgent Care NHS England (NHSE) confirming that the terms of the funding agreement for paramedic re-banding had been met and that Clinical Commissioning Groups (CCGs) had been instructed to release the funding.

5. Paramedics are seen as central to the plans to transform urgent and emergency care by implementing new models such as 'See and Treat' and 'Hear and Treat'; and the re-banding and job description are seen as essential enablers but insufficient on their own. They will continue to work with us to ensure that all aspects of the re-banding are implemented and embedded over the next year.

6. Funding will be released each month subject to confirmation that the key deliverables have been achieved namely:-

31 Mar. 2018	▪ Detailed training plans to be agreed and implemented from 1 April 2018, based on an assessment of each individual paramedic's training needs. ▪ Trusts ready to start implementation of the national B6 job description. ▪ Ongoing delivery of the Newly Qualified Paramedic (NQP) consolidation of learning programme and SOPs. ▪ Non-conveyance Commissioning for Quality and Innovation (CQUIN) payment incorporated into contracts for 2018/19.

30 Sept. 2018	▪ Training plan implementation on track; at least 60% of all paramedic training requirements planned and accepted; at least 20% of all identified training completed. ▪ B6 national job description being implemented as planned. ▪ Ongoing delivery of the NQP consolidation of learning programme and Standards of Proficiency (SOPs).
31 Mar. 2019	▪ Training plan implementation on track; all paramedic training requirements planned and accepted; at least 50% of all identified training completed. ▪ B6 national job description fully implemented in all ambulance trusts. ▪ Ongoing delivery of the NQP consolidation of learning programme and SOPs.
30 Sept. 2019	▪ Training plan implementation on track; at least 80% of all identified training completed. ▪ Ongoing delivery of the NQP consolidation of learning programme and SOPs.
31 Mar. 2020	▪ Training plan implementation completed; all identified paramedic training requirements delivered in full. ▪ Ongoing delivery of the NQP consolidation of learning programme and SOPs.

7. I have specifically been asked to ensure that the Board has a clear oversight of the implementation of the agreements. Therefore in-line with our Board Governance Framework, I am asking the People and Organisational Development Committee to do so on our behalf with regard to the training aspects and the Finance and Investment Committee to ensure that we track the funding. This will then be reported to the Board via the usual mechanism of the Assurance Report from each of these Committees.

Visits to Bow and Oval and Deptford stations

8. I visited Bow and met with staff from Fleet and Logistics', Scheduling and the Emergency Operations Centre (EOC), they spoke clearly about the issues they are currently facing i.e.
    - Space
    - Recognition from other parts of the Service
    - Staffing

9. The visit demonstrated the importance of a close relationship between Scheduling, EOC and Operational staff and how it is paramount despite the pressures they are under.

10. In addition I visited Oval and Deptford stations and Kings Healthcare, this was hosted by Chrissie Masson, Group Station Manager (GSM); in the course of the visit I met other GSMs, Clinical team leaders and staff on duty. It is clear there are good working relationships and evidence of sickness management taking place in this sector, for instance Oval station's sickness level is less than four percent; i.e. evidence of pro-active people management and training giving the impression that things are working well from the Assistant Director of Operations down.

11. One issue highlighted was that c10% of Australians form the first cohort have returned home for family reasons.

Afternoon tea re Women of the Year Award (12 December 2017)

12. On 12 December I hosted afternoon tea for a number of women in the Service in recognition of their contribution to the 'Women of Achievement' award that Tracey Porter and I received on their behalf in October. I was delighted to be joined by Baroness Dido

Harding, Chair of NHSI and Dr Kathy McLean National Medical Director, who thanked those present for their contribution over the difficult events of the last year.

Meeting with the Mayor of London (19 December 2017)

13. Our Chief Executive, Garrett Emmerson and I met with the Mayor, who remains supportive and interested in the services we provide at the London Ambulance Service NHS Trust (LAS). A focus of our discussion was the emerging LAS strategy and how we can link into the Mayor's plans for housing and property in London to enable us to deliver our strategy once agreed.

Meeting with Claire Murdoch, National Director of Mental Health Services NHS England (20 December 2017)

14. The purpose of the meeting was to both introduce Garrett to Claire and to discuss how the Service can best liaise with the London Mental Health Groups, to assist in providing better and more appropriate care to those clients' with mental health needs. Claire was most receptive to this and has invited Garrett to the Cavendish Group Mental Health CEOs meeting to take this forward.

Meeting with Assembly members Fiona Twycross (09 January 2018) and Tony Devenish (18 January 2018)

15. These meetings were arranged following the invitation by Garrett to meet with us. They were predominantly an introductory meeting for both parties.

Price Waterhouse Cooper (PWC) dinner with Alan Milburn (10 January 2018)

16. I was invited to join a small round table discussion to explore digital technologies and the opportunity for transformation through adoption of new ways of working in healthcare and where the pace of change is variable in the NHS.

17. Two key digital providers presented:-

    - Perfect Ward and LAS was cited as an early adopter.
    - Patients know best - where patients can access their record and share their information across the NHS spine as appropriate which I understand has been adopted in North West London. Jamie O'Hara Director of Strategy and Communication is going to contact them to see if there is potential for us to connect with them should it meet our strategic needs.

Launch of Governance and Inclusive Leadership (GAIL) report – All Party Parliamentary Group led by Dawn Butler MP (08 January 2018)

18. Patricia Grealish, Director of People and Organisational Development, and I were proud to attend this event at the invitation of Melissa Berry our Equality and Inclusion Manager. As a result of her work at LAS, Melissa has developed a 'Maturity Matrix', a simple and effective toolkit to help organisations move the dial within the ethnicity and race agenda.

19. The event was attended by large private and public sector organisations and showcased the Maturity matrix which has been adopted by the All Party Parliamentary group as good practice.

Clinical Council

20. The Medical Director, with support from the Chief Quality Officer and Deputy Director of Nursing and Quality, is setting up a Clinical Council. This group will bring together representatives from across the organisation to reflect and promote the developing multi-disciplinary clinical workforce. It's draft Terms of Reference are provided as an annex to this report.

21. The purpose of the group is to provide assurance to the Executive Leadership Team and Trust Board that the clinical elements of the CQC and recovery action plans are being implemented effectively and in a timely manner; to develop and support delivery of all of the clinical strategies and support their delivery; to promote the highest standards of clinical care demonstrating the values, attitudes and behaviours of the Trust and the wider NHS; to provide direction, advice and leadership in the clinical planning, development and delivery of health services within the Trust; to strengthen the essential partnership between the Trust's management team and senior medical clinicians and to discuss clinical ethical issues that arise that could have a legal, statutory or reputational effect on the Trust and advise the Executive and the Board as appropriate.

Heather Lawrence OBE
Chair

London Ambulance Service NHS Trust

Terms of Reference

Clinical Council

January 2018

1. Purpose

The purpose of the Clinical Council is to:

1. 1 Provide assurance to the Executive Leadership Team and Trust Board that the clinical elements of the CQC and recovery action plans are being implemented effectively and in a timely manner

1. 2 To develop and support the delivery of all of the Trust Clinical Strategies

1. 3 To promote the highest standards of clinical care demonstrating the values, attitudes and behaviours of the Trust and the wider NHS

1. 4 Provide direction, advice and leadership in the clinical planning, development and delivery of health services within the Trust

1. 5 To strengthen the essential partnership between the Trust's management team and senior medical clinicians

1. 6 To discuss clinical ethical issues that arise that could have a legal, statutory or reputational effect on the Trust and advise the executive and the board as appropriate

2. Scope and Objectives

The scope of the Clinical Council is to play a key role in safeguarding high standards of patient and family centred care while ensuring continuous clinical practice improvements across the Trust. This will be achieved by:

2. 1 Providing high quality, evidence based and timely direction and advice to the Board and Chief Executive on issues of strategic importance to the delivery of high standards of clinical care and service design

2. 2 Developing and implementing a 5 year clinical strategy for the Trust

2. 3 Provide analysis and evaluation of internal and external policy changes that impact on the planning, development and delivery of Urgent & Emergency Care

2. 4 Provide timely, impartial, transparent, inclusive and evidence based advice on strategic and emergent clinical issues

2. 5 To receive regular updates on the themes arising from reports / information through Clinical Governance, Clinical Commissioning Groups, NHS England and regulatory bodies (GMC,NMC, HCPC, NHS Improvement and the CQC) and ensure learning is shared effectively to all staff

2. 6 Provide a mechanism to enable effective two-way consultation and communication with clinicians across the Trust and broader healthcare system on issues of strategic clinical importance

2. 7 To take collective responsibility for the clinical elements required to consistently and constantly improve the quality of care provided by the Trust

2. 8 Provide opportunities for the development of clinical leaders within a whole of system, strategic perspective

2. 9 Represent the Chief Executive and the Trust at other system wide clinical engagement, clinical service planning and others as required

2. 10 Select 2 representatives to attend the Quality Assurance Committee rotating every two years

2. 11 Review the clinical elements of the CQC and Trust recovery plan and take collective responsibility within their clinical areas to deliver the required outcomes effectively and in a timely manner

3. Membership

- Medical Director (Chair)
- Deputy Director of Nursing (Deputy chair)
- Clinical Directors
- Allied Health Professional Lead
- Deputy Nurses
- Deputy and Associate Medical Director
- Chief Executive Officer
- Chief Quality Officer
- GP representative (to be nominated by the CCGs or Local Medical Committee)

4. Other Participants

4. 1 Other persons agreed to by the Chair may participate in the Clinical Council proceedings/activities. However, such persons do not assume membership or participate in any decision making processes of the committee.

- NED Sponsor – Chair of Quality Committee by invitation
- Executive Directors by invitation
- Director of Strategy

- Lead for Clinical Audit & Research

4. 2 The Clinical Council has the authority to invite or co-opt other members of staff and to establish time limited working parties as required.

5. Secretariat

5. 1 To be provided from the Medical Directorate office.

6. Reporting Relationships

6.1. The Clinical Council, through the Clinical Chair, reports to the Trust Chief Executive Officer and may make recommendations to the Executive Leadership Team and / or the Quality Oversight Group. The Clinical Council will provide a quarterly update to the Public section of the Trust Board meeting.

6.2. They will provide a monthly update to the Executive Leadership Team on the delivery of the clinical elements of the CQC and Trust Recovery plans.

7. Frequency of Meetings

7.1. The Clinical Council will meet monthly. The Chair may call working group meetings as required.

8. Quorum

8.1. The quorum for the Clinical Council will be half of the membership plus the Chair.

9. Agenda Items

9.1. CQC action plan update and discussion

9.2. Issues raised by QICG

9.3. Issued raised by the Executive Leadership Team or Trust Board

9.4. Clinical Strategy Development (task and finish sub group of the Clinical Council)

9.5. Agenda items together with the relevant discussion papers and cover sheets must be submitted by the lead Clinical Council members not less than seven days prior to the meeting

9.6. Out of season items can be considered where the item is urgent and must be considered before the next scheduled meeting or in circumstances when face-to-face meetings are not possible, to enable business to be progressed

10. Action Points

10.1 Action Points shall be disseminated to all Clinical Council members within seven days of the meeting.

10.2 Action Points confirmed by the Clinical Council Chair will be provided to the Lead Clinical Council Group members.

10.3 Action Points are a business document and should capture the recommendation / decision and appoint a responsible officer and timeframe.

11. Performance

11.1. The Clinical Council will be evaluated in terms of its performance against the approved ToR, approved Annual Clinical Council Work plan and relevant KPIs through an annual self-assessment. Should the Clinical Council and/or its Chair and CE identify the need, the Clinical Council may determine a process for additional external evaluation.

Domain	Performance Indicator	Assessment/Reporting Timeframe	Evaluation Method
NHSFT key performance indicators		Report on current status of standards and recommendations	Self-assessment
National Safety and Quality Health Service Standard			Self-assessment
Legislation / Governing Bodies			Self-assessment
Risk Management	All Risks are reviewed, recommendations considered and implemented in accordance with risk management framework	Report on trended Risks	Self-assessment

12. Annual Committee Work Plan

12.1 The plan is to be developed by April 2018.

12.2 This plan is to be reviewed quarterly

12.3 The plan forms the basis of the standing agenda

13. Conflict of Interest

13.1. Members of the Clinical Council must declare any conflicts of interest whether actual, potential and apparent or appear likely to arise and manage those in consultation with the Chair, normally at the start of the Clinical Council Meeting.

14. Access to information / confidentiality

14.1 Members of the Clinical Council have the right to access information and documents relevant to issues being considered within the terms of reference. It is acknowledged that certain issue being examined may be of a confidential and/or sensitive nature, which will require members of the Clinical Council and secretariat, to exercise discretion and ensure and confidential information is maintained and managed accordingly.

15. Authorisation

15. 1 The Lead Clinical Council functions under the authority of the Medical Director

15. 2 The Lead Clinical Council reports to the Chief Executive Officer.

15. 3 The Clinical Council Chair has the authority to create relevant sub-committees or other subordinate bodes it deems necessary to assist the Lead Clinical Council in discharging its responsibilities.

15. 4 Decision Making;

15.5.1 Lead Clinical Council recommendations are made by consensus.

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	30 January 2018			
Report title:	Report from the Chief Executive			
Agenda item:	07			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Chief Executive's report gives an overview of progress and key events within the Service since the last time the Board convened.

The report is structured in sections, covering key areas of focus of the Trust and Board.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Chief Executive's Report

This report provides the Trust Board with an update regarding key issues, events and activities.

Operational Performance

1. The Trust's performance during the busiest times in December was significantly stronger than in previous years. This was the first year that the Trust's performance was recorded under the new Ambulance Response Programme (ARP) standards and since its introduction the Trust has:

    - Achieved a ten second improvement in mean call answering time from November to December 2017
    - Been in the top three performers in England for Category 1 mean delivery for each week since the week commencing 13 November to 1 January 2018 including Xmas and New Year
    - Consistently delivered well within the Category 1 90th centile target of 15 minutes
    - Was one of the top two performers in England for Category 3 and 4 90th centile delivery in the week commencing 25 December 2017 including Xmas and New Year
    - Delivered the Category 4 90th centile target of 3 hours with a 5 second breach in the week commencing 11 December 2017.

2. The Trust's IT system coped under the strain of nearly 400 calls per hour on New Year's Eve. The Trust was able to support other ambulance services when they were receiving high levels of call volume. This demonstrates how much pressure the whole system is under nationally. The comprehensive planning and implementation of a detailed operational plan alongside the support of colleagues in Operations, IM&T and the Medical Directorate should be acknowledged. Teams in HR, Finance and Communications also played a tremendous role in supporting us through this challenging period.

3. Coming out of December and into 2018, there remains pressure in some areas of London, particularly in terms of hospital handover delays. We are working across the London healthcare system - every day - to help fix this, using, for example, the vast amount of data we collect to inform Trusts of the number of patients we expect to convey. The Trust has also worked at very short notice to arrange for our crews to be re-directed to other hospitals in order to help ease the pressure on those which are most challenged. And for the first time, one of our senior managers has been embedded within the London group managing handover delays alongside NHS Improvement and NHS England and this has proved invaluable.

4. Both the Business Intelligence and Forecasting & Planning teams have also continued to be instrumental in the Winter Planning and Winter Performance Oversight groups which operated throughout the festive period. By contributing data-driven intelligence (around hospital pressures, demand levels, capacity, and efficiency measures) and providing forecasts for coming days (including resourcing recommendations and comparison of actuals against forecasted trends), the teams were able to provide assurance regarding plans and support operational colleagues in decision making.

5. As we have now entered quarter 4 of 17/18, the forecasts have been refreshed to adjust for current activity levels and to recommend resourcing levels to maintain performance through to the end of the financial year. The Forecasting & Planning team are also

working on creating activity projections for the next financial year, and are collaborating with Finance, Workforce and Contracts in order to understanding the impact on staffing, budget and equitable performance under ARP in 18/19.

Finance

6. As reported in detail elsewhere on the agenda the overall financial position for the Trust is £4.5m ahead of the internal plan at Month 9, largely due to on-going vacancies in front-line staff groups. This is despite incident activity continuing to run at 2.0% above contract baseline for the year to date. Executive focus remains on acceleration of recruitment to address resilience and catch up with the pipeline required to deliver the requirements introduced recently through ARP.

7. The latest forecast is that the Trust will achieve the £2.4m deficit control total and could deliver further improvement on this subject to a number of risks as the Trust continues through winter such as overtime and incentive payments. The CIP savings programme remains behind trajectory and additional support has been put in place to build in a more strategic programme approach to savings and efficiency delivery, to ensure that we identify recurrent efficiency savings for 18/19 onwards to replace some element of non-recurrent savings to date.

8. Capital spend is £9.9m against a YTD plan of £15.1m, £5.2m behind plan. The current forecast is to spend £19.4m vs the plan of £24.6m. The Capital Programme Group will now consider further schemes that can quickly be brought forward to ensure the Trust utilises its capital allocation in 2017/18.

9. Business Intelligence has remained engaged with the ARP Programme and Delivery Boards since implementation. Some of the newly developed reports have even been considered exemplary and requested to be shared with other trusts. Over the coming months, the Performance team will continue to develop additional reporting and forecasting suites. As more information and data becomes available, it is possible to begin evaluating the emerging operational trends and identify ARP related changes as they materialise.

10. A new forecasting model is being developed, utilising the ever growing intelligence from recent ARP data to enable predictions to be made around future performance. This will be fundamental to operational planning and service delivery, tactical planning for special events, ongoing reporting and internal benchmarking, and contract negotiations.

11. Additionally, the team has been working to develop a Data Quality Improvement strategy. A draft paper has been presented to ELT, and attention now turns to the establishment of a new specialist team to lead in this business objective.

IM&T

12. December saw IM&T focus on preparation for the winter period including enhanced support to the 111 and 999 services during Christmas and New Year, both of which were managed successfully.

13. We welcomed Richard Browne as Interim Head of Business Engagement & Change, completing the Senior Management Team. Richard is focussing on improvements to how we manage and deliver technology change and optimise the value from our investment in technology.

14. Ross Fullerton, Vic Wynn and Richard Deakins attended a GLA-led event chaired by David Bellamy, Chief of Staff to the Mayor meeting colleagues from across London and identifying a range of collaboration opportunities that are being pursued in the New Year.

15. A small team visited NorthropGrumman in McLean, Virginia to undertake early testing of the forthcoming CommandPoint release, agree the final steps required ahead of NYE, and explore future capability and review quality & performance. They also visited Chicago to share experiences and understand how the City of Chicago operate and use the NorthropGrumman public safety tools to run an integrated control room for police, fire and EMS.

16. We became signatories to the BT tri-borough procurement framework for a range of IT services. This framework was competitively tendered and is managed by Westminster on behalf of a range of public sector organisations in London. It provides a compliant route to market and allows us to collaborate efficiently with partners from across London.

17. The finance systems underwent a substantial upgrade in December. The iPad deployment is continuing on-plan and preparation re-commenced for the forthcoming power works at Bow.

Strategy

18. Since the November Trust Board meeting, we have held a number of events associated with Our Strategic Intent and emerging strategic direction; the most significant being our Strategy Engagement Day on 7 December 2017. This comprised of three separate engagement events attended by patient representatives, staff and stakeholders. All were very well received and generated a great deal of valuable feedback.

19. The engagement period closed in December, having had over 1,600 interactions with staff members, engaging with 23 stakeholder organisations including all five London STPs and face to face meetings with the Patients' Forum as well as responding to their formal feedback submission. We have produced a document summarising the key comments and themes that we received from staff, patients and stakeholders and will use the feedback received to help develop the content of our final strategy which will be published in early 2018

20. As part of the next stage of strategy development we are working to develop the detail of the four pioneer services. These pioneer services will identify how we can offer a different response to four patient groups (maternity, falls, mental health and end of life care) where we think that improved patient outcomes and/or greater efficiencies could be achieved. The strategy team is working closely with our subject matter experts and we are undertaking detailed modelling in order to develop business cases which will identify the specific quantifiable benefits that the pioneer services could offer.

21. The Finance & Performance Directorate has also been involved in the Pioneer Service development in line with the Strategic Intent – helping scope out possible changes to the delivery of specific services, and providing quantifiable evidence to begin evaluating impact and benefit of the strategic changes.

22. We are also carrying out the initial design work for the 'Single Point of Access'. Over the first few weeks of January 2018 a working group has been exploring the elements of a blueprint for moving to a 'Single Point of Access'. The work has focussed on a shared vision for the service, and the channels of contact for future patient journeys through the new operating model for 4 scenarios across 'Advice', 'Urgent', 'Emergency' and 'Major Incident'. The work is also looking at the clinical assessment service (CAS) and a discussion was had on key capability requirements and next steps required to develop a more detailed view. The plan is now to organise a clinical and operations workshop

before the end of January to work through the detail of the CAS and a further IT focused working session to assess key IT infrastructure requirements.

23. In terms of Blue Light Collaboration, we continue to work with our blue light colleagues and have appointed a programme manager who is jointly funded by all three services. We contributed to a bid to the police transformation fund with the purpose of establishing a programme of works to verify and validate the merits (or not) of a single control room for all three services. It must be stressed that this funding is for the feasibility study alone. The funding for year one, 2018/19, is £1.8million.

Quality Improvement

24. The Trust have now received formal notice of the CQC inspection. The announced Well-led inspection will be conducted on 21st and 22nd March. Prior to this date the Trust will also have 2 unannounced visits to core services/sites. We will get half an hour's notice for the site visit and 1 weeks' notice for the core service inspection. Preparation for the CQC inspections are under way and included as an agenda item in the Board report.

25. The recruitment for mental health nurses has now begun and piloting of mental health nurses on the fast response cars started at the end of December. A review will take place with a view to rolling out this practice to all sectors, this will form part of our strategy going forward.

26. The directorate will be developing a business case in relation to frequent callers to increase the resource to the team. This will provide the capacity to engage with the system to ensure that, particularly for complex cases, care management is provided more quickly. In addition to the benefits to these patients, this will also bring increased financial savings via the significant reduction on demand on the service, which will in turn mean other patients should be seen more quickly. The implementation group for quality improvement and quality assurance framework will hold its first meeting in February. In addition the Trust were successful in gaining support from UHCL to provide training in human factors for a core group of staff. The aim is to then support the roll out of the training to all other staff in conjunction with the QI training. This will be a significant step change in building capacity and capability and developing a culture of continuous learning and improvement.

27. On-going progress with the Health and Safety action plan (see Board update report). Dates have been set for the H&S Executive to meet the executive (7th March), this meeting is to provide assurance to the H&S Executive that the Trust has all the systems and processes and reporting mechanisms to support compliance with regulations. The second stage is for H&SE to meet with the unions and staff. We are confident we will have completed and provided assurance in relation to the H&S high priority actions prior to this meeting.

Medical Directorate

28. As forecast for the festive period, December saw a surge in demand for Emergency and Urgent Care calls across London. This was further compounded by pressures in the health system as a whole resulting in an increase in the number of patient handover delays at hospitals. In order to support service delivery, the Medical Directorate led on a number of initiatives.

29. As part of the Safety Huddle the Trust Medical Director chaired daily conference calls with managers from directorates across the organisation. These meetings were aligned to daily performance cell meetings but maintained a clinical safety and quality oversight focus. Incidents of note were brought to the group for discussion and escalated where

appropriate. Assurance was provided by the Clinical Hub and Operations that staffing levels were adequate in order to provide a safe service for the following shift enabling shortfalls to be proactively managed

30. A weekly Winter bulletin issued to Acute Trusts detailing expected demand, upcoming events, weather related impact on service delivery, hospital breach data and reiterating the need for hospitals to prioritise the release of ambulance crews by facilitating a rapid handover either through hospital led nurse cohorting or the 'Fit to Sit' initiative.

31. In December 2017 a Cohort 1 of ten individuals completed the LAS paramedic programme - the first cohort to do so in the LAS. Seven staff are now registered with the HCPC and are in the process of being credentialed to NQP1s on our system. Feedback about the programme from staff remains positive. Cohorts 2 – 6 are in progress. Aligned to the strategy, the plan is to increase available places on the programme. A project group has been set up to drive this agenda.

32. In the last month the Infection Prevention & control (IPC) team have continued recruitment to new posts and staff joining the organisation are attending corporate induction programmes. This now includes an IPC Training session which has been resurrected to ensure all new joiners have a thorough understanding of the Trust's expectations for IPC standards, clarity of roles and responsibilities, practical session to ensure competency for hand hygiene, including the use of alcohol based hand sanitisers.

33. A number of outstanding actions from the IPC work plan have been closed including bespoke training sessions for Logistic Support Unit staff, a meeting with the Trust occupational health provider to clarify roles, responsibilities and to ensure a robust governance process is in place. The Head of IPC and Health & Safety will now attend all occupational health contract meetings.

34. The Clinical Audit & Research Unit (CARU) have worked efficiently to incorporate ARP guidelines into our data capture, processing and monthly reporting, whilst continuing to meet all Trust and national deadlines. Through membership of the ARP Ambulance Clinical Quality Indicators (ACQIs) sub-group, they are working closely with NHSE to develop the new ACQI data set, which services will start reporting on from April 2018.

35. CARU are also currently developing a Sepsis Registry to meet a requirement of the new ACQIs and will be submitting a Business Case to request that funding for this registry is continued into 2018/19. In November and December, as a result of our Continuous Re-contact Clinical Audit, 38 crews were recommended for feedback (19 positive & 19 constructive), 26 EOC staff were recommended for constructive feedback (23 EMDs & 1 CTM), and two potential incidents were flagged on Datix (SIG deemed LAS decision making to be appropriate but both were flagged to the Independent Police Complaints Commission for further investigation).

36. The clinical audit work plan was formally reviewed at November's Clinical Audit and Research Steering Group (CARSG) and found to be progressing well.

37. An independent annual review of our clinical audit practices, undertaken by a member of the LAS's Patient Forum, was also presented at CARSG. The review found that we are highly compliant with best practice, LAS audit strategy and procedural documents, and no recommendations for improvement were made.

38. Our research trials are all running to time and target. Of particular note, the ARREST trial went live on the 15th January which aims to determine the best post-resuscitation care pathway for patients.

People and Organisational Development

39. The launch of My ESR has been a success with over 79% of Trust staff (4,502) accessing the system. We have the highest number of users using the new ESR Portal in London (71 Trusts). The ESR Workforce Dashboard has been positively received and we have launched two new reports this month ('monthly view by hierarchy' and 'other training') and we have had over 5,000 views from 350 managers. At the recent Project Board, we reviewed the high level plan for 2018/19, this will be reviewed in detail at the Project Board in March

40. At the end of December 2017 the Statutory & Mandatory training compliance is 75% with corporate compliance at 94% (target 100%). The operations compliance figure is 73% with a targeted compliance for CSR to the end of March 2018 although consideration is being given to revising this to the end of February. The Equality, Diversity & Human Rights module has not been included in the CSR 2017/18 programme as it is a statutory requirement and will be targeted for full compliance Trust wide via e-Learning within MyESR as soon as possible. As expected December completions plateaued whilst the Trust operated at REAP level 3 however now that REAP 2 is in place a communication to staff will be issued as a reminder to continue with and complete their e-learning. Those staff within corporate services will also be reminded to regularly access MyESR to ensure ongoing compliance together with specific targeting of those staff who have outstanding modules.

41. The new Bank contract with new Terms and Conditions has now been introduced which requires all Bank staff to meet the LAS role's Statutory and Mandatory training requirements before they can undertake operational duties. The training requirements for Bank staff remains under review. The aim is to produce data that will inform a capacity plan for any face to face training requirements identified.

42. Following the staff engagement event held on 14th December as a result of a CQC request work is underway to gain an idea of how well staff feel engaged, how meaningful various interventions in the organisation were. A "You said we did" paper has been drafted with recommendations that map to the P&OD Strategic themes. The recommendation is to plan quarterly events out in the wider organisation to achieve greater reach to the workforce as opposed to holding the event centrally.

43. On the 8th of January we started our road show of community engagement events at Westfield (East) and the Stratford Centre. The LAS were there for 7 days in total and we had 208 expressions of interest.

44. To address reported incidents of Bullying & Harassment I am pleased to report that following a robust procurement process LAS has appointed an independent mediation provider for complex or entrenched cases of conflict. The provider Total Conflict Management, will resolve up to 14 cases annually and will collect detailed metrics on themes and trends which allow for bespoke training to be delivered and review the efficacy of the interventions. The contract will be reviewed after 12 months as to the impact on reducing protracted grievances.

45. A Focus Group to consider future solutions in reducing Bullying & Harassment led to a facilitated first workshop which has generated staff discussions concerning the next steps to creating a culture of conflict competence, staff who are trained facilitators spoke about their lived experience of round table facilitation and why resolving conflict informally is beneficial to the workforce. This is the first of three focus groups planned and will result in an action plan based on staff ideas for future solutions.

46. Following the appointment of an interim PAM Contract Manager a number of activities have been delivered to continue the work to improve on the delivery of the OH service:

    - Briefings with sector based teams to give reassurance and encourage feedback through correct channels
    - Trade Union Health and Safety Meetings
    - Direct response to Lia threads to address concerns and to share information
    - Communication of physiotherapy to face to face rather than telephone triage
    - Update on immunisation programme and full review of immunisation records.

47. We have established a dedicated email box for all issues and concerns. An issues log is compiled and weekly calls with PAM are held to ensure all issues are cleared within a 3 days period.

48. Major areas for development continue to focus on:

    - More effective delivery of physiotherapy, this is now closely monitored on a weekly basis
    - Increasing access to counselling and introducing clear reporting. Including assessing the methodology used by PAM and its relevance to LAS (CBT rather than psychotherapy)
    - Improving the quality of OH management referrals, particularly in recruitment.

49. From 22nd January we will have a full time Occupational Health Nurse allocated to LAS to take responsibility for vaccinations. We will be coordinating the time of this individual to ensure we make maximum use of the allocated time, this will be in addition to the normal OH clinics where staff will be booked in for immunisations.

50. Access has been allocated to the OH Contract Specialist to respond directly to LAS staff on Listening in Action Facebook page. 48 messages were exchanged over a 2-day period, most of which are resolvable. All matters have been taken forward with PAM for resolution and staff will be responded to directly.

51. An Occupational Health re-launch plan has now been completed in collaboration with the Communications team to roll out mid-late February. It was felt that an earlier relaunch was inappropriate due to current operational pressures.

Communications

52. I met with Simon Stevens CEO NHS England in early December when I took the opportunity to tell him about our new strategy and our ambition to provide integrated urgent and emergency care for London. We also spoke about how the introduction of the new national targets had gone and our wider performance. Simon went on an observer shift during his Friday evening visit.

53. The Archbishop of Canterbury Justin Welby visited our headquarters in mid-December to hear staff's experiences from last year's terrorist attacks. As well as meeting control room and frontline staff, he spoke with members of our Christian Fellowship about how their faith helps them in their job. During his visit he recorded his New Year message in our specialist operation centre which was broadcast on New Year's Day on BBC1. His message was also reported by the Guardian, the Times, and BBC News.

54. Along with twenty members of our staff I represented the Trust at a service at St Paul's Cathedral on the six-month anniversary of the Grenfell fire.

55. Our communications team has been supporting operations through the winter period through targeted campaigns and media opportunities. In the run up to Mad Friday (12 December), we focused our messaging on responsible drinking and the impact that alcohol-related calls can have on demand for our Service. We hosted ride-outs and interviews with ITV's Good Morning Britain and the Evening Standard, and shared our messages across our social media channels. Post Mad Friday, the Sun, Daily Mirror, Evening Standard, LBC News, Heart London and Capital radio all reported the increase in demand we experienced on the night.

56. We did broadcast interviews with Channel 4 News, BBC London TV news and ITV London TV news ahead of New Year's Eve. Assistant Director of Operations Ian Johns encouraged people to be sensible if they were drinking on New Year's Eve and to look after their friends. An interview with General Manager Craig Harman also ran on LBC promoting safe drinking advice. The demand figures we issued post New Year's Eve were used in round-up pieces of the celebrations by national media including BBC News, Mail Online and the Daily Telegraph.

57. In early January, Director of Operations Paul Woodrow was interviewed by BBC London TV as part of a piece looking at how the NHS was coping with winter pressures across the capital. Paul spoke about how we are playing our part to try and relieve pressure on emergency departments and give patients the best possible experience. More recently Sky News reported what resource escalation action plan (REAP) levels ambulance services were operating at – we were the only service to be operating at level two, with the others all at level three.

58. Jeremy Hunt paid an informal visit to our Service on 4 January. He met with members of our executive leadership team and visited our control room to hear about current demand, and praised staff and our planning for winter.

59. I attended a ceremony at Guildhall hosted by London's three police forces where a member of our staff, Andy Beasley, received a bravery commendation for his response to the attack at London Bridge. Andy, who was one of the first of our staff on scene, was interviewed by BBC London TV when he talked about his role on the day, the teamwork involved and how his training kicked in as he and his colleagues reached patients quickly and helped to save lives.

60. I had the opportunity to recognise the first 11 winners of our 2017/18 VIP awards in December; these are staff who have been nominated by their peers for going the extra mile. The second round of the awards has recently closed, and once the winners have been chosen, staff will have the chance to vote for our Employee of the Year who will be announced at our annual VIP Awards.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	30 January 2018			
Report title:	STP Engagement Update			
Agenda item:	08			
Report Author(s):	Adam Levy, Strategy and Planning Manager			
Presented by:	Jamie O'Hara, Director of Strategy & Communications			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

At October Trust Board there was a discussion about Sustainability and Transformation Partnership (STP) engagement and it was identified that Trust Board were not sufficiently briefed on the ways in which we engage with STPs. It was agreed that a paper would be brought back to Trust Board outlining the Trust's approach to STP engagement.

Recommendation(s):

The Board is asked to note the report

Links to Board Assurance Framework (BAF) and key risks:

None

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☐

STP Engagement Update

Background

1. Sustainability and Transformation Partnerships (STP) were formally established in 2016. They are 'place-based plans' for improving heath and care services in 44 areas of England, including five STPs in London.

2. STPs were established to strategically plan and fund all health and care activities within the geographical areas that they cover. The intent is that these partnerships can use a collaborative approach to plan around the needs of whole areas, not just those of individual organisations.

3. Each STP has a named Accountable Officer:

   - North West London – Mohini Parmer
   - North East London – Jane Milligan
   - North Central London – David Sloman & Helen Pattersen
   - South West London – Sarah Blow
   - South East London – Andrew Bland (from April 2018)

4. Since the establishment of STPs, we have ensured that we are proactively and regularly engaging with each of the STPs to help develop the five London STP plans.

5. In 2017, we reflected the changes to the sector and re-organised our operational footprint to match the STP structure.

6. Initially, each of the five STP sectors was assigned an Executive Director lead and an Assistant Director of Operations operational lead. Each sector also has a Sector Engagement Manager to support lead, focussing particularly on some of the sector specific operational matters.

7. However. In 2017, we saw a number of changes in our Executive Leadership Team so the Chief Executive took personal responsibility for overall service engagement across the five STPs. This was initially supported by the Director of Strategy and Transformation until she left the Trust, and then subsequently by the Director of Strategy and Communication and Deputy Director of Strategy.

8. Throughout this period of change continuity and consistency has been ensured through the continued involvement of the Assistant Directors of Operation and Sector Engagement Managers. The ADO operational leads are:

   - North West London – Ian Johns
   - North East London – Natasha Wills
   - North Central London – Peter Rhodes
   - South West London – Graham Norton
   - South East London – Darren Farmer

9. The following Non-Executive Director leads had also been identified for each sector:

   - North West London – Fergus Cass
   - North East London – The de Pencier

- North Central London – John Jones
- South West London – Robert McFarland
- South East London – Heather Lawrence

Types of Engagement

10. Our engagement with STPs falls within four categories
    - CEO and/or Director engagement
    - Subject specific engagement
    - Local operational engagement
    - Data and analysis

11. Each category of engagement has a different purpose and allows us to work with STPs and other provider organisations in order to influence improvements to the Urgent and Emergency Care sector in London. These types of engagement are detailed in section 3 below.

Purpose of and examples of activities undertaken within each category of engagement

Chair/CEO/Director engagement
Purpose of engagement To contribute to the overall strategic development and transformation of the urgent and emergency care sector across London whilst ensuring that the views of LAS are reflected in STP discussions. Activities undertaken include: • Attendance at STP board meetings • Attendance and presentation at Emergency Care Improvement Programme (ECIP)
Subject Specific Engagement
Purpose of engagement To contribute to the development of specific pathways, clinical innovations and changes to the way that specific sections of the system function including for specific patient groups such as mental health and maternity Activities undertaken include: • Deputy Director of Nursing (and Mental Health Lead) attending Pan-London Mental Health Transformation Board • Consultant Midwife attending Maternity System meetings • Clinical Lead attending End of Life Care Steering Group

Local Operational Engagement

Purpose of engagement

To work with STPs and other organisations to overcome problems and/or make improvements to specific operational matters in sector. This section accounts for the bulk of our engagement at SRP level, led predominantly by Assistant Directors of Operation (ADOs) and Stakeholder Engagement Managers (SEMs).

Activities undertaken include:

- Working with STPs and providers to support further development of alternative pathways, allowing for a reduction in conveyance directly to Emergency Departments
- Hospital specific meetings to address handover delays or specific issues (e.g. ambulance access during upcoming building works)
- Identifying local demand management initiatives
- Identifying communication difficulties and implementing solutions
- Patient group specific meetings in CCG or STP areas, such as Mental Health Oversight Board
- Attendance at rapid response, surge and other meetings to address time specific issues
- Introduction of frequent caller forums
- Presentations at Local Authority Health and Oversight Scrutiny Boards

** there are a significant number of activities undertaken by ADOs and SEMs which can be found in appendix 1 – STP Engagement CQUIN report for Q3*

Data, Information and Analysis

Purpose of engagement:

To use our unique position as the only pan-London NHS provider to provide data and intelligence to provider and commissioner organisations

Activities undertaken include:

- Our Performance Directorate produce STP data packs which include breakdowns on key areas of working including: Pathway usage, frequent callers, care home usage, HCP referrals and demographics
- We provide a number of subject specific regular reports to STP and CCGs including: Alternative Care Pathway usage, Care home referrals and Police referrals
- Ad hoc requests and reports which are managed by our Business Intelligence Team

How we monitor STP engagement

12. One of the 2017/18 CQUINs looks at how we engage with STPs in support of the delivery of STP plans and demand management actions. Our Contracting Team work with ADOs and others to produce quarterly reports outlining some of the specific activities that have been undertaken.

Next Steps

13. We have made great strides over the past six months in increasing the effectiveness of our engagement with STPs. We recognise the centrality of STPs to the future of the urgent and emergency care sector and we know that we need to continue to improve the consistency and quality of our engagement at that level

14. As part of '*Our Strategic Intent',* we identify that in order to more effectively engage and influence the system in which we operate, we need to invest. Our final strategy will further detail how we will invest in this important relationship

15. In November 2017 we created the Strategy and Communications directorate. This new directorate has provided the opportunity for us to forge stronger and more strategic links between the operational engagement, led by ADOs and SEMs, with our developing wider strategic stakeholder engagement

16. As part of our developing strategy and the work plan for the Strategy & Communications Directorate, we will be refreshing our approach to STP engagement. This will include opportunity for Trust Board to discuss how Executive and Non-Executive engagement should be taken forward.

Jamie O'Hara
Director of Strategy & Communication

Appendix 1 – LAS 2017-19 STP CQUIN Indicator Q3 report

#	CQUIN Title	CQUIN Description	CQUIN Lead
N1	**STP engagement**	To support engagement with STP's are per national guidance.	AF/FC/JO

Progress report - Quarter 3

Aims and objectives

As per the national CQUIN indicator, the Trust aims to support engagement with STPs. This report covers the following work streams:

- Provide activity in the form of CCG Demand packs to support meetings and actions monthly
- Work carried out by the Sector ADOs to collaborate proactively with STPs to target actions to support the management of demand. This senior commitment is designed to ensure active engagement, investigation, action and ownership

Progress made so far

- Engagement with the STP leads has continued over the past quarter. We have strengthened relationships across STP's with the LAS CEO attending the STP Board meetings over the coming months. There are a number of dates for the STP meetings that are outstanding and the Trust is working with our stakeholders to ensure we are fully cited on dates to enable better future engagement.
- The Performance Directorate continue to collate individual CCG and sector specific demand packs which include detailed breakdowns on the following key areas: ACPs, Frequent Callers; Care Home usage; HCP referrals to the 999 service and also the demographics of the boroughs. These are submitted to LASCt on a monthly basis for distribution to all 32 CCGs, this has continued to be completed for each month in Q3.
- LAS' ADOs and their Stakeholder Engagement Managers undertake a number of sector based engagement initiatives, to support local demand management for each sector. The LAS ensures regular attendance, from senior operational managers at:
    - Local A&E Delivery Boards
    - STP Health Programme Boards
    - Local A&E Operations Boards
    - Hospital specific meetings to address demand management of hospital handover delays
    - CCG Demand Management meeting

Our local Senior Operational Management teams undertake a number of sector specific tasks, including working with the STPs for a reduction in transport direct to Emergency Departments (where clinically appropriate), further supporting the development of alternative care pathways as well

as engaging in local conversations directly with CCG colleagues; this has enabled us to form single points of contact for each of the respective areas.

Below is a sample of the work continually carried out by ADO's and SEM's across London – please note much of this work is replicated across STP's

- South East London: the ADO and SEM are currently focusing on demand management with the STP, with key themes including:
  - Eltham Community Assessment Unit, developed and implemented. This includes weekly strategy and operational meetings that are currently ongoing.
  - Regular contact and visits to all the South East Acute Trusts including Darent Valley Hospital (DVH).
  - ECIP Conference and presentation re Hospital Handovers (October 2017) also attended by the Medical Director, Director of Operations and Deputy Director of Operations
  - All 3 A+E Boards attended in quarter 3. Lambeth and Southwark, Bromley and Bexley Lewisham and Greenwich.
  - Monthly information for DVH on ambulance attendances by day of week and hour of day.
  - Regular requests for Care Home data with a view to reducing demand, this is followed up with face to face meetings.
  - Quarterly Demand Management Meetings with lead South East CCG Commissioner. Attended by ADO and SEM.
  - Regular meetings re frequent callers in an effort to reduce demand with varying levels of success.
  - Meetings regards the implementation of Red Bags to Care Homes. This is expected and proven to reduce length of stay and subsequently reduce demand for acute beds.
  - November presentation to the Bromley CCG Integrated Governance Committee re reducing demand and what else can be done to assist the LAS.
  - Mental Health Oversight Board to try and reduce demand for MH Patients.
  - Weekly Emergency Care Pathway meetings at Kings College Denmark Hill site re flow and ambulance handovers.
  - Regular meetings with each Acute Trust re reductions in ambulance handover times, this includes working with ECIP.
  - Regular information updates to the Acute Trusts re their current handover positions

- North West London:
  - Key work streams focused on across the Sector in Q3
    - End of Life Care
    - Frequent Callers
    - Care Homes
    - Safeguarding
  - Attendance at
    - Frequent Caller Forums across the STP
    - NWL STP Health Programme Board
    - A&E Delivery Boards e.g. Hillingdon, Imperial, Chelsea & Westminster

        - Surge Calls
        - Rapid Response Meetings
        - Demand Management Meetings
        - Safeguarding Strategy Meetings
        - Meeting with local Hospitals to look at several areas e.g. 'Red Bag' schemes, Clinical Governance and Hospital Site Team visit
        - Training days in collaboration with CLCCG
        - CCG wide Care Home meetings
        - Operational Board Meeting at Chelsea & Westminster Hospital

- North Central London:
    - Attendance at
        - All A&E Delivery Boards across the STP
        - U&EC Programme Board
    - Key work streams
        - Working with a local GP to rotate patients through a 'surgery' and understand better rapid triage and risk avoidance
        - Delivering an admission avoidance CPD day in sector with external speakers
        - Rotating new NQP's through Camden Rapids team to better understand rapid response teams

- North East London:
    - Proactive engagement by LAS – setting up meetings with STP leads
    - Attendance at
        - STP stakeholder launch events.
        - STP community events.
        - STP provider events.
        - LAS NEL Demand Management Meetings
        - All CCG AGMs and other meetings as required.
        - And working with CCGs /partners at UCWGs and AEDBs.
    - Working with
        - The STP lead and the CSU on reviewing all ACPs ensuring standardisation, publication and promotion for City and Hackney, Waltham Forest, Tower Hamlets and Newham .
        - With the STP lead on the dissemination of deep dive data on all frequent callers for City and Hackney, Waltham Forest, Tower Hamlets and Newham.
        - STP on LAS data requests for City and Hackney, Waltham Forest, Tower Hamlets and Newham.
        - STP leads on their key work streams

        - STP and partners on the provision of care and nursing home data for City and Hackney, Waltham Forest, Tower Hamlets and Newham**.**
        - STP on hospital handover delays at Homerton, Royal London, Newham and Whipps Cross.
        - CCG partners to ensure GP and other HCPs demand is managed appropriately through joint initiatives.
        - The police to ensure demand is managed appropriately through joint initiatives
        - CCGs/ ECIP and hospital improvement managers on flow, capacity and demand.
    - Providing
        - Data to CCGs on handover delays at hospitals.
        - Regular LAS updates and presentations to CCGs
    - Analysing
        - Data for CCGs in relation to ambulance numbers attending acute sites.
        - Analysing data for CCGs in relation to appropriateness of conveyance to acute sites
    - Partnership working with STP to jointly present on LAS issues to AEDB on performance, handover delays etc.
    - LAS stakeholder event working with LAS NEL STP link and stakeholders on strategic planning.
    - Organising site visits for CCG leads to attend high performing acute sites such as Luton and Dunstable to learn from best practice.
    - Developing new pathways and services along with CCGs to reduce demand on hospitals and supporting patients in the community.

- South West London:
    - Key work streams and attendance at
        - Frequent Callers – working with colleagues via individual forums
        - Working to update and clarify ACP's across the STP
        - LAS' integration into the new Urgent Treatment Centres across the STP
        - Attending working groups to set-up the new Mental Health 136 Pathways.
        - Attendance at the SWL Transformation and Delivery board

Attendance by SEM and ADO at the SWL LAS Demand Management meetings

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report Title:	Integrated Quality and Performance Report			
Agenda Item:	09			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Executive Leadership Team members and Board Assurance Committee Chairs			
History:	Executive Leadership Team			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This high level Integrated Performance Report serves to provide an Executive Summary for Trust Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendation(s) to Trust Board:

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

Links to Board Assurance Framework (BAF) and key risks:

This report contains an overview of Trust risks directly linked to the BAF but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUST BOARD EXECUTIVE SUMMARY

January 2018

* All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout December 2017 unless otherwise stated.

Delivery of care continues to be safe, but the rising demand pressures on the system continues to remain challenging.
LAS is currently the 2nd highest reporter to NRLS across the ambulance trusts.
The Mean response time for Category 1 was 7 minutes 25 seconds for December 2017. This is 25 seconds above the target of 7 minutes.
Year to date the position is £3.9m ahead of plan and £4.5m ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.
Trust vacancy rates have decreased from 7.3% to 6.5%. Appraisal rates have improved from 52% to 54%.

OUR PATIENTS

- There has been a further reduction in number of non-controlled drugs incidents and no unaccounted losses of Controlled Drugs.
- LAS is currently the 2nd highest reporter to the NRLS across the ambulance trusts.
- At the London Clinical Senate, Dr Vin Diwakar (NHS England Medical Director, London Region) placed on record his thanks to the LAS for our efforts to support the healthcare system in London over the winter period.
- The documented care for patients not conveyed remains unchanged at 97% against a target of 95%.
- Safeguarding Adults & Children level 2 (EOC) training at 42% against a target of 58%.
- Despite escalation and weekly reminders actions from serious incident investigations continue to breach the assigned deadline.

OUR PERFORMANCE

- The Mean response time for Category 1 was 7 minutes 25 seconds for December 2017. This is 25 seconds above the target of 7 minutes and is 21 seconds higher than the previous month.
- The C1 90th Centile was 12 minutes 4 seconds. This has remained within the 15 minute national standard each week since the implementation of ARP.
- There were a total of 97,934 Incidents in December that were provided with a face-to-face response.
- The Trust was ranked 1st in the Category 1 90th centile performance measure when compared to all other ambulance services nationally.

OUR MONEY

- Plan / Target – Year to date the position is ahead of plan.
- YTD demand is currently running at 2% ahead of contract baseline. This is below the budgeted level of activity included in the Trust's plan, and as such main contract variable income is £1.8m below budget.
- Year to date CIPs are £5.9m behind plan and are currently offset by non recurrent underspends on pay budgets.
- Capital spend is £9.9m against the initial Capital plan of £17.7m, £7.8m behind plan. The forecast is to spend £19.4m vs the plan of £24.6m. In month 7 the Trust revised its Capital plan and this spend is £5.2m behind this plan.
- Cash is £32.4m, £7.1m above plan. This is made up of a number of offsetting variances. The Trust has outstanding debts of £6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.9m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £8.3m. These movements are being offset by under payments of £11.2m on capital, provision of £0.8m and £10.8m on pay.

OUR PEOPLE

- Vacancy rates have decreased from 7.3% to 6.5%. This reflects the increase to the EOC budget (73FTE posts).
- Overall turnover has remained at 10.3%.
- The monthly sickness position for December is 5.2%, a decrease from 5.4% in November.

111 service delivery remains safe with no Serious Incidents declared during December. LAS has ranked 1st for % calls abandoned < 30 seconds achieving 0.99%. December saw a drop in the number of journeys with a total of 1,169 journeys being delivered as compared to the November total of 1,410 journeys.

LAS 111 (SOUTH EAST LONDON)

- 111 achieved an overall figure of 89% of calls answered within 60 seconds during December.
- The call demand profile over Christmas and New Year weekends was different to previous years with the greatest demand experienced on 23rd and 30th December. Boxing Day however was quieter than planned.
- Referrals to 999 remain consistently low at 7.96%. This is below the London (10.05%) and National (10.95%) positions. There was also a reduction in referrals to Emergency Treatment Centres compared to previous months.
- LAS has ranked 1st for % calls abandoned < 30 seconds achieving 0.99%. This is also lower than the overall London (3.84%) and national (7.35%) position.
- Direct booking into GP extended opening hours hubs went live for Lewisham and Southwark now giving 50% coverage for SEL CCGs.

LAS IMPROVEMENT

Single Oversight Framework

The purpose of the Single Oversight Framework (SOF) is to identify where providers may benefit from, or require, improvement support across a range of areas. The five themes are: Quality of care, Finance and use of resources, Operational performance, Strategic change, and Leadership and improvement capability.

NHSI segment the provider according to the scale of issues faced.
It does not give a performance assessment in its own right.

1 - Providers with maximum autonomy
2 - Providers offered targeted support
3 - Providers receiving mandated support for significant concerns
4 - Special measures

LAS Current Status	
LAS Shadow Segmentation	4
LAS Breach Status	Breach & Special measures

CQC Overall Rating	Caring	Effective	Responsive	Safe	Well-led
Requires improvement	Outstanding	Good	Good	Requires improvement	Requires improvement

PATIENT TRANSPORT SERVICE

- December saw a drop in the number of journeys with a total of 1,169 journeys being delivered as compared to the November total of 1,410 journeys.
- PTS now have only two contracts operating; St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March 2018.
- Departure against patient ready time saw an increase to 92% for December (87% in November) against the background of activity as given above. This was below the target of 95%.

↑	Increasing concern	↓	Decreasing concern
↑	Increasing negatively	↓	Decreasing negatively
↑	Increasing positively	↓	Decreasing positively
↔	Remains steady	↔	Information only

Key Performance Indicator Report Summary

	Key Performance Indicator	Dec-17	Nov-17	Oct-17	Chart
QUALITY	Adverse Incidents (Patient)	↑	↓	↓	
	Adverse Incidents (Staff)	↓	↑	↑	
	Potential Serious Incidents referred to SI Group	↑	↑	↓	
	Serious Incidents (LAS Declared)	↓	↑	↓	
	Serious Incidents (LAS Declared) Overdue	↓	↑	↔	
	Regular Reporting of Incidents - Shared Learning	↔	↔	↔	
	Total Complaints	↓	↓	↑	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↑	↓	↑	
	Controlled Drug Incidents - Not reportable to LIN	↓	↑	↑	
	All LIN Reportable Incidents	↓	↔	↑	
	Overall Medication Errors	↑	↑	↓	
	Missing Equipment Incidents	↑	↓	↑	
	Failure of Device/Equipment/Vehicle Incidents	↑	↓	↑	
	CPI - Completion Rate*		↑	↓	

	Key Performance Indicator	Dec-17	Nov-17	Oct-17	Chart
111	Calls answered within 60s	↓	↓	↓	
	Calls abandoned after 30s	↔	↑	↓	
	Percentage of calls referred to 999	↔	↑	↓	

	Key Performance Indicator	Dec-17	Nov-17	Oct-17	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↑	↔	↓	
	Vacancy Rate (Frontline)	↑	↑	↓	
	Vacancy Rate (Trust)	↓	↑	↓	
	Turnover Rate (Frontline Paramedic)	↑	↑	↔	
	Turnover Rate (Frontline)	↑	↑	↓	
	Turnover Rate (Trust)	↔	↑	↑	
	Sickness (Trust)	↓	↑	↑	
	Sickness (Frontline)	↓	↑	↑	

	Key Performance Indicator	Dec-17	Nov-17	Oct-17	Chart
PERFORMANCE	A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. The six key performance measures are listed below, which will be monitored in this document. The arrows show the movement in the measures when compared to the performance from the previous month.				
	Cat 1 Mean	↑			
	Cat 1 90th Centile	↑			
	Cat 2 Mean	↑			
	Cat 2 90th Centile	↑			
	Cat 3 90th Centile	↑			
	Cat 4 90th Centile	↑			

	Key Performance Indicator	Q1	Q2	Q3	Q4
FINANCE	Financial Stability Risk Rating (FSRR)	↔	↔		
	Capital Service Capacity	↔	↔		
	Liquidity Days	↔	↔		

	Key Performance Indicator	Dec-17	Nov-17	Oct-17
	Cash Balance - Monthly Profile - £000s	↓	↑	↓
	Income and Expenditure Deficit by Month - £000s	↑	↓	↑
	Income and Expenditure Deficit Cumulative - £000s	↑	↓	↑
	Income Variance from re-phased budget - £000s	↑	↓	↑
	CIP Delivery Against Plan - £000s	↑	↓	↑
	CIP Forecast Against Plan - £000s	↓	↑	↑
	Forecast Capital Spend Against the CRL - £000s	↑	↑	↑
	Debtor Days	↑	↓	↑
	Creditor Days	↔	↔	↔
	Agency spend against plan - £000s	↑	↑	↑

The RAG status is calculated against targets/trajectories/thresholds where available. The Chart column shows the trend over the previous 3 months | The arrows indicate the direction of KPI compared to previous month

A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. These Key PERFORMANCE measures will be included from January onwards and, continued to be monitored in this document.

Executive Summary: Exception Report (Positive)

Safety

- Reduction in number of non-controlled drugs incidents.
- Confirmation from Education Manager that the learning shared by SW Ambulance Service to raise awareness about Sudden Death in Epilepsy (identifying risk factors to help minimise risk) will be used in the Trust's training programme.
- The Trust Medical Director and Chief Quality Officer co-chaired twice daily Safety Huddle conference calls with managers from directorates across the organisation. These meetings were aligned to daily performance cell meetings but maintained a clinical safety and quality oversight focus. Incidents of note were brought to the group for discussion and escalated where appropriate. Assurance was provided by the Clinical Hub and Operations that staffing levels were adequate in order to provide a safe service for the following shift enabling shortfalls to be proactively managed.
- LAS is currently the second highest reporter to the NRLS across the ambulance trusts. It should be noted No & Low harm patient safety incident reporting has increased from 42% to 90% which is well above the national benchmark.

Actions & Assurance

- Ongoing monitoring via Datix system.
- Training plan to be agreed with Education and Training Senior. Manager and rolled out by end of Q4.
- The next training session has 15 managers attending.
- All incidents of note were collated on a spreadsheet and will be included in the clinical safety review being undertaken by the Medical Director.

Effectiveness

- Multi-professional team debrief undertaken with LAS staff and Homerton Hospital ED and Maternity staff following a breech birth at home.
- The Trust provided a weekly bulletin to Acute Trusts detailing expected demand, upcoming events, weather related impact on service delivery, hospital breach data and reiterating the need for hospitals to prioritise the release of ambulance crews by facilitating a rapid handover either through hospital led nurse cohorting or the 'Fit to Sit' initiative.

Actions & Assurance

- CPD event to be undertaken in January 2018 at Homerton Ambulance Station to provide shared learning event with Homerton Hospital midwives.
- Feedback was received from Imperial Heath stating the weekly bulletin was found to be accurate, gave relevant information and became a useful source of information.

Caring

- Letter of thanks received from the Senior Coroner for Inner London South on the comprehensive response to the PFD report sent on 20th November 2017.
- A maternity service user is represented on the Maternity Differentiated Workstream and is keen to be part of working with LAS on a user engagement event.

Actions & Assurance

- Draft proposal for procurement of external facilitation team for maternity engagement event "whose shoes" – Transformation Team to provide support.

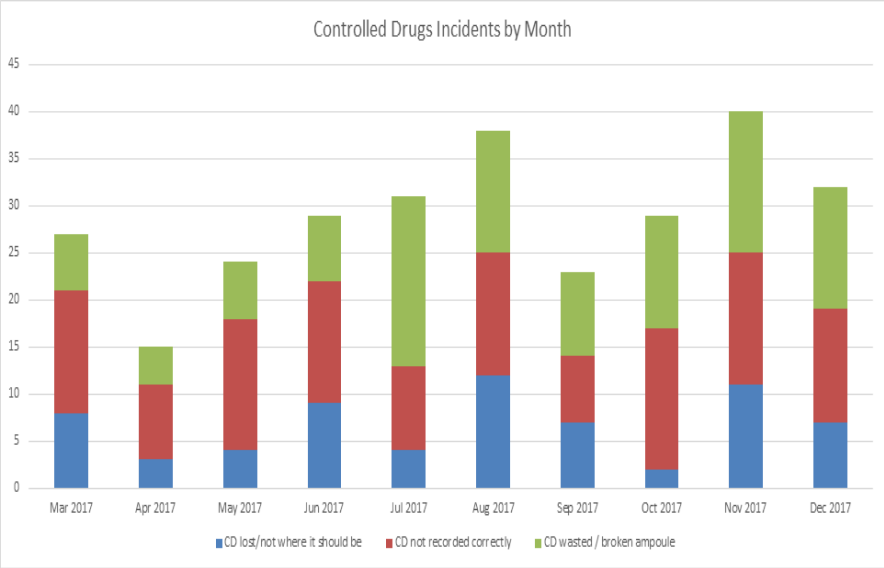
Patient Safety

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	83%	91.4%	98.0%	59.5%	↓			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	2.6	2.7	2.7	↑					
Patient related Adverse Events - NO HARM	1200	G	1957	204	187	178	↓					
Patient related Adverse Events - LOW	30	G	220	18	23	36	↑					
Patient related Adverse Events - MODERATE	25	G	147	13	21	28	↑					
Patient related Adverse Events - SEVERE			61	9	10	8	↓					
Patient related Adverse Events - DEATH			96	8	10	19	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.4	3.5	3.9	2.8	↓					
Staff related Adverse Events - **NONE**			1617	223	218	164	↓					
Staff related Adverse Events - **LOW**			1169	107	136	101	↓					
Staff related Adverse Events - **MODERATE**			58	11	11	8	↓					
Staff related Adverse Events - **SEVERE**			1	0	0	0	↔					
Controlled Drugs - Other Reportable Incidents			255	33	34	31	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	3	1	1	0	↓					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	95%	95%	97%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			285	23	37	39	↑					
Serious Incidents declared in-month			53	3	9	5	↓					
Serious Incidents breaching 60 days	0	G	24	0	2	0	↓					
Serious Incidents breaching 40 days	0	G	27	0	5	0	↓					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			5%	3%	6%	6%	↓					
Needle Stick Injuries as % of Staff Adverse Events			2%	3%	3%	3%	↓					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	3	0	0	0	↔			LQ25	✓	
Safeguarding Adults & Children Level 1 (3 Years)	90%	G	76%	88.0%	79.9%	92.1%	↑					
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	R	79%	76.4%	81.8%	83.8%	↑					
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	48.0%	42.6%	42.0%	↓					
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	57%	56.9%	76.9%	78.4%	↑					
Safeguarding Trust Board (3 Years)	90%	G	79%	78.6%	100.0%	100.0%	↔					
Total Inquests where LAS asked to give evidence - In-Month			53	4	6	4	↓					
Total Inquests where LAS asked to give evidence - Year to Date			268	43	49	53	↑					
Missing Equipment Incidents as % of all reported incidents			3%	4%	3%	4%	↑					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	11%	8%	9%	↑					
Number of NRLS uploads In-Month	1	G	9	1	1	1	↔			LQ21		

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- One unaccounted for loss of 2x ampoules injectable morphine in Dec 2017.
- Total of 31 other controlled drugs incidents including the following:
  - Morphine retained off-duty (n=3)
  - Paramedic drugs pack containing CDs lost (n=1)
  - Documentation errors (n=13)
  - Broken morphine ampoules (n=12)
  - CD safe left open (n=2)
- Other medicine management issues:
  - Medicines in wrong location (n=3) or lost (n=4)
  - Cabinets not secure (n=5) or access code visible (n=1)
  - Confusion over glucagon expiry dates (n=1)
  - Overdoses of ibuprofen (n2), paracetamol (n=1) & ipratropium (n=1)
  - Adrenaline given in hypothermic cardiac arrest (n=3)
  - Wrong drug or dose administered (n=3)

Actions

- Bulletin explaining presence of two expiry dates on glucagon packaging (one relates to manufacturers date and one to shorter shelf life when removed from fridge and placed in LAS drugs packs.
- Implementation of new more comprehensive medicines audit procedures at LSU.
- Increased focus on spot check audits by IRO team and LAS CQC team.
- Purchase of morphine ampoule racks for use in CD safes to reduce incidence of breakages during transfer of ampoules in/out of safe.
- E-learning CSR package during December 2017 emphasising cross checking of drugs prior to administration.

Assurance

- Unaccounted for losses of controlled drugs remain stable and consistent with previous months for which data available.
- No reported PGD breaches during December 2017.
- Reduction in number of non-controlled drugs incidents.
- No incidents of incorrect dose with 1:1,000 adrenaline.
- Progress of secure drugs on stations project will continue to further enhance medicines management within the Trust.
- It should be noted that the hypothermic cardiac arrests were not due to environmental factors (i.e. exposure to extremes of temperature) but were a natural result of death whereby upon review the patient had been deceased for longer than first thought.

Effectiveness (Clinical Measures) Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Sep-17	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	30%	31%	36%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	42%	42%	62%		↑			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	74%	74%	73%		↓			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	64%	60%	59%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:31		↓					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:41	00:40	00:36		↓					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	93%	92%	94%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	6.0%	9.9%	14.4%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.3%	97.3%	97.0%		↓		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	91.0%	92.0%	92.0%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	96.0%	96.0%	97.0%		↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%			↑		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%		97%		↔			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	90%	89%	87%	92%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						19%	30%	↑			LQ11	✓	

Assurance

In November, LAS CPI completion increased for the first time in three months. Team Leaders audited 49% of the PRFs available, with a further 44% audited by other members of staff. CARU trained eight members of staff on restricted duties on how to undertake CPI audits in November, as well as one Team Leader and one Team Coordinator. Five student paramedics from the LAS Academy were also trained on the CPI process and the content of the CPIs.

Caring

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	96%	67%	100%	↑			LQ27	
Friends and Family Test Response Rate			1.8	0.0	0.0	0.0	↔			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	116	19	15	24	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.81	1.0	0.9	0.9	↓			LQ29c	
Positive Feedback Compliments			838	91	90	80	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	8.0%	7.6%	6.6%	↓				
Mental Health related MPS calls as percentage of all calls			2%	2.2%	2.0%	1.7%	↓				
Mental Health related Incidents as percentage of all calls			5%	5.4%	4.9%	3.7%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.2%	↓				
Rate of Frequent Callers per 1,000 Calls			3.11	3.3	3.6	3.2	↓				
CMC records viewed			3012	291	778	1458	↑			LQ30	

Assurance

Since the CMC app was included on iPads, the number of CMC records reviewed have continued to increase month on month and reached a record 1,458 in December 2017. With plans for CMC to be used Pan London endorsed by all 32 CCG and standardisation of Patient Specific Protocol (PSP), it is envisaged that records access will significantly improve for specialist patient groups.

Public Engagement

Owner: Margaret Luce | Exec Lead: Dr. Trisha Bain

Events on database	Events attended	Interested staff
19	12	1229

National Guardians Office CPR Information Session – 11th December 2017
"Thank you very much indeed for the first aid and CPR/ AED training. I really enjoyed it and the team told me that they felt much more confident in dealing with an emergency. It was great that everyone had the opportunity to practice CPR and to see how straightforward the defibrillator is. Also, the information and training on choking and stroke were invaluable.
As a medic, I am always keen that everyone is aware, able and ready to assist and your training really supported this for my team."
Junior Police Cadets 13th December 2017
"Very, very well received. Very poplar presenter. The BEST we have welcomed. All the cadets were engaged and included, even the quiet ones could not resist joining in."

Key Updates

- On 7th December we held an event for our Partnership Reference Group, which is made up of representatives from Healthwatch groups and voluntary sector organisations across London. We gave them an overview of our new strategy and invited their feedback on key areas. Their ideas and contributions are being fed into the final version of the strategy.
- We have updated the presentation we deliver to primary school children for their "Work Week" topic, and can now show images of our vehicles and equipment on the interactive white boards in their classrooms. For the teenagers we are constantly enhancing and updating the Knife Crime presentation we deliver to make it more interactive, and this has received positive feedback.

Staff Awards

- Incident Response Officer Andy Beasley received a commendation at the first ceremony celebrating the work of the 3 police forces serving London (Metropolitan Police Service, British Transport Police & City of London Police) recognising the efforts of officers, emergency service staff and members of the public. Andy was recognised for his bravery at the London Bridge terrorist attack for which he was one of the first people on scene and described working through gunfire whilst setting up a casualty clearing stations and command structure.
- A member of staff from the service recently joined a group of volunteers in a visit to India where they delivered lifesaving first aid training to people in several regions including 2 schools. Since returning from the trip the team received a commendation from the Asian Fire Service Association at an awards ceremony in Slough.

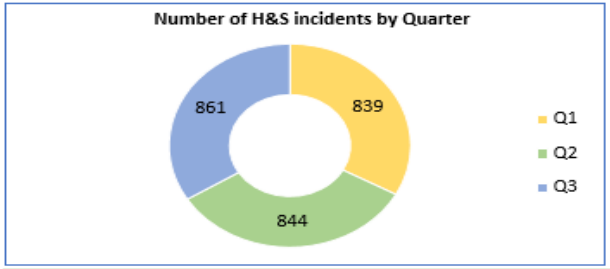
Staff Recognition

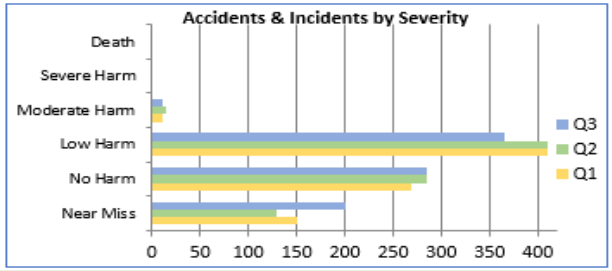
- An amazing 1,231 letters and messages of thanks were received by the Trust in 2017 – with some sent by people as far away as Japan and the United States of America.
- Senior Paramedic Ben Woodhart has been named #AuditHero for his work and involvement in research and clinical audit in particular the introduction of the Clinical Audit and Research Unit Engagement Facilitator in order to bridge the learning gap.
- The Archbishop of Canterbury visited the service in December to give thanks and to hear staff experiences following the major incidents of 2017. The Archbishop met frontline and control room staff along with members of the service Christian Fellowship.

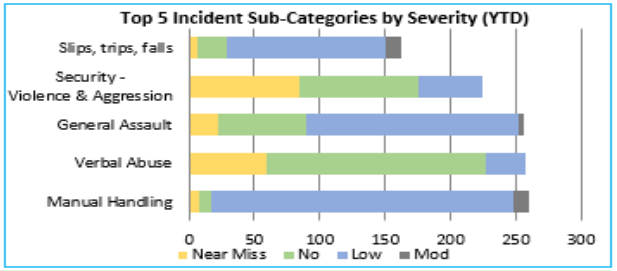
Health & Safety

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Health & Safety Scorecard – Q3 (December 2017)







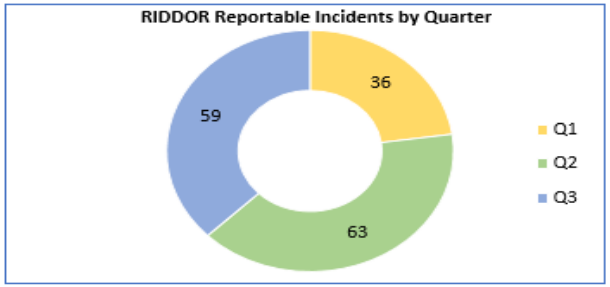
2544 health and safety related incidents have been reported during 2017/18. 91 additional incidents (covering Q1 & Q2) were identified during Q3. Total YTD H&S incidents account for 40% of all incidents reported Trust-wide during the year.

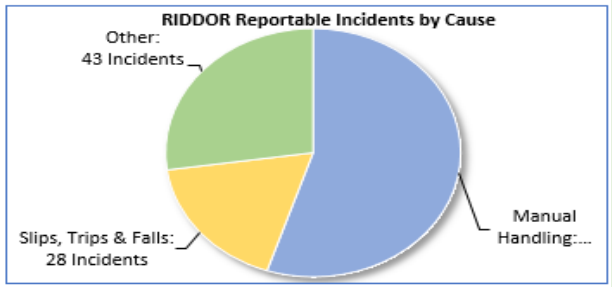
1192 (46.8%) of the H&S related incidents reported during 2017/18 resulted in low harm. 36 (1.4%) incidents resulted in Moderate Harm. 1316 (52%) of the incidents were reported as 'No Harm/Near misses'.

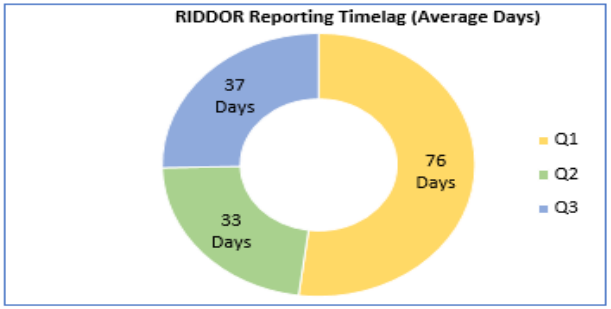
Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

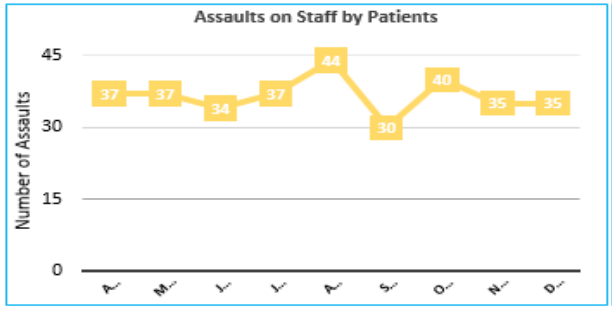
Key Updates:

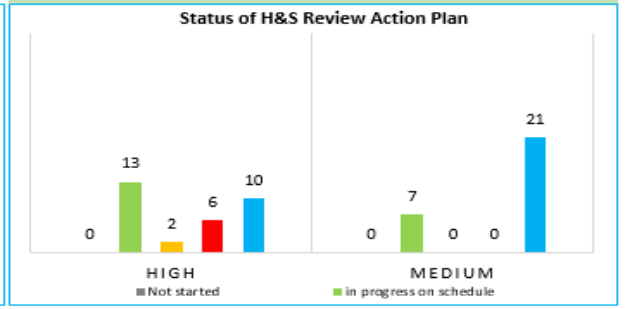
1. Key training in practical MH commenced on 04/12/2017 for 44 Clinical Tutors. Additional sessions have been planned for 36 tutors and will be completed by 31/01/2018.
2. Practical MH refresher training will be provided for all frontline operational staff from CSR 1 – April 2018.
3. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Color categorization of Mangar Elks to commence by end of January 2018. 12 weekly maintenance plan has been implemented for all equipment including tail lifts and track chairs. This will be supported by 6 weekly visual inspection checks to identify and rectify faults/defects.
4. No trends identified with increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
5. Prototypes of the proposed integrated Vehicle based ALS and first response bags to go on trial from 22/01/2018.
6. Dynamic Risk Assessment Training rolled-out to all frontline staff as part of MAST training during CSR 2 – 2017.











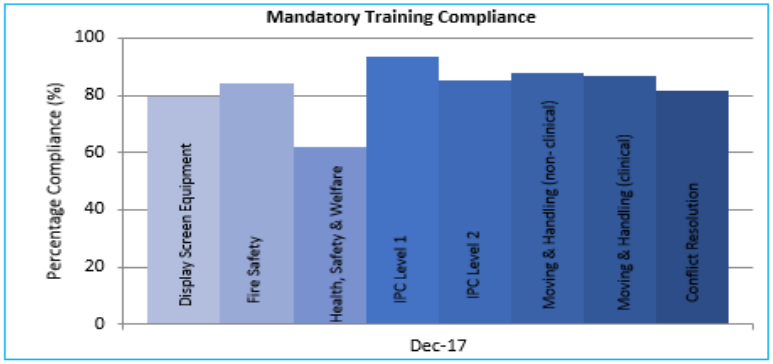
7. The average time lag for reporting RIDDOR incidents across the Trust in Q3 was 37 days. This exceeds the average time lag of 33 days during Q2 as well as the statutory reporting timeline of 15 days for most RIDDOR incidents. 35 RIDDOR incidents were reported out of time in Q3.

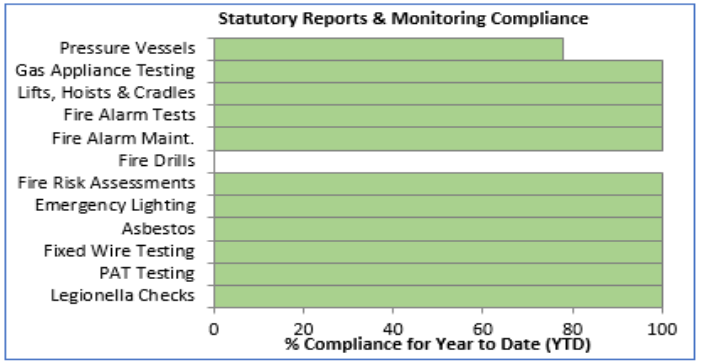
8. Assaults on staff by patients make up 31% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required.

9. 31 of the 59 actions recommended have been completed.
   - 22 actions are currently in progress with 5 actions due to be completed by 31/01/2018.
   - **2 actions are overdue.**

Health & Safety

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain





Trust-wide compliance in December 2017 for 5 out of the 8 mandatory health and safety training courses was below 85%.

The H&S Dept. is reviewing arrangements to improve the inconsistent practice and Trust-wide compliance with statutory fire drills.
All sites have been asked to nominate fire marshals who will be trained in Q4 to support the department with maintaining compliance.

The H&S Team are also liaising with an external contractor regarding the review of fire risk assessments and maintenance of equipment.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Target Risk Rating	Key changes/updates since last review
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	15	15	9	Key training in practical MH has been provided to Clinical Tutors in December 2017. Training to be completed in January 2018. Practical MH refresher training to be provided from CSR 1 – April 2018. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – to be tabled for approval at January H&S Committee meeting.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	3	The average time lag for reporting RIDDOR incidents across the Trust in Q3 is **37 days.** There are still inconsistencies in RIDDOR reporting however, these are reviewed with the relevant Managers in order to address the gaps.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Risks approved by H&S Committee and RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q4, 2017-18.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is currently under review.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 key complaints themes : December 2016 to December 2017

Complaints by subject 2015/17	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Delay	19	36	16	27	21	17	16	14	26	9	22	33	19	275
Conduct	15	26	27	36	16	19	24	19	19	16	17	25	20	279
Road handling	8	7	9	16	12	11	13	14	10	7	14	9	7	137
Treatment	1	3	3	5	1	2	5	1	7	5	16	8	9	66
Non-conveyance	1	1	3	4	3	0	4	12	0	1	6	1	7	43
Total these subjects	44	73	58	88	53	49	62	60	62	38	75	76	62	800
Overall totals	58	90	74	105	66	70	76	73	86	51	94	85	84	1012

Complaint summary April 2017 to December 2017

- Of all the complaints received to 31 December 2017, 106 remain under investigation or have been re-opened.
- Of these, 24, were over 35 working days as at 03 January. Reduced staff numbers due to annual leave and sickness impacted on turnaround and complaint numbers have risen in recent weeks.
- Of the 84 complaints received in December, 64 remain under investigation, 13 were actioned or referred to other agencies, 6 were not upheld and 1 was partially upheld.
- The highest number of complaints by sector was EOC x 19 followed by South East x 13 and NHS 111 x 11.
- Winter measures remain in place and continue to impact on completion of QA reports, operational input and clinical reviews. It is anticipated that this will improve from 08 January.
- Our revised trajectory for complaint totals based on current numbers is 930 for 2017/18.
- We have noted that a number of complaints about driving standards relating to our Make Ready contractor using LAS vehicles has been received.

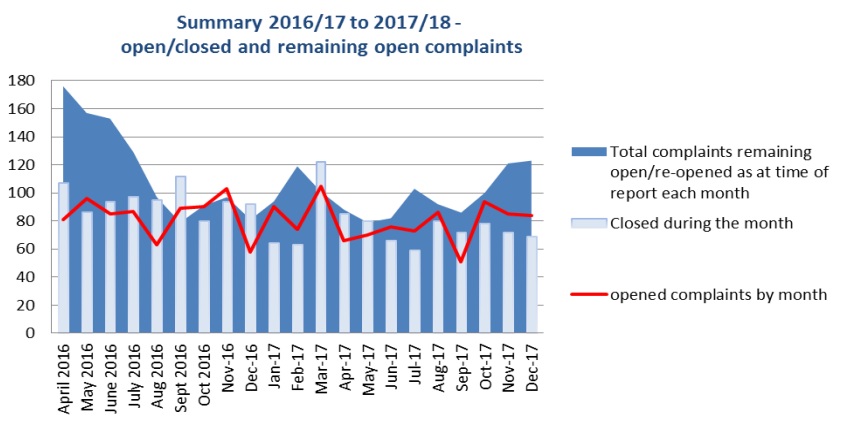
Actions

- During December we received 84 complaints which included 6 from other Health Care Professionals on behalf of the patient.
- This represents a slight decrease over November but a 31% increase over December 2016 (58 complaints).
- Since 01 November 2017, 7 complaint cases have been referred to the Serious Incident Group (one not declared – outcome of x6 awaited).
- During November to December we have been managing a number of Quality Alerts, of these 2 related to Cat 1 ARP, 6 to Cat 2 ARP and 2 Cat3/4.
- We are planning a launch of the Quality Alert process in April 2018, liaising with G&A and QGAM's and updating the website.
- Of the 104 complaints where the call was between 01 November to 31 December , the split of call categories was as follows:

ARP Cat 1 x 7 complaints, ARP Cat 2 x 43 complaints, ARP Cat 3 x 17 complaints, ARP Cat 4 x 18 complaints, not CAD related x 18

- A summary report of complaints post ARP will be shared with G&A.

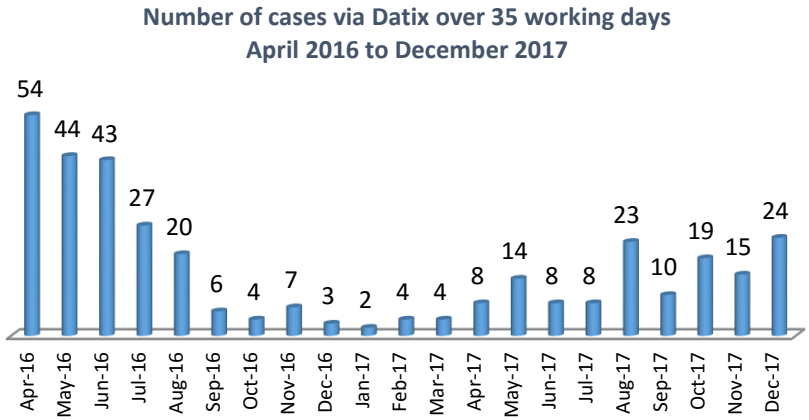
Assurance and learning



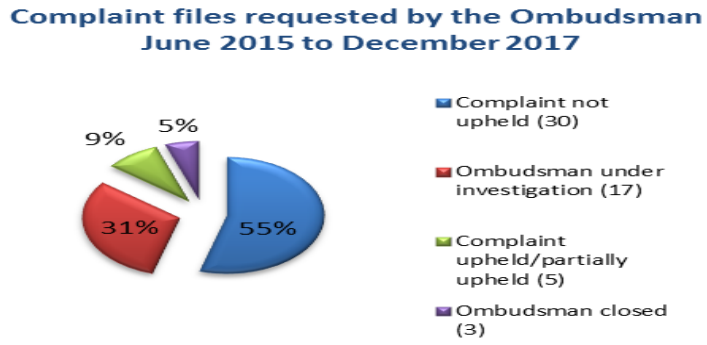
Learning from Complaints

Owner: Gary Bassett| Exec Lead: Dr. Trisha Bain

Performance against 35 day response target



Overview of Ombudsman cases 2015-2017



Assurance and Learning – Case examples

Case example one

Complaint hosted by Acute Trust from the patient who has raised concerns that the attending ambulance staff appeared to question why an ambulance had been called when he suffered an Achilles injury.

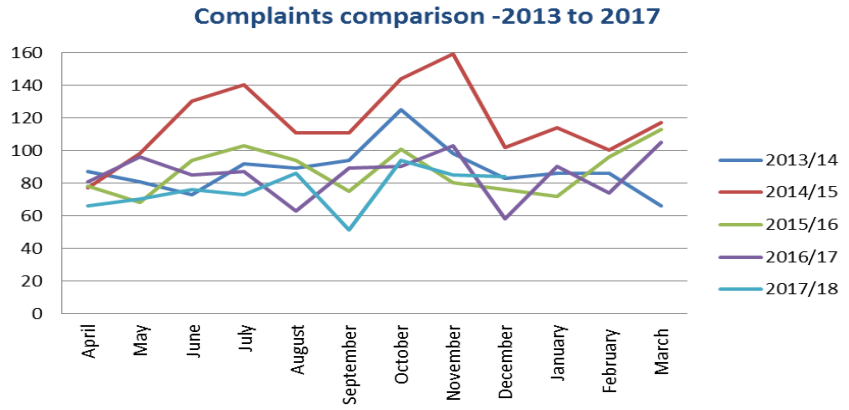
The paramedic acknowledged that he made a comment about it not being a ruptured Achilles tendon based on the fact the patient was not in acute distress and accepts that although he did not mean to be derogatory, this was inappropriate.

Case example two

Complaint from child's mother that she was declined an ambulance for her daughter despite her symptoms.

The Quality Assurance evaluation concludes that the call handler made an error of judgement when applying the initial clinical triage protocol. Although call handlers do not have any clinical expertise, they are trained to ask a series of structured questions to progress through the triage process in order to assess the patient's condition and to determine the appropriate level of priority response. In this case, the 'Heart problems/AICD' protocol should have been applied which would have indicated a Category 2 priority, although priority would still have been given to patients determined at a higher categorisation.

Assurance and learning



PERFORMANCE EXECUTIVE SUMMARY
Ambulance Response Programme Overview

Since February 2015, three other ambulance services - South West, Yorkshire and West Midlands - have been involved in trials led by NHS England of the new standards. They focused on four main areas:

- Identifying the most seriously ill patients as early as possible through processes known as Pre-Triage Sieve and Nature of Call.
- Giving control room staff more time (up to 240 seconds) to assess incidents through a process known as Dispatch on Disposition.
- Developing new clinical code sets and response categories using the best available clinical evidence.
- Developing new targets, indicators and measures.

The trials have also been independently reviewed by the University of Sheffield.

Category	Percentage of calls per Category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	• 7 minutes mean response time • 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 30 seconds from the call being connected	The first emergency vehicle that arrives on scene stops the clock.(There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	• 18 minutes mean response time • 40 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 3	34%	• 120 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 4	10%	• 180 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

The new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response
- Ensure national response targets to apply to every patient for the first time – so ending 'hidden waits' for patients in lower categories
- Ensure more equitable response for patients across the call categories
- Improve care for stroke and heart attack patients through sending the right resource first time.

Due to the nature and impact of these changes, the previous performance measures are not comparable. However, NHS England have published National Standard for a number of the key measures which are included here.

PERFORMANCE EXECUTIVE SUMMARY
Ambulance Response Programme Overview

Category	Measure	LAS Monthly Performance	National Standard	Variance
Category 1	Mean Response Time	**00:07:25**	7 minutes	**00:00:25**
	90th centile	**00:12:04**	15 minutes	**00:02:56**
Category 2	Mean Response Time	**00:24:14**	18 minutes	**00:06:14**
	90th centile	**00:51:14**	40 minutes	**00:11:14**
Category 3	90th centile	**02:58:23**	120 minutes	**00:58:23**
Category 4	90th centile	**02:51:44**	180 minutes	**00:08:16**

EXECUTIVE SUMMARY
Ambulance Response Programme - Summary

	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
Reporting Month (Dec-17)	00:07:25	00:12:04	00:24:14	00:51:14	02:58:23	02:51:44
Previous Month (Nov-17)	00:07:03	00:11:28	00:18:25	00:36:28	02:13:10	02:28:48

Demand

- **97,934** Incidents were provided with a face-to-face response.
- In December **8,551** incidents were categorised as **Category 1** and were provided with a face-to-face response.
- There were **56,506 Category 2** patients receiving a face to face response.
- There was a **4.7% increase** in demand from November to December.

Performance

- The Mean response time for C1 was **7 minutes 25 seconds**.
- The C1 90th Centile was **12 minutes 4 seconds**.
  This has remained **within the 15 minute** national standard each **week** since the implementation of ARP.
- The Mean response time for C2 was **24 minutes 14 seconds**, this is above the 18 minute national standard.

The Trust's performance during the busiest times in December was significantly stronger than in previous years. This was the first year that the Trust's performance was recorded under the new Ambulance Response Programme (ARP) standards and, in December, the Trust was ranked 1st in the Category 1 90th centile performance measure when compared to all other ambulance services nationally.

New Year's Eve weekend saw a strain of nearly 400 calls per hour. Furthermore, the Trust was also able to support other ambulance services when they were receiving high levels of call volume.

EXECUTIVE SUMMARY
Ambulance Response Programme Overview - Categories

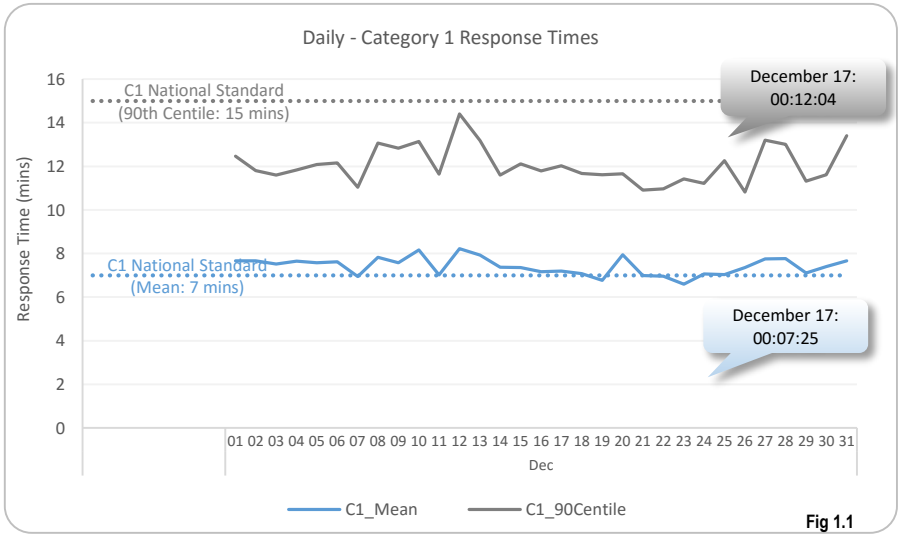


Fig 1.1

Category 1

The NEW Category 1 (C1) measure comprises of approximately 8% of all incidents and covers a wider range of conditions than the former Red 1 category. These will be responded to within an average time of seven minutes.

Fig 1.1 shows the time taken to respond to patients triaged as Category 1 (C1)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 15 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
  - The dotted blue line shows the National Standard of 7 minutes average (mean) response time.

The C1 mean response time in December was **00:07:25**. This is marginally above the 7 minute standard.

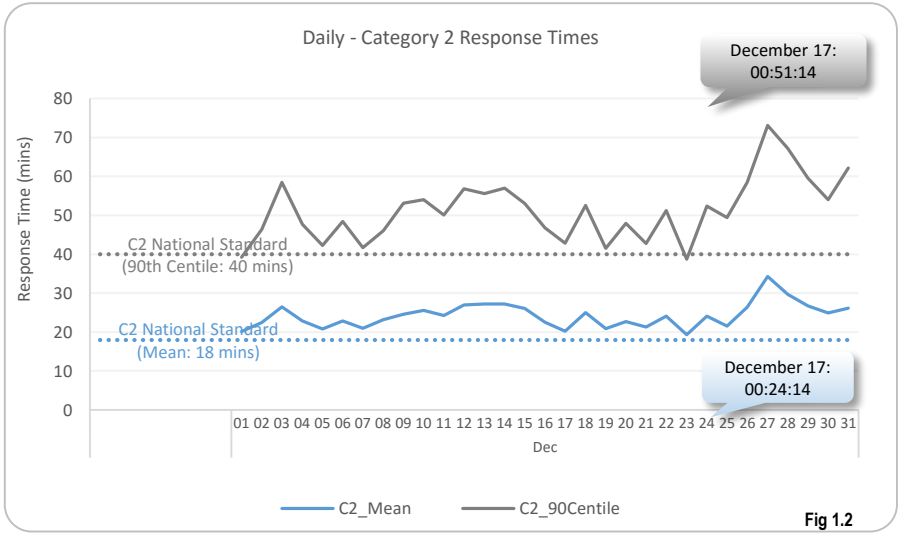


Fig 1.2

Category 2

The NEW Category 2 (C2) measure comprises of approximately 48% of all incidents. These will be responded to within an average time of 18 minutes.

Fig 1.2 shows the response time for patients triaged as Category 2 (C2)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 40 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
  - The dotted blue line shows the National Standard of 18 minutes average (mean) response time.

The C2 mean response time in December was **00:24:14**. This is above the 18 minute standard.

EXECUTIVE SUMMARY
Ambulance Response Programme Overview - Categories

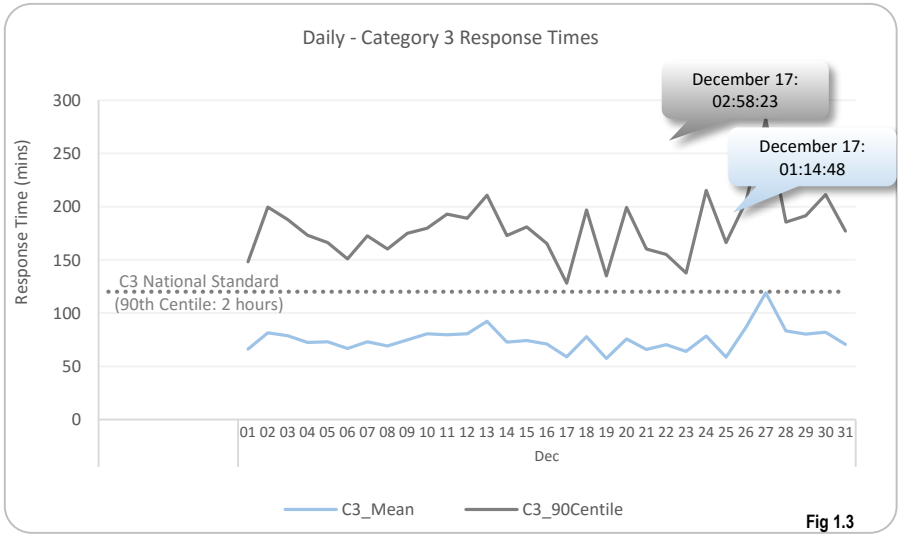


Fig 1.3

Category 3

The NEW Category 3 (C3) measure comprises of approximately 34% of all incidents.

Fig 1.3 shows the time taken to respond to patients triaged as Category 3 (C3)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 120 minutes (2 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
  - There is no National Standard for the mean response time.

The C3 90th centile response time in December was **02:58:23**. This is above the 2 hour standard.

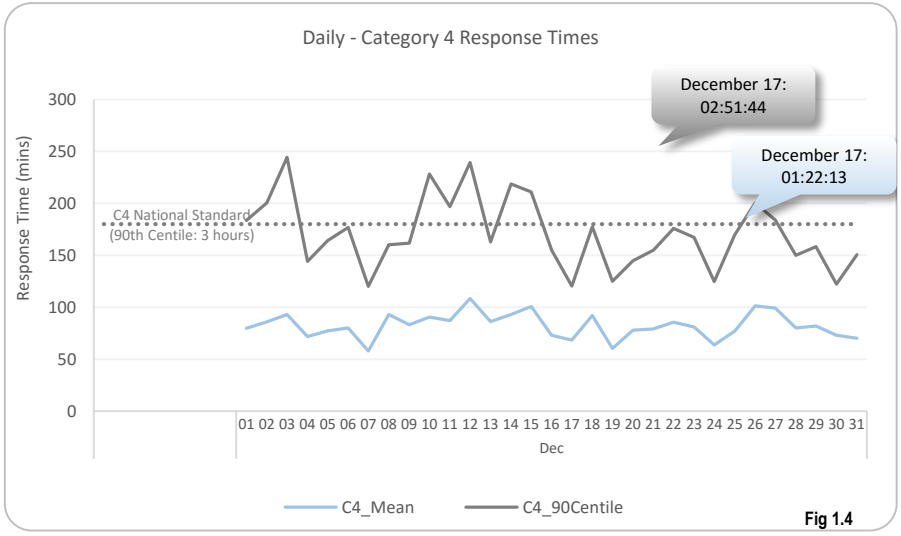


Fig 1.4

Category 4

The NEW Category 4 (C4) measure comprises of approximately 10% of all incidents.

Fig 1.4 shows the response time for patients triaged as Category 4 (C4)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 180 minutes (3 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
  - There is no National Standard the mean response time.

The C4 90th centile response time in December was **02:51:44**. This is within the 3 hour standard.

EXECUTIVE SUMMARY
Ambulance Response Programme Overview – Category Demand

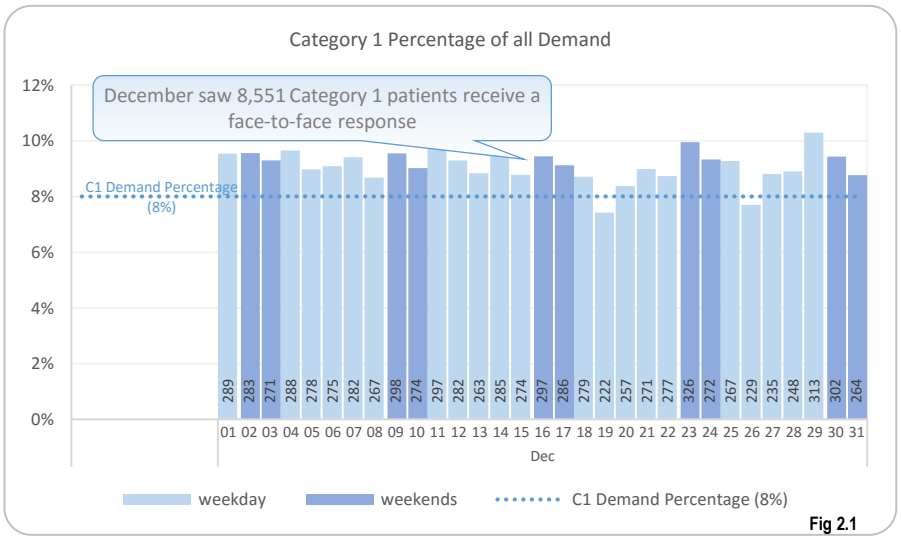


Fig 2.1

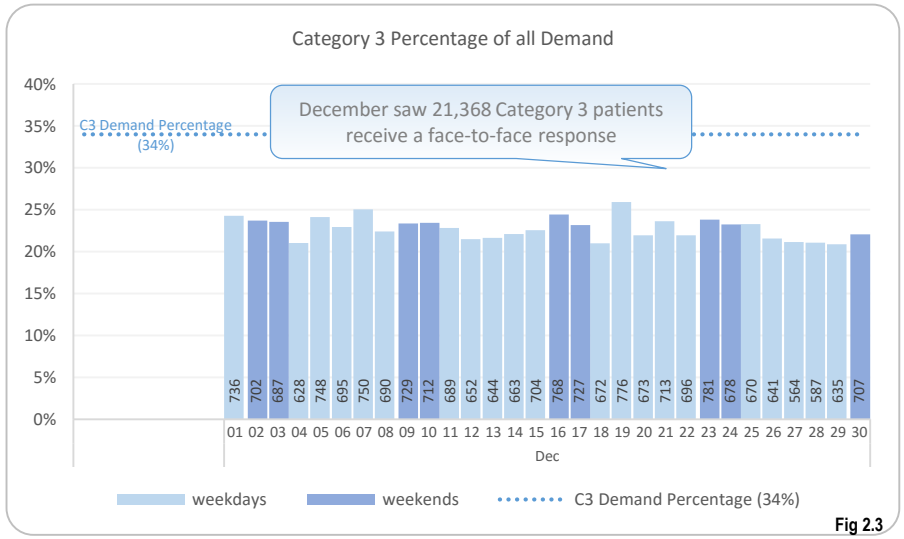


Fig 2.3

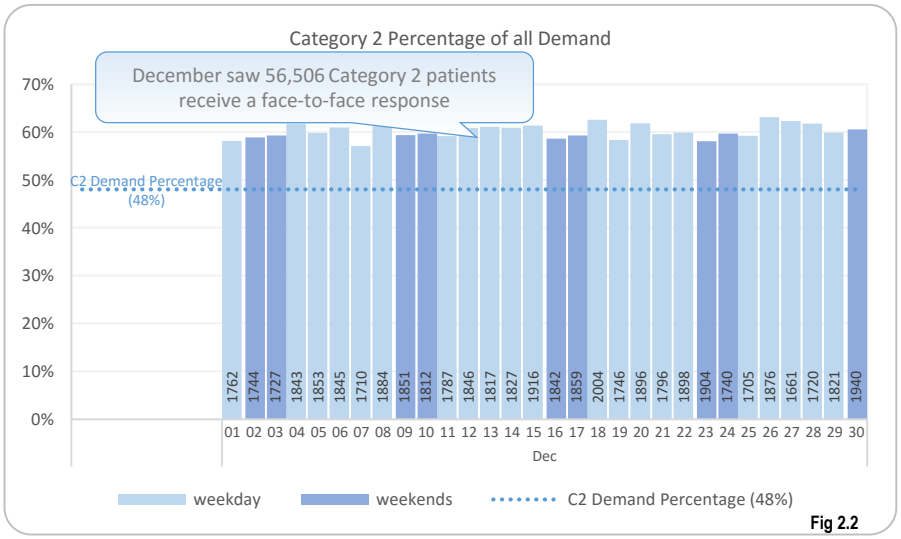


Fig 2.2

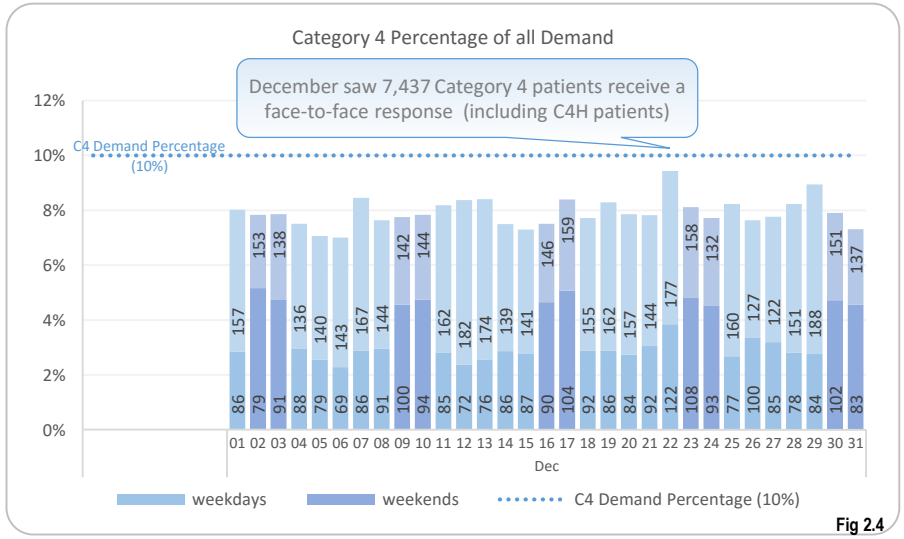


Fig 2.4

EXECUTIVE SUMMARY
Ambulance Response Programme Overview – 90th Centile

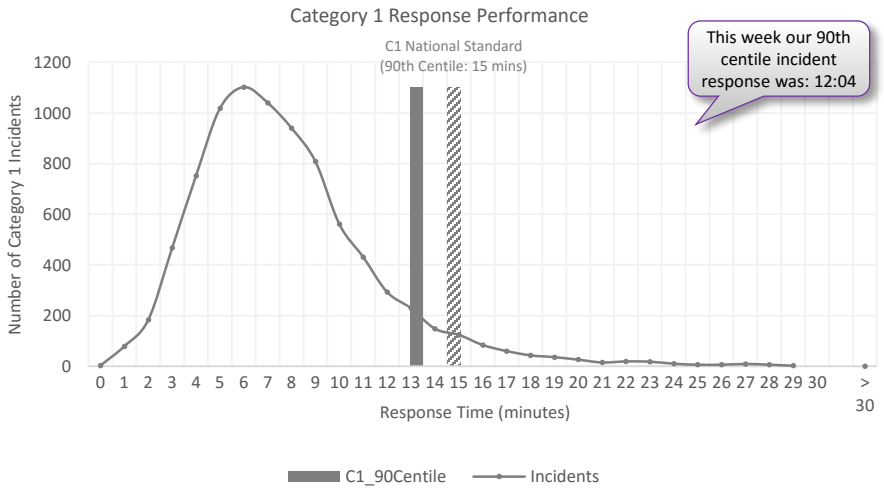


Fig 3.1

- Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The 90th centile response time in **December** was **00:12:04** minutes, within the 15 minutes National Standard as set out in the guidelines by NHSI.

Of the 8,551 incidents requiring a Category 1 response, 7,695 incidents received a face to face response within 00:12:04 minutes.

The LAS 90th centile has been **consistently within the 15 minutes** standard **each week** since ARP was implemented.

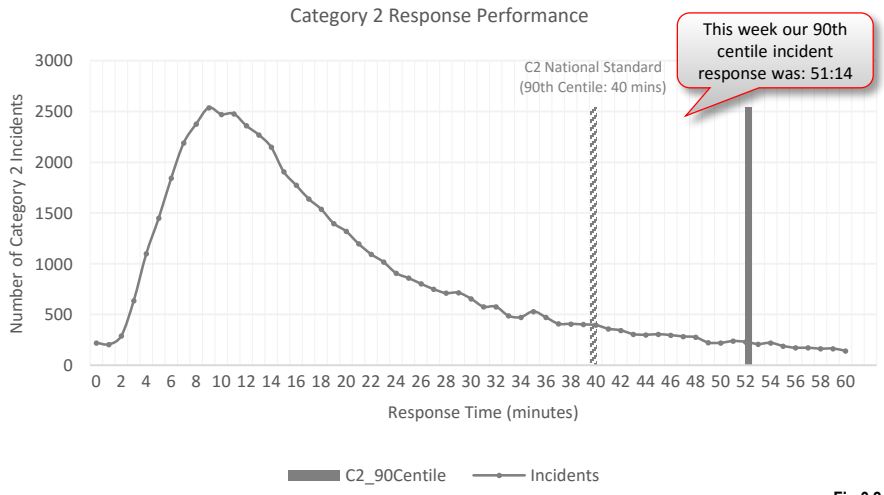


Fig 3.2

- Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The 90th centile response time in **December** was **00:51:14** minutes, above the 40 minutes National Standard as set out in the guidelines by NHSI.

Of the 56,506 incidents requiring a Category 2 response, 50,855 incidents received a face to face response within 00:51:14 minutes.

EXECUTIVE SUMMARY
Ambulance Response Programme Overview – 90th Centile

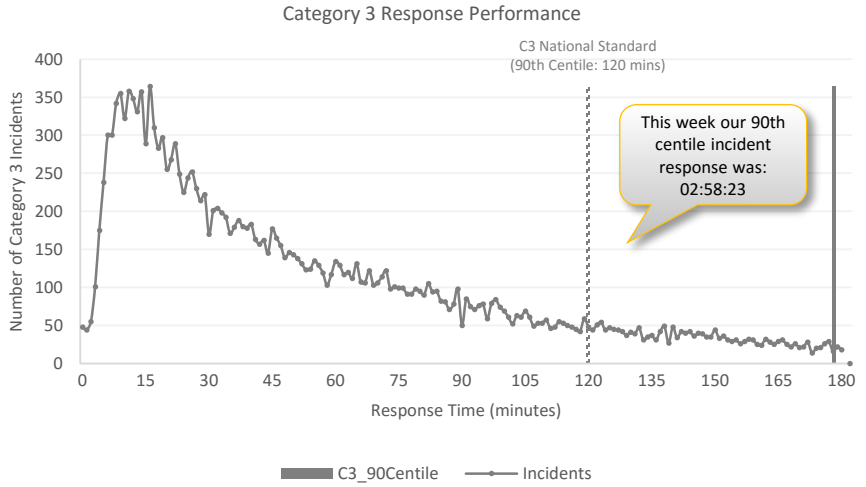


Fig 3.3

- Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The LAS 90th centile response time in **December** was **02:58:23**
This is above the 120 minutes (2 hours) National Standard as set out in the guidelines by NHSI.

Of the 21,368 incidents requiring a Category 3 response, 19,312 incidents received a face to face response within 02:58:23 minutes.

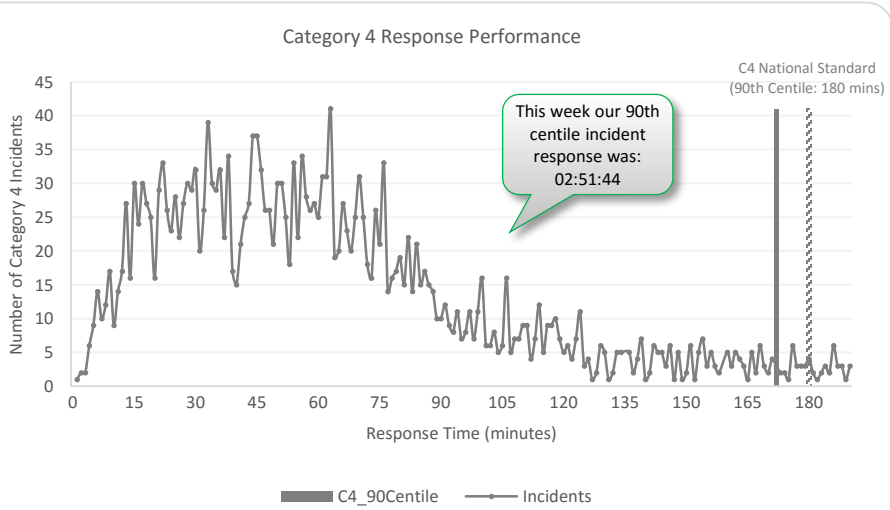


Fig 3.4

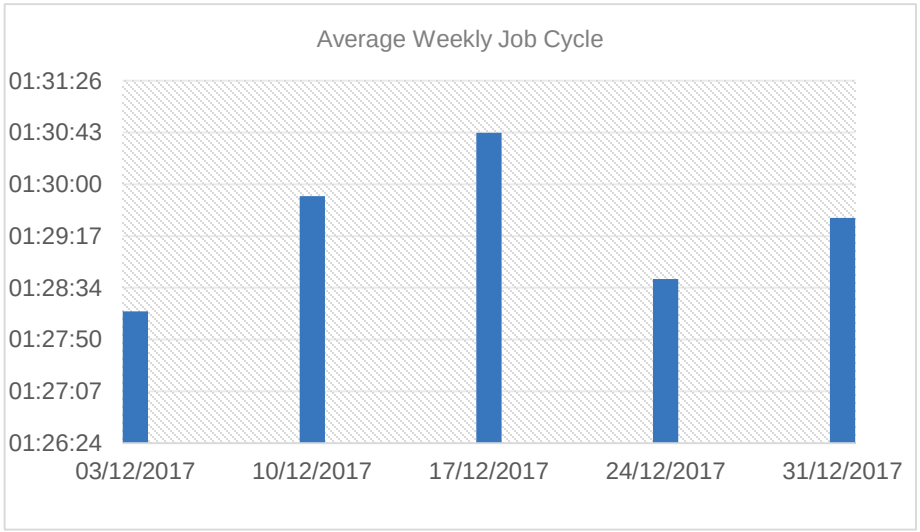
- Fig 3.2 Demonstrates the response distribution for Category 4 incidents.

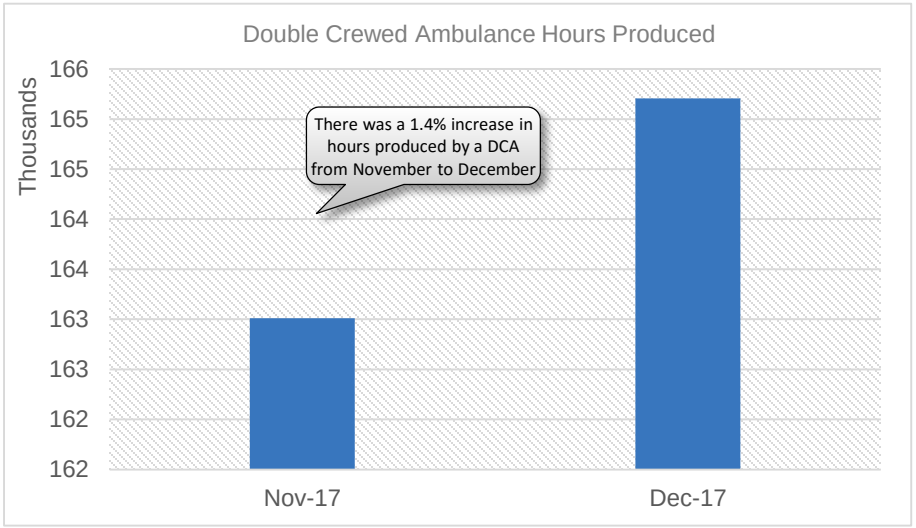
The 90th centile response time in **December** was **02:51:44** minutes, within the 3 hours National Standard as set out in the guidelines by NHSI.

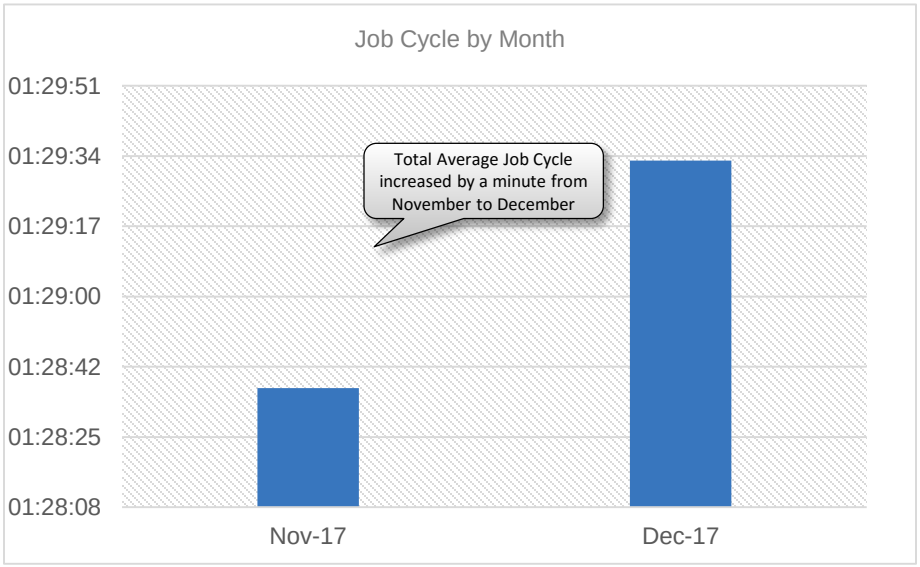
Of the 2,749 incidents requiring a Category 4 response, 2,474 incidents received a face to face response within 02:51:44 minutes.

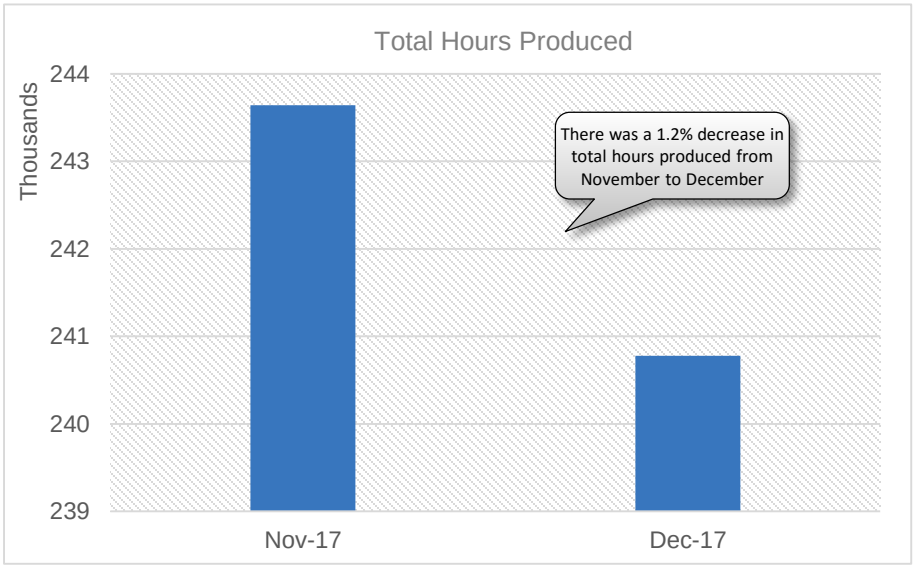
The LAS 90th centile has been **within** the 3 hours standard for 10 **weeks** since ARP was implemented.

Job Cycle & Capacity
Ambulance Response Programme









EXECUTIVE SUMMARY
Ambulance Response Programme – National Picture

December 2017

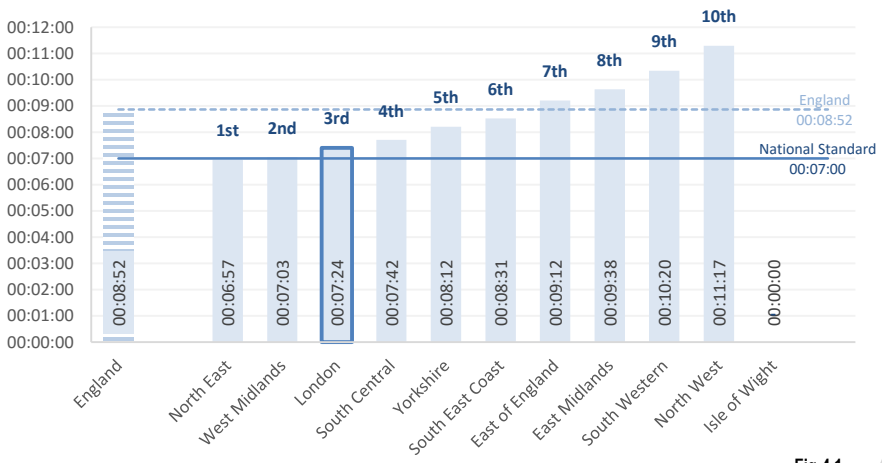


Fig 4.1

■ Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England during December 2017.

Additional information also displayed :
The National Standard (00:07:00)
The average for England (00:08:52).
The ranking position for each Trust *

- LAS achieved **7 minutes and 24 seconds** as the **mean** response time for **Category 1** patients. This is marginally above the 7 minute national standard.
- LAS ranked **third** when compared to 10 Ambulance Trusts across England.
- LAS also performed **within** the England average by **1 minute and 28 seconds**.
- One Trust performed within the National Standard at 00:06:57 (North West).

* Isle of Wight excluded due to lack of data

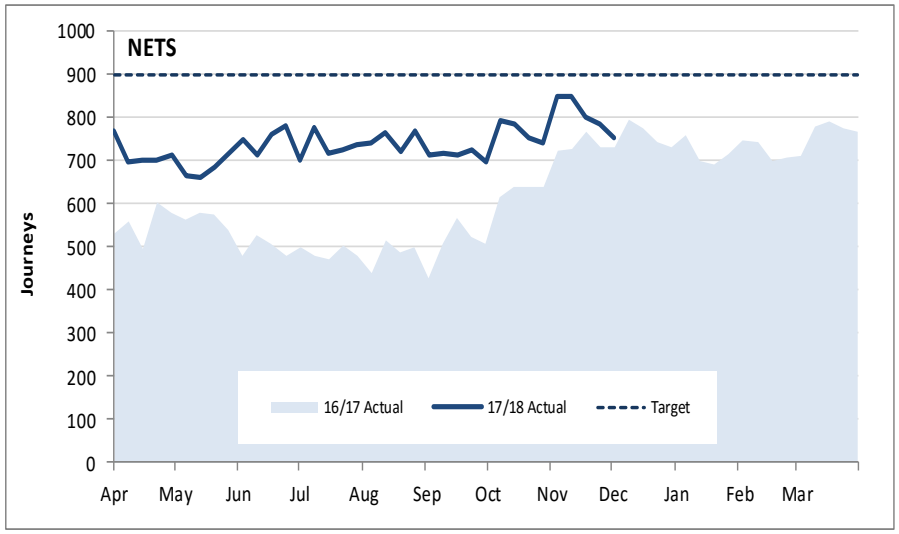
Fig. 4.2 Displays the six key ARP performance measures for each Ambulance Trust across England during December 2017.

- **LAS ranked 1st** in the **Category 1 90th centile** performance measure, compared to the other Trusts.
- For **Category 4 90th centile**, **LAS ranked 2nd** compared to the other Trusts.

December 2017	Category 1	Category 1	Category 2	Category 2	Category 3	Category 4
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00
England	00:08:52	00:15:25	00:29:41	01:03:14	03:06:35	04:07:35
East Midlands	00:09:38	00:17:11	00:39:29	01:26:08	03:59:57	04:42:22
East of England	00:09:12	00:16:44	00:32:04	01:05:07	04:40:34	05:14:02
London	00:07:24	**00:12:04**	00:24:11	00:51:11	02:58:56	**02:51:49**
North East	00:06:57	00:12:10	00:28:52	01:00:23	05:17:41	03:36:38
North West	00:11:17	00:18:37	00:44:49	01:43:58	02:54:47	03:33:35
South Central	00:07:42	00:14:27	00:19:08	00:39:01	02:53:18	04:09:38
South East Coast	00:08:31	00:15:16	00:18:41	00:34:58	03:47:52	05:59:15
South Western	00:10:20	00:18:38	00:37:06	01:16:59	03:37:01	04:55:31
West Midlands	00:07:03	00:12:10	00:13:12	00:24:16	01:32:56	02:46:15
Yorkshire	00:08:12	00:14:19	00:27:58	01:00:47	02:41:47	04:22:05
Isle of Wight	-	-	-	-	-	-

Fig 4.2

Non-Emergency Transport Service

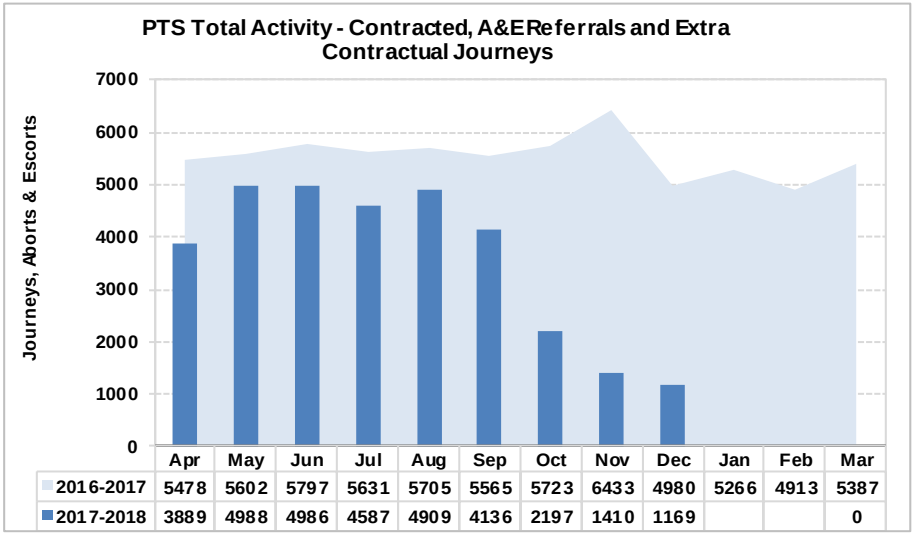


Non-Emergency Transport Update

- NETs saw an increase in the month. NETS delivered an average of 844 journeys per week for the month, up from the previous month average of 805.
- During December we saw the NETS overall weekly performance peak in the first three weeks and then decline in line with the impacts of resources, activity levels and waiting times.
- The team maintained its continued focus in ensuring the quality and number of calls to the NETS dispatch group was maintained. The average number of calls passed to NETS also increased from last months 1,098 per week to 1,179 calls per week for the month.
- Performance continued to suffer due to increasingly lengthy handover times at hospitals with specific issues with North West London hospitals.
- From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETS and completed.

Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
06/11/2017	1185	13	327	845
13/11/2017	1095	14	275	806
20/11/2017	1114	19	312	783
27/11/2017	1044	15	279	750
04/12/2017	1116	8	258	850
11/12/2017	1221	20	325	876
18/12/2017	1261	23	355	883
25/12/2017	1118	14	337	767

Patient Transport Service – Activity and Profitability Update



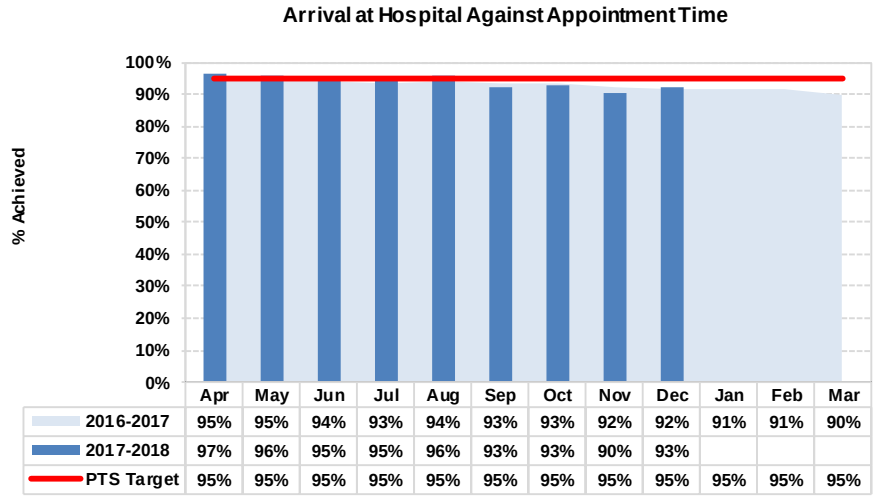
December saw a drop in the number of journeys with a total of 1,169 journeys being delivered as compared to the November total of 1,410 journeys.

The drop in journeys was the result of the impact of the Christmas break in reducing the number of working days when transport was provided.

PTS now have only two contracts operating; St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March 2018.

Month	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Apr	15044	13227	8495	5478	3889
May	15987	13164	7943	5602	4988
Jun	14852	10129	8967	5797	4986
Jul	16481	10508	8923	5631	4587
Aug	14401	9028	5457	5705	4909
Sep	15002	9602	6097	5565	4136
Oct	16739	10957	5841	5723	2197
Nov	15981	10063	5989	6433	1410
Dec	13986	9250	4943	4980	1169
Jan	16409	9753	5103	5266	
Feb	15232	9787	5306	4913	
Mar	13978	10520	5264	5387	
Total	184092	125988	78328	66480	32271

Patient Transport Service – KPI Update

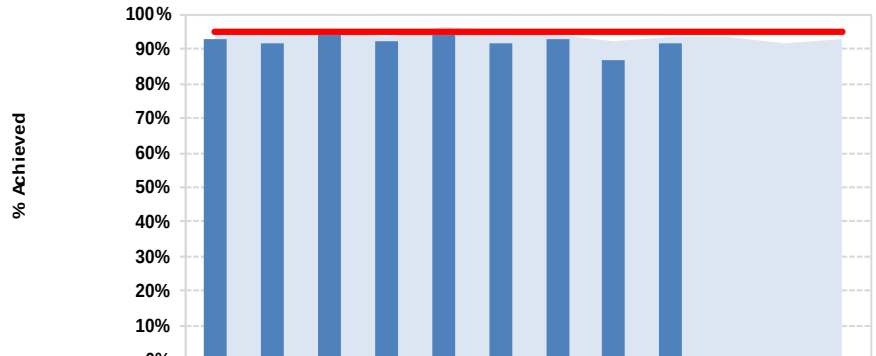


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	95%	95%	94%	93%	94%	93%	93%	92%	92%	91%	91%	90%
2017-2018	97%	96%	95%	95%	96%	93%	93%	90%	93%			
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

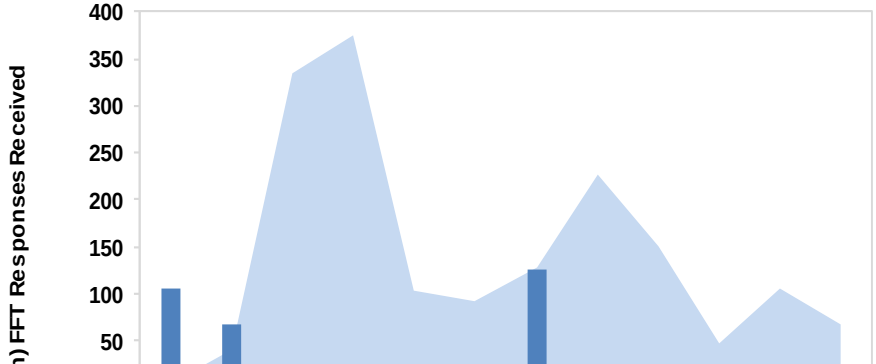
The arrival at hospital against the appointment time increased by 3% to 93% in December considering the drop in overall activity for the month.

Our activity profile is linked to one of the remaining two contracts where we are providing transport in the community settings with longer distances and spread of care centres where patients are being taken to.

Departure against patient ready time also saw an increase from the 87% we had in November back to 92% for December against the background of activity as given above. This was below the target of 95%.

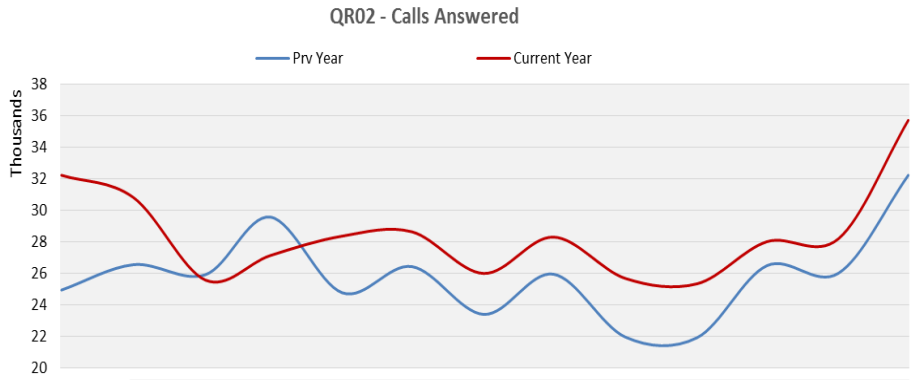


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	96%	95%	96%	94%	96%	96%	94%	92%	93%	94%	92%	93%
2017-2018	93%	92%	94%	92%	94%	92%	93%	87%	92%			
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	3	39	335	374	102	92	127	227	150	46	106	68
2017-2018	106	66	1	3	2	4	125	3	1			

LAS 111 (South East London) - Demand and Capacity – December 2017



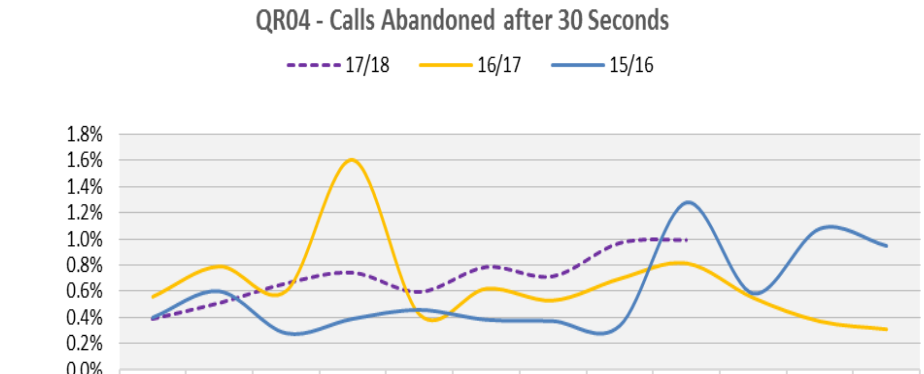
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Prv Year	24,963	26,573	25,935	29,586	24,791	26,451	23,419	25,971	21,988	21,947	26,505	26,037	32,237
Current Year	32,237	30,826	25,596	27,151	28,381	28,656	26,015	28,321	25,703	25,361	28,026	28,225	35,721

Demand: Call volume was 11.2% higher than in December 2016. Demand on Saturday 23rd and Sunday 30th December was 26% above forecast.

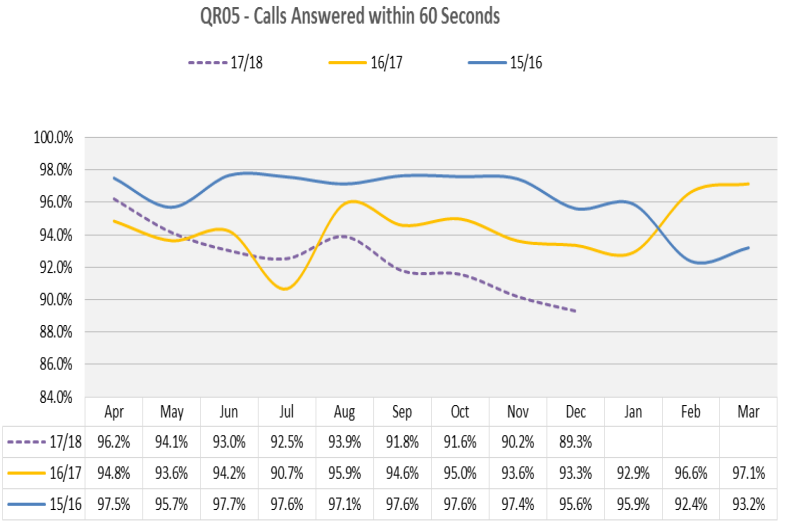
Capacity: The rolling recruitment plan is in place to maintain robust Call Handler capacity and increase Clinical Advisor establishment fill.

Efficiency: The percentage of calls answered in 60 seconds was 89.3% in December, with the target achieved on 8 days. LAS 111 had the lowest abandonment rate nationally in weeks ending 24th and 31st December.

Service Projects: The service focus throughout December has been on go live for 111 online and Direct booking into GP hubs in Lambeth, Lewisham and Southwark.

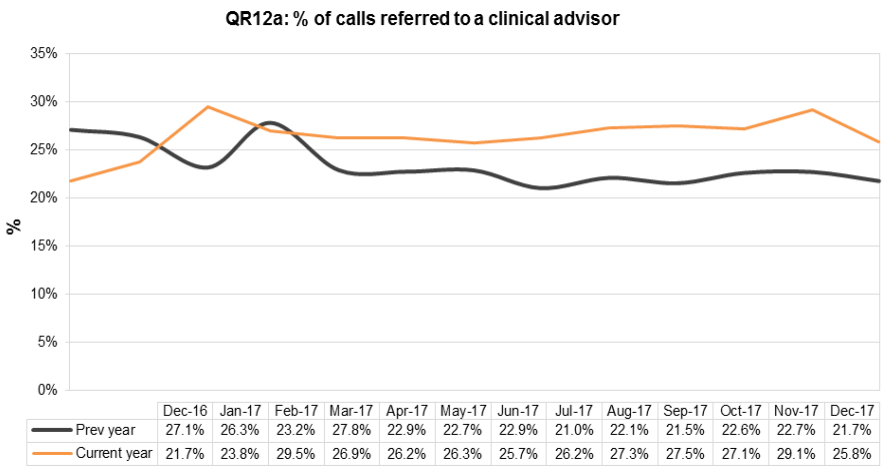


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.4%	0.5%	0.7%	0.7%	0.6%	0.8%	0.7%	1.0%	1.0%			
16/17	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%
15/16	0.4%	0.6%	0.3%	0.4%	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%	0.9%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	96.2%	94.1%	93.0%	92.5%	93.9%	91.8%	91.6%	90.2%	89.3%			
16/17	94.8%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%
15/16	97.5%	95.7%	97.7%	97.6%	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%	93.2%

LAS 111 (South East London): Call Destinations – December 2017

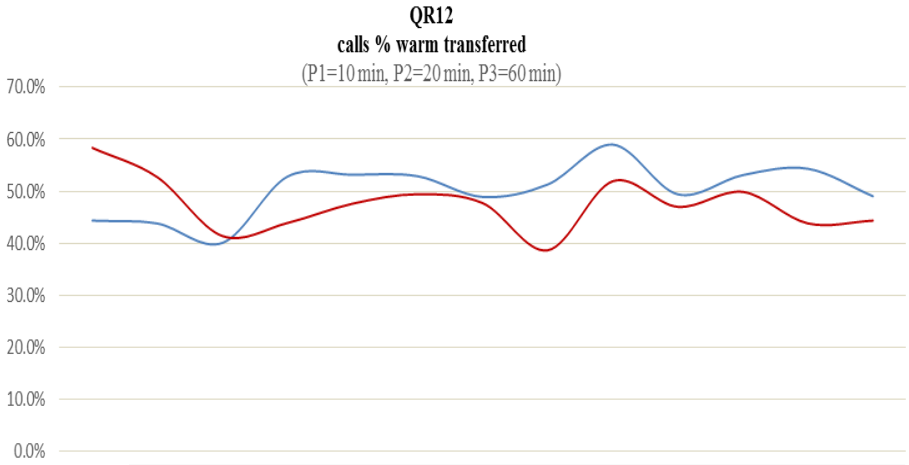


	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Prev year	27.1%	26.3%	23.2%	27.8%	22.9%	22.7%	22.9%	21.0%	22.1%	21.5%	22.6%	22.7%	21.7%
Current year	21.7%	23.8%	29.5%	26.9%	26.2%	26.3%	25.7%	26.2%	27.3%	27.5%	27.1%	29.1%	25.8%

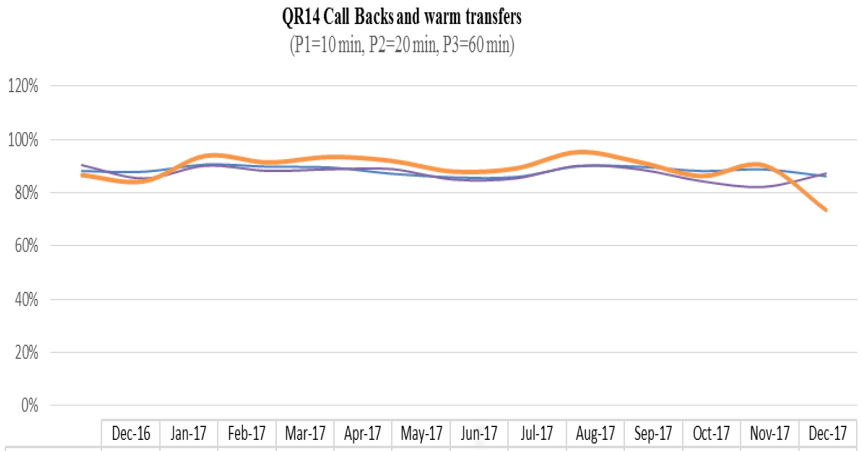
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for low acuity ambulance outcomes and availability of Clinical Advisors to accept a warm transfer. A prioritisation system is in place to inform those decisions.

Safety: There were 101 Incidents in Datix with completed investigations in December. Of these 10.9% (n=11) related to authorised breaches in confidentiality including safeguarding referrals made with our patient consent, 19.8% (n=20) in failure to follow procedure, 55% (n=56) in delay of care and the remaining 13.9% (n=14) to other issues. Incidents are under investigation and feedback given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received 19 complaints, 6 compliments and feedback from 3 HCPs. The reason for the increase in complaints is being investigated but likely to be due to high demand over the winter period.

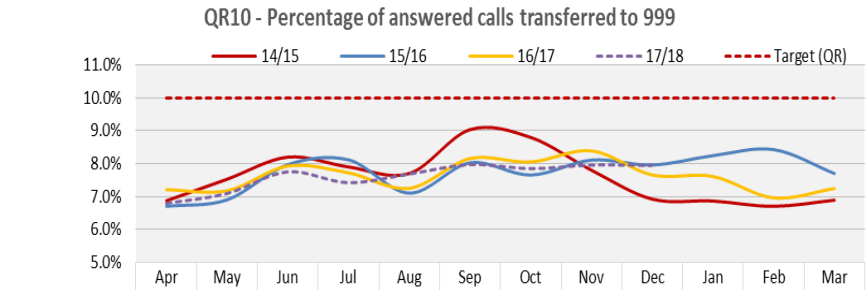


	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
current year	44.4%	43.8%	40.1%	52.8%	53.2%	52.9%	48.9%	51.3%	59.0%	49.4%	53.1%	54.3%	49.0%
prev year	58.3%	52.7%	41.4%	43.9%	47.6%	49.4%	47.7%	38.7%	51.9%	47.0%	49.9%	43.8%	44.4%



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
P1 <10m)	88%	88%	91%	90%	89%	87%	86%	86%	90%	90%	88%	89%	86%
P2 <20m)	90%	85%	90%	88%	89%	89%	85%	85%	90%	89%	84%	82%	87%
P3 <60m)	87%	84%	94%	91%	93%	92%	88%	89%	95%	91%	86%	90%	73%

LAS 111 (South East London): Triage Destinations – December 2017

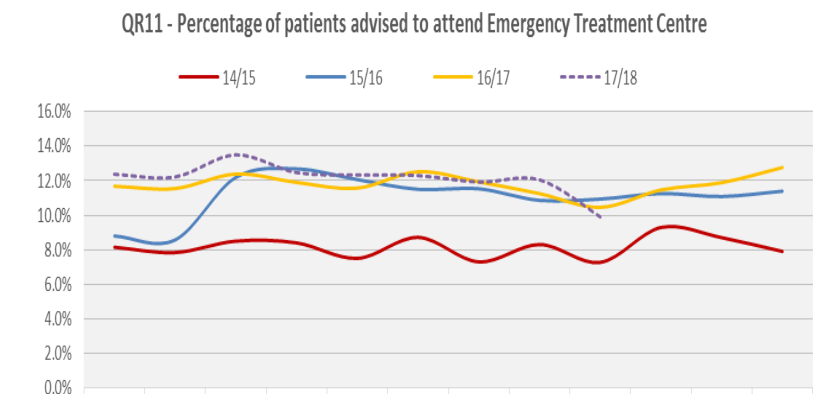


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14/15	6.9%	7.5%	8.2%	7.9%	7.7%	9.0%	8.8%	7.8%	6.9%	6.9%	6.7%	6.9%
15/16	6.7%	6.9%	8.0%	8.1%	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%	7.7%
16/17	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%
17/18	6.8%	7.1%	7.8%	7.4%	7.7%	8.0%	7.9%	8.0%	8.0%			
Target (QR)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

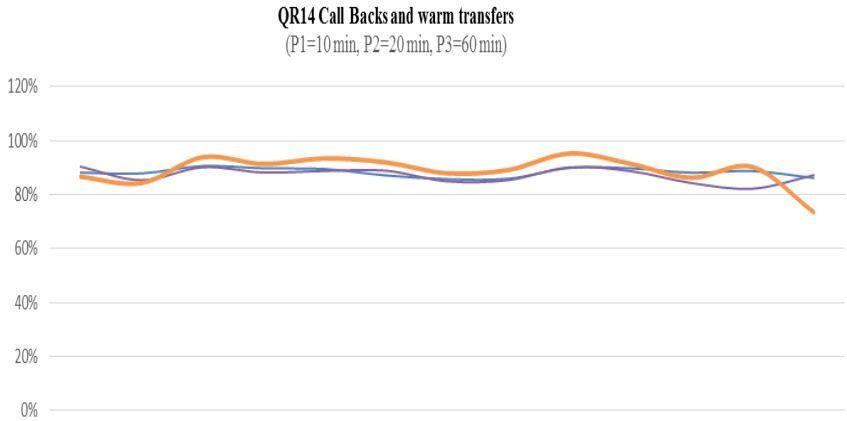
LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for low acuity ambulance outcomes.

Referrals to Emergency Departments are higher than three other providers however lower than recent months, this figure includes Urgent Care Centres and Walk-in Centres.

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 refers the lowest number of calls overall.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14/15	8.1%	7.8%	8.5%	8.4%	7.5%	8.7%	7.3%	8.3%	7.3%	9.3%	8.7%	7.9%
15/16	8.8%	8.6%	12.2%	12.7%	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%	11.4%
16/17	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%
17/18	12.4%	12.2%	13.5%	12.5%	12.3%	12.3%	11.9%	12.1%	9.9%			



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
P1 <10m)	88%	88%	91%	90%	89%	87%	86%	86%	90%	90%	88%	89%	86%
P2 <20m)	90%	85%	90%	88%	89%	89%	85%	85%	90%	89%	84%	82%	87%
P3 <60m)	87%	84%	94%	91%	93%	92%	88%	89%	95%	91%	86%	90%	73%

LAS 111 (South East London): London & National Comparison – December 2017

The table below shows LAS' performance on key Quality Requirements (QRs) agreed in Schedule 12 contract of the SEL CCGs contract for providing 111 services. It shows a comparison to that of the other three London providers and the regional and national totals.

Our ranking is out of five London providers.
Data is taken from the weekly NHS England 111 Situation Report, and is collated for December 2017.

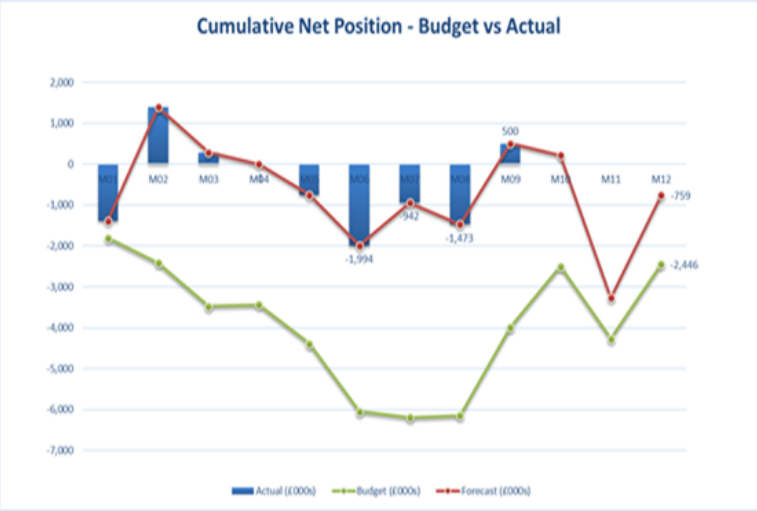
December 2017									
Description	Target	LAS	Care UK	LCW	PELC	Vocare	London	LAS ranking (pan-London)	England
Total calls answered	N/A	35,721	29,061	36,988	42,883	32,398	156,655		1,422,923
% of Calls answered within 60 seconds	95%	89.29%	71.38%	77.62%	93.24%	70.78%	81.48%	2	72.65%
% of Calls abandoned after 30 seconds	5%	0.99%	9.29%	3.90%	2.16%	6.59%	3.84%	1	7.35%
% of Calls transferred to, or answered by a clinical advisor	N/A	25.55%	22.24%	30.42%	23.97%	24.00%	25.36%		22.81%
Of calls transferred, percentage transferred warm	N/A	47.32%	25.76%	73.19%	63.43%	37.10%	52.62%		37.31%
Of call backs, percentage within 10 minutes	100%	51.71%	47.05%	49.78%	65.83%	39.48%	50.07%	2	40.95%
% of Calls referred to 999	10%	7.96%	10.76%	12.04%	9.19%	10.57%	10.05%	1	10.95%
% of Calls referred to Emergency Department	N/A	9.92%	8.41%	9.12%	11.30%	9.13%	9.67%	4	7.34%

*Modified clinical call back model agreed with commissioners. Contract QR target does not reflect this
*Ranking is from 1-5 with 1 representing the best performance in that area.

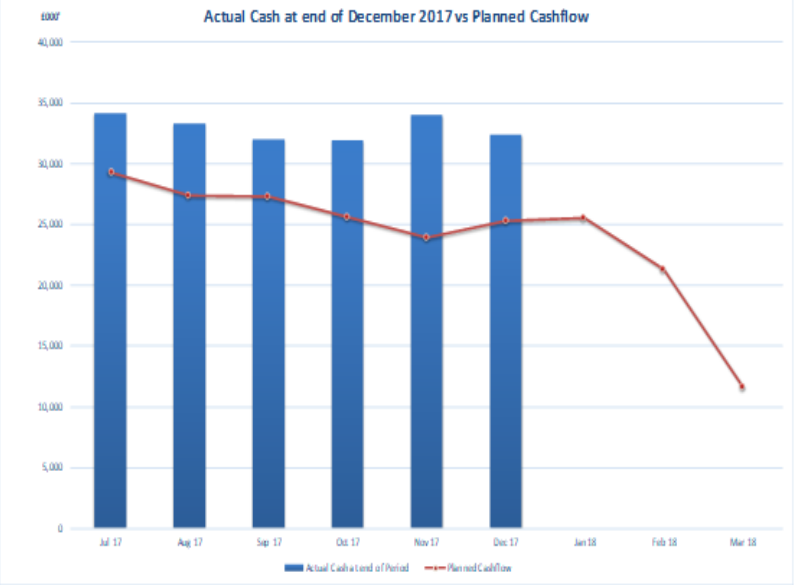
Our Money

Financial Indicator	Key Headlines	Forecast Outturn	Current Month	Previous month
Surplus/Deficit (Year to date and Forecast)	Year to date the position is £3.9m ahead of plan and £4.5m ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. The month 9 forecast is to achieve plan. Key issues in the position are: • Income is £1.4m adverse compared to re-phased budget due to the budget including over activity at 3% and only 2% being achieved YTD. • On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued demand pressure			
Income	Income is £0.4m adverse in month, and £1.4m adverse year to date compared to re-phased budget due to: • PTS £0.1m favourable variance in month as contract was initially budgeted to have ended in July. • Main contract activity for M9 YTD is 2% higher than the contract baseline, and the variable income in relation to this (£3.5m) has been recognised in the Trust accounts. • The risk regarding the central funding for the Paramedic band 6 re-banding has now been removed following conformation that LAS meets all the requirements in 2017/18.			
Expenditure (incl. Financial Charges)	In month expenditure is £0.2m favourable to re-phased budget in month, and £5.9m favourable YTD. The key drivers for this are: • On-going vacancies in operational pay (incl. EOC) (£2m favourable in month, £18.2m favourable YTD) • PAS overspends to compensate for vacancies (£0.5m unfavourable in month, £4m unfavourable YTD) are offset by various underspends in budgeted services spend			
CIPs	Year to date CIPs are £5.9m behind plan and are currently offset by non recurrent underspends on pay budgets. The Trust will now not deliver the full £17.8m planned CIP recurrently in 17/18 and is developing improved governance for recurrent CIP implementation and tracking in 2018/19.			
Balance Sheet	Capital spend is £9.9m, £5.2m behind a revised internal Capital plan of £15.1m and £7.8m behind the NHSI submitted plan of £17.7m. In addition to the previously reported confirmation of the carry forward and Digital Maturity funding, the Trust has received a further £0.34m to fund improvements to Cyber Security.			
Cashflow	Cash is £32.4m, £7.1m above plan. This is made up of a number of offsetting variances. The Trust has outstanding debts of £6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.9m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £8.3m. These movements are being offset by under payments of £11.2m on capital, provision of £0.8m and £10.8m on pay.			
BPPC	Non-NHS 93%, NHS 89% performance (volume) for this month, performance is still below 95% target however the current trajectory is that this is improving month on month.			

Executive Summary - Key Financial Metrics



	Month 9 2017-18 £000			YTD Month 9 2017-18 £000			Full Year 2017-18 £000
	Re-phased Budget	Actual	Variance fav / (adv)	Re-phased Budget	Actual	Variance fav / (adv)	Plan
Surplus / (Deficits)	2,155	1,973	(182)	(3,987)	500	4,487	(2,438)
EFL				(1,078)	(13,714)	12,636	12,538
CRL				17,729	9,825	7,904	28,806
Suppliers paid within 30 days - NHS	95%	89%	(6.0%)	95%	87%	(8.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	93%	(2.0%)	95%	86%	(9.0%)	95%
EBITDA %	11.4%	10.5%	(0.9%)	3.7%	5.0%	1.3%	5.0%
EBITDA	3,713	3,394	(319)	9,860	13,327	3,467	18,185
NRAF (net return after financing)				(0.29%)	2.64%	2.9%	1.2%
Liquidity Days				(1.72)	5.32	7.04	(9.90)
Use of Resources Rating				3.0	1.0	2.0	2.0



- Year to date the position is £3.9m ahead of plan and £4.5 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.
- Income is £0.4m adverse in month due to PTS contract planned to be completed and adjustments made to the phasing of contract income and CQUIN.
- On-going vacancies in core frontline staff groups offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand.
- Demand is currently running above 2017-18 contracted baseline activity (2016-17 contract activity plus 6%) by circa 2% YTD, lower than the level included in the budget of 3%. This figure differs from the figures quoted in the weekly performance packs as the weekly performance data includes activity for dates outside the reporting period (i.e. week 1 includes 2016/17 activity and the YTD activity in the weekly performance packs will not align exactly to the end of each month).
- CRL position – the capital plan is £7.8m behind target.
- Cash is £32.4m, £7.1m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.9m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £8.3m. These movements are being offset by under payments of £11.2m on capital, provision of £0.8m and £10.8m on pay.
- Non-NHS 93%, NHS 89% performance (volume) for this month, performance is still below 95% target however the current trajectory is that this is improving month on month.

Forecast and CIP Outturn (I&E)

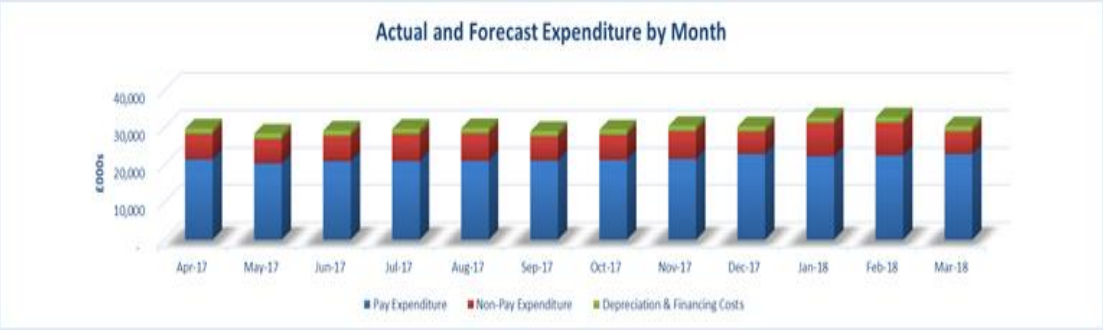
Performance Review Meetings - Financial Proforma
Divisional Budget Summary
2017/18

	Income and Expenditure						Memorandum Items Cost Improvement Plan					
	YTD			Full Year			YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Division	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Central Corporate	17,957	14,172	3,785	25,634	19,359	6,275	(1,970)	(1,571)	(399)	(2,899)	(1,980)	(919)
Central Income	(256,980)	(253,697)	(3,283)	(346,668)	(345,570)	(1,097)	(1,525)	0	(1,525)	(2,225)	(1,125)	(1,100)
Chairman & Non-Executives	83	81	2	111	106	5	0	0	0	0	0	0
Chief Executive	2,422	2,189	233	3,112	2,881	230	(189)	(535)	346	(250)	(596)	346
Corporate Services	3,527	3,267	260	4,702	4,463	239	0	0	0	0	0	0
Estates	7,839	7,540	299	10,400	10,391	9	(189)	(189)	0	(250)	(90)	(160)
Finance	2,559	1,829	730	3,435	2,605	830	0	0	0	0	0	0
Fleet & Logistics	20,530	23,983	(3,454)	27,188	32,697	(5,509)	(908)	(360)	(548)	(1,257)	(500)	(757)
IM&T	10,172	9,382	791	14,478	14,150	328	0	0	0	0	0	0
Clinical Education & Standards	10,413	7,395	3,017	13,336	10,731	2,605	0	0	0	(250)	(250)	0
Medical	3,740	2,972	767	4,975	4,430	545	0	0	0	0	0	0
111 Service	(17)	(186)	169	(94)	(186)	92	0	0	0	0	0	0
Central Operations	16,925	16,122	802	22,533	21,679	855	(360)	(360)	0	(500)	(594)	94
Control Services	17,403	18,362	(960)	23,403	24,302	(899)	(1,650)	(1,275)	(375)	(2,000)	(1,929)	(71)
Core Frontline Central	16,808	31,989	(15,181)	21,109	43,714	(22,605)	(4,154)	(350)	(3,804)	(6,550)	(712)	(5,838)
South East Sector	26,302	23,638	2,664	35,064	31,653	3,411	0	0	0	0	0	0
South West Sector	16,947	16,107	840	22,591	21,492	1,098	0	0	0	0	0	0
North West Sector	28,347	24,784	3,563	37,791	33,305	4,485	0	0	0	0	0	0
North Central Sector	19,111	16,283	2,827	25,477	21,872	3,605	0	0	0	0	0	0
North East Sector	25,300	21,318	3,982	33,723	28,698	5,025	0	0	0	0	0	0
Non Emergency Transport	5,216	4,641	575	6,937	6,392	544	(667)	(1,117)	450	(1,000)	(1,450)	450
Patient Transport Service	(331)	(436)	104	(331)	(444)	113	0	0	0	0	0	0
Performance	901	823	77	1,201	1,042	159	0	0	0	0	0	0
Quality & Assurance	2,445	1,846	599	3,348	2,811	537	0	0	0	0	0	0
Special Measures	0	0	0	0	(0)	0	0	0	0	0	0	0
Communications	774	724	49	1,032	1,005	27	0	0	0	0	0	0
Support Services Senior Mngmnt	0	(0)	0	0	0	(0)	0	0	0	0	0	0
Strategy	1,025	423	602	1,643	889	754	0	0	0	0	0	0
People & Organisational Development	4,571	3,947	624	6,317	6,293	25	(441)	(359)	(82)	(600)	(359)	(241)
Total	**3,987**	**(500)**	**4,487**	**2,446**	**759**	**1,687**	**(12,053)**	**(6,116)**	**(5,937)**	**(17,781)**	**(9,585)**	**(8,196)**

Year to date CIPs are £5.9m behind plan and are currently offset by non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.
NB: Forecast above is before month 9 performance review updates.

Statement of Comprehensive Income

	Month 9 2017-18 £000				YTD Month 9 2017-18 £000					Full Year 2017-18 £000		
	Plan	Re-phased Budget	Actual	Re-phased Budget Variance fav/(adv)	Plan	Re-phased Budget	Actual	Plan Variance	Re-phased Budget Variance fav/(adv)	Re-phased Budget	Forecast	Re-phased Budget Variance fav/(adv)
Income												
Income from Activities	31,200	32,373	31,861	(512)	268,838	266,002	263,671	(5,167)	(2,331)	358,182	355,813	(2,369)
Other Operating Income	255	255	409	154	1,810	1,811	2,742	932	931	2,673	3,807	1,134
Total Income	**31,455**	**32,628**	**32,270**	**(358)**	**270,648**	**267,813**	**266,413**	**(4,235)**	**(1,400)**	**360,855**	**359,620**	**(1,235)**
Operating Expense												
Pay	(22,483)	(22,687)	(22,932)	(245)	(203,552)	(201,633)	(192,394)	11,158	9,239	(269,210)	(260,277)	8,933
Non Pay	(5,905)	(6,228)	(5,944)	284	(55,385)	(56,319)	(60,692)	(5,307)	(4,373)	(74,968)	(84,115)	(9,147)
Total Operating Expenditure	**(28,388)**	**(28,915)**	**(28,876)**	**39**	**(258,937)**	**(257,953)**	**(253,086)**	**5,851**	**4,867**	**(344,178)**	**(344,392)**	**(214)**
EBITDA	**3,067**	**3,713**	**3,394**	**(319)**	**11,711**	**9,860**	**13,327**	**1,616**	**3,467**	**16,677**	**15,228**	**(1,449)**
EBITDA margin	9.8%	11.4%	10.5%	(0.9%)	4.3%	3.7%	5.0%	0.7%	1.3%	4.6%	4.2%	(0.8%)
Depreciation & Financing												
Depreciation & Amortisation	(1,386)	(1,204)	(1,084)	120	(11,896)	(10,663)	(9,736)	2,160	927	(14,487)	(13,142)	1,345
PDC Dividend	(350)	(350)	(350)	0	(3,150)	(3,153)	(3,150)	0	3	(4,204)	(4,200)	4
Finance Income	8	8	9	1	72	71	62	(10)	(9)	95	73	(22)
Finance Costs	(11)	(11)	(2)	9	(99)	(103)	(20)	79	82	(137)	(27)	110
Gains & Losses on Disposals	0	0	5	5	0	0	17	17	17	0	18	18
Total Depreciation & Finance Costs	**(1,739)**	**(1,558)**	**(1,421)**	**137**	**(15,073)**	**(13,847)**	**(12,827)**	**2,246**	**1,020**	**(18,733)**	**(17,277)**	**1,456**
Net Surplus/(Deficit)	**1,328**	**2,155**	**1,973**	**(182)**	**(3,362)**	**(3,987)**	**500**	**3,862**	**4,487**	**(2,056)**	**(2,049)**	**7**
NHSI Adjustments to Fin Perf												
Remove Depr on Donated assets	3	3	3	0	27	29	29	2	0	38	38	0
Remove STP funding 2016/17	0	0	0	0	0	0	(419)	(419)	(419)	(420)	(419)	1
Adjusted Financial Performance	**1,331**	**2,158**	**1,976**	**(182)**	**(3,335)**	**(3,958)**	**109**	**3,444**	**4,068**	**(2,438)**	**(2,430)**	**8**
Net margin	4.2%	6.6%	6.1%	(0.5%)	(1.2%)	(1.5%)	0.2%	1.4%	1.7%	(0.6%)	(0.6%)	0.1%



Income

- YTD the Trust has achieved £3.9m of its annul Cquin of £7.8m. The month 9 forecast has provided £981k against this annual total.
- Main contract activity for M9 YTD is 2% higher than the contract baseline, and the income relating to this (£3.5m) has been recognised in the Trust accounts.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £9.2m under re-phased budget, due primarily to frontline vacancies.
- The underspend on frontline pay is partially offset by private ambulance expenditure (£4m YTD) in non-pay. This underspend is expected to reduce with targeted recruitment.
- Private Ambulance expenditure is overspent by £4m (this is offset by vacancies as noted) and rent, leases costs and training and recruitment related expenditure are underspent due to differences in the phasing of the budget vs actual expenditure.

EBITDA

- The Trust delivered an EBITDA of £3.4m in December which represents 10.5%. This was due to increased income in December through over-performance.

Depreciation and Financing

- Overall Financial Charges are £1m favourable YTD due to lower than budgeted depreciation.

Risks

- The Trust's main A&E contract incorporates variable income for the first time and as such variations in activity may result in either the Trust receiving additional income or being required to pass back income to Commissioners. This fluid budget structure will need to be carefully managed to ensure resourcing expenditure aligns with income and is managed sustainably.
- If the criteria for STP funding is not met (e.g. Agency restrictions) then £1.9m would be withheld which would put the Trust's control total at risk.

Main Contract Variable Income

Month:	Dec-17	2017-18 Monthly Contract Base (2016-17 Plan plus 6%)			2017-18 Actual Activity			2017-18 Actual Activity Increase / (Decrease) vs Contract Base			CCG Split Based on Incident Difference
Area	CCG Names	Cat A	Cat C (ind Othe	Total Incidents	Cat A	Cat C (ind Othe	Total Incidents	Cat A	Cat C (ind Othe	Total Incidents	
NEL	NHS City and Hackney CCG	13,582	14,259	27,841			28,242			401	£ 84,611.00
NEL	NHS Newham CCG	16,183	16,018	32,201			31,166			-1,035	-£ 218,385.00
NEL	NHS Tower Hamlets CCG	13,629	12,648	26,277			26,175			-102	-£ 21,522.00
NEL	NHS Waltham Forest CCG	12,499	12,153	24,652			23,512			-1,140	-£ 240,540.00
NEL	NHS Barking and Dagenham CCG	10,935	11,638	22,573			21,986			-587	-£ 123,857.00
NEL	NHS Havering CCG	12,367	13,802	26,169			26,319			150	£ 31,650.00
NEL	NHS Redbridge CCG	13,244	13,073	26,317			26,304			-13	-£ 2,743.00
NEL	**NEL Total**	**92,439**	**93,591**	**186,030**	**0**	**0**	**183,704**	**0**	**0**	**-2,326**	**-£ 490,786.00**
NCL	NHS Barnet CCG	16,280	16,987	33,267			33,441			174	£ 36,714.00
NCL	NHS Camden CCG	13,578	13,442	27,020			27,716			696	£ 146,856.00
NCL	NHS Enfield CCG	16,127	14,219	30,346			30,072			-274	-£ 57,814.00
NCL	NHS Haringey CCG	12,488	12,242	24,730			24,875			145	£ 30,595.00
NCL	NHS Islington CCG	11,420	12,395	23,815			23,915			100	£ 21,100.00
NCL	**NCL Total**	**69,893**	**69,285**	**139,178**	**0**	**0**	**140,019**	**0**	**0**	**841**	**£ 177,451.00**
NWL	NHS Brent CCG	16,018	15,388	31,406			32,622			1,216	£ 256,576.00
NWL	NHS Harrow CCG	9,283	9,682	18,965			20,217			1,252	£ 264,172.00
NWL	NHS Hillingdon CCG	15,267	18,210	33,477			34,928			1,451	£ 306,161.00
NWL	NHS Central London (Westminster) CCG	14,101	13,235	27,336			29,925			2,589	£ 546,279.00
NWL	NHS Ealing CCG	15,676	15,557	31,233			33,684			2,451	£ 517,161.00
NWL	NHS Hammersmith and Fulham CCG	8,740	8,522	17,262			19,226			1,964	£ 414,404.00
NWL	NHS Hounslow CCG	12,883	12,992	25,875			25,538			-337	-£ 71,107.00
NWL	NHS West London CCG	10,682	10,870	21,552			23,364			1,812	£ 382,332.00
NWL	**NWL Total**	**102,650**	**104,456**	**207,106**	**0**	**0**	**219,504**	**0**	**0**	**12,398**	**£ 2,615,978.00**
SEL	NHS Bexley CCG	10,414	12,059	22,473			23,201			728	£ 153,608.00
SEL	NHS Bromley CCG	12,994	15,593	28,587			28,935			348	£ 73,428.00
SEL	NHS Greenwich CCG	12,526	13,491	26,017			26,113			96	£ 20,256.00
SEL	NHS Lambeth CCG	15,536	18,208	33,744			33,103			-641	-£ 135,251.00
SEL	NHS Lewisham CCG	12,714	13,850	26,564			27,609			1,045	£ 220,495.00
SEL	NHS Southwark CCG	15,007	17,850	32,857			33,059			202	£ 42,622.00
SEL	**SEL Total**	**79,191**	**91,051**	**170,242**	**0**	**0**	**172,020**	**0**	**0**	**1,778**	**£ 375,158.00**
SWL	NHS Croydon CCG	17,452	19,865	37,317			38,966			1,649	£ 347,960.10
SWL	NHS Kingston CCG	6,266	8,009	14,275			14,722			447	£ 94,317.00
SWL	NHS Merton CCG	7,467	9,775	17,242			17,680			438	£ 92,418.00
SWL	NHS Richmond CCG	6,291	8,303	14,594			14,797			203	£ 42,833.00
SWL	NHS Sutton CCG	7,866	10,338	18,204			18,962			758	£ 159,938.00
SWL	NHS Wandsworth CCG	11,639	13,621	25,260			25,706			446	£ 94,106.00
SWL	**SWL Total**	**56,981**	**69,911**	**126,892**	**0**	**0**	**130,833**	**0**	**0**	**3,941**	**£ 831,572.10**
London Total		**401,154**	**428,294**	**829,448**	**0**	**0**	**846,080**	**0**	**0**	**16,632**	**£ 3,509,373.10**

Initial reported activity at M9 YTD was 2% above the contract baseline. This is 1% lower than the planned level of activity in the Budget (3%).

On this basis the LAS would be able to invoice £3.5m of additional variable income. This has been recognised in the accounts at month 9.

The YTD activity is based on April, May, June, July, Aug, Sep & Oct freeze and Nov and Dec flex.

Cash flow Statement YTD

	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Nov-17 Actual	Dec-17 Actual	Dec-17 YTD Move	Dec-17 YTD Plan	Dec-17 Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	**28,740**	**34,142**	**33,342**	**31,985**	**31,916**	**33,997**	**18,637**	**18,700**	**(63)**
Operating Surplus	1,146	669	181	2,454	875	3,395	13,320	11,712	1,608
(Increase)/decrease in current assets	8,535	965	5,815	(1,826)	1,999	(1,761)	15,084	16,002	(918)
Increase/(decrease) in current liabilities	(2,588)	(1,850)	(3,355)	229	407	(1,899)	26	(1,111)	1,137
Increase/(decrease) in provisions	(175)	87	(630)	(120)	15	83	(464)	(270)	(194)
Net cash inflow/(outflow) from operating activities	6,918	(129)	2,011	737	3,296	(182)	27,966	26,333	1,633
Cashflow inflow/outflow from operating activities	**6,918**	**(129)**	**2,011**	**737**	**3,296**	**(182)**	**27,966**	**26,333**	**1,633**
Returns on investments and servicing finance	4	6	5	18	6	9	62	72	(10)
Capital Expenditure	(1,520)	(677)	(1,324)	(824)	(1,221)	(1,410)	(12,202)	(23,227)	11,025
Dividend paid	0	0	(2,049)	0	0	0	(2,049)	(2,100)	51
Financing obtained	0	0	0	0	0	0	0	5,520	(5,520)
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(1,516)**	**(671)**	**(3,368)**	**(806)**	**(1,215)**	**(1,401)**	**(14,189)**	**(19,735)**	**5,546**
Movement	5,402	(800)	(1,357)	(69)	2,081	(1,583)	13,777	6,598	7,179
Closing Cash Balance	**34,142**	**33,342**	**31,985**	**31,916**	**33,997**	**32,414**	**32,414**	**25,298**	**7,116**

There has been a net inflow of cash to the Trust of £13.8m.

Cash funds at 31 December stand at £32.4m.

Operating Surplus

- The operating surplus at £13.3m is higher than planned.

Current Assets

- The YTD movement on current assets is £15.1m, £1.0m lower than planned movement.
- Current assets movement was higher than planned due to receivables (£1.2m), accrued income £1.3m and prepayments (£1.0m).

Current Liabilities

- The YTD movement on current liabilities is £0.03m, a £1.1m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£3.7m), accruals £2.7m and deferred income £2.1m.

Provisions

- The YTD movement on provisions is (£0.5m), is a (£0.2m) decrease on plan.

Capital Expenditure

- Capital cash outflow is £11.0m behind the initial NHSI plan for the year. This is due to capital slippage and a high level of work-in-progress.

Financing obtained

- DH have only approved £1.0m of the £5.5m central capital funding requested by the Trust. The £1.0m funding is expected later in the year.

CQUINs

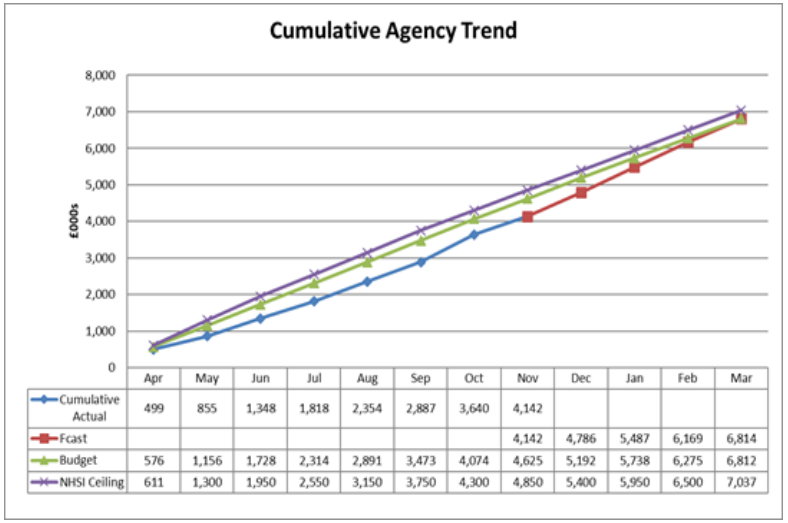
FIC - LAS 2017/18 ES & UC Contract – Commissioning for Quality & Innovation (CQUIN) SCHEDULE & UPDATE – as at 11th January 2017

#	CQUIN Indicator title	ELT lead	Local lead	Final indicator period	Annual value	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Risk/ Issue/Notes
	Note all CQUINs follow a two year contract period and so apply across 2017/18 – 2018/19. The below outlines commitments and funding related to 2017/18 financial year only.									
1a	**National CQUIN 1a:** Improvement of health and wellbeing of NHS staff	Patricia Grealish	Jessica Bochenek	Final Period – Q4 17-18	**£263,701**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Preliminary results received. Q3 Report received due to commissioners 22nd January 2018.
1b	**National CQUIN 1b: Healthy food** for NHS staff, visitors and patients	Lorraine Bewes	Martin Nelhams	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Q3 Report received due to commissioners 22nd January 2018.
1c	**National CQUIN 1c:** Improving the uptake of **flu vaccinations** for front line staff within Providers	Fenella Wrigley	Neil Thomson Julia Hilger-Ellis	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £263,701	Q3 Report received due to commissioners 22nd January 2018. Flu cohort for CQUIN is confirmed as frontline and EOC staff.
12	**National CQUIN 12: Ambulance Conveyance**	Paul Woodrow	Craig Harman	Final Period – Q4 17-18	**£784,825**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 30% £235,488	Q4 = 70% £549,378	Q3 Report due internally 5 January 2018. Partially complete. Proposal sent to commissioners to bring forward some funding to Q3.
STP 1	**National CQUIN: STP Engagement**	Angela Flaherty	TBC	Final Period – Q4 17-18	**£1,569,650**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 50% £784,825	Q4 = 50% £784,825	Q3 Report and due internally 5 January 2018. Partially complete. STPs to complete proformas and confirm view on LAS' achievement.
STP 2	**National CQUIN: STF Delivery (Control Total)**	Lorraine Bewes	James Corrigan	Final Period – Q4 17-18	**£1,569,650**	-	Q2 = 100% £1,569,650	-	-	Achieved - confirmed at CQRG 28 November 2017.
L1	**Mobile Devices**	Ross Fullerton	Ian Golding	Final Period – Q4 17-18	**£3,139,299**	N/A	N/A	Q3 – 50% £1,569,650	Q4 – 50% £1,569,650	Q3 Report due internally 5 January 2018. Partially complete.
	Total Value (2.5% of contract value)				£7,878,248	-	£1,569,650	£2,589,923	£3,688,678	
	Total Value Achieved				-	-	£1,569,650	-	-	

Key - RAG status	
INTERNAL RAG (for ELT / monitoring)	
	Red denotes: High risk for achievement
	Amber denotes: Risk for financial achievement / achievement not confirmed by commissioners
	Green denotes: CQUIN confirmed as achieved in full

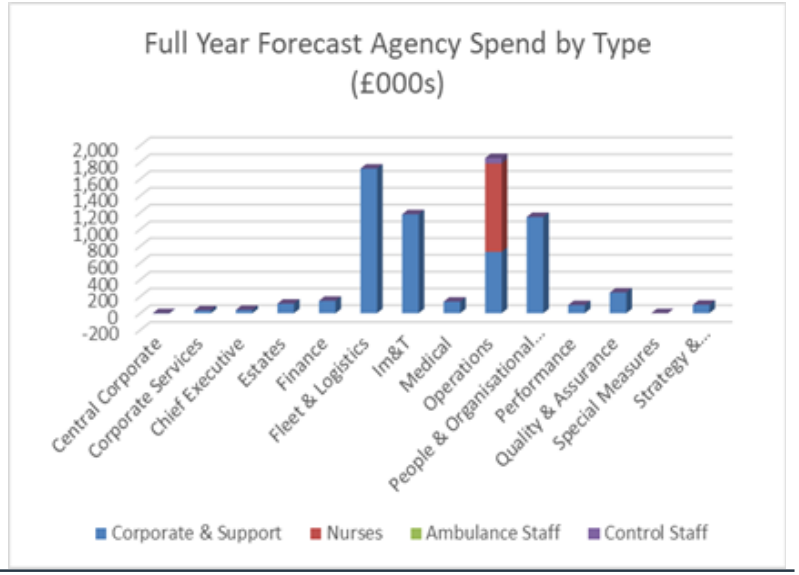
Agency Analysis

Agency Summary by Type	Month 9 2017-18 Budget £000s	Actual £000s	Variance £000s	Actual WTE	YTD Month 9 2017-18 Budget £000s	Actual £000s	Variance £000s	Average WTE	Full Year 2017-18 Budget £000s	Forecast £000s	Variance £000s	Forecast WTE
Operational												
Nurses	113	65	48	10	820	738	81	12	1,123	1,053	69	12
Ambulance Staff	0	0	0	0	0	0	0	0	0	0	0	0
Control Staff	0	12	-12	4	0	64	-64	2	0	64	-64	2
Subtotal	113	77	35	14	820	802	18	15	1,123	1,117	6	14
Non Clinical												
Managers & Professionals	255	340	-85	29	2,258	2,186	73	21	2,995	3,152	-157	22
Admin & Clerical	177	174	3	55	1,908	1,363	546	49	2,421	1,966	455	52
Maintenance & Works	23	53	-30	13	205	437	-231	14	274	579	-305	14
Other	0	0	0	0	0	-1	1	0	0	-1	1	0
Subtotal	454	567	-113	97	4,372	3,984	388	84	5,690	5,697	-7	88
Total	567	645	-78	111	5,192	4,786	406	99	6,812	6,814	-1	102

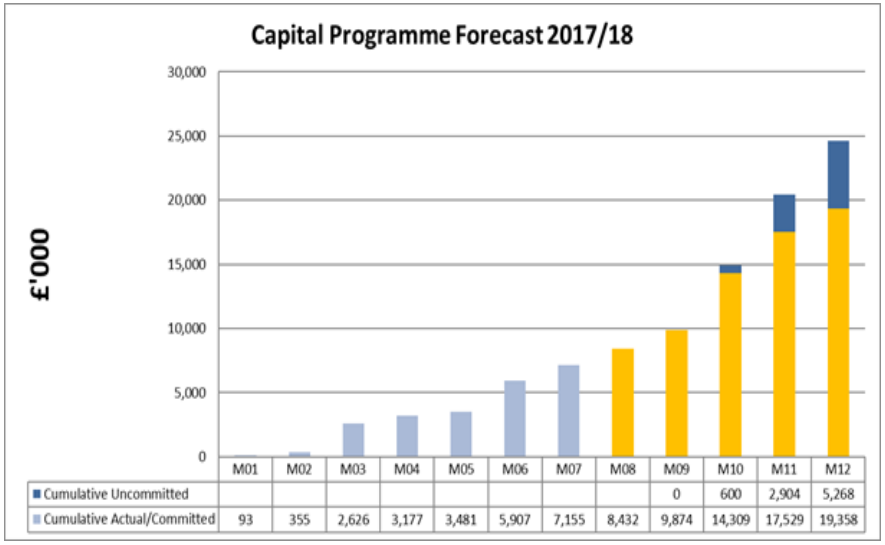


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Actual	499	855	1,348	1,818	2,354	2,887	3,640	4,142				
Fcast								4,142	4,786	5,487	6,169	6,814
Budget	576	1,156	1,728	2,314	2,891	3,473	4,074	4,625	5,192	5,738	6,275	6,812
NHSI Ceiling	611	1,300	1,950	2,550	3,150	3,750	4,300	4,850	5,400	5,950	6,500	7,037

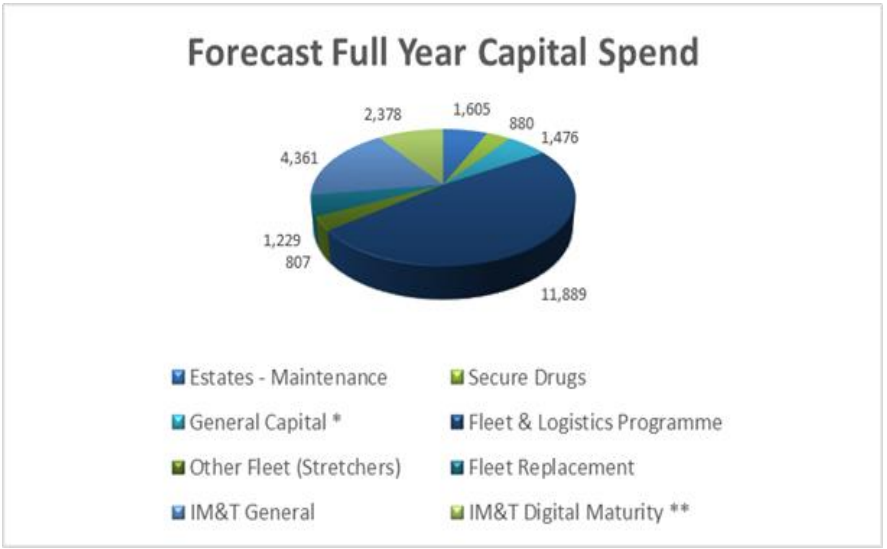
Agency Summary by Division & Type	Full Year Forecast (£000s) Corporate & Support	Nurses	Ambulance Staff	Control Staff
Central Corporate	-2	0	0	0
Corporate Services	35	0	0	0
Chief Executive	39	0	0	0
Estates	114	0	0	0
Finance	148	0	0	0
Fleet & Logistics	1,724	0	0	0
Im&T	1,179	0	0	0
Medical	137	0	0	0
Operations	732	1,053	0	64
People & Organisational Dev	1,147	0	0	0
Performance	97	0	0	0
Quality & Assurance	246	0	0	0
Special Measures	0	0	0	0
Strategy & Communications	101	0	0	0
Total	5,697	1,053	0	64



2017/18 Capital Plan/Spend YTD – Month 5 Summary



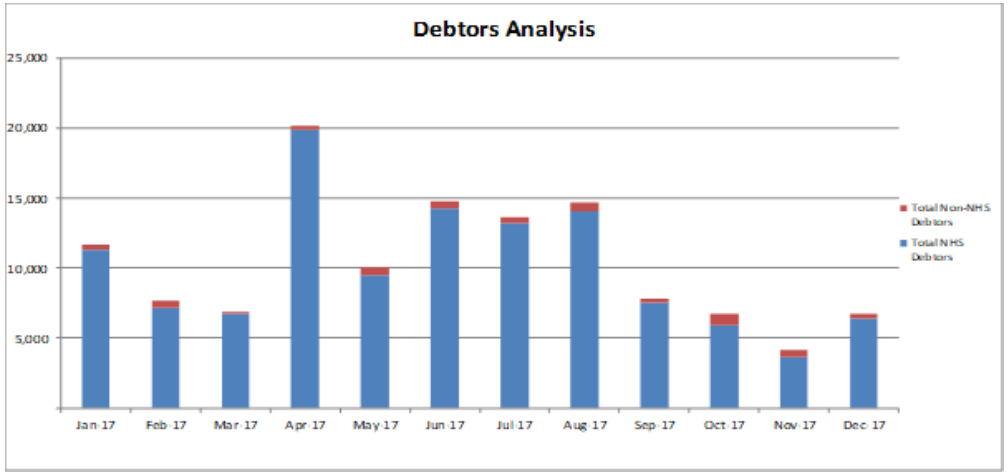
Capital Programme	Exec Lead	Operational Lead	Month 9 Revised Plan £'000	Month 9 Actual £'000	Month 9 Variance £'000	Forecast Outturn £'000
Expenditure Plan:						
Estates - Maintenance	L Bewes	M Nelhams	1,158	764	395	1,605
Secure Drugs	L Bewes	M Nelhams	231	267	(36)	880
General Capital *	L Bewes	L Bewes	640	84	556	1,476
Fleet & Logistics Programme	L Bewes	J Wand	7,685	5,477	2,208	11,889
Other Fleet (Stretchers)	L Bewes	J Wand	743	743	0	807
Fleet Replacement	L Bewes	J Wand	654	653	0	1,229
IM&T General	R Fullerton	J Downard	2,710	1,006	1,704	4,361
IM&T Digital Maturity **	R Fullerton	R Fullerton	1,300	879	421	2,378
Capital Expenditure Plan			**15,120**	**9,873**	**5,247**	**24,625**



- The latest capital plan shows £24.6m of Capex. The plan has been profiled in month 9 to reflect forecast profile spend as agreed with operational leads.
- £24.6m has been confirmed as the Trusts capital resource limit for 17/18.
- Since month 5 the Trust has had confirmation of the £6.9m carry forward from 2016/17 and an additional £341k for Cyber security.
- The initial capital plan assumed £5.5m Central Programme funding. The Trust has received confirmation that it will receive only £0.998m in 2017/18. The shortfall in funding created by this has been met from the General Capital allocation.

Debtors Analysis

	Note	Total	Current	Days Overdue 1 - 30	31 - 60	61 - 90	91 - 180	181 - 365	> 365
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Debtors									
NHS Bromley CCG	1	678	-	678	-	-	-	-	-
NHS Wandsworth CCG	1	593	-	323	270	-	-	-	-
NHS Central London (Westminster) CCG	1	503	-	318	185	-	-	-	-
NHS Trust Development Authority	2	500	500	-	-	-	-	-	-
NHS Ealing CCG	1	468	-	267	202	-	-	-	-
NHS West London (Kandc And Qpp) CCG	1	426	-	295	121	-	9	1	-
<£426,000	1	4,026	913	1,821	651	28	264	155	195
Total NHS Debtors		**7,194**	**1,413**	**3,701**	**1,429**	**28**	**272**	**156**	**195**
Income Received In Advance (January SLA)									
Tower Hamlets CCG	3	-824	-824	-	-	-	-	-	-
Total NHS Ledger Balance		**6,370**	**589**	**3,701**	**1,429**	**28**	**272**	**156**	**195**
Non-NHS Debtors									
Twickenham Rugby Football Union	4	52	52	-	-	-	-	-	-
Chelsea Football Club	5	36	28	8	-	-	-	-	-
University Of Warwick	6	27	26	1	-	-	-	-	-
Arsenal Football Club	7	25	-	25	-	-	-	-	-
London Stadium 185	8	19	19	-	-	-	-	-	-
<£19,000	9	229	68	8	26	13	28	14	73
Total Non NHS Debtors		**388**	**193**	**42**	**26**	**13**	**28**	**14**	**73**
TOTAL DEBTORS 31st December 2017		**6,758**	**782**	**3,743**	**1,455**	**41**	**300**	**169**	**268**



Debtors Position: 31st December 2017

Total outstanding NHS and Non-NHS debtors as at 31st December 2017 amounted to £6.8 million. The NHS over 60 day's figure of £0.7m includes amounts due from both CCGs £0.5m and NHS Trusts £0.2m.

1. NHS Debtors over 60 days.

- 2016/17 CQUIN Funding - £10k Richmond CCG has confirmed payment will be made on the 15th January 2018.
- 2016/17 QIP Investment Funding - £47k Kingston CCG has confirmed payment will be made on the 15th January 2018.
- 2017/18 Paramedic Re-banding M1-M4 - £114k was paid on the 2nd January 2018.
- PTS Non-Contract Activity - £80k – The PTS ECJ invoices have been queried by various CCG's who dispute the charge. The LAS contracts team is liaising with the CCG's to resolve the issues.
- Out of London (A&E ECJ) Journeys - £80k – The A&E ECJ invoices have been queried by various CCG's who have disputed the charge. The LAS contracts and EOC team is liaising with the CCG's to resolve the issues.
- Sector Services (Falls Specialist Response -K466) - £44k (Barking & Dagenham CCG) – PO number has not been supplied by the CCG. LAS has actively pursues the PO number from the CCG.
- PTS Non-Contract Activity - £80k – The PTS ECJ invoices have been queried by various CCG's who dispute the charge. The LAS contracts team is liaising with the CCG's to resolve the issues.
- Neonatal Transfer Service - £115k – The NTS invoices have been queried by various CCG's who dispute the charge. The LAS contracts team is liaising with the CCG's to resolve the issues.

The Trust is actively pursuing the outstanding debts.

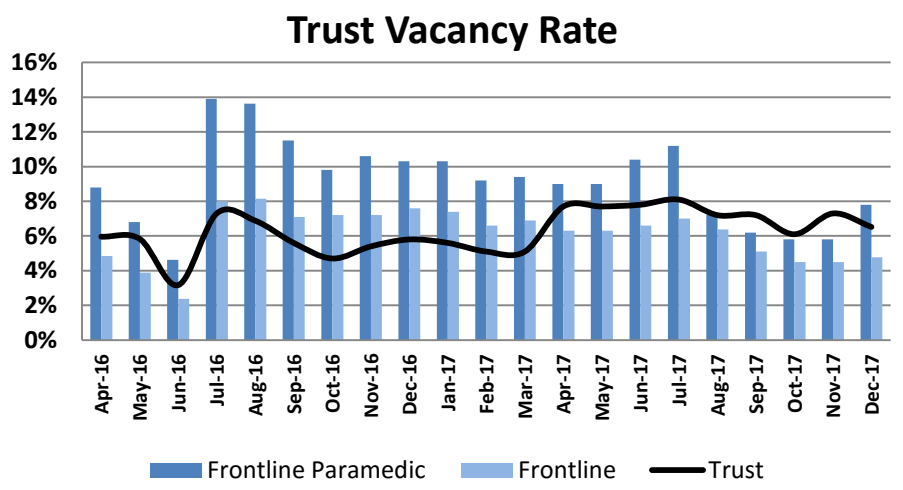
2. NHS Trust Development Authority – £0.5m (1 invoice) has been processed by the organisation for payment on the 15th January 2018.
3. Tower Hamlets CCG - £0.8m - January SLA paid in advance.
4. Twickenham Rugby Football Union - £52k (10 Invoices) copies of the invoices sent to Twickenham RFU on the 05/01/2018. The invoices are due for payment on the 19th January 2018.
5. Chelsea Football Club - £8k was paid on the 2nd January 2018. The remaining £28k will be paid on the 26th January 2018.
6. University Of Warwick - £27k (4 Invoices). The invoices have been queried by Warwick University. LAS are liaising with the relevant team internally to resolve the queries to ensure the invoice are paid promptly. The invoices are due for payment on 26th January 2018.
7. Arsenal Football Club - £25k – (1 invoice - £25k) invoice has been approved and payment will be made on the 26th January 2018.
8. London Stadium 185 - - £19k (3 invoices), invoices are due on the 27th January 2017. London Stadium has confirmed the invoices will be paid on the 26th January 2018.
9. Non-NHS Debtors - £229k consists of; £102k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £23k of stadia events, the stadiums are been chased for payment on a regular basis. The remaining £104k is due from local Government bodies and other miscellaneous organisations.

The graph to the left shows the debtors trend for the last 12 months.

Our People

Section	Key Headlines	Dec	Nov	Oct
Vacancy and Recruitment	• The overall vacancy rate has decreased from 7.3% to 6.5% against a 5% target. This includes the increased budgeted posts in EOC (see below). • We have identified additional core frontline posts to deliver the 17/18 increased demand. Work is in progress with colleagues in Operations to determine how these posts should be allocated across the Sectors. Please note that the vacancy rates for both paramedics and the total frontline will increase as a result of these additional posts. • A recent paper to the ELT ('EOC Capacity Review' - 4th October 2017) identified an additional 73 posts for EOC which has increased the current vacancy rates.			
Turnover	• Total Trust turnover has remained at 10.3% against a threshold of 10%. • Frontline turnover has increased from 8.5% to 8.8%. Please note this does not include Control Room or NHS 111 leavers. • Frontline paramedic turnover has increased from 9.6% to 9.9%.			
Sickness	• Monthly sickness for December is 5.2% against a target of 5%. • Sector Operations sickness has decreased from 5.9% to 5.7%.			

Vacancy – Trust wide



Paramedic Recruitment

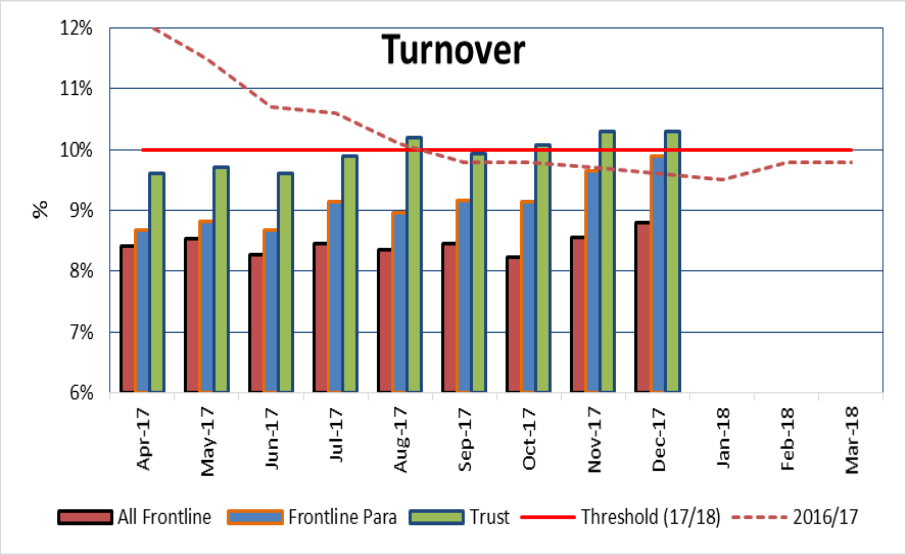
The first cohort of January iPara started on 15th January and the confidence level for the 29th January iPara starters is 94%.
The most recent international recruitment trip to Australia resulted in 166 conditional offers being made. We are currently working with the individuals themselves and Education to co-ordinate visas and start dates to maximise use of training places.
Based on 16/17, a drop-out rate of up to 25% could be expected and we are constantly monitoring any changes to start dates (including deferrals and withdrawals).
We have recruited 106 UK Graduate and Qualified Paramedics against our target of 90, all of whom have started/ are due to start by end Feb 2018. In addition we have 13 UK Paramedics awaiting course allocation.
In July and August we had 76 Apprentice Paramedics who graduated, taking up NQP positions. In December, there are 10 APs graduating, with a further 13 in May 2018 and 30 in July 2018.

The establishment figures represent current budgeted position and may be subject to change following completion of current forecasting activities	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	5,420.45	4,994.27	353.18	6.52%
Total Frontline (Sector)	3,111.00	2,962.45	148.55	4.78%
Frontline (Sector) Paramedics	1,821.24	1,679.43	141.81	7.79%
Frontline (Sector) Non-Paras	1,289.76	1,283.02	6.74	0.52%
EOC (includes 73FTE 'new' posts)	502.00	420.67	8.33	1.66%
Other staff (including Corporate)	1,807.45	1,611.15	196.30	10.86%

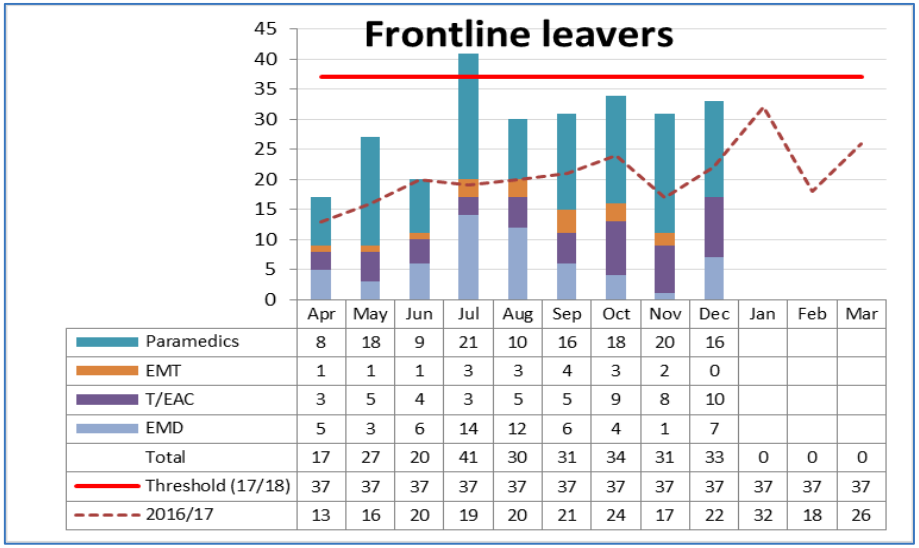
Trainee Emergency Ambulance Crew Recruitment
Against our 17/18 plan of 375, we have filled 297 **TEAC** training places to date. We have 8 TEAC places available on our March course and we are planning to recruit to all of these places resulting in a total recruitment of 301 TEACs in 17/18. We have 80 candidates in the pipeline, 38 of whom have a C1 Provisional and/ or C1 Theory & Hazard Perception and/or full C1 Licence. There are 3 assessments scheduled to take place in January (141 candidates awaiting assessment)

EOC Recruitment (Emergency Medical Dispatchers)
103 EMDs recruited against plan of 186 for 17/18. Additional course places had already been planned to meet new establishment. Whilst applicant numbers remain high, conversion rates from shortlisting to appointment still remain a challenge. We have 29 places available on our February and March courses and we are preparing to 'overfill' training place to allow for drop out. A new part-time rota has been designed to help recruitment and retention. There are 38 candidates scheduled for assessment on 13th January with a further 35 booked for interview between 11th and 20th January 2018. An EOC Monthly Project board is tracking an Action Plan with weekly calls to maintain focus on progress.

Turnover/Leavers – Trust wide



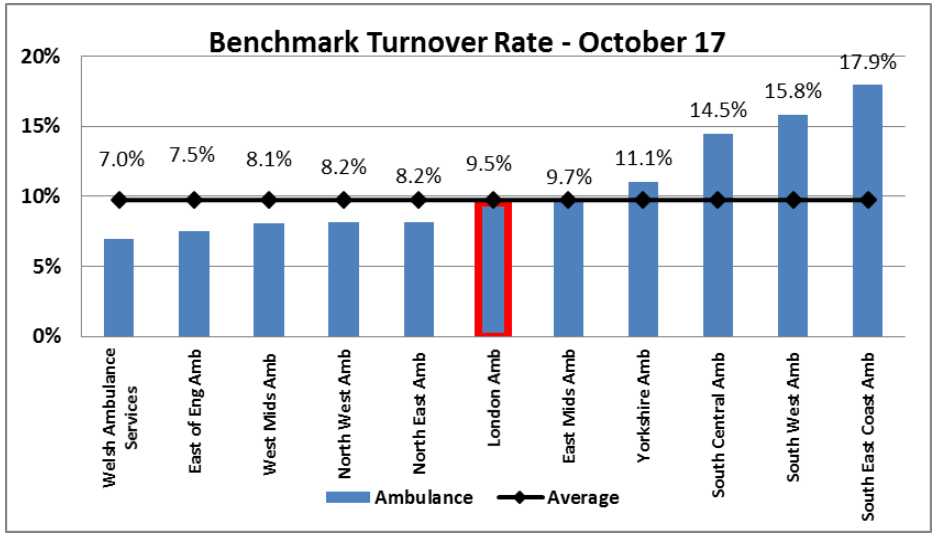
- The total Trust turnover has remained at 10.3% (12 month rolling figure).
- Frontline turnover (Sector Ops) has increased from 8.5% to 8.8%.
- Frontline paramedic turnover has increased from 9.5% to 9.9%.
- EOC turnover is 15.5% (EOC 18.1%).
- NHS 111 turnover is 16.7%, down from 18.4%.
- Corporate Directorates turnover is 15.3%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paramedics	8	18	9	21	10	16	18	20	16			
EMT	1	1	1	3	3	4	3	2	0			
T/EAC	3	5	4	3	5	5	9	8	10			
EMD	5	3	6	14	12	6	4	1	7			
Total	17	27	20	41	30	31	34	31	33	0	0	0
Threshold (17/18)	37	37	37	37	37	37	37	37	37	37	37	37
2016/17	13	16	20	19	20	21	24	17	22	32	18	26

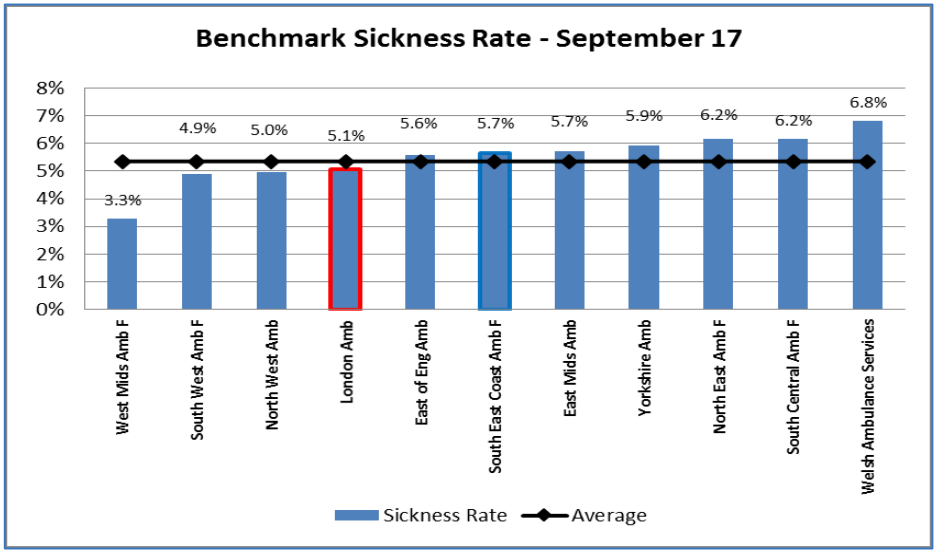
- There were 33 frontline leavers in December (see table opposite).
- 97% of the frontline leavers (32 staff) were resignations i.e. unplanned.
- 75% (12) of paramedics left for reasons of relocation.
- Year to date there have been 134 paramedic and 56 EAC leavers (190 total). This is a total of 53 FTE less than we had built into the planning model for 17/18.

Benchmarking Turnover/Sickness – Trust wide



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has remained in 6th place.
- The LAS is below the national average of 9.7%.

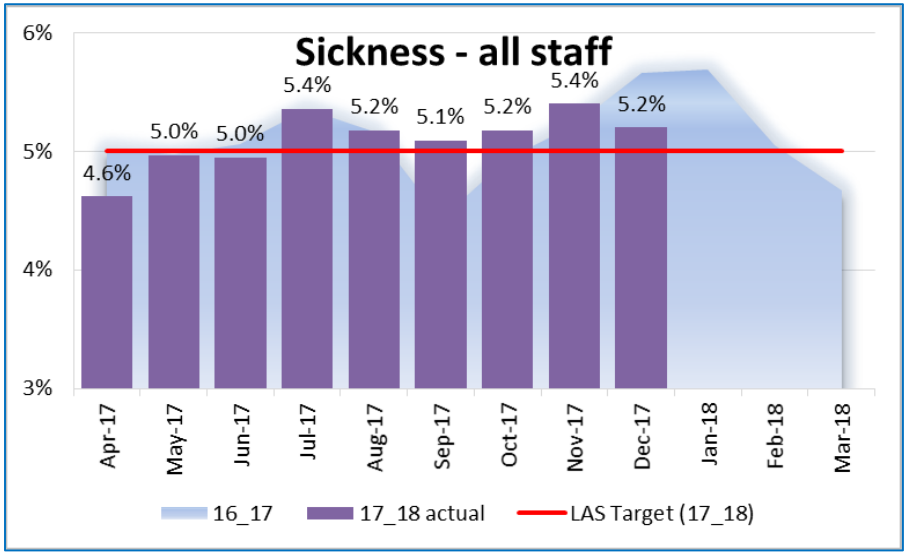
Source of data: NHS Health and Social Care Information Centre – data as at 31st October 2017. Data is available two months in arrears.



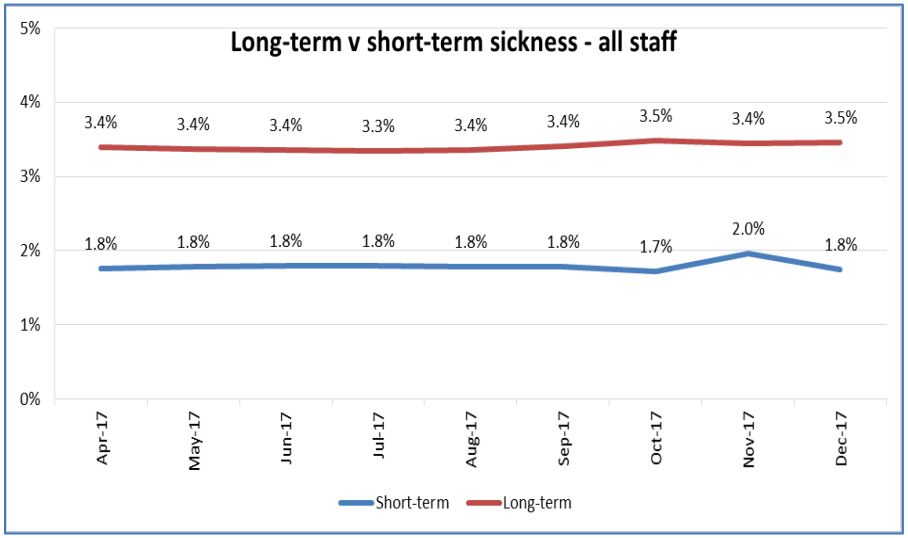
- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has moved from 2nd to 4th place.
- The LAS is below the national average of 5.4%.

Source of data: NHS Health and Social Care Information Centre – data as at 30th September. Data is available three months in arrears.

Sickness Absence – Trust/Sector level



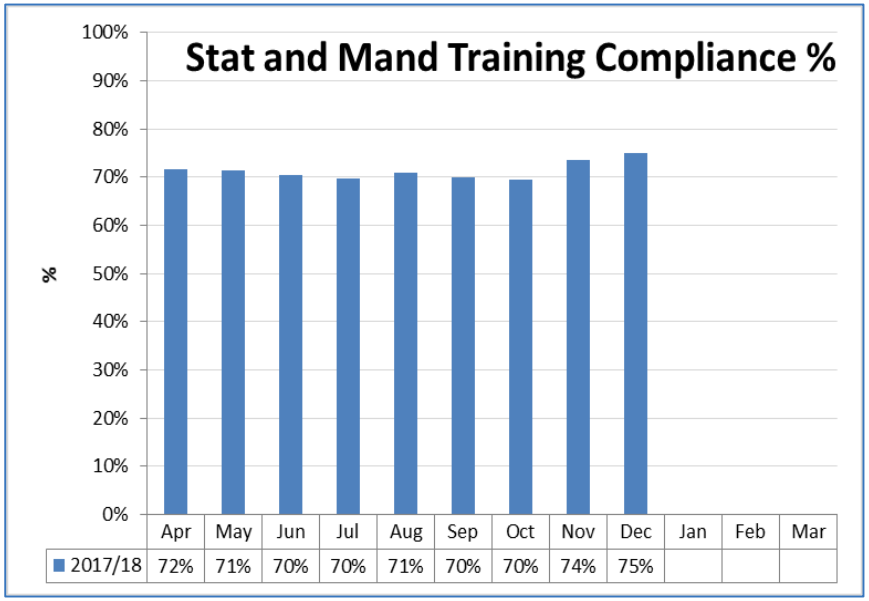
- Trust wide sickness for December was 5.2%.
- Frontline sickness (non-corporate) has decreased from 5.9% to 5.7%.
- Corporate sickness is at 2.9%.



- This graph shows the sickness rate for all staff split by short-term and long-term sickness.
- The LAS 17/18 target for sickness is 5% (2% short-term, 3% long-term), a reduction of 0.5% from 16/17.
- In December, the short-term sickness reduced from 1.96% to 1.75% and the long-term sickness increased from 3.44% to 3.46%.
- Long-term sickness accounts for 67% of all sickness.

Long-term sickness is any continuous episode of sickness lasting for 28 days or longer.

Statutory and Mandatory Training Compliance/Appraisal



Current Trust compliance is 75% as at the end of December 2017.

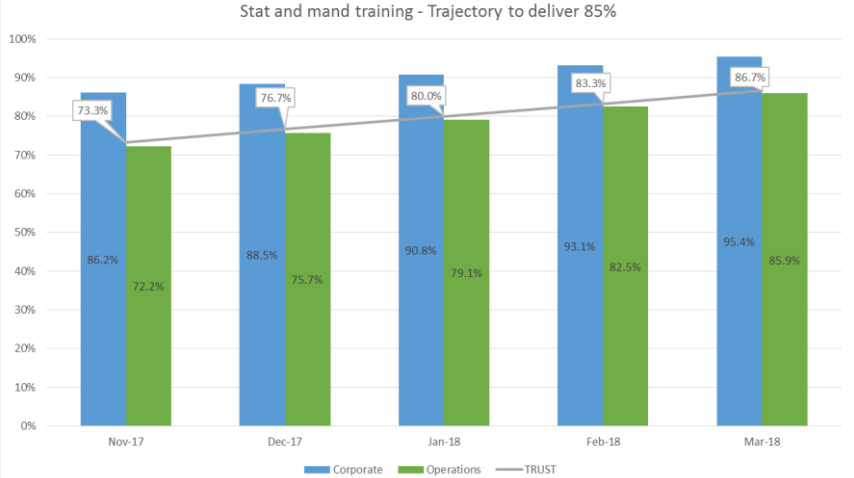
Corporate compliance is currently 94% as at 27th December 2017 (Target 100%).

Current Operations compliance is 73% as at the end of December 2017. Reviewing whether targeting compliance for CSR.2017.2 to end of February 2018 rather than the original date of March 2018 is an option.

All PDR Paperwork now includes objectives for individuals to meet 85% Statutory and Mandatory Compliance and one for Managers to maintain 85% compliance across their team.

One statutory training module, Equality, Diversity & Human Rights, has not been included in the CSR 2017/18 programme. As it is a statutory requirement, it will be targeted for full compliance Trust wide as soon as possible via e-Learning in MyESR. Current requirements mean that Equality, Diversity & Human Rights will need to be added CSR.2018.1.

The new Bank contract is in operation and the new Terms and Conditions require all Bank workers must meet the LAS role's Statutory and Mandatory training requirements before they can go on shift. Bank workers training requirements is still under review and data will be provided in order to capacity plan for any face to face training required.



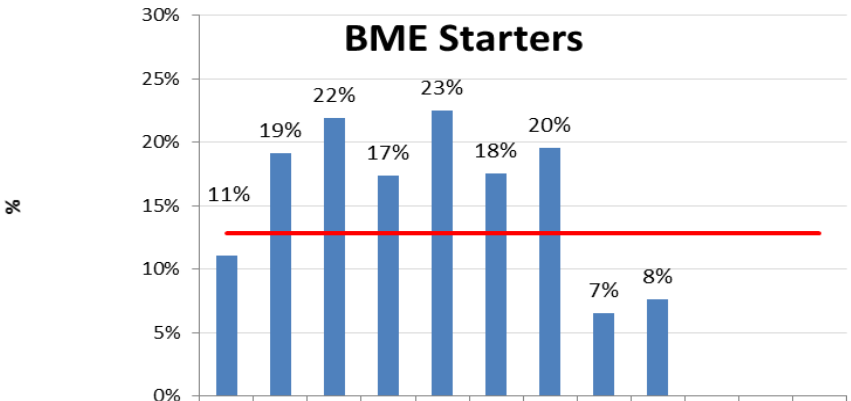
CSR 2017.2 for clinical staff is an e-learning CSR and went live on 31st October. Staff will be able to complete this via the new ESR Portal and will be given until the end of March 2018 to complete the 8 modules which include Health, Safety and Welfare. As expected December completions plateaued whilst at REAP 3. Now that has been reduced to REAP 2 new communications to remind staff to continue with and complete their e-learning will generated and sent.

CSR.2017.3 is also now live so there will be a progressive improvement across the Stat/Mand elements of Resuscitation – Level 3 (Adults/Paeds/Newborn), Moving and Handling – Level 2 and PREVENT – Level 2.

Looking forward to meet the 95% requirements of the IG Toolkit (required by NHS Digital in March) focused work will be completed alongside the SME, Stephen Moore to engage and encourage staff to complete by end of February 2018.

Further ongoing communications will be sent to Corporate services reminding staff to keep checking their dashboard in MyESR to remain compliant as well as targeting staff who have outstanding requirements.

Workforce Race Equality Standard (WRES)



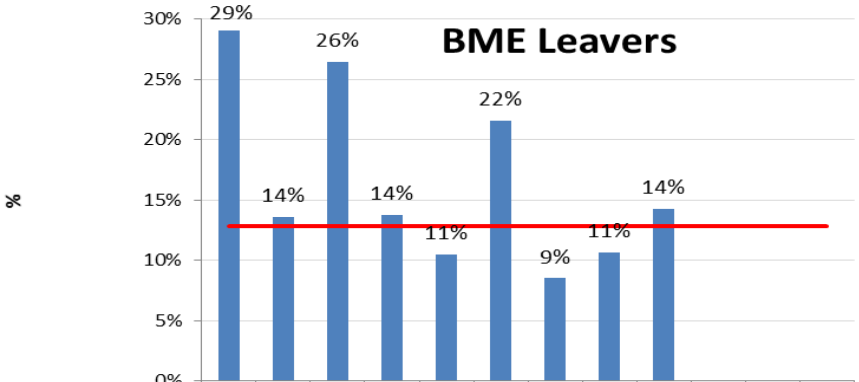
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BME	11%	19%	22%	17%	23%	18%	20%	7%	8%			
BME (heads)	3	9	9	8	9	16	18	6	7			
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

As part of the WRES action plan and the People & OD Strategy we are required to report on our monthly starters and leavers and quarterly on our recruitment and disciplinary data. The first of these are featured in the table opposite. These show the numbers of BME starters and leavers from April to December 2017 compared to the current Trust BME profile.

In December we had 7 BME starters and 6 were in frontline roles.

In December we had 6 BME leavers, 3 of whom were in frontline roles.

Year to date we have 85 BME starters and 64 BME leavers.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BME	29%	14%	26%	14%	11%	22%	9%	11%	14%			
BME (heads)	9	6	9	8	6	11	4	5	6			
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

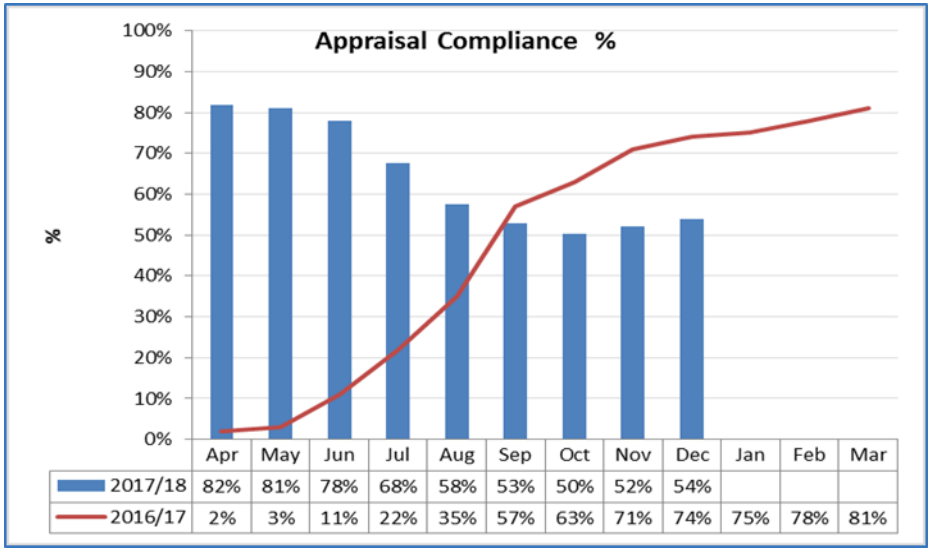
The WRES report has highlighted a number of planned activities to positively affect the experience of BME employees at the LAS. BME Focus groups were held world café style on the 14th December and in addition we have also started a series of "lunch and learn" sessions to build understanding of equality and the challenge faced by the Trust to address the balance in our workforce. The first session was held on 15th December.

Community Engagement Events

On the 8th of January we started our road show of community engagement events at Westfield (East) and the Stratford Centre. The LAS were there for 7 days in total and we had 208 expressions of interest.

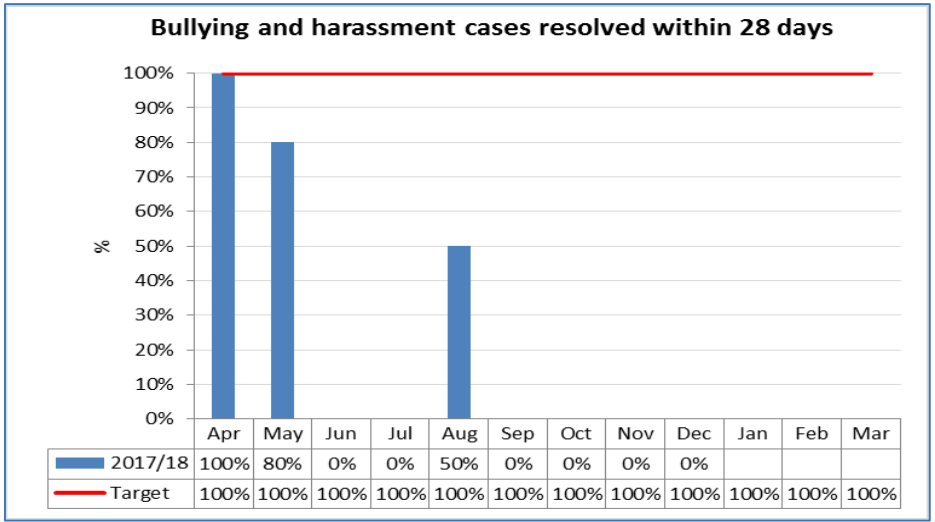
Heather Lawrence and Patricia Grealish attended the Investing in Ethnicity & Race launch of the Maturity Matrix at the House of Commons hosted by Dawn Butler, Shadow Minster for Equalities. The Maturity Matrix is a tool to help embed change on Race in the workplace.

Bullying & Harassment/DBS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	82%	81%	78%	68%	58%	53%	50%	52%	54%			
2016/17	2%	3%	11%	22%	35%	57%	63%	71%	74%	75%	78%	81%

- The appraisal rate has improved from 52% in November to 54% in December.
- From 1st January to 31st December 2017 there have been 2,539 appraisals completed out of 4,710 eligible staff (we exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS).
- These rates are being discussed at the monthly performance review meetings to ensure management awareness and that all PDRs are completed as required.
- A communication has been sent to the LAS Workforce during January. The communication emphasises both the importance of quantity and quality appraisal. In order to support quality, a paper has been drafted to conduct an appraisal audit with recommendations and desired outcomes which is ready for Executive approval and which will be conducted by the P&OD team across the Spring of 2018.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	100%	80%	0%	0%	50%	0%	0%	0%	0%			
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Independent mediation services

The LAS has appointed an independent mediation provider for complex or entrenched cases of conflict (12 month contract). The provider Total Conflict Management, will resolve up to 14 cases annually and will collect detailed metrics on themes and trends which allow for bespoke training to be delivered and review the efficacy of the interventions.

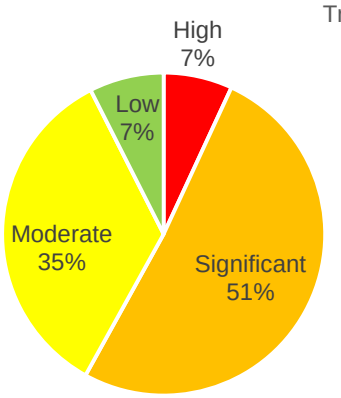
Focus group - Future solutions in reducing Bullying and Harassment – a first workshop was facilitated and has generated staff discussions concerning the next steps to creating a culture of conflict competence. This is the first of three focus groups planned and will result in an action plan based on staff ideas for future solutions.

In December, there was one open formal bullying and harassment case and this has breached the 28 day target.

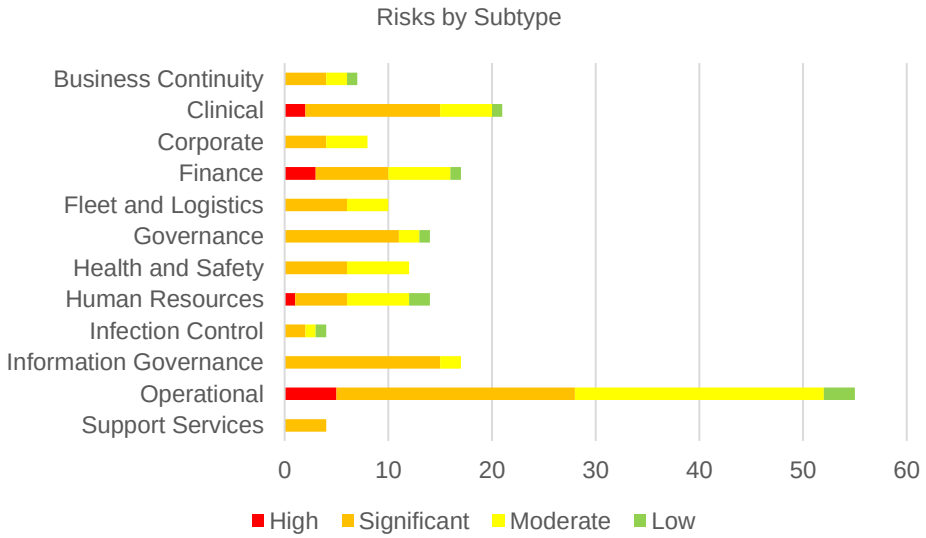
Our Risks

There are 12 risks with a risk level of High, these sit in Operations (4), Finance and Performance (2), Quality Directorate (2) People and Organisational Development (2) IM&T (2) . The highest risk scores at 20, with the others at 15 or 16. These risks are:

Section	Risks
Operations	709 – Impact of tax liability on blue light vehicles – new risk added with a current rating of 15 in November 2017, current rating not changed since risk opened. 430 - Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability, risk opened December 2016, current rating 16 not changed since risk opened. 559 - Delays in ambulance crews handing over their patients at Northwick Park Hospital ED will reduce operational cover in the surrounding area and compromise patient care - risk opened in December 2016 with a current rating of 9 which was escalated to a current rating of 16 in November 2017, current rating not changed since November 2017. 598 - Current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed - risk opened in February 2017 with a current rating of 15. Risk due for closure January 2017.
Quality	676 – Lack of compliance with Health and Safety regulations – new risk added with a current rating of 20 in November 2017, current rating not changed since November 2017. 677 – Risk of musculo- skeletal injuries to front line staff – new risk added with a current rating of 15 in November 2017, current rating not changed since November 2017.
Finance	713 - The preferred LAS strategy is not deliverable within the Trust's identified strategic timeframe due to the scale of investment required – new risk opened November 2017 with a current rating of 15, current rating not changed since November 2017. 647 - The Trust may not receive the full £7.8 million attached to the contractual CQUINs – risk opened June 2016, current rating 15 not changed since risk opened. This risk was removed from the BAF in December and the current rating being proposed for de-escalation to the next RCAG meeting in February.
IM&T	577 - Operating the LAS CAD system with continued levels of activity above the contract baseline will cause the system to fail and hence impact on patient care – risk opened in January 2017 with a current rating of 15, this risk is proposed for closure and will be discussed by RCAG on 18 January 2018. 734 - A cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period – risk opened in November 2017 with a current rating of 20, current is being proposed for de-escalation by the RCAG on 18 January to 15.
People and Organisation Development	533 - The Trust may not be able to recruit to the increased number of established Paramedic positions to meet the amended workforce profile requirements in 2017/18, risk opened in November 2016 with a current rating of 16 not changed since risk opened. 704 - The Trust may be unable to maintain service levels due to insufficient staff in the EOC – new risk added with a current rating 16 in November 2017, current rating not changed since November 2017.



	Risk Rating	Risk Level	Risks	
	15-25	High	12	7%
	8-12	Significant	89	51%
	4-6	Moderate	60	34%
	1-3	Low	13	7%
		Total	**174**	



The register of risks approved showed the following at 16th January 2018:

• 58% of the Trusts risk register has a risk level of High or Significant.

• Just under a third of the overall Trusts risks are Operations risks (29%), with Clinical risks accounting for 8%, Finance risks accounting for 10%, Health and Safety risks accounting for 11% and Information Governance risks accounting for 9%.

Top 3 Risks:

BAF Risk 46
Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.

BAF Risk 47
The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

BAF Risk 45
There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description
ADO	Assistant Directors of Operations
ARP	Ambulance Response Program
APP	Advanced Paramedic Practitioners
AQI	Ambulance Quality Indicator
BME	Black and Minority Ethnic
CARU	Clinical Audit and Research Unit
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDLO	Controlled Drugs Liaison Officers
CISO	Clinical Information & Support Overview
CPI	Clinical Performance Indicator
CPD	Continuing Professional Development
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRU	Cycle Response Unit
CSR	Core Skills Refresher (Training)
DBS	Disclosure & Barring Scheme
DOC	Duty of Candour
EAC	Emergency Ambulance Crew
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Dispatcher
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ESR	Employee Service Record
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)
FFT	Friends and Family Test
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale
FRU	Fast Response Unit
GCS	Glasgow Coma Scale
GTN	Glyceryl Trinitrate

Acronym	Meaning / Description
HAC	Heart Attack Centres
HART	Hazardous Area Response Teams
HASU	Hyper Acute Stroke Unit
HCP	Health Care Professional
iPara	International Paramedic
JCT	Job Cycle Time
KPI	Key Performance Indicator
LIN	Local Intelligence Network
LINC	Listening Informal Non-Judgemental Confidential
MAR	Multiple Attendance Ratio
MRU	Motorcycle Response Unit
MTC	Major Trauma Centre
NETs	Non-Emergency Transport
NRLS	National Reporting and Learning System
OOH	Out Of Hours
OWR	Operation Workplace Review
PAS / VAS	Private / Voluntary Ambulance Services
PED	Patient Experiences Department
PGD	Patient Group Directions
PFVH	Patient Facing Vehicle Hours
PRF	Patient Record Form
PSP	Patient Specific Protocal
PTS	Patient Transport Service
QGAM	Quality, Governance and Assurance Manager
QR	Quality Requirement
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
SI	Serious Incident
SIG	Serious Incident Group
STEMI	ST-Segment Elevation Myocardial Infarction
TEAC	Trainee Emergency Ambulance Crew
TRU	Tactical Response Unit
YTD	Year to Date
WTE	Whole Time Equivalent

LAS 111 (South East London): Glossary December 2017

QR	Measure	Target	Description
	Total calls answered		Number of calls made to 111 and answered by an LAS call handler.
05	Calls answered within 60 seconds	95%	Of the total answered calls, how many were answered within 60 seconds of being queued for an advisor?
04	Calls abandoned after 30 seconds	1%	Of the total calls offered and reaching 30 seconds following being queued for an advisor, how many did the caller hang up before they were answered?
	Calls transferred to or answered by a clinical advisor		Of the total answered calls, what percentage were directly triaged by a clinician during their 111 episode?
	Of calls transferred, percentage transferred warm		Of the total answered calls that were transferred to a trained 111 clinical advisor, how many were transferred while the caller was on hold?
13	Of call backs, percentage within 10 minutes	100%	Of the total calls where person was offered a call back by a 111 clinician, for how many was the person actually called back within 10 minutes of the end of their first call?
10	Calls referred to 999	10%	Of the total number of calls answered, what were the number of final dispositions that result in an ambulance being dispatched?
11	Calls referred to Emergency Department	5%	Of the total calls received and triaged by a 111 call handler or clinician, how many were referred to a type 1 or 2 A&E department?

London providers – areas covered:

London Ambulance Service (LAS): 1. South East London
Care UK: 1. Hillingdon,, 2. North West London
Partnership of East London Co-operatives (PELC): 1. East London & City
London Central & West: 1. Inner North West London, 2. North Central London
Vocare : 1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**09/01/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**30/01/2018**
Presented by:	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**	**Prepared by:**	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**

Matters for escalation:

- There is a risk that, next year, not all training can be delivered within the current resource. The Education and Standards team has significant vacancies which, whilst not impacting on training delivery this year, need to be filled before next year to deliver the required training across the service. There is also a need to provide on-going development for Clinical Tutors to ensure provision of high quality training in the future. The Deputy Director of Education and Standards is undertaking an initial review which will be brought to the March Quality Assurance and People and Organisational Development Committees. A risk about the capacity for training is on the agenda for the next meeting of the Trust's Risk, Compliance and Assurance Group (RCAG). This is an immediate difficulty but is set within the context of development of the Academy and relationships with Universities and other Ambulance services.
- There is continuing concern about Emergency Operations Centre (EOC) staffing – call handling numbers - this is a national problem. Pauline Cranmer (Deputy Director of Operations (Control Services)) outlined how the Intensive Support Programme is working to address recruitment and retention and we were reassured that there has been some recovery of the previous good performance. However, this reflects enhanced overtime, turnover remains high and although there is a good response to advertisement only a small number of those who apply are appointed. Pay differentials are being discussed at national level. There are also difficulties staffing the Emergency Bed Service (EBS) which has prevented 24hour telephone safeguarding reporting.

Other matters considered:	• Damian Marchese and Graham Norton presented the quality governance processes in the south west sector. The Committee noted the good work and how improved metrics were facilitating governance discussions locally. • Justin Wand presented the completion of the remedial actions following adverse findings at Deptford Logistics Support Unit. It was noted that the inspection occurred during building works and so some procedures were not followed. We were assured by Trisha Bain (Chief Quality Officer) that processes were being put in place to ensure all major projects (not just building projects) would first undergo a Quality Impact Assessment (QIA) to ensure standards are maintained during the project. There are also some issues at some sites around the way staff groups (staff and contractors) are working together • The 111 Service – Nic Daw and Mary Emery gave an update. The committee was assured our current performance was good as evidenced by several of our processes being adopted in national guidelines. Plans for development of integrated services in south east and east London were outlined. Risks that had been identified were around IM&T infrastructure and possible unpredictable increases in call volume. • Patient Care Plans – a paper was circulated. Work is continuing to improve access to care plans across the Health System and will be facilitated by plans for Clinical Commissioning Groups (CCGs) to engage with a common portal (e.g. Coordinate my Care) and by the rollout of personal digital equipment to crews. • The Committee also reviewed the Serious Incidents report; Quality Report; Quality Improvement Plan (and Care Quality Commission (CQC) Inspection plan). • Lesson learnt. Following thematic analysis of Serious Incidents related to EOC three policies were identified that required review and two were not being followed reliably. Action has been taken.
Key decisions made / actions identified:	• Trisha Bain (Chief Quality Officer) presented the outline for the next Quality Account including the broad priority areas for 2018/2019. After discussion these were approved and will be taken forward for wider consultation. • Philippa Harding (Director of Corporate Governance) presented the Annual Committee Effectiveness review. The review demonstrates that we have fulfilled our purpose in the current year and some minor changes to our ToR were endorsed. These will be submitted to the Board for approval in March, as part of a Trust-wide corporate governance review.

Risks:	• BAF Risk 7 (Patients could suffer avoidable harm across shift change…..). Progress is being made towards the achievement of the target for the take up of rest breaks. Paul Woodrow is to review the process with the unions and discuss spreading of the rest breaks offered. Guidance has been written to assist the allocators in determining which calls are clinically safe (based on the information provided at call-handling) to be held for a short time to facilitate rest breaks. In addition there is work ongoing regarding the possibility of changes in the CAD system to enable crews to be "stood down" for breaks on the system in an orderly way. Other measures (tethering of ambulances within sector; end of shift protection) have yet to be implemented. However, we were assured that even so performance has been smoothed over the day and is above ARP target level. • BAF Risk 48 (Major incident..impacted by insufficient managers …..access to blue light vehicles – change by HMRC). There are solutions for this issue – quick fixes and longer-term, perhaps better, changes. This is a critical function of the London Ambulance Service and the Executive Leadership Team should cost options and make a prompt decision.
Assurance:	• We were assured that appropriate controls are in place where necessary for medicines management in stations during the roll out of secure drug rooms to all stations, and that control would be strengthened following completion of the project.

London Ambulance Service NHS Trust

Assurance report:	Finance and Investment Committee	Date:	16/01/2018

Summary report to:	**Trust Board**	**Date of meeting:**	**30/01/2018**
Presented by:	**Fergus Cass, Non-Executive Director, Finance and Investment Committee Chair**	**Prepared by:**	**Fergus Cass, Non-Executive Director, Finance and Investment Committee Chair**

Matters for escalation:

- Based on results to date (the end of December), there is a high level of confidence that the 2017/18 control total – a deficit of £2.4m – will be delivered and that improvement on that figure is likely.
- Capital expenditure to date is £9.9m, out of a planned full year total of £24.6m. The Committee noted that urgent management action is in hand to accelerate spending.
- A draft of the 2018/2019 Annual Financial Plan will come to the Board on February 27th. The Committee discussed the work done so far and the assumptions being used. An initial computation has suggested that savings of up to £21.5m could be needed in order to deliver the target control total surplus of £1m. The Committee noted that the projection of front line resources will reflect performance in 2017/18 against the new ARP response times, which may result in budget savings.
- The Committee discussed a plan to take forward the Cost Improvement Programme (CIP). This incorporates the learnings from 2017/18. Based on benchmark data, it is estimated that moving to a median position would give annual savings of £16m and that further savings are feasible. Delivery will take time and will require a Programme Management Office (PMO), which will cost an additional £0.6m per annum. The Committee endorsed the plan but requested confirmation that the PMO would support not only CIP but the full range of change activities.
- The Committee noted that there is an urgent need to progress savings that will impact 2018/19; projects not delivered in 2017/18 are a likely source.

Other matters considered:	The Committee: • noted that the Trust's costing capability is being enhanced. It reviewed the Reference Costs in respect of 2016/17, recently published by NHSI. After adjusting for regional cost factors, LAS costs were 5% above the national average; based on 2017/18 expenditure this represents approximately £18m per annum. • noted progress in developing the Quality and Performance Review framework; this involves the metrics, formats and processes that enable reporting within directorates, to ELT and to the Board. Balanced scorecards are being refined and consideration is being given to the creation of business units within directorates, each with their own scorecard. • welcomed improvements to the format of the monthly Finance Report. • noted a report on recent accounting, legal and regulatory developments; inter alia, this indicated that IM&T are preparing a gap analysis relating to the General Data Protection Regulation (GDPR), which comes into effect on 25th May 2018.
Key decisions made / actions identified:	The Committee • discussed the financial aspects of the contract to provide 111 and Integrated Urgent Care (IUC) services to North East London and will report separately to the Board. • noted that a review of the use of agency staff will be submitted to the People and OD Committee on 8th February 2018. • agreed to hold an additional meeting in February to review the draft 2018/19 Annual Financial Plan before it comes to the February Board meeting. • discussed the annual review of the Committee's effectiveness; noted that the Committee had substantially achieved its workplan; and agreed to recommend minor amendments to its Terms of Reference, including a more explicit reference to the Committee's role in relation to financial risks. The Terms of Reference will be submitted to the Board for approval in March, as part of a Trust-wide corporate governance review. • agreed that the assurance responsibility in relation to the recently approved Procurement Maturity Plan will move to the Logistics and Infrastructure Committee.
Risks:	• Risks relating to the delivery of the 2017/18 results and cash flow are referred to below ("Assurance") • The Committee recommended reconsideration of BAF Risk 49, which currently reads: "The preferred LAS strategy may not be

	deliverable within the Trust's timeframe due to the scale of investment and resource required". This is felt to be insufficiently specific and is being overtaken by the work on the Five Year Financial Strategy • The Committee suggested inclusion of a risk relating to the deliverability of the efficiency improvements needed to achieve the 2018/19 control total. It recognised that the development of the 2018/19 Annual Financial Plan could result in a degree of mitigation, especially in relation to staff costs.
Assurance:	The Committee reviewed financial performance, cash flow and capital expenditure to the end of December 2017 and the related forecasts for the full year 2017/18. • In the first nine months there was a £0.5m surplus of income over expenditure, which is £4.5m ahead of the rephased budget. Clear explanations were provided of variances from budget and of assumptions underpinning the full year forecast, covering: activity levels and the related income; CQUIN delivery; staff costs; non-pay costs; CIP performance; depreciation; and capital expenditure. • The December Finance Report forecasts that the deficit target of £2.4m will be achieved. The Committee's review of results to date, and of risks, indicates that this is likely to be improved upon, especially as a result of once-off savings and staff costs that are lower than plan. However, risks remain from the possible impact of winter pressures and it is felt appropriate not to change the forecast at this point. • The Committee concluded that the relevant reports and explanations support the expectation that the Trust will maintain a positive cash balance across the next 12 months and will achieve or exceed its March 2018 target cash balance of £11.7m.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	30 January 2018			
Report title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Review			
Agenda item:	12			
Report Author(s):	Brian Jordan, Business Manager to the Director of Operations			
Presented by:	Paul Woodrow, Director of Operations			
History:	Trust Board correspondence in 31 October 2017			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Trust Board was previously briefed on the Trust's EPRR annual assurance process and National Ambulance Resilience Unit (NARU) visit in October 2017.

The EPRR annual assurance process is used by NHS England in order to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

The attached paper provides a background summary of the process; assurance that the Trust has been assessed as 'substantially' compliant; details of the three amber ratings; the governance arrangements in place to ensure that the actions required are fully completed on time; and a summary of the current position concerning the NARU inspection which took place in December 2017.

Recommendation(s):

The Board is asked to note the content of the report.

Links to Board Assurance Framework (BAF) and key risks:

No BAF risks are associated with the content of this paper.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐

Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☒

Emergency Preparedness, Resilience And Response (EPRR) Annual Assurance Review

Background

1. The Trust Board was briefed in October 2017 about the 2017/18 Emergency Preparedness, Resilience and Response (EPRR) assurance process. This is the process which NHS England (London) uses in order to gain assurance that the London Ambulance Service NHS Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

2. The Trust submitted its annual self-assessment to NHS England (London) by the deadline of 13 September 2017 and this had required 46 EPRR, 14 Chemical Biological Radiological Nuclear (CBRN), 19 Marauding Terrorist Firearms Attack (MTFA) and 21 Hazardous Area Response Team (HART) related standards to be RAG-rated against our level of compliance. At the same time, a number of key documents and plans were submitted to NHS England (London) as supporting evidence. A 'deep dive' into the Trust's EPRR governance arrangements was also conducted as part of this year's review.

3. In terms of the outcome, there are four compliance levels which Trusts can be assessed against. These are as follows:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately address all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place, however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed
Non-Compliant	Arrangements in place do not appropriately address eleven or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

4. This year's assurance process also included a more detailed review of NHS strategic assets and national capabilities. As part of this review, a four day inspection was undertaken by the National Ambulance Resilience Unit (NARU) on behalf of NHS England between 11 and 14 December 2017.

Annual EPRR Review Outcome

5. An assurance meeting was held with NHS England (London) on 21 November 2017 to review the self-assessment and to agree any actions which are required to address any

deficiencies. The Director of Operations was in attendance at this meeting together with the Deputy Director of Operations (Central Operations) and other senior EPRR leads.

6. A Trust's overall level of compliance is based on the total number of amber and red results agreed at the review. NHS England (London) formally confirmed on 1 December 2017 that the Trust had three amber ratings and is therefore assessed as SUBSTANTIALLY compliant for EPRR under this year's process.

7. The NARU review is undertaken separately and does not contribute to this compliance level. Further details about the outcome and process concerning the NARU review is provided below.

Amber Ratings

8. NHS England (London)'s commentary around the three amber ratings is as follows:

Core Standard 8: Duty to maintain plans – Incident Response Plan (IRP)

"*The plan is currently in draft form however it is deemed fit for purpose and contains the appropriate information. The Trust recognised that the plan is still under review and learning from recent incidents - and any subsequent inquiries - will need to be incorporated.*

The Trust has demonstrated a number of changes in the last year including: moving information out of the plan and into action cards; changing the format of the document to make it more straight-forward; and as requested by members of staff, the inclusion of tabs on action cards for easier reference and finding information.

The Trust confirmed that the action cards are currently being re-printed. Final sign-off of the IRP is expected in March 2018 and as such the Review Team agreed with the self-assessment of Amber with the expectation that this core standard should be in a position to be rated as green by the 2018 assurance review".

Core Standard 9: Duty to maintain plans – corporate and service level business continuity

"*The Trust confirmed that the current corporate business continuity (BC) policy is in draft format, still requiring a few amendments before it goes to the Board for sign-off. In addition to this, there are over 100 local BC plans each with business impact assessments. The Trust confirmed that the timeline for completion of these local and corporate plans is January 2018. Plans will be operationally tested following winter operations (March - April) and are expected to be signed-off by May 2018.*

The Trust highlighted the links between the BC policy and the BC plan, as outlined in the BC Framework document, and confirmed that two BC exercises have taken place this year with a further programme of testing and validation expected to take place in the spring of 2018.

The Review Team acknowledged the amount of work and revisions which have taken place over the last year but also recognised the effort still required to get the plan signed-off. As such, the Review Team agreed with the self-assessment of Amber with the view that this should be in a position to be rated as green by the 2018 assurance review".

Core standard 24: Duty to maintain plans in line with current guidance

"*The Trust confirmed that they rated themselves Amber on this core standard due to its relation to the IRP which is still in draft form. They are currently reviewing all the interdependencies and ensuring alignment and consistency of formatting (i.e. using same language, terminology, reference points etc.).*

The Trust confirmed that, as this standard is linked to the IRP, it should be in a position to be rated green once the plan has been signed off in March 2018. The Review Team agreed with this self-assessed rating of Amber and was encouraged by the expectation of a green rating next year".

Next Steps

9. An action plan has been developed and will be agreed with NHS England (London) to address all the standards rated as amber. A copy of the action plan is attached as an Annex to this report for the Board's information. At the time of preparing this report, all actions have either been completed or are within the agreed timescale for completion.

10. Quarterly meetings are scheduled between NHS England (London)'s EPRR team and the Trust to monitor and review progress against the action plan.

11. On-going monitoring and progress against the action plan will also be reported to the Emergency Preparedness and Response Strategic Group and quarterly to the Operations Board which in turn will provide assurance upwards to the Executive Leadership Team and the Audit Committee.

12. The Trust Board will receive an update in six months so that the Board can assure itself that adequate resources are being made available to enable the Trust to meet the requirements of these core standards.

13. The Trust's EPRR annual assurance outcomes which have been reported in this paper will now be shared with each Area Local Health Resilience Partnership (LHRP), with the formal reporting being undertaken at the Regional Local Health Resilience Partnership meeting in March 2018.

NARU Inspection – December 2017

14. As mentioned previously, this year's assurance process has also included a more detailed review of NHS strategic assets and national capabilities. As part of this review, a four day inspection was undertaken by NARU on behalf of NHS England between 11 and 14 December 2017.

15. The Chief Executive and the Director of Operations received verbal feedback from NARU on the last day of their inspection. They described the interim report for the Trust as 'very good'. This is particularly reassuring given that the Trust is the last ambulance service to be inspected and NARU had all the other services to benchmark us against. NARU were also clear that the Trust is evidencing notable best practice nationally in some areas.

16. The Trust received NARU's interim report on 15 December 2017 and, at the time of preparing this paper, it has until 9 January 2018 to challenge any of the findings or provide any corrections. Following this, we will receive NARU's final report and formalise a final action plan. Both documents will be shared with the Trust Board in the near future.

17. The main issues which the Board can expect to see in the action plan include:

- The Trust's ability to provide full HART and Tactical Response Unit (TRU) teams at all times. The Panel observed that HART's operational effectiveness and safe systems of work have been maintained within London but the Trust will need to focus on filling the small number of HART vacancies and work with NARU to minimise the time taken to access places on the national HART training programmes.

  Steps have already been taken to ensure that these issues are a priority for the Trust's new Operations Resourcing Group (which is chaired by the Director of Operations/Accountable Emergency Officer and attended by the Director of People and Organisational Development) and which reports to the Trust's Executive Leadership Team. This group will also be monitoring the previous week's HART, MTFA and CBRN team compliance levels to continually drive improvements in this area and to identify/resolve any barriers to full compliance.

- A scavenging system will need to be installed at the Cody Road site and EPRR will work with Estates to implement an appropriate system.

- A number of issues concerning space at Cody Road have been identified and which the Trust will address as we develop our new estates strategy. NARU does however acknowledge that London presents limited viable options without significant additional capital investment.

Paul Woodrow
Director of Operations

NHS Clarifying Information	Assurance RAG Rating	Action	Due Date	Responsible Person	Notes
Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))		IRP review in relation to EPRR policy	Jan 18	L Lehane	
		Refresh IRP structure/streamline contents	Jan 18	L Lehane	
		Update Chair/CEO statements	Jan 18	L Lehane	
		Inclusion of updates from recent AACE National learning event	Jan 18	L Lehane	
		Inclusion of updates from recent London Incidents	Jan 18	L Lehane	
		Draft for review - LAS Senior Ops Team	Feb 18	L Lehane	
		Draft for review - Peer Review/NHSE EPRR London	Feb 18	L Lehane	
		Draft for review - key partners	Feb 18	L Lehane	
		Review Comments for Consideration/Inclusion from review	Feb 18	L Lehane	
		Finalise IRP	Feb 18	L Lehane	
		Approval of IRP at EPRSG	Feb 18	L Lehane	
		Approval of IRP at Operations Board	Mar 18	K Bate	
		Commence publication of New 2018-2020 IRP	Mar 18	L Lehane	
Corporate and service level Business Continuity (aligned to current nationally recognised BC standards)		Revision of Corporate and local BC plans	Jan-18	Sarah Rodenhurst-Banks	
		Ongoing training of local BC plans	Jan - March 18	Sarah Rodenhurst-Banks	
		Circulation of revised plans for feedback and update	Feb-18	Sarah Rodenhurst-Banks	
		Revised BC plans to Board	Mar-18	Sarah Rodenhurst-Banks	
		Implementation of BC communication process	March/April 18	Sarah Rodenhurst-Banks	
		Trust exercise of Corporate BC plan	May/June 18	Sarah Rodenhurst-Banks	
		Review and revision of plan following exercise as required	June/July 18	Sarah Rodenhurst-Banks	
		Communication of changes	Jul-18	Sarah Rodenhurst-Banks	
		Implementation of corporate plan	Jul-18	Sarah Rodenhurst-Banks	
		Review and update of BC Strategy/Framework	Aug-18	Sarah Rodenhurst-Banks	
		Develop revised BC work plan	Aug-18	Sarah Rodenhurst-Banks	

NHS Clarifying Information	Assurance RAG Rating	Action	Due Date	Responsible Person	Notes
• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).		Review current EPPR documents including EP/HART/CBRN/TRU	Jan-18	T Porter	
		Align documents as appropriate	Apr-18	T Porter	
		Document consultation	May-18	T Porter	
		Finalise documents	Jun-18	T Porter	
		Publish	Jun-18	T Porter	
		Check and summarise review dates	Jun-18	T Porter	
		Create EPRR document library/database	Jan-18	T Porter	
		Develop EPRR document control procedure	Jan-18	T Porter	

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	13			
Report Author(s):	Frances Field, Risk and Audit Manager			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Leadership Team and Board Assurance Committees			
Status:	☒	**Assurance**	☒	**Discussion**
	☒	**Decision**	☒	**Information**

Background / Purpose:

This paper provides the Board with an updated Board Assurance Framework (BAF) and Corporate Risk Register.

Recommendation:

The Board is asked to consider and agree the BAF.

Links to Board Assurance Framework (BAF) and key risks:

This paper sets out the content of the BAF.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒

Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Board Assurance Framework (BAF)

Current BAF Risks

1. There are currently seven risks on the BAF which have a net rating of 15 or above they are set out below in descending order of severity. Following review by the Executive Leadership Team (ELT), it is proposed that three of these should be removed (these are set out below):

Severity	Risk	Risk Owner	Scrutinising Committee	Comments
1	**BAF Risk 46** Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Trisha Bain, Chief Quality Officer	Corporate Health and Safety Committee and Board	
2	**BAF Risk 47** The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre (EOC).	Patricia Grealish, Director of People and Organisational Development	People and Organisational Development Committee	
3	**BAF Risk 49** The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 2018/19.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	Wording amended in January 2018, following discussion at Finance and Investment Committee (see para 6 below)
4	**BAF Risk 45** A cyber-attack could materially disrupt the trust's ability to operate for a prolonged period.	Ross Fullerton, Chief Information Officer	Logistics and Infrastructure Committee	

Risks that the ELT proposes should be removed from the BAF				
	BAF Risk 7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability	Paul Woodrow, Director of Operations	Quality Assurance Committee	Propose de-escalate from BAF. See further information provided at paragraph 8 of this report.
	BAF Risk 40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.	Patricia Grealish, Director of People and Organisational Development	People and Organisational Development Committee	Propose close. See further information provided at paragraphs 9 and 10 of this report.
	BAF Risk 43 The management of bank workers may not meet current standards relating to training, governance and management	Patricia Grealish, Director of People and Organisational Development	People and Organisational Development Committee	Propose close, see further information provided at paragraph 11 of this report.
	BAF Risk 48 The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational managers having out of hours access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities which has resulted in increased personal cost to managers for having access to vehicles with emergency response capabilities	Paul Woodrow, Director of Operations	Quality Assurance Committee	Propose close, see further information provided at paragraph 12 of this report.

Risks added to the BAF since the last Board meeting

2. No new risks have been added to the BAF since the last Board meeting.

Risks removed from the BAF since the last Board meeting

3. The following risks have been removed from the BAF since the last Board meeting:

BAF Risk 41
The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.

4. Following the roll out of new mobile devices to staff across the LAS, Risk 41 was agreed for closure, as indicated at the meeting of the Board on 28 November 2017.

BAF Risk 42
The Trust may not receive the full £7.8 million attached to the contractual CQUINs.

5. The Board agreed at its meeting on 28 November 2017 to de-escalate Risk 42 from the BAF, following recommendation by the Finance and Investment Committee.

Risk discussions in December and January

Board Assurance Committees

6. At its meeting on 16 January 2018, the Finance and Investment Committee discussed the articulation of BAF Risk 49. It was considered that its previous articulation (the preferred LAS strategy may not be deliverable within the Trust's identified strategic timeframe due to the scale of investment required) did not accurately reflect the risk faced by the Trust and therefore this has been updated as set out earlier in this report.

Executive Leadership Team proposals to de-escalate BAF risks

7. The ELT discussed the content of the BAF at a formal meeting on 17 January 2018 and an informal meeting on 24 January 2018. At these meetings it was proposed that the following risks should be closed/de-escalated from the BAF, for the following reasons:

BAF Risk 7
Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability

8. The ELT agreed to propose the de-escalation of Risk 7 in light of the Trust's safety performance at times of shift change and the fact that there had been no increase in the number of serious incidents experienced by the Trust. Further information relating to this risk will be tabled at the meeting of the Board on 30 January 2018.

BAF Risk 40
The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.

9. The ELT agreed to propose that Risk 40 should be closed, as it was too broad. Instead it was considered that four risks should be raised, relating to the recruitment of the following staff groups:

   a. Those in the Emergency Operations Centre (EOC);
   b. Paramedics;
   c. TEACs and EACs; and
   d. Those providing the 111 service.

10. Of the groups identified, the ELT considered that only the first carried a BAF-level risk, as already reflected in BAF Risk 47

BAF Risk 43

The management of bank workers may not meet current standards relating to training, governance and management

11. The ELT agreed to propose to de-escalate Risk 43 in light of the delivery of all required mitigating actions. The Trust now had a clear process in place for the recruitment and management of bank workers, which requires them to provide evidence of completed DBS checks and statutory and mandatory training before they can be employed.

BAF Risk 48
The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational managers having out of hours access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities which has resulted in increased personal cost to managers for having access to vehicles with emergency response capabilities.

12. The ELT agreed to propose de-escalation of Risk 48 following discussions at the Finance and Investment Committee and the Quality Assurance Committee. This risk is being reviewed following investigations into various mitigation strategies. Although the changes to HMRC tax rules have been modified, this has not seen any reduction in management blue light capacity as yet and it is intended that the mitigations will have been considered and implemented prior to any such risk being realised.

Executive Leadership Team horizon scanning

13. The ELT identified two potential future BAF risks, which will be proposed for consideration at forthcoming Board Assurance Committee meetings:

    a. The potential risk that the Trust may not be able to deploy enough ambulances (as a result of technical equipment requirements) – for consideration by the Logistics and Infrastructure Committee at its meeting on Tuesday 6 February 2018; and
    b. The potential risk that the Trust does not have sufficient training capacity – this has already been considered by the Quality Assurance Committee and a detailed review is being undertaken, which will be reported to the next meeting of that Committee on 20 March 2018.

Corporate Risk Register

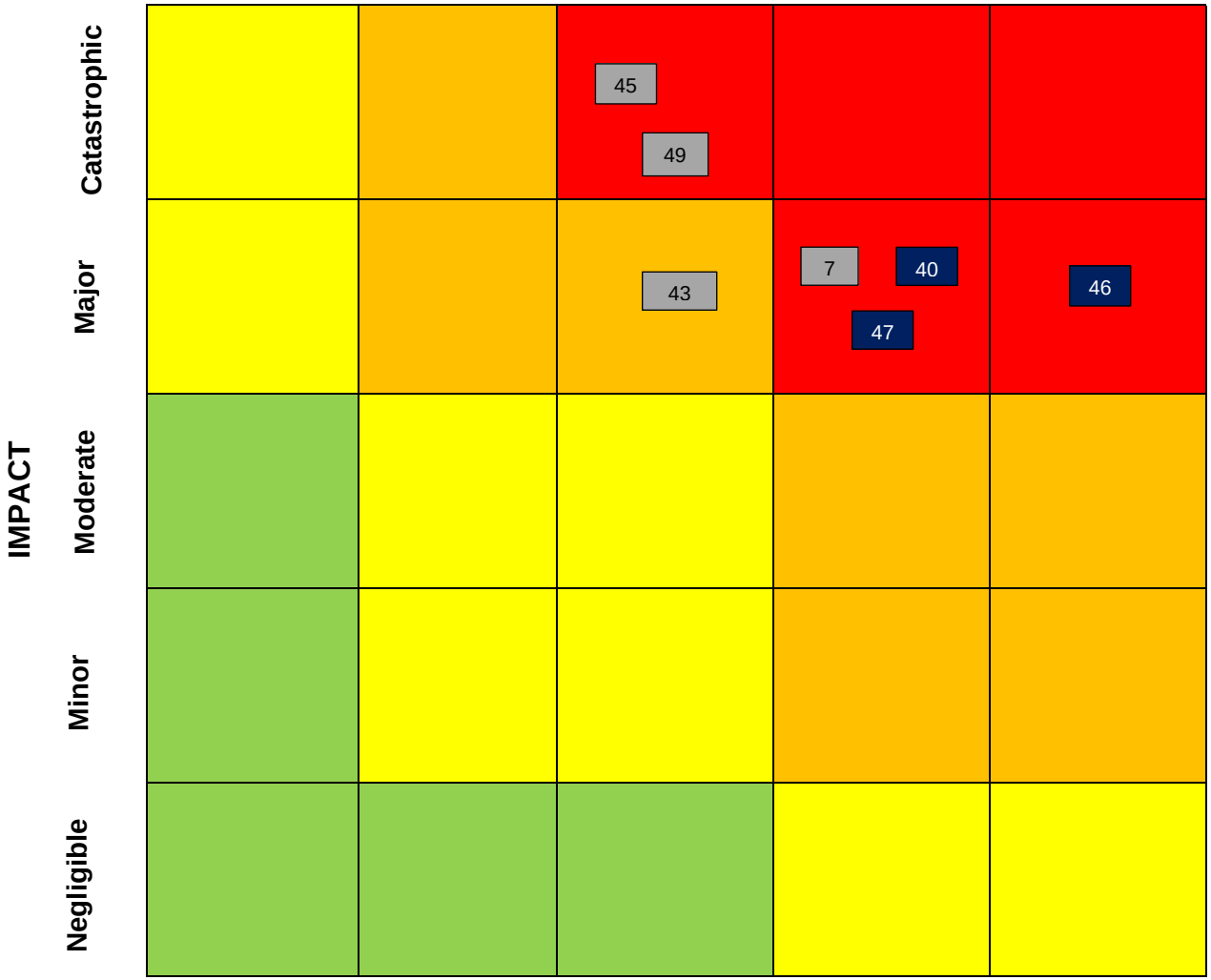
14. The Corporate Risk Register is also attached for the Board's information.

Risk Appetite Statement

15. Board members discussed the approach to be taken to the annual review of the Trust's Risk Appetite Statement at the Board development session on 12 December 2017. It was agreed that this should be presented to each Board Assurance Committee for consideration early in 2018, before final presentation to the Board for agreement. So far this has been presented to the Quality Assurance Committee and the Finance and Investment Committee. It will be presented to the People and Organisational Development Committee, the Logistics and Infrastructure Committee and the Audit Committee in February 2018, ahead of the Board's consideration at its meeting on 27 February 2018.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – January 2018



In order of severity:

BAF Risk 46
Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust

BAF Risk 47
The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

BAF Risk 49
The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19

BAF Risk 45
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

Proposed to be removed:

BAF Risk 7
Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.

BAF Risk 40
The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.

BAF Risk 43
The management of bank workers may not meet current standards relating to training, governance and management.

Risk Severity

- High Risk (15-25)
- Significant Risk (8-12)
- Moderate Risk (4-6)
- Low Risk (1-3)

Key

- Net risk rating
- Gross risk rating = net risk rating

GOAL 1	Patients Receive Safe, Timely & Effective Care

OBJECTIVES	1. To drive high quality and safe patient care 2. To improve clinical outcomes and enhance clinical excellence 3. To achieve agreed performance, ambulance and regulatory standards

Links to Objectives	BAF Risk	Further mitigation required
1, 2, 3	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	• Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) . • Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements
1, 2 3	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service. • Continuation of the support offered to recruitment for shortlisting, assessment space and interviews.
1, 2, 3	45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
	PROPOSED TO BE REMOVED:	
1, 2, 3	7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	• Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements
1, 2, 3	40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.	• Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1, 3	43 The management of bank workers may not meet current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts

GOAL 2 Staff are Valued, Respected & Engaged	OBJECTIVES	1. To ensure our workforce model meets future patient needs 2. To support the health and wellbeing of our staff 3. To develop our culture and improve our diversity 4. To support and equip our managers to lead well, from 'Board to Station' 5. To make things easier for our staff to do their jobs

Links to Objectives	BAF Risk	**Further mitigation required**
2, 4	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	• Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) • Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements
1	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service. • Continuation of the support offered to recruitment for shortlisting, assessment space and
	PROPOSED TO BE REMOVED:	
1	40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.	• Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1	43 The management of bank workers may not meet current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts

GOAL 3	Partners are Supported to Deliver Change in London

OBJECTIVES	
	1. To proactively work with London's five STPs to support delivery of the Five Year Forward View
	2. To expand our reach into the London Integrated Urgent & Emergency Care System
	3. To use data and system intelligence to improve patient care
	4. To work with partners to improve patient care and value for money

Links to Objectives	BAF Risk	**Further mitigation required**

GOAL 4	Efficiency & Sustainability Will Drive us

OBJECTIVES	
	1. To achieve financial targets and deliver a £17.8m Cost Improvement Programme
	2. To deliver a transformation programme to continue our improvement journey
	3. To have stable and reliable IT platforms to enable 21st century working
	4. To deliver the LAS 5 year strategy and strategic plans for essential infrastructure

Links to Objectives	BAF Risk	Further mitigation required
1, 2, 4	49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19	• Review Finance structure and prepare case to Trust Board to enable business partnering support • Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme
3	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
	PROPOSED TO BE REMOVED:	
4	7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability	• Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements

BAF Risk no. 46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust

Risk Classification: Health and Safety	**Risk Owner:** Trisha Bain	**Scrutinising Committee:** Corporate Health and Safety Committee
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF: 31/03/18**	

Underlying Cause/Source of Risk: The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance.

Gross Rating	Current/Net Rating	Target Rating
20	16	4

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Corporate Health and Safety Committee in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in place through Datix. 7. ELT/Board oversight for H&S compliance through the Trust's committee reporting structure. 8. Regular update reports are provided for Trust-wide committees. 9. Responsible Director for Health and Safety in place for the Trust. 10. Regular reporting of H&S action updates through the monthly Quality Report, Quarterly Health and Safety Committee and the Quality Oversight Group. 11. Senior Management Level H&S Training completed by ELT/Board Members. 12. Health & Safety Strategy agreed by the Board. 13. Non-Executive Director appointed for Health & Safety.	1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 4. Non-Executive Director appointed for Health & Safety. **Gaps in Controls** 1. Lack of capacity within the Health and Safety Department to support the Trust, and to ensure Trust-wide H&S compliance. 2. A large number of the Trust-wide H&S policies require updating as they refer to out dated processes, legislation or to staff who have left the Trust. 3. The health and safety training provided is limited with gaps in areas such as manual handling refresher training, general health and safety refresher training for Managers. 5. Lack of robust arrangements for monitoring/checking the effectiveness of the training provided to staff as well as staff competency.	1. Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed seperately) . 2. Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements. 3. Agree Terms of Reference for the Corporate Health and Safety Committee ensuring appropriate representation. 4. Implement a system of annual health and safety audits to identify and address areas of gaps in Trust-wide H&S performance.	31/03/2018 31/03/2018 31/03/2018 31/03/2018

Signed: **Trisha Bain**

BAF Risk no. 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre

Risk Classification: People & OD	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF: ~~31/03/17~~ 31/10/2018**	

Underlying Cause/Source of Risk:
Recruitment: Competition for similar roles is strong and offer higher salaries (in the vicinity of HQ and Bow). Retention: The working environment in control rooms is frequently pressurised and staff turnover is high compared to other roles in the Trust

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. A monthly EOC Board tackles underlying causes of recruitment and retention, with a weekly call update to ensure progress is being made. This meeting is chaired by the Deputy Director of Operations (Control Services). 3. The existing recruitment process has been discussed and reviewed to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment function to ensure specialist knowledge in the recruitment team to allow good decisions on passing candidates through the shortlisting process. 7. A range of recruitment activities throughout Q1 will specifically target recruitment to EOC. 8. EMDs have been released to support job fairs to promote the role. 9. EMDs support EOC Training team delivering Open Evenings for potential candidates interested in joining 10. EOC are participating in the ongoing Talent Review which will look at the end to end process and identify improvements / gaps. 11. The team are currently looking at an alternative online assessment (NWAS currently use this approach) and will look to pilot a scheme should it prove affordable and of value **Gaps in controls** Knowledge of LAS experience - although trying to build the allocated EMD focus staff member's knowledge, there is a significant amount of time required to do so.	1. Monthly recruitment project meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support from PLM, Control Services 4. Recruitment activity added to weekly tracked reported to Operational Resourcing Group	1. Role will be included as part of planned recruitment campaign. 2. Continuation of the project meetings to maintain the level of scrutiny required by the service. 3. Continuation of the support offered to recruitment for shortlisting, assessment space and interviews 4. Review of approach to assessment in order to improve conversion rate of interested candidates. 5. Contact with Met Police to share experiences and explore mutually beneficial ways of working. on-going	31/03/2018 Ongoing Ongoing 31/03/2018 Ongoing

Signed: Patricia Grealish

BAF Risk no. 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee
Date risk opened: 17/011/2017	**Date risk expected to be removed from the BAF:** September 2018	

Underlying Cause/Source of Risk:
1. Unknown Target Operating Model
2. The LAS strategy is to become the integrated emergency & urgent care provider and a significant transformation of service delivery is required to enable system-wide financially sustainable operating model.
3. Size of and pace of delivery of recurrent CIPs will need to increase - need to be driven by evidence-based, relevant benchmarking metrics in order to achieve full efficiency opportunity
4. Sources of funds for capital investment to be confirmed to support the LAS strategy
5.Need for appropriate programme approach/resource to deliver strategy
6. Up until 2017/18, the LAS operated within a block contract and fixed income financial envelope and has been in special measures over the last year, with the result that priority could not be given to developing financial and commercial awareness of budget holders to develop a devolved service level management model in line with the norm in other NHS organisations, which will accelerate delivery of value improvement.
7. Instead, budget control has largely been achieved through central management and contingency accounting so need to develop more mature financial framework and capability for budget delivery.

Gross Rating	Current/Net Rating	Target Rating
25	15	10

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process.	Trust Board and FIC finance reports Capital Programme action plans	1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency). 3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme. 4. Revenue and Capital financing options to be identified. 5. Confirm programme resource budget to deliver strategy. 6. Review Finance structure and prepare case to Trust Board to enable business partnering support. 7. Develop budget and business case training programme to support financial strategy.	31/03/18 31/03/18 31/03/18 30/09/18 31/12/17 31/01/18 31/01/18

Signed: Lorraine Bewes

BAF Risk no. 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period

Risk Classification: IM&T	**Risk Owner:** Ross Fullerton	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 01/06/2017	**Date risk expected to be removed from the BAF:** ongoing	

Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats has accelerated rapidly in the last 5 years; cyber-attacks are regularly successful at disrupting many organisations in ways that weren't considered possible only a short time ago. This is compounded by an under-investment in IT security at LAS over the same time frame. As a consequence there is a deficiency in the overall awareness of cyber risk inside and outside of IM&T and we lack the skillsets, processes, governance and tools to mitigate the evolving threat profile effectively.

Gross Rating	Current/Net Rating	Target Rating
20	15	12

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Existing defences have mitigated threats to-date; these include various technical and procedural elements 2. Independent review by PA Consulting has identified necessary mitigations for CAD system **Gaps in Controls** The existing controls do not meet good practice requirements as defined by HMG's National Cyber Security Centre.	1. Reports to Information Governance Group of cyber-related incidents each quarter – Reporting will be tied to Key Performance Indicators and services. 2. Reports from IGG to RCAG – All work carried out as part of the Cyber Security Improvement Programme will be reported to the IGG and RCAG. 3. To align with the NCSC guidance we will look to comply with Cyber Essentials by the end of February 2018. **Gaps in Assurance** The gaps are being investigated by the Cyber Security Improvement team and pragmatic/practical recommendations and an action roadmap will be drawn up.	Initial Bid to NHSD for Cyber funding Capital (Bid 1) NHS Digital led review of LAS cyber security (November 2017). Implementation of HMG good practice in cyber controls (Cyber Essentials) Potential second bid to NHSD for Cyber funding Capital (Bid 2) Implementation a Cyber programme of works (to include the recommendations from the PA consulting report)	30 Nov 2017 Successfully Completed March 2018 March 2018 April 2018 May 2018

Signed: Ross Fullerton

PROPOSED FOR REMOVAL FROM THE BAF

BAF Risk no. 7 **Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.**				
Risk Classification: Operational	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Quality Assurance Committee		
Date risk opened: 08/12/2006	**Date risk expected to be removed from the BAF:** 31/03/2018			
Underlying Cause/Source of Risk: Roster configuration, rest break arrangements, increased Out of Service (OOS) , staff wanting to finish their shifts on time and avoid late finishes		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		20	**16**	**8**
Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 5 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Robust implementation of the existing rest break policy 6. On-going rigorous management of out of service. **Gaps in Controls** 1. Culture and behaviour of staff being driven by perverse incentives within the current rest break agreement 2. The desire of staff to end their shift on time and avoid late finishes 3. Sufficient management capacity within EOC	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the Operations Board on progress and compliance 5. Rest break allocation rates are reviewed at Chief Executive performance reviews 6. A task and finish group which includes executive directors, control services managers and medical directorate representatives are monitoring rest break allocation rates and have agreed the actions which are due to be delivered by 1 February 2018. 7. An operational roster review has commenced with ten stations due to go live with new rosters in September 2018 with the following 8 group stations going live in March 2019. **Gaps in Assurance** There appears to be a relationship between the number of rest breaks allocated per day and out of service (OOS) rates at shift end. The more rest breaks that are given the higher the end of shift OOS and this is being looked into	1. Increase rest break window to allow more time for the allocation of breaks. 2. Move 5 identified DCAs per hour and per sector onto an 'out of service' code so that it is only possible for them to be interrupted for a Category 1 call. 3. Identify 15 - 30 ambulances to provide extra DCA shifts between 11:00 and 23:00 hours (bridging shifts) so that additional cover is in place over the rest break window to protect the allocation of breaks. 4. Development of a clear clinical safety process to support dispatch staff at times of reduced DCA availability. 5. Launch a robust communications strategy for internal and external parties which will explain the rationale for changes being implemented from 1 February 2018. 6. Formal review of the number of rest breaks/flexible breaks taken three months after implementation. 7. An end of shift working group which includes trade union representatives commenced in early January and will publish its plan by 1 February 2018.		01/02/2018 01/02/2018 01/02/2018 01/02/2018 02/02/2018 28/02/2018 31/03/2018
Signed: McKenna, Peter				

BAF Risk no. 40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18

Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 06/03/2017	**Date risk expected to be removed from the BAF:** 31/05/2019	

Underlying Cause/Source of Risk: Increase in paramedic numbers over and above planned 2016 levels in order to meet agreed 2017/18 contract; existing and known shortfall in supply of UK graduate paramedics, exacerbated by "fallow year" in 2017 due to degree programme extending from 3 to 4 years.

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Recruitment Plan for 2017/18 has been developed to track all front line posts (including EOC)and now includes revised funding against projected increase in demand 2. Weekly meetings take place (Operational Resourcing Group) chaired by the Director of Operations (deputy Director of People and OD) to bring focus on progress and ensure decisions can be made quickly if delays / blocks are identified 3. A second international recruitment campaign was completed in October 2017 4. Clinical Education capacity identified **Gaps in Controls** 1. Skill mix profile as yet undefined/unconfirmed. 2. Identify source of supply of additional paramedics	3. Initial recruitment Plan for 2017/18 developed and is evolving 4. Weekly meetings in place, chaired by the Director of Operations to review recruitment activities, education capacity and outcomes and numbers released to operations (Operational Resourcing Group) 5. Weekly recruitment tracker and slide pack in place focusing on performance against plan, attrition and internal staff movements 6. Monthly reporting to ELT on front line recruitment 7. Progress against recruitment plan a standing item at People & OD Committee 8. Number of Paramedics required identified 9. International Recruitment campaigns in Australia (April and October) - we have recruited over 350 paramedics with start dates betwn Jan & Jun 2018. 10. Monthly contact with iPara cohorts to confirm starting arrangements 11. Improved UK Graduate numbers for 2018/19 – estimated to recruit 244 FTE 12. Healthy TEAC recruitment pipeline – we have recruited 244 this year with over 80 in the pipeline 13. Working with partner universities to encourage graduates to London 14. Working with non-partner universities to increase graduate numbers to London 15. Implementation of Band 6 - will reduce migration to other Trusts 16. Development of an improved workforce planning report 17. Closer working relationships with HEE 18. Potential conversion of other HCPS 19. Encourage UK graduates to see LAS as 'employer of choice' through direct engage at universities	1. Further improved workforce planning and reporting to include supervision 2. Continue to identify additional partner Universities 3. Review mentoring capacity to ensure ability to process numbers of employees in training 4. Review skill mix in line with clinical strategy 5. Review skill mix in line with ARP 6. Apprentice paramedic pipeline including EAC progression 7. Further development of LAS Academy pathway 8. Confirm 2017/18 core frontline funded establishment	08/02/2018 31/03/2018 31/03/2018 31/03/2018 31/03/2018 31/02/2018 31/03/2018 Complete

Signed: Patricia Grealish

BAF Risk no. 43	**The management of bank workers may not meet current standards relating to training, governance and management**	
Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 04/07/2017	**Date risk expected to be removed from the BAF:** ~~30/11/2017~~ 30/03/2018	

Underlying Cause/Source of Risk: No manager identified for Bank Workers and no one responsible for ensuring compliance with Trust requirements. There is a need to ensure bank workers have a current DBS and that current driving licences are provided. Bank Workers are expected to attend CSR but are not paid for attending this training. We have historically not had robust and readily available training completion data.	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	16	**12**	**4**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**	**Due Date**
1. There is a co-ordinator in post to manage Bank Workers. For performance management Bank Workers are allocated to a sector, central control will be held by Resourcing who will ensure compliance with necessary check (driving licences, DBS and training). 2. New Terms of Engagement have been completed and have now been issued to all Bank Workers. This sets out expectations on remaining compliant with the Trust's StatMan training. 3. Bank Workers found not to be compliant with training obligations have been removed from the Register until they have completed the training or provide evidence of acceptable standards from work with other Trusts. 4. All external Bank Workers go through full recruitment process (in the same way as substantive employees). External bank workers (i.e. not-ex LAS) are Paramedics required to uphold their professional registration. Core skills must be maintained to successfully re-register. 5. DBS re-checks are prioritised as part of the DBS re-checking project agreed by the Trust in 2017. 6. A process has been set out to manage the recruitment and employment checks for Bank Workers.	1. Bank Worker contracts, reviewed by Beachcroft, are now in use 2. Only 'active' Bank Workers – who have worked a shift within the last 12 months will be on the active register (they will be required to give evidence of training to remain 'active')	Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts.	Complete

Signed: Patricia Grealish

Comment: Good progress has been made with the appointment of a Bank Co-Ordinator. A refresh of the Register is underway to ensure that only Bank Workers that are working shifts and have the right checks and training are included. This will also significantly reduce the size of the Register to approximately 171 individuals.Regular meetings will be scheduled with Resourcing (who hold responsibility for managing the Bank Worker Register and allocating to rotas) to check progress. In relation to training, once the Refresh is complete the Bank Workers will be included as a group on the Trust's Stat Man training reports. Currently training records for this group are held by the Resourcing Team.

Corporate Risk Register as at 12th January 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
676	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust. The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance some of which are listed below: 1. Lack of arrangements to clearly identify, assess and manage significant risks associated with manual handling, lone working and driving. 2. Outstanding actions from the HSE Improvement Notice issued to the Trust in 2010	20/09/2017	46	20	High	1. Corporate Health and Safety Committee meeting structure in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in	Bain, Trisha	09/01/2018	20	High		1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 4. Non Executive Director appointed for Health & Safety.	4	Moderate
430	There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	08/12/2006	7	20	High	1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 5 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Robust implementation of the existing rest break policy 6. On-going rigorous management of out of service. 7. Implementation of the Ambulance Response Programme (ARP) will see less cancellations and more efficiency in dispatch which will produce more capacity and resource availability over the shift changeover period	Woodrow, Paul	10/11/2017	16	High	757 - Out of Service (OOS) Hub implemented. Central Support Unit (CSU)on PD33 deals with all OOS requests Recruit additional frontline staff Review management and EMD capacity within EOC Agree the new rest break policy with Trade Unions Current rest breaks arrangements to be reviewed Update skill mix model Enact end of shift protection arrangements Implement new rest break policy Current rest break arrangements to be robustly applied Out of service HUB implemented Agree the process for the rest break arrangements to be implemented. Recruiting frontline staff to 3169 by March 2016 Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the scrutinising committees on progress and compliance 5. Sector GSM will spend time on DDS desk in EOC to challenge non-compliance issues in real time 6. Instigation of New Dispatch Model Trial in North Area to include tethering to Sectors which will make rest break implementation easier. Extension of critical cover at end of shift for NC Sector FRUs	8	Significant

533	The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18	15/11/2016	40	16	High	• Recruitment Plan for 2017/18 developed against initial requirement for paramedics (prior to agreed projected increase in demand) • Based on anticipated graduate numbers (90) and apprentice paramedics (76), an additional requirement for c.400 has now been confirmed, 300 of which we have already planned to source internationally. • Clinical Education capacity identified	Grealish, Patricia	13/11/2017	16	High	Increased Recruitment activity and engagement with Universities/graduates Review recruitment plan and capacity against revised requirements Improved workforce planning and reporting International Recruitment of paramedics Review skill mix in line with clinical strategy Review skill mix in line with ARP Apprentice paramedic pipeline including EAC progression further development of LAS Academy pathway Continue to identify additional partner Universities Review mentoring capacity Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'.	1. Initial recruitment Plan for 2017/18 developed and is evolving 2. Weekly meetings in place, chaired by the Deputy Director of Operations to review recruitment activities, education capacity and outcomes and numbers released to operations (A&E Resourcing) 3. Weekly recruitment tracker and slide pack in place focusing on performance against plan, attrition and internal staff movements 4. Monthly reporting to ELT on front line recruitment 5. Progress against recruitment plan a standing item at People & OD Committee 6. Number of Paramedics required identified 7. International Recruitment campaigns in Australia (April and October) - we have recruited over 350 paramedics with start dates betwn Jan & Jun 2018. 8. Monthly contact with iPara	8	Significant
704	The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre	20/10/2017	47	16	High	1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. They have discuss and reviewed the existing recruitment process to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment	Grealish, Patricia		16	High		1. Monthly recruitment project meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support form PLM, Control Services	8	Significant

713	There is a risk that... The preferred LAS strategy is not deliverable within the Trust's identified strategic timeframe due to the scale of investment required.	17/11/2017	49	25	High	Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process.	Bewes, Lorraine		15	High		Trust Board and FIC finance reports Capital Programme action plans	10	Significant
577	There is a risk that operating the LAS CAD system with continued levels of activity above the contract baseline will cause the system to fail and hence impact on patient care. Please see note re interim description*	12/01/2017		20	High	1. Resilience designed into the CAD architecture (multiple servers with semi-automated failover and secondary datacentre sites) to cater for complete CAD failure. 2. Maintenance Contract in place with the supplier to recover the system from incidents. This include oncall staff. 3. LAS Technical and management staff on call to manage incidents 4. Automated alerting of rising issues and system monitoring to both supplier and LAS staff. 5. Daily and weekly assurance checks of the system and fall back mechanisms. 6. Documented paper process for paper operations (OP66) intended for EOC to operate safely.	Fullerton, Ross	17/11/2017	15	High	Reports to May Board	An external review has been commissioned to undertake a root and branch review of the LAS CAD environment. This will; 1. Fully understand the complex underlying issues with the CAD solution to evaluate, respond to and ensure appropriate actions are taken from the Root Cause Analysis. 2. Support and enhance the IM&T management and leadership capability, including implementing any immediate actions that come out of the incident review or are required from the application of Best Practice IT service management. 3. Perform a more holistic resilience review that will cover a range of business and technology resilience angles including, but not limited to, hardware infrastructure resilience; software package resilience; contractual position of IT services; EOC business resilience; staff resilience	5	Moderate

647	There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs	22/06/2017		20	High	1. A full review of all reports prior to submission undertaken to ensure achieving as specification 2. CQUIN briefing papers distributed to all Directors and CQUIN leads 3. Contracting and Commissioning Team hold monthly catch up calls with all CQUIN owners 4. Quarterly, face to face, meetings held with the Director of Transformation and Strategy, in conjunction with the Contracting and Commissioning Team 5. Monthly CQUIN working group established in partnership with the commissioners to recover a particular CQUIN 6. Monthly meetings now amended to fall in sequence with submission dates and external CQUIN meetings	Bewes, Lorraine	17/11/2017	15	High		1. Reports to be submitted to ELT updating progress against all key milestones 2. Update reports to FIC and Trust Board where required	10	Significant
709	The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability.	03/11/2017	48	20	High	1. Strategic and Tactical Commanders can attend out of hours incidents by driving under normal road conditions when on-call	Bate, Kevin	15/11/2017	15	High		None	5	Moderate

559	there is a risk that ongoing delays in ambulance crews handing over their patients at Northwick Park Hospital ED will reduce operational cover in the surrounding area and compromise patient care.	05/12/2016		16	High	1. Intelligent conveyance desk 2. 24/7 monitoring of London EDs by Incident and Delivery Manager (IDM) 3. Regular hospital visits by Incident Response Officers 4. Regular meetings with NWP and NW SEM 5. Trolley bed vehicle can be deployed to EDs where there are significant problems	Woodrow, Paul	19/12/2017	15	High	Hospital Meetings Raise hospital issues at CCG meetings attend daily NWL surge conference calls Daily contact with NWP Staffing of performance cell Attendance at daily LAS performance meetings staff communication Provide updates on NWP patient Cohort nurse Deep dive analysis System review attend meetings Frequent caller activity Standardise ACP raise profile of handover delays work with STP	1. Intelligent conveyance report - including crew compliance 2. IDM shift report 3. Report by exception in the IDM shift report 4. feedback at the weekly NW Sector performance meeting 5. Strong local links with NWP senior/Exec Management team Archived: 6. Trust Performance cell running for 16hours daily which monitors ED activity/build up. 7. 2 x daily performance meetings/conference calls 8. Daily NWL Surge conference calls attended by SEM 9. Daily visits/contact with NWP by SEM (completed)	4	Moderate
598	The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed. The current losses of devises means that not enough devises are available for operational crews and journeys are being dispatched via voice instructions from control. There is an urgent requirement about replacing our devices to ensure maximisation of crew efficiency. Furthermore the safety of crews is compromised as one means of contact with control has been eliminated, albeit mitigation has been put in place through the introduction of handheld radios.	07/02/2017		15	High	Hand held airwave radios. Crews personal mobile phones. Data collection currently verbally relayed to control. Crews advised to contact control every 20 minutes where delays occur.	Woodrow, Paul	21/11/2017	15	High	Purchase replacement devices Roll out on NETs Devices to NET Operational Staff	Manually collected data is recorded in Meridian and Command Point. Telephone conversations with crews are recorded within EOC.	6	Moderate

677	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments. In 2016/17, 506 out of the 3309 health and safety incidents reported on Datix related to manual handling incidents. 486 of the incidents reported resulted in low/moderate harm. 75 of the harm related incidents were reported as RIDDOR. The impact of this risk includes: 1. Moderate/severe harm to staff. 2. Staff injury claims. 3. Impact on patient care and the delivery of services due to staff absences/shortage of resources.	20/09/2017		15	High	1. Manual Handling Group in place – Chaired by a DDO. 2. Manual handling policy implemented across the Trust. 3. Awareness training provided to all front line staff during their Corporate Induction to the Trust. 4. Monitoring of incidents, trends and compliance undertaken by the Corporate Health and Safety Committee. 5. Small handling kits available on all vehicles to aid the easy handling of patients. 6. Specialist MH equipment e.g. Manger Elk, trolley beds, Ferno Tracked Carry Chairs e.t.c are available to all front line staff. 7. Trust-wide incident reporting and management system in place through Datix. 8. Additional support available for staff where they are unable to safely lift a patient or equipment. 9. Risk assessments has been completed for high risk manual	Bain, Trisha	09/01/2018	15	High		1. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 2. Review and oversight by Manual Handling steering group.	9	Significant
288	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients.	14/11/2002		20	High	1.Monitor level of CSR training and delivery. 2. CPIs are used to monitor the standard of assessments provided. 3. Incident reporting is in place and reports are provided to the Clinical Safety & Standards Committee (CSSC) and the Area Governance Groups. 4. The Operational Workplace Review has been reviewed and will now include ride outs. 5. A system for clinical updates is in place. 6. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 7. Introduction of Paramedic Pathfinder – an adaptation of the Manchester Triage System to safely identify the most appropriate destination for	Wrigley, Fenella	28/12/2017	12	Significant	2. Design processes to audit and monitor the effectiveness of the pathfinder tool. Incorporate a defined clinical career structure within the clinical strategy New risk to be submitted to SMT/ELT to reflect current clinical risk for ongoing clinical supervision. Core Skill Fresher Training 2016/17	CPI reports OWRs CSDEC EMT/TB reports Learning from Experience	9	Significant

451	There is a risk that staff members who drive on behalf of the trust are not compliant with Trust policy, which states that checks will be undertaken every six months and these do not always occur to the standard or frequency defined. Whilst 93% may appear to be a high compliance this leaves 7% of our frontline staff open to this risk. We are currently unable to identify which of these 7% it may apply to.	09/08/2016		20	High	Driving license checks to ensure drivers are doing so legally. UPDATE 7/3/17. All drivers without valid driving licences checks have been identified (focussing on Ops). Letters will be going out to staff this month to stand them down from driving duties until checks are completed. Work on going to implement an electronic solution c6 months away that will adequately control this risk	Bate, Kevin	27/12/2017	12	Significant	Scope market for driving licence checking software Shortlist potential driver database solutions Initial review of technical spec Initial review of governance documentation Contact DVLA regarding Access to Database Update required	Driving licence checks every 6 months Check drives and licence checks following long term absences and some driving related incidents Driving course proof asked for and checked at recruitment stage	4	Moderate
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands	10/06/2016		16	High	1, Forward view of fleet requirement for next 5 years 2, Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that unplanned maintenance levels do not adversely affect fleet capacity and the provision of safe environment to operational staff 3, Ensure capital investment is committed to support fleet volume and replacement 4,External/stakeholder support in place as required 5, Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan 6, Have an agreed vehicle specifications 7, Agree and maintain adequate headroom in fleet numbers to manage variation 8, BC 140 new vehicles agreed	Lorraine Bewes	14/12/2017	12	Significant	Retain up to 50 ambulances following introduction of 140 new vehicles Manage roll out of 60 new FRU cars Progress Business Case for further FRU cars Review case to retain ambulances following introduction of 140 new vehicles Retain 20 FRU cars to increase size of fleet to 180 Review additional ambulance capacity to support roll out of new Vehicle Preperation Scheme Delivery of 140 new vehicles throughout 2017	1, Forward view of fleet requirements 2, Plan in place to move current fleet to under 7 years 3, Capital investment requirement understood and reflected in LTFM 4, vehicle specification in place.	9	Significant
117	There is a risk that the equipment for front line vehicles may not be properly maintained. This may result in clinical failure due to faulty equipment	21/05/2015		16	High	1,Replacement equipment budgets in place, process agreed and adhered to. 2, Maintenance/Replacement of kit undertaken when required 3, Process for maintenance of equipment reviewed 4, asset database showing maintenance records	Lorraine Bewes	14/12/2017	12	Significant	introduce improved asset tracking to improve location tracking of equipment Clarify the risk and totally review Roll out of vehicle preperation project	Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet Reports and OOS reports	6	Moderate

120	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care	21/05/2015		16	High	1, Serial numbers on all re-usable equipment that can be accurately tracked. 2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4. Vehicle Preparation HUB scheme in place - vehicles checked nightly for missing equipment 5.Audit system in place for missing equipment 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP	Lorraine Bewes	14/12/2017	12	Significant	Email Justin Wand to see if thinks this risk should be merged with 121 Enhanced daily vehicle check Roll out Vehicle Preparation to rest of service Ensure adequate stocks of consumables and equipment are available to VP staff Fully develop equipment database reports to indicate where any equipment is missing	1, Clinical Equipment Group; 2, Asset tracking report; 3, VP reports; 4, VP Contract; 5, Equipment Process; 6, Project completion 7, Board reports and meeting minutes.	8	Significant
121	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care	21/05/2015	25	16	High	1. Agreed 'standard load list' of vehicle equipment including re-usable v disposable in place. 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit 6, A "core" equipment list for DCA & FRU has been defined and agreed 7, Funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed. 8, An equipment amnesty and physical review all stations and complexes for "retained" equipment has been undertaken. 9, A new paper based VP VDI form has been introduced. 10, Pilot to assess benefits of VP proposal carried out and documents describing benefit drafted	Lorraine Bewes	14/12/2017	12	Significant	Implement enhanced asset tracking system Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG Email Justin Wand to see if thinks this risk should be merged with 120	1, Progress made in agreement of core equipment and further equipment amnesty. 2, Decontamination of equipment commenced and robust. 3, Analysis of asset tracking systems being undertaken. 4, VP VDI improved 5, Ops VDI process changed and LA1 updated 6, required committees and working groups have been established to review	8	Significant

240	Archiving space for training records is insufficient and now decentralised	20/06/2016		16	High	1) Systems are in place to organise existing documents but don't incorporate new documents	Ivanov, Tina	12/01/2018	12	Significant	Transfer risk to corporate risk register Compose an options paper Construct gating template review risk and its activity with Deputy Director, Clinical Education Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting Gain formal project management support for this risk	Reviewed at monthly managers meeting	8	Significant
289	There is a risk that the management of controlled & non-controlled drugs at Station level is not in accordance with LAS procedure (TP/008 Policy & Procedure for the Use of Medicines by LAS Staff).	21/10/2008		16	High	1. Policy reminder to be reinforced by bulletins from Director of Operations/Medical Director. 2. Independent audits to be carried out throughout the Trust. 4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 5. Daily audit checks 6. The policy itself defines individual responsibility 7. Area governance reports to CQSEC 8. Mandatory LIN reports to CCG 9. Unannounced visits by MPS 10. Annual attendance by MMOG to AO update days 11. MMOG reports to ELT and Trust Board 12. Meds mgt events for Station Group management teams ongoing. 13. Seconded paramedic for audit / information collation and	Woodrow, Paul	20/12/2017	12	Significant	Trust Pharmacist to undertake review of operational estate to access suitability for storage and security of medicines Estates department to review and audit operational sites to look at feasibility of secure drugs rooms with CCTV/swipe card access Review process for managing controlled drugs Convert or create secure drugs rooms in the 24 stations identifed for completion by end of 17/18 Funding request for LAS pharmacist and subsequent recruitment to post	1. Internal Audit 2. Independent Audit (MET Police carrying out spot checks) 3. LIN oversight of system 4. MMOG to CQSEC, EMT and Trust Board 5. New Medicine Safety Officer will carry out unannounced spot checks and provide feedback	8	Significant
302	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system. NOTE: Risk ID 205	01/06/2005		16	High	1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc. 2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system	Ivanov, Tina	12/01/2018	12	Significant	Management of student records Transfer risk to the corporate risk register. Construct gating template Compose an options paper Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting Gain formal project management support for this risk	Manager Governance responsible for: 1) Records are stored safely and securely, are identifiable and easily accessed, and meet all records management policies. 2) Records are archived in a timely manner as per Information Governance policy	8	Significant

380	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	11/06/2014		16	High	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies. 3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available.	Fullerton, Ross	17/11/2017	12	Significant	1. The current MDT software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 & 3. 2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above. 3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process. 5. Obtain 2nd hand SatNavs from other Trusts.	IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweigh the volume of units required. In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles.	4	Moderate
420	There is a risk that Trust systems are vulnerable to cyber attacks that could defeat industry standard firewalls and virus detection systems, resulting in loss of sensitive personal data and access to critical operational systems.	01/07/2016		16	High	1.Enterprise antivirus monitoring all desktops 2.Enterprise grade firewall on external facing ports 3.Email system scanning for viruses and malware 4.File on access scanning for viruses and malware 5.Desktop ports disabled (i.e. USB, DVD) 6.Web filter scans for viruses and malware 7.No access to internet/ email for command and control desktops 8.Air-gapped DMZ for external facing services 9.Automated patch management, including for non MIcrosoft 10.Strength in depth, layered security architecture	Fullerton, Ross	16/11/2017	12	Significant	Implement Firewall between CAC and LAS corporate Networks Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed. RCAG approval of report and format Additional information, such as patches applied / outstanding to be included in subsequent reports	1.IM&T daily monitoring 2.Firewall patched and malware detection software kept up to date. 3.Detected intrusion instances reported to IGIST and IGG 4.Detected and treated virus manifestations instances reported to IGIST and IGG 5.Anti-virus software updated at least daily. 6.Firewall and anti-virus software subject to formal change control 7.Firewall and anti-virus software on the daily IM&T assurance process	8	Significant
468	Risk that the communications team is unable to obtain accurate, timely information about casualties from Gold during a major incident, which leads to inaccurate information being put into the public domain, risking a drop in public and stakeholder confidence in our ability to manage major incidents.	14/09/2016		16	High	1. Communications team attend Gold meetings during a major incident. 2. It has been agreed that Gold will be the link for the communications team in terms of providing casualty numbers and details. e. Communications team policy is not to work with the lowest figure provided regarding casualties and provide a round number, for example, over xx casualties.	Patton, Angela	19/07/2017	12	Significant	Meet with Ops to clarify risk and identify mitigation - post RCAG 12 May 2017 Request that process re provision of casualty figures is added to major incident plan	This issue has been discussed with former Director of Operations and EPRR lead.	12	Significant

469	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	11/02/2015		16	High	1. Corporate communications channels reviewed and refreshed as part of communications strategy approved by the Board in June 2014. Team Talk introduced in September 2014 and now the operational management restructure is now in place – it is believed delivery and feedback will be improved. 2. Operational restructure will improve engagement with line managers. 3. Quality Improvement Programme Governance Structure in place.	Patton, Angela	19/07/2017	12	Significant	Develop engagement processes for operational staff Communication audit to evaluate internal comms and engagement Hold regular managers' conferenes Staff engagement effectiveness to be evaluated	Management restructure now complete and new ADOs committed to and making plans for strong staff engagement. CTLs now have 50% role for supporting staff.	8	Significant
470	There is a risk that that sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch). This could result in a lack of support by stakeholders: at best this would mean no support for improvement programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	11/02/2015		16	High	1. ADOs are developing strong relationships with key stakeholders from Aug 2015 2. New Communication Public Affairs Manager started in September 2015 supporting local stakehold engagement.	Patton, Angela	19/07/2017	12	Significant	Work with local stakeholder engagement managers Participate in weekly ADO call Introduce local stakeholder bulletin Support local leads Design process for local stakeholder feedback and reporting Evaluate effectiveness of stakeholder engagement Continue to support local stakeholder leads	To be confirmed	8	Significant

589	There is a risk that the Clinical Hub are unable to achieve optimal staff retention which will decrease its capacity to carry out the required functions and therefore may impact on patient care.	26/01/2017		16	High	1/ Staff are given clinical shifts at every opportunity. A second FRU has been sourced and equipped for clinical shifts. Work is on-going to source a second DCA. Staff are aware that we are looking at options to present a rota that will incorporate clinical time. Individual staff are prioritised for clinical shifts if their PDR / action plan prescribes it as an issue. CTLs use a 97 call sign when there are enough staff on the desk which allows them to respond to critical calls or those to support staff on scene. 2/ CTLs have been given the opportunity to undertake office shifts on one of their relief lines (where staffing allows) allowing them to carry out their management functions. 3/ Work is underway to trial a remote site at either Croydon or New Malden control room. 4/ No controls currently in place for Band 6 issue except all of the	Cranmer, Pauline	05/12/2017	12	Significant	Source and equip a second ambulance Rota review to include clinical shifts Remote site working	1/ Actively working with the DDO Logistics who is very keen to improve the CHUB clinical issues and wants CHUB to assist with equipment trials. Preparing information for DDO Control Services to consider around staffing options. 2/ 12 Field Ops CTLs to CHUB recently - recruitment for CAs just completing - CHUB CTL advert has been placed. All will likely improve staffing. 3/ Close working is on-going with IMT to review requirements for a remote site. Survey results will determine the effectiveness of this trial. 4/Team will review all Band 6 information to determine CHUB impact.	4	Moderate
650	There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management.	04/07/2017	43	16	High	HR to prioritise DBS checks for all bank workers and volunteers; All external Bank workers go through full recruitment process (as per substantive employees); External bank workers (i.e. not-ex LAS) are Paramedics required to uphold their professional registration. Core skills must be maintained to successfully re-register. There is now a co-ordinator in post to manage Bank Workers. For performance management it is proposed to allocate Bank Workers to a sector, central control will be held by Resourcing who will ensure compliance with necessary checks (driving licences, DBS and training).	Grealish, Patricia	17/11/2017	12	Significant	Stat + Mand training Recruit Bank Coordinator DBS check all Bank workers	1. Ongoing reports have been made via Statutory Mandatory training reports to ELT and CEO performance reviews. 2. Discussions at ELT have included paying Bank Workers to undertake CSR training. This route was not pursued 3. Bank Worker contracts for paramedics have been reviewed by Beachcroft and are being finalised for issue w/c 13 November 2017. 4. Only 'active' Bank Workers – who have worked a shift within the last 12 months will be on the active register. We will require them to evidence their training as part of the registration. This numbers 171 individuals – 43 of whom are ex-LAS employees.	4	Moderate

612	The Department of Clinical Education & Standards has very limited tutors who are current with the BTEC Manual Handling Qualification, therefore making compliance with Service Policy HS005 in respect of Manual Handling Training difficult. The risk is that when manual handling training is delivered the department will not have a sufficient number of qualified staff and will therefore not be compliant with service policy.	16/03/2017		15	High	The controls in place at present involve matching the qualified tutors to the manual handling activity which is difficult considering the variety of locations that the department operates from and the amount of activity within the department.	Ivanov, Tina	08/12/2017	12	Significant	Close Risk Create gating template Submit gating tempalte	The assurance of the controls is currently weak	3	Low
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement	27/05/2016		12	Significant	Risk management training sessions for managers was rolled out across the Trust from November 2015 and monthly sessions are still on-going. Risk registers are reviewed quarterly by the Governance and Assurance Team and areas of non compliance are reported to the Risk Compliance and Assurance Group. The Governance and Assurance Team provide support to areas and directorates through the attendance at meetings and 1:1 support where required.	Harding, Philippa	03/01/2018	12	Significant	Review areas review processess with reviewing and updating risks Review progress with risk management of higher level risks within directorates. Audit of local risk registers to be presented to RCAG each month for escalation of non compliance.	Compliance with the process is reviewed by the Risk Compliance and Assurance Group and areas of non compliance are escalated to the appropriate Directors.	4	Moderate
18	There is a risk that declared serious incidents are not investigated thoroughly and within a timely manner. TRR 405	09/07/2014		12	Significant	Interim agency support brought into the governance team to support the process. Monthly LI training for new investigators. Attempts to encourage none-operational manager to attend the training to provide robust investigator cover during times of significant operational demand.	Bain, Trisha	14/12/2017	12	Significant	SI process review SI training for lead investigators SI policy review SI session for assigned LIs as part of the new process SI training session for lead investigators	A monthly outstanding investigations paper is presented at ELT detailing all SIs where a finalised report has not been submitted. This information is also presented Trust Board. % out of 7 reports were submitted in time in September-Early October. The governance Trust board paper includes current SI workload and compliance. The quality report includes the above, learning from incidents/SIs, outstanding actions from investigations and SI trajectory figures.	6	Moderate

28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule. The impact of this may be: * adverse publicity / reputation * court order for specific disclosure which has financial implications; * adverse finding by HM Coroner / trial judge; * financial implication of settling claim as a result of not having any evidence to rebut allegations which could be	10/02/2016		12	Significant	Whilst the call log provides a summary of information noted this is not deemed to be an adequate control. Work is being undertaken by IM&T to source parts to keep the system running as and when required	Harding, Philippa	17/10/2017	12	Significant	Have we heard from R Clifford? Provide update for Risk Register HWH from R Clifford? Speak with IM&T re 111 risk Speak with Pauline Cramer re risk of over-recording Revert to RC for more detail Procurement and installation of new equipment Investigate conversion of DAT tapes to a modern media	IM&T are working on two projects to convert existing tapes and to procure and install new equipment and to investigate conversion of DAT tapes into a modern media	8	Significant
63	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to manage the increased workload, notably Marac requests for information. This may impact on the care of vulnerable adults and children. Original Risk ID 426	10/09/2014		12	Significant	1. Local managers running own reports in absence of safeguarding officer. 2. Out of office message to manage expectations.	Sloper, Briony	14/11/2017	12	Significant	1. Increase in members of safeguarding team to provide support across trust and partners (pending agreement of funding). 2. Develop an administrator post for safeguarding to cover increase workload and also support Safeguarding Officer when off (pending agreement of funding). Obtain resources to employ full time administrator	1. None. 2. Limited effectiveness. 3. None.	6	Moderate

263	There is a risk that there are currently no arrangements in place for routine quality assurance of dispatch functions which may affect the quality of call management and the service provided to patients. Lack of QA for dispatch resulting in an unquantifiable level of risk from poor compliance with dispatch protocols. Links to TRR 429	24/02/2012		12	Significant	1. Training for CP Dispatch and Allocation 2. QA audit of DDS and METDG calls. 3. QA of dispatch undertaken when complaints or incidents arise. 4. Updated Operational procedures 5. Increased breach analysis 6. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care.	Cranmer, Pauline	05/12/2017	12	Significant	Loading of Tableau to Desktop and Laptops Introduce KPIs into dispatch Write Business plan for QAD, incorporating a plan for the introducion of Dispatch QA Functions Development of a suite of KPI's for Dispatch QAD audit of DDS embedding into normal procedures to improve standards and mitigate risks to patients of poor quality welfare checks.	Implementation of KPIs dispatch and integration into performance management systems. Reduced complaints/issues arising from Call backs. How are controls measured/monitored? The Dispatch function is reviewed through a Quality Improvement process arising from the investigation of complaints Seriously Incidents and Inquests. Issues relating to technical and individual performance are identified through this process and actioned accordingly The Quality Assurance. Unit is now starting regular reviews of EMDs adherence to protocol on both the DDS (welfare ring backs) and on similar functions on Met DG. SMT Five-weekly watch reviews	9	Significant
327	NC13 - There is a risk that... ambulance availability will be reduced, where ambulance staff are waiting to obtain clinical and patient handover at Barnet Emergency Dept.	21/06/2016		12	Significant	1. ADO / SEM already engaging with Barnet ED Senior Team with SEM having weekly / monthly meetings and site visits. 2. Local CTLs are able to spend some of their 97 time supporting hospital flow. 3. GSMs continue to focus on HTT which is the LAS element to allow us to clear the ED. 4. Local messaging to staff to engage and reiterate the importance of timely escalation to Intelligent Conveyance / IRO teams. 5. SEM has made specific requests to the IDMs to gain IRO support particularly at weekends and OOH. 6. LAS Director-led Tri-partite calls continuing weekly - Commissioners are aware.	Brinicombe, Sean	13/12/2017	12	Significant	Update on BARNET ED	SRG engagement by ADO, and local ED engagement by SEM. QIP (Detailed objectives): Improving Patient Experience: Response Times Manage Risk Reduce hospital arrival to handover times	6	Moderate

349	There is a risk that the processes and enabling technology for operating on paper across two sites are not sufficiently robust and resilient resulting in a delayed LAS response	23/06/2016		12	Significant	1. PC Logger with current configuration now enhanced to more directly support fall back to paper by substantially increasing print speed. 2.OP/66 operational procedure updated for two site paper operations.	Woodrow, Paul	05/12/2017	12	Significant	Planned OP66 exercise dates	The PC Logger product after enhancement is fit for purpose. Assurance is gained from successful exercising of the OP66 procedure by all control room staff across all watches. Paper ops will remain as the 'back stop' business continuity procedure for EOC, a level of risk therefore must be tolerated.	6	Moderate
411	There is a risk that the lack of ownership of and responsibility for information assets will increase the likelihood of a security breach or data loss incident occurring.	08/10/2014		12	Significant	None	Fullerton, Ross	10/01/2018	12	Significant	Create and launch IA management framework Identify the IT information assets and owners Introduce a policy to assign an Information Asset owner (individual) to every new and existing IT information asset	Risk discussed and monitored by IM&T SMT	3	Low
431	There is a risk that... the LARP2 project will not deliver its main objectives (of implementing the new ESN based radio system in the control room, all LAS operational vehicles and other key areas before Jan 2020 when the current DH contract with Airwave Ltd. expires). This will result in the Trust not being able to deliver an adequate accident and emergency service.	05/07/2016		12	Significant	Project board set up and meeting monthly, pan Trust representation. Close working relationship with National programme for replacement of Airwave (ARP); represented on the LAS' project board. Project governance in place i.e. risk and issue logs etc. National programme risks are being managed by DH and HO project teams Increased level of Project Management - additional team members to be recruited to assist in the management of this programme.	Fullerton, Ross	21/11/2017	12	Significant	Sufficient resources being available to the Project to deliver the internal changes that will be required as/when the national programmes have delivered the new ESN and different frameworks	Project board established, meeting regularly. Its terms of reference reviewed in December 2015 and amended to include requirement of 75% attendance by the project board members. Close working relationship with the national programme and attendance at Pan London ES monthly meetings to ensure that risks/issues relating to London are fully understood. Representation on the national ARP board (VW); representation from the national programme on the LAS' project board (RC & CL).	8	Significant

439	There is a risk that tail lift failures on operational ambulances will impact on patient care. Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07/10/2013		12	Significant	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis (Updated 11/15 – S.Westrope amended maintenance schedule for A&E – every 12 weeks). 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with Loler compliance. Additionally independent inspections by the Freight Transport Association are undertaken. These are on a 10% inspection basis. 4. Reduce age of vehicles as the tail-lift is being used past the "designed life". 5, Ambulance design reviewed to include tail lift (from further actions) 6,Alternative tail lift has been fitted to a small percentage of vehicles (from further actions) 7, Training programme for workshops on fault finding organised (from further actions)	30S	14/12/2017	12	Significant	Fit new parts and springs to tail lifts at LOLER safety checks 6 week saety check on tail lift Fit new springs and covers to vehicles at next service and then at MOT Change tail lift springs annually and place protective cap on mechanism. 140 new ambulances with new external tail lift l	1. Motor risk management group review identified incident related to operational vehicles. 2. Corporate Health and Safety Group review all incident statistic trends. 3. Fleet management meet on a weekly basis and also review vehicle incident rate trends.	8	Significant
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made and appropriate help and support may not be provided by the local authority or other agencies as a result.	18/10/2016		12	Significant	1. EBS to check for gang involvement on safeguarding concerns raised. 2. Article written for clinical update (to be included in October 2016 edition).	Sloper, Briony	21/11/2017	12	Significant	1. RIB article reminding crews of need to report and undertake staff survey post CSR to check learning. 2. CSR 2016.3 session on children and gangs. 3. Scope possible gang work with Red Thread. 4. Undertake a re Audit of code 65 PRF's 5. Raise awareness in EOC to identify potential gang involvement and notify EBS.	1. EBS to continually review referrals data.	6	Moderate

634	There is a risk that... ambulance availability will be reduced, where ambulance staff are waiting to obtain clinical and patient handover at Royal Free (Hampstead Site) Emergency Dept.	05/06/2017		12	Significant	1. ADO / SEM already engaging with Royal Free (Hampstead site ED) Senior Team with SEM having weekly / monthly meetings and site visits. 2. Local CTLs are able to spend some of their 97 time supporting hospital flow. 3. GSMs continue to focus on HTT which is the LAS element to allow us to clear the ED. 4. Local messaging to staff to engage and reiterate the importance of timely escalation to Intelligent Conveyance / IRO teams. 5. SEM has made specific requests to the IDMs to gain IRO support particularly at weekends and OOH. 6. LAS Director-led Tri-partite calls continuing weekly - Commissioners are aware. 7. Discussed at contracts performance meeting. Daily information is sent to Commissioners for daily breach reports.	Rhodes, Peter	13/12/2017	12	Significant		SRG / CCG engagement by ADO, and local ED engagement by SEM. QIP (Detailed objectives from 16/17): Improving Patient Experience: Response Times Manage Risk Reduce hospital arrival to handover times	6	Moderate
678	Risk of physical and non-physical assault to frontline staff who come into contact with patients and members of the public during the course of their work. The impact of these incidents include: 1. Emotional, psychological distress to staff members. 2. Physical harm/injury to staff members where they are physically assaulted.. 2. Loss/decline of staff morale. 3. Increase in staff absences thereby impacting on service delivery. 4. Negative reputational damage to the LAS as an employer. 5. Increase in claims and litigation to the Trust.	20/09/2017		12	Significant	1. Security Management Policy implemented. 2. Violence Avoidance and Reduction Procedure in place. 3. Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4. Local management support, LINC and counseling services are available to staff. 5. Monitoring of incidents via the Trust's Health & Safety Committee where incident trends are reviewed and actions agreed to mitigate risks to staff. 6. Specialist advice available across the Trust via the LSMS and Health, Safety & Security Team. 7. High risk address flagging procedure in place and communicated to all relevant staff. 8. Air Wave radios and panic alarm systems implemented for all front-line staff. 9. Where appropriate, IRO and	Bain, Trisha	09/01/2018	12	Significant		1. Incidents reported on the Datix System. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Periodic review of High Risk addresses by the Operations Team.	6	Moderate

681	There is a risk that the Trust will be unable to meet it's statutory RIDDOR reporting requirements due to: 1. lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. delayed reporting of incidents received or reported retrospectively.	20/09/2017		12	Significant	1. Daily monitoring of Datix incident reports to highlight and follow up on likely RIDDOR incidents. 2. Support and expertise available from the Health and Safety Team. 3. Training provided to all Team Leaders and Managers as part of the Managing Health & Safety course. 4. Highlight reports from GRS relating to staff members who are injured at work. 5. Datix incident reporting system in place to capture RIDDOR incidents when reported across the Trust. 6. Monitoring of RIDDOR incidents through the Corporate Health and Safety Committee. 7. Trust wide Sector based H&S reports provided to ELT and to Trust Senior Management.	Bain, Trisha	09/01/2018	12	Significant		1. Review and oversight of RIDDOR incident reporting by the Corporate Health and Safety Committee. 2. Gaps in RIDDOR reports provided to Committee due to the timeliness of identifying RIDDOR Incidents and reporting to the HSE.	3	Low
714	There is a risk that the Trust will be subject to regulatory intervention as a result of not achieving its 20178/18 control total	17/11/2017		20	High	1. Contract has been signed off with Commissioners for 17/18 with clarity on CQUIN, activity funding and STP funding requirements. Cycle of strategic, contracting and technical meetings with commissioners is in place. 2. Financial Plan for 17/18 has been signed off by Executive Leadership Team and detailed budget provision has been made by outgoing FD; this is clearly understood by the senior finance team reporting into FD and Deputy. 3. Budget sign off process & review of forecast assumptions has been commissioned by interim FD to be completed for M4 Performance Management cycle. 4. Financial plan is allocated to budget owners for holding to account through the Performance Management meetings for M4 for I&E, Capital, CQUIN & CIPs. CQUIN progress	Bewes, Lorraine		10	Significant		To be assessed	10	Significant

246	Failure of the 999 line recording system to record all calls into and out of the Control Suites will compromise the Trust's ability to maintain a full Patient Record, to manage quality or respond or learn from queries, complaints and investigations.	15/03/2012		15	High	1. Review by IM&T of all lines to be recorded and provision of extended service to EBS 2. Testing of recording at Bow to ensure consistency of service	Wynn, Victor	05/12/2017	10	Significant	Provide links for Access to Airwaves recordings via Redbox Ongoing monitoring of the system, particularly at Bow, where problems have been experienced. IM&T to work to ensure all critical lines recorded at both sites.	1. On-going monitoring of the system, particularly at Bow, where problems have been experienced. 2. IM&T to work to ensure all critical lines recorded at both sites	5	Moderate
712	There is a risk that the Trust remains subject to Special Measures as a result of not having made sufficient sustained improvement in its CQC ratings	17/11/2017		15	High	Quality Improvement Programme	Harding, Philippa		10	Significant		On-going reporting to the Board and ELT CQC re-inspection in Q4 2017/18	10	Significant

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Document Title:	Serious Incident Management			
Report Author(s):	Kirstie Smith, Clinical Adviser to Legal Services, Governance & Assurance			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	Executive Leadership Team meeting 17 January 2018 Quality Assurance Committee meeting 09 January 2018 Quality Oversight Group meeting 14 December 2017			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The purpose of the document is provide an update on the current status of Serious Incident (SI) Investigation compliance across the Trust and update the Board on the current projects and improvements that are being made within the Quality, Governance and Assurance Team.

Attachment 1: Sets of the current status of SI investigation reports within the Trust, provides a status update on the reports sent to the CCG for closure during the month of December 2017 and includes a update on the thematic review and EOC action plan. Additional information regarding the improvements made to the Datix system, a progress update on the implementation of Health Assure and an overview of incident management across the Trust is included.

Attachment 2: Executive summaries relating to the SI investigations that were closed during December 2017.

Recommendation(s) to Trust Board:

The Board is asked to note the report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Serious Incident Management

Introduction and Background

1. An outline of the current status in relation to serious incidents (SIs) and to provide assurance to the Board that actions from closed incidents are complete and/or on track.

2. This paper also provides the executive summaries from all in-month serious incident reports that have been sent to our commissioners for closure to meet the 60 day contractual obligations (Appendix 1).

Investigation Update

3. To recap on in-month activity: Closed SI investigations and actions (November data)

StEIS Number	Incident type	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales (60 days)
2017/20068	Operations - Accident	09.08.2017	Feedback provided to the attending crew regarding their decision making on scene and quality of documentation	Completed	03.11.2017	Submitted by deadline
			Review of the Road Traffic Collision Policy to explore the opportunity to include Duty of Candour at the point of the accident	Completed		
			Collison investigation in conjunction with the police	Completed		
2017/20697	Delayed response	06.08.2017	Facilitated reflection by the attending crew regarding the application of the Major Trauma Decision Tree and the significance of neck injuries in elderly fallers	Completed	01.11.2017	Submitted before deadline
			Article to be included in the North West Newsletter	December 2017		
2017/20749	Clinical – sub-optimal care	06.08.2017	Feedback to the Emergency Medical Dispatcher (EMD) involved in triaging the call.	Completed	13.11.2017	Submitted on deadline
			Facilitated discussion with the attending crew and a Clinical Team Leader on the challenges during the call and the trigger	Completed		

StEIS Number	Incident type	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales (60 days)
			points for making a safeguarding referral.			
			Attending crew to undertake a reflective essay on the feedback received during the above action	December 2017		
2017/21262	Delayed response	23.08.2017	Clinical debrief to be undertaken with the crew reviewing the concerns highlighted in the report and electrocardiogram recording	Completed	16/11/2017	Submitted before deadline
			An enhanced patient report form audit should be undertaken by a Clinical Team Leader for the attending paramedic	Completed		
			Sharing of the findings of the investigation for organisational learning	Completed		
2017/21237	Medication incident meeting SI criteria	23.08.2017	Share final report with Advanced Paramedic Practitioner (APP) concerned	Completed	17/11/2017	Submitted by deadline
			All previous PGD breaches identified to be reviewed at SIG	Completed		
			Interview paramedic A on their return to work	Completed		
			Review the APP drug administration book to ensure the issues highlighted during the investigation are addresses and corrected	Complete		
			Undertake an audit of the use of PGDs within the organisation to provide assurance of adherence to the document	January 2018		
2017/20764	Delayed response	16.08.2017	Embed a process whereby all EMDs submit an incident report when experiencing issues finding a location within the system	Complete	13/11/2017	Submitted by deadline
			Review of OP/060 to include the need to convert 3rd/4th party calls to 1st/2nd party	Q2 2018		

StEIS Number	Incident type	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales (60 days)
			calls			
			Inclusion of learning in the EOC governance bulletin for organisational learning	January 2018		
			Evidence of reflective learning and self-directed study from the paramedic in attendance	Completed		
			Share the findings of the report with the 3rd party ambulance provider	Completed		
2017/21257	Delayed response	23.08.2017	Review of the process for managing calls by the Non-Emergency Transport Service	Completed	30/11/2017	Breached by 9 days
			Review of Operational Policy OP/023 to revise the actions to be taken when the Trust is holding calls	Completed		
			Produce a quality assurance tool to be used for allocating decisions	Completed		
			Retrospective safeguarding referral to be made	Completed		
			Thank you letter send from the Trust to St John Ambulance crew for their actions	Completed		
			Meet with the staff from the care home and share the findings of the report	Completed		
			Clinical Team Leader to review the call and actions of the crew with the staff involved	Completed		
			Feedback to be given to the Allocators on their responsibilities when managing held calls across the Trust	Completed		
2017/22222	Delayed response	06.09.2017	Undertake a thematic review of spinal care and adherence to accepted standards of practice	End of Q1 18/19	30/11/2017	Submitted by deadline
			Facilitated feedback and reflection for paramedic involved with Clinical Team	January 2018		

StEIS Number	Incident type	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales (60 days)
			Leader			
2017/22232	Delayed response	06.09.2017	Training for attending crew on medical clerking	December 2017	30/11/2017	Submitted by deadline
			Further familiarisation and training regarding clinical decision making in the presence of trauma with particular attention being made to concealed bleeding and the assistance that is available from other clinical resources within the Trust	December 2017		
			Apprentice paramedic to undertake a reflective practice assignment in relation to the incident to form part of their student paramedic portfolio	Completed		
2017/22241	Delayed response	06.09.2017	Feedback to be provided to the EMD involved via the normal processes	Complete	30/11/2017	Submitted by deadline
			Continue with recruitment plan	Linked to Trust Risk 533		

4. Since the completion of the report, the total number of actions (n=36) completed for the above reports is 27. The remaining actions, four are currently overdue. The remaining actions are currently on track for completion within the assigned timeframe. One action has been linked to the on-going recruitment plan and closed on this basis.

5. Reports currently with commissioners for closure, including those identified in Table 1, currently stands at 09.

Thematic review of closed investigations (EOC)

6. Analysis of the reports this month showed the two themes of the incidents to be:
   - Failure to follow policy
   - Policies identified as unfit for purpose or in need or review

Please note the above now forms part of the EOC intensive support programme which is monitored by the Executive Leadership Team

Contributory Factors Update

7. The Quality Assurance Committee has requested further detail on the contributory factors (task factors) identified from serious incident investigations.

Dispatch and Call Issues

Tasks Factors

8. Issues relating to task factors typically included:

- Operational policies were identified to be unfit for purpose or in need of review (please note this data was taken before the implementation of ARP)
    - OP/023: Procedure for the Dispatch of Resources by EOC
    - OP/060: Control Services – Call Taking Procedure
    - OP/066: Operational Procedure for the Use of Paper Operations within Control
- Operational polices had not been adhered to (OP/023 and OP/060)

OP/023: Procedure for the Dispatch of Resources by EOC

9. The thematic review highlighted repeated instances whereby welfare ring backs have not been made or, when they have been made, the correct process (as detailed at section 17 of the policy) was not followed when there was no answer.

10. This policy will therefore be reviewed and refreshed by the Head of Quality Assurance by the end of January 2018 which is the review date on the current version of the policy. Any revisions/changes to the policy will be clearly communicated to EOC staff, together with the need to comply with the content, by the end of January 2018.

11. Compliance with the refreshed policy will then be formally reviewed by the Operations Board on a quarterly basis from April 2018.

OP/060: Control Services – Call Taking Procedures

12. The thematic review highlighted repeated instances where has been a lack of adherence to this policy. There are also examples of specific situations which need to be added to the policy, for example, action when there is no telephone number logged in the caller identification line (CLI).

13. Given the concerns raised, this policy will be reviewed and updated by the Head of Quality Assurance by the end of January 2018. Any revisions/changes to the policy will be clearly communicated to EOC staff, together with the need to comply with the content, by the end of January 2018.

14. Compliance with the refreshed policy will then be formally reviewed by the Operations Board on a quarterly basis from April 2018.

OP/066: Operational Procedure for the Use of Paper Operations within Control

15. In response to the learning from the unplanned CAD outage on New Year's Day 2017, a significant rewrite of the action cards associated with this policy has taken place to support the delivery of an OP66 event. Additional action cards have been written to further strengthen systems and processes, these include the command and control arrangements of an unplanned CAD outage.

16. A completely revised OP66 procedure has been written and has been subject to table top and real time unpressured testing. As a result of these exercises, further changes were identified within the new procedure. These changes have been made however implementation of the newly developed plan has been deferred until the end of January 2018 as there has been insufficient capacity to take the plan through suitable table top and exercise planning to test out the revisions.

17. The current operating procedures with the new and amended action cards have been used in the last two planned elective takedowns (including the go-live of the Ambulance Response Programme which used these procedures) and were found to be fully effective. There was also an unpressured live exercise for the Watch (which was on duty on New Year's Eve/Day 2017/18) on 5 December 2017 which tested these new procedures.

18. The Chief Quality Officer and Director of Corporate Governance are working together to improve the implementation of new processes within the Trust to ensure all relevant policies are updated to reflect any change within the Trust prior to implementation.

In-month Quality Assurance System and Process Developments

19. The quality assurance directorate have continued their improvement plans and this month have completed:

Datix Project Updates

20. Following on from last month, there is a concern that staff are not receiving feedback from incidents they have reported. In addition to the implementation of the feedback email system and a weekly overdue incident report distributed to Assistant Directors of Operations and Quality, Governance & Assurance Managers, however it is appreciated that this will take time to embed before the benefits are seen Trust wide.

21. System wide coding is currently being worked through across the Trust and now including LAS111.

22. E-learning New Content request form has been approved and due for delivery January 2018. Two new e-learning packages will be designed in relation to patient safety and non-clinical incident management.

23. The quality assurance and closure of incidents has been restricted to the Quality Governance and Assurance Team to ensure a uniformed approach to reviewing all investigations and ensuring that reported incidents are correctly graded and investigated to an acceptable level prior to closure and reporting to the NRLS.

24. The Quality Governance and Assurance Team have instructed assistance from two established Governance Managers on a contractual basis to assist in clearing a backlog of incidents that have been investigated and require quality checking prior to closure from the system.

Health Assure Project

25. Training and roll out for Health Assure will be in January 2018.

26. Site visits have been conducted with East of England Ambulance Service NHS Trust and Manchester University NHS FT.

27. Process mapping of the 'as is' and 'to be' process have commenced to support the design and workflow for the system.

Safety and Risk

28. A weekly report of overdue risks and incidents is now being circulated to the Assistant Directors of Operations and Quality, Governance & Assurance Managers. The report has been in circulation for the past four weeks and has seen a reduction of 102 overdue incidents and 142 overdue risks across the Trust.

Overdue Incidents by Sector						
11/12/2017	**Overdue Incidents**	**Overdue Incidents**	**Overdue Incidents**	**Overdue Incidents**	**Overdue Incidents**	**Trend on previous week**
	30/10/2017	**06/11/2017**	**13/11/2017**	**04/12/2017**	**11/12/2017**	
North West	279	266	261	239	208	↓
North Central	73	70	66	66	69	↑
North East	309	291	327	291	287	↓
South West	110	99	87	83	92	↑
South East	256	259	248	236	227	↓
Grand Total	**1027**	**985**	**989**	**915**	**883**	↓

All Other Areas	Unapproved Risks	Unapproved Risks	Unapproved Risks	Unapproved Risks
	16/11/2017	**27/11/2017**	**04/12/2017**	**11/12/2017**
EOC incl. Quality Assurance	7	7	4	4
LAS111	5	3	3	3
EPRR	2	1	3	5
HR / Workforce	9	3	10	10
Safeguarding	0	0	0	1
Resourcing	2	2	0	0
Recruitment	3	2	2	2

All Other Areas	Unapproved Risks	Unapproved Risks	Unapproved Risks	Unapproved Risks
	16/11/2017	27/11/2017	04/12/2017	11/12/2017
Clinical Education and Standards	2	2	2	2
Quality	2	6	2	2
Governance and Assurance	3	3	3	3
PTS	0	0	0	0
Performance	0	0	0	0
Public Engagement (PPI)	0	0	0	0
Procurement	0	0	0	0
PED	6	6	6	6
DDO - Ops	4	4	4	4
Mental Health	0	0	0	0
Medical Directorate incl Spec. Care	2	2	2	2
Legal	0	0	1	1
IPC	2	1	1	1
Incident & Delivery	2	2	2	2
IM&T	6	1	8	8
Health & Safety	10	1	0	0
Health & Wellbeing	3	3	3	3
First Responders	7	7	7	7
Fleet & Logistics	13	20	20	20
Finance	10	10	10	10
Estates	3	3	5	5
EBS	3	3	1	0
Central Ops	11	11	6	12
Contracts and Commissioning	0	0	0	0

All Other Areas	Unapproved Risks	Unapproved Risks	Unapproved Risks	Unapproved Risks
	16/11/2017	27/11/2017	04/12/2017	11/12/2017
Communications	3	3	3	3
CARU	0	0	0	0
Service Improvement	3	3	3	3
All Non-Sector Risks	**123**	**109**	**111**	**119**

29. Training in incident investigation delivered on 17th November 2017 was well attended. The next training date is scheduled for 19th January. A total of 19 managers have confirmed their attendance. The Trust is currently struggling to support Lead Investigators due to operational demand. The Quality Governance and Assurance Team are attempting to locate Lead Investigators from corporate and support services.

Conclusion

30. We are maintaining our contractual targets in relation to SI investigations and action compliance is continually being monitored. One out of the ten investigations due for submission in November breached the deadline.

Dr Patricia Bain
Chief Quality Officer

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/21237	**Datix reference: 9624**
Date of Incident: 28/06/17	**Date report: 17/11/2017**

Incident description:

The LAS received a call requesting an ambulance attendance to a school for a 13 year old male presenting with an allergic reaction and difficulty in breathing.

Additional information provided informed the LAS that the patient was asthmatic, an EpiPen® had been administered, the patient was unconscious and his breathing was deemed to be ineffective.

Multiple emergency resources were dispatched to the call.

On the arrival of the first emergency resource the patient suffered a cardiac arrest. An advanced life support attempt was commenced which included advanced interventions undertaken by the Advanced Paramedic Practitioner on scene.

The crews achieved a return of spontaneous circulation and the patient was treated for a terminal asthma attack and transferred to the nearest emergency department.

On the arrival at the hospital the APP received additional information that the patient had come into contact with a dairy product which was a known allergen to the patient. At this point the APP realised that they had breached the Patient Group Direction (PGD) regarding the administration of magnesium sulphate. Additionally, during a clinical de-brief, which was conducted immediately after the patient was handed over to the hospital staff, it was discovered that there had been a second drug administration error concerning the concentration of adrenaline.

It is understood that the patient died 10 days after admission to the hospital.

Immediate risk mitigation:	Both members of staff undertook a clinical debrief with their respective line managers. The APP undertook a peer support shift the day after the incident. Paramedic A was required to undertake a clinical reflection.
Findings of investigation:	• Paramedic A administered the incorrect concentration of adrenaline • The APP administered Magnesium Sulphate in breach of the PGD • There was insufficient governance and around the use of PGD's within the Trust.
Recommendations:	1. Paramedic A was not available to be interviewed due to absence from work. In the interests of not delaying the investigation, the report was concluded with reference to the statement and Datix reports provided. 2. It is recommended that for completeness, Paramedic A is interviewed on their return to work and any fundamental learning or changes will be communicated and incorporated into the report. 3. A clinical debrief was conducted with both the APP and Paramedic A during the investigation process. The report will be shared with the respective managers responsible for conducting the de-brief and the findings compared to the content of the de-briefs. 4. A review of the PGD's should be undertaken to ensure they are accurate and fit for purpose. 5. A review of the APP drug guidelines pocket book should be undertaken with particular attention to the format of the inclusion and exclusion criteria. Specifically, negative criteria (do not administer/do not give for etc) must be included in the exclusion criteria rather than inclusion criteria. 6. The draft policy detailing the management of PGD breaches must be formally approved and shared across the Trust. 7. Formal refresher training on the legal framework around the use and application of PGDs should be provided to the existing APP groups and included on the core training programme for all future courses.

	8. All identified cases of PGD breaches must be referred to SIG for review. This recommendation should have retrospective effect and therefore include the six other breaches that were identified. 9. An audit of PGD compliance across the Trust should be undertaken with specific terms of reference to provide assurance that PGD application and use is safe and robust across the Trust.

Current Risk Score:	**A: Potential impact / severity (1-5)**	**B: Likelihood of recurrence at that severity**	**C: Risk (C = A x B)**
	5	2	10

Action plan/owner:	• Interview Paramedic A. Any fundamental concerns or additional information should be communicated appropriately. **Owner:** Head of Governance. • The report should be shared with the members of staff involved and their respective managers. Any additional information highlighted during the report should be feedback to the staff concerned. **Owner:** Deputy Medical Director. • Review of the APP drug guidelines pocket book should be undertaken with particular attention to the format of the inclusion and exclusion criteria. Specifically, negative criteria (do not administer/do not give for etc) must be included in the exclusion criteria rather than inclusion criteria. **Owner:** Consultant Paramedic. • A formal policy for the management of PGD breaches is awaiting approval. It was recommended that this policy was formally approved during this investigation. **Owner:** Deputy Medical Director • Formal training for the use of PGD's to be delivered to the existing APP group and included in the formal core training for future courses. **Owner:** Consultant Paramedic.

- Refer the six identified PGD breaches to the SIG for formal review and consistency.

  Owner: Head of Governance.

- Commission an audit looking at PGD compliance across the Trust using the two most commonly administered medications and comparing the drug use and patient factors to the PGD criteria. Those found to be a breach should be reviewed by SIG.

  Owner: Medical Director / Trust Pharmacist.

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SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/20764 **Datix reference: 9931**

Date of Incident: 11.07.17 **Date report: 14.11.17**

Incident description:	On the 11th July 2017 East of England Ambulance Service NHS Trust received a call for a patient located in London. The caller was the patient's uncle in Bedfordshire. The uncle supplied the correct postcode and address for the patient but the East of England call handler advised their computer system provided a different (incorrect) postcode. The LAS received the details of the emergency from East of England Ambulance Service NHS Trust. The call was for a 24 year old female who had taken an overdose and the call was correctly triaged as a C1 priority which in London has an aspirational response target of 45 minutes. The East of England Ambulance Service passed the incorrect postcode to LAS, therefore when the postcode was entered into the gazetteer the exact house number match was not displayed as a potential option. The Emergency Medical Dispatcher (EMD) in call handling selected the incorrect house number to display in the location field and documented the actual house number in the comments field beneath location. There was delay in the dispatch of a resource to the patient and the call was not escalated to the appropriate line manager. The correct address was not discussed between the private ambulance crew and the EMD in dispatch. Falck Medical Services management representation at the MDT meeting suggested that this issue had been communicated to all their staff as their responsibility. The attending ambulance crew was dispatched at 00:35 but went to the incorrect house number and this resulted in a further delay in attending the patient; arriving with the patient at 01:20 hours.

	When the ambulance crew arrived the patient was unconscious and during extrication, suffered a seizure. The paramedic in attendance delayed the administration of naloxone and incorrectly administered intravenous (IV) diazepam, giving the full 10 milligrams (mgs) instead of titrating to effect. En route to the Emergency Department (ED) under emergency conditions, the patient suffered a respiratory arrest.
Immediate risk mitigation:	• The EMD managing the initial call from East of England Ambulance Service NHS Trust is no longer employed by the Trust, and therefore could not be interviewed. • Both the attending staff, Paramedic A and Emergency Medical Technician (EMT) A have undertaken self-directed learning and reflective practice. These documents were reviewed and approved by the LAS' third party ambulance manager.
Findings of investigation:	• East of England Ambulance Service NHS Trust's computer system supplied an incorrect postcode, leading to the incorrect postcode being passed to the LAS. • The above led to a delayed arrival at the patient by the LAS. • Paramedic A, the only attending paramedic, delayed the administration of one drug and incorrectly administered a second drug, by failing to titrate to effect.
Recommendations:	• A process needs to be implemented to ensure incorrect address entries are captured and managed during the shift in which they occur. Currently the Quality Assurance (QA) of a 999 call retrospectively monitors if an address is requested and verified by an EMD. If the address is then incorrectly entered into the system, this will not be identified during QA compliance feedback. This new process should be used to identify the extent of the issue, in order that remedial action can be taken. Datix incident reporting would be the most appropriate process to utilise as already embedded in the Trust. This would require communication to all Emergency Operations Centre (EOC) managers that it is a mandatory requirement on all incorrect address entries. • Policy OP060; Control Services Call Taking Procedures needs to specifically task an EMD who takes a call from an outer county

ambulance trust to contact the origin caller if attempts to contact the patient have failed. This is of particular importance in cases of patients that may not answer due to their clinical or psychological condition.

- EMD B to receive feedback on escalating held calls to their line manager when patient contact cannot be made.
- Falck Medical Services to confirm the issue with verbal address confirmation has been resolved.
- Paramedic A completed reflective practice and undertook self-directed learning regarding drug administration and the Patient Report Form (PRF) as part of the investigation and provided evidence of learning at the Multi-Disciplinary Team (MDT) Meeting

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
4 (major)	2 (unlikely)	8

Action plan/owner:

- Datix entry MUST be undertaken for all incorrect addresses identified during a shift. **Owner:** EOC Interim General Manager for Performance and Process.
- OP060 needs to include advice to contact origin callers in circumstances where a 3rd/4th party call cannot be converted to a 1st/2nd party call due to lack of contact. **Owner:** Head of QA.
- EMD B to receive feedback by line manager within four weeks. **Owner:** EOC Watch Manager.
- Falck Medical Services to confirm the issue with address confirmation has been resolved. **Owner:** Third Party Ambulance Manager.
- Paramedic A to complete a reflective practice and undertake self-directed learning regarding drug administration and PRF completion. **Owner:** Third Party Ambulance Manager (completed and evidence provided).

- Information on the medication errors identified needs to be fed back to Falck Medical Services, LAS Education and Development team and Medical Directorate to help inform future improvements in training delivery.

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/20068 **Datix reference: 10476**

Date of Incident: 21/07/17 **Date report: 31.10.17**

Incident description:	On the 31st July 2017 the London Ambulance Service (LAS) received a call via the 111 NHS Transfer. The call requested LAS to attend a residence, for a 2 year old female child. The call was correctly triaged and given a DX Code: DX012 requiring an Emergency Ambulance Response. Attempts were made to locate a resource to respond, and at 12:52 an enhanced clinical telephone assessment commenced, resulting in an upgrade of the call at 12:55 hours to a Response 3 profile (20 minute emergency response post clinical assessment). An ambulance crew consisting of a paramedic and a Trainee Emergency Ambulance Crew (TEAC), was dispatched at 12:56 hours and upon arrival and assessment of the patient, appropriate care was provided and the patient was transported to North Middlesex hospital under emergency conditions The paramedic was driving the vehicle and the TEAC was providing care to the patient in the rear of the ambulance. At 13:36 an incident occurred where the ambulance was involved in a road traffic collision, involving a pedestrian. The pedestrian sustained significant injuries to the lower limb, and was transported to a major trauma centre. The Road Traffic Collision also resulted in a 21 minute delay to transporting the paediatric patient to hospital.
Immediate risk mitigation:	• The Emergency Operations Centre (EOC) was contacted immediately following Road Traffic Collision (RTC), and an incident recorded. Police were notified. • 2 Incident Response Officers (IRO's) attended scene • London Helicopter Emergency Medical Service (HEMS) assessed and transported pedestrian involved in Road traffic collision

	• A second ambulance arrived on scene, received handover and transported paediatric patient to hospital. • Driver of the vehicle restricted from driving duties until RTC investigation complete
Findings of investigation:	1. The actions of the paramedic and TEAC were appropriate for the presenting condition of the paediatric patient. The decision to transport the paediatric under emergency conditions, and identify a 'Blue Call' was warranted due to the past history and complicated medical history of the patient. There were some concerns regarding the decision to have the less experienced clinician managing the patient in these circumstances, while the paramedic drove the vehicle, however the decision was acceptable. The delay in transporting the patient, due to the road traffic collision, did not impact the care provided to the patient and did not result in harm. 2. The response to the Road Traffic Collision and the immediate assessment and management of the patient struck by the ambulance was appropriate. HEMS attended scene, and the patient was transported under emergency conditions to a Trauma centre. The Collision investigation has been completed and the recommendation is that the Paramedic return to driving duties and this collision be considered as non-blameworthy on the Paramedic's part. 3. There was a delay in LAS meeting their Duty of Candour requirements with the pedestrian patient. This was noted by LAS and a nominated contact was appointed who meet with the patient 10 days after the event.
Recommendations:	• Local discussion with crew members regarding the decision to have the less experienced clinician managing the paediatric patient in the setting of an emergency transport, and where it may be acceptable, to ensure clear communication of a distinct plan to recognise and respond to any changes in condition. • A full RTC investigation to be completed • Review process for Road Traffic Investigation to ensure Duty of Candour is incorporated into the process where applicable

	• The crew of H201 to have feedback on the standards of documentation required by LAS

Current Risk Score:	

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
4 (major)	1 (rare)	4

Action plan/owner:	• A discussion with crew members regarding the decision to have the less experienced clinician managing the paediatric patient in the setting of an emergency transport, and where it may be acceptable, to ensure clear communication of a distinct plan to recognise and respond to any changes in condition: to be completed by Medical Directorate (Staff Officer to the Medical Director) • Review of the Road Traffic Collision policy to incorporate Duty of Candour where applicable. To be completed by Head of Driving Standards • Full RTC investigation to take place. To be completed by Head of Driving Standards (Completed in parallel with this investigation and report available) • The crew of transporting the paediatric patient to hospital to have feedback on the standards of documentation required by LAS. To be completed by the Staff Officer to the Medical Director

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/20697 **Datix reference: 10636**

Date of Incident: 26/04/17 **Date report: 08/08/17**

Incident description:	On 26 April 2017 the London Ambulance Service (LAS) received a 999 call at 05:19 to an address in North West London. The call was to a 68 year old female; the call details were given a "heart patient, has had a heart transplant, right arm tingling and can't move legs, previously fell earlier, no chest pain." The call was categorised as a Category A - Red 2 response. The call was connected at 05:19 with a call start time (the point from which LAS response times are measured) of 05:22. A Double Crewed Ambulance (DCA) staffed by a paramedic and Emergency Medical Technician (EMT) arrived on scene at 05:34. The patient was found to be conscious and breathing having fallen from bed against a wardrobe at approximately 04:00. On the arrival of the crew the patient was sitting upright in bed, having got back into bed following the fall. The patient had a past medical history including a heart transplant, pacemaker, osteoarthritis, osteoporosis, and hypertension. The patient was conveyed to the Emergency Department (ED) of a local hospital; the patient was later transferred on 26 April to a London Major Trauma Centre (MTC) with multiple c-spine fractures. This incident was detected through an audit of major trauma patients and was declared as a Serious Incident on 16th August 2017 following a review by the LAS Serious Incident Group.
Immediate risk mitigation:	Once this was identified through the audit, immediate actions undertaken by the Quality Governance & Assurance Manager included interviews and reflection with the crew.
Findings of investigation:	• The crew undertook a patient assessment and were able to obtain a thorough medical history for the patient on which to make a

clinical decision on the best course of treatment and destination for this patient.

- Whilst taking into account the comments provided by the patient's sister the crew should have based their clinical decision making on the patient's medical history and the observations and assessment they performed on scene.
- There were sufficient clinical red flags as a result of the medical history and assessments / observation taken by the crew to suggest a more serious injury had been sustained.
- This should have prompted the crew to consult with the LAS Major Trauma Decision making tool, which would have highlighted to the crew that the patient may benefit from being conveyed to a MTC rather than the local ED.

Recommendations:

- The crew have undertaken a facilitated reflection on the call to cover the use and criteria of London Major Trauma Decision Tree and documentation
- Article to be written for Sector newsletter summarising incident/learning

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
4 (major)	1 (rare)	4 (moderate)

Action plan/owner:

- Crew facilitated reflection – (completed) Lead Investigator
- Newsletter article – Lead Investigator

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/20749 **Datix reference: 10826**

Date of Incident: 02/07/17 **Date report: 16/08/17**

Incident description:	On 2nd July 2017 a call was received in the Emergency Operations Centre (EOC) regarding a 12 year old female who was suffering from back pain after jumping from a first floor window in a block of flats. On arrival the ambulance crew found the patient was experiencing lower back pain, with increased discomfort on moving. The Patient Report Form (PRF) noted that there was no shortness of breath, difficulty in breathing, numbness, paresthesia (tingling) or incontinence on assessment of the patient. The patient was later discovered to have sustained a spinal fracture complicated by a dislocation to the spine. The patient was transferred to a Major Trauma Centre (MTC) for ongoing care. The incident was later identified to the London Ambulance Service (LAS) by a Consultant, who expressed concerns relating to the management of the patient by the DCA. This led to a review by the Serious Incident Group (SIG) who declared a serious incident (SI) investigation was warranted.
Immediate risk mitigation:	Following the identification of the incident immediate actions undertaken by the Group Station Manager included making contact with the crew for interviews and reflection to take place.
Findings of investigation:	The 999 call should have received a C1 priority rather than a C2 priority. Based upon the clinical presentation, history of events and current guidance, the patient should have been fully immobilised at the scene and transported to a facility capable of dealing with suspected spinal injuries in children.

	When managing the patient's pain, the crew should have established a pain score (by whatever means were appropriate) before and after administering pain relief, and documented their rationale accordingly.
Recommendations:	a. The EMD to receive feedback on the importance of correctly categorising calls using the appropriate call categorisation guidance. b. The crew to take part in a professional discussion with a Clinical Tutor or Clinical Team Leader (CTL). This should cover current drug administration and immobilisation guidance, including the recent core skills refresher training package. c. The crew to receive feedback on the importance of documenting whether or not they have safeguarding concerns in cases involving children. d. Following the professional discussion with a Clinical Tutor or Clinical Team Leader, the crew should complete a reflective practice essay, based upon learning from this experience and with reference to current guidance as well as their recent core skills refresher attendance.

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
3 (moderate)	2 (unlikely)	6

Action plan/owner:

To ensure the EMD interprets current guidance appropriately in order to assign the correct priority to a call

Owner: Quality Assurance Manager for EOC

To ensure the crew fully understand the current guidance in this area, as well as the importance of relating said guidance to their clinical practice

Owner: Clinical Education Manager

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/21262 **Datix reference: 10835**

Date of Incident: 16/08/17 **Date report: 24/08/17**

Incident description:

- On Tuesday 15th August 2017 a call was received in the Emergency Operations Centre (EOC) regarding a 57 year old male with chest pain. The call was categorised as Red 2 requiring a response within 8 minutes 75% of the time.
- A Double Crewed Ambulance (DCA) staffed by a paramedic (Paramedic A) and a Trainee Emergency Ambulance Crew (TEAC A) were dispatched to the call. The total response time for the call was 19 minutes and 9 seconds.
- The Patient Report Form (PRF) stated several days of a non-constant central burning pain in the chest. The patient had woken that morning with pain, which was worse in intensity and relieved by Gaviscon.
- Observations taken were normal and the crew documented a working impression of gastric pain.
- The crew's plan indicated that treatment was not required and hospital conveyance was declined by the patient. The patient was advised to see their own General Practitioner (GP) within 48 hours or as soon as they were able. It was documented on the PRF that red flag chest pain advice was given.
- The patient was left in the care of their wife.
- On Wednesday 16th August 2017, a 999 call was received relating to a 57 year old male, who was not conscious and not breathing. Cardio Pulmonary Resuscitation (CPR) instructions were commenced with the caller and this continued until the crew arrived.
- It is recorded on both of the PRF's that the patient was cold, not breathing; the electrocardiogram (ECG) was asystolic.
- Paramedic B carried out the Recognition of Life Extinct.

Immediate risk mitigation:	The case was immediately reviewed by the IRO on scene and raised for consideration as a serious incident.

Findings of investigation:	• The Clinical Opinion states that the subtle changes on the ECG alongside the lack of diagnostic capabilities of ambulance clinicians indicates that it may have been beneficial for the patient to have been seen at the local ED • The documentation should have been improved and the initial review of the first crew's PRF raised further questions, particularly in the area of decision making and safety netting. • Through interview with the ambulance crew (Paramedic A and TEAC A), although there were concerns about the PRF documentation, the thought processes around the decisions made and information provided to the patient was comprehensive and relevant to that presentation. • The 'safety netting' (Providing a patient and carer/family with verbal and/or written information on warning symptoms, how further healthcare can be accessed and to arrange a follow-up referral) was appropriate to these circumstances and clinical presentation.

Recommendations:	• The crew have reflected on this case and the feedback from the NOK as part of their interview with the Lead Investigator. • The crew have reflected on the subtle abnormalities on the 12 lead ECG with the Lead Investigator for learning to take place • Documentation on PRFs needs to be comprehensive including all the conditions you considered and checked for as part of the patient assessment • The SI report is shared widely through the Sector Governance Group for organisational learning to take place

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
5	2	10

Action plan/owner:	The case was reviewed and discussed with the crew The 12 lead ECG was reviewed

Owner: Lead Investigator

That enhance PRF audit and feedback takes place over a specified and agreed time frame for Paramedic A

Owner: Clinical Team Leader

Dissemination of the incident and findings for organisational learning

Owner: Quality Governance and Assurance Manager

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/21257 **Datix reference: 10965**

Date of Incident: 12.07.17 **Date report: 27.11.17**

Incident description:	The LAS received a call, from a Health Care Professional (HCP), to attend an 86 year old female presenting with possible pneumonia and dehydration. The call was triaged by an Emergency Medical Dispatcher (EMD) using the Medical Priority Dispatch System (MPDS) and achieved a C4 response priority (Protocol 35). The HCP, a General Practitioner (GP) who was on scene with the patient, stated that the condition of the patient did not present an immediate threat to life and that a four hour response time was acceptable. The call was automatically transferred to the Non-Emergency Transport Service (NETS). Four minutes after the call had been received the NETS allocator transferred the call to the geographical dispatch group, as a Non-Emerg4 category as there were no NETS crews available to respond to the call. A Non-Emerg4 is classified as suitable for NETS to attend within 4 hours. An allocator viewed the call at 20:19 but no resource was dispatched. A different allocator looked for an available vehicle on five occasions from 22:30 with resources being either not available or too far away. Additionally at this time the area was dealing with two Road Traffic Collisions (RTC) requiring fifteen resources. There were no welfare calls made in relation to the patient to check on their condition.

	A St John Ambulance vehicle was dispatched and arrived on scene at 01:47, one hour and thirty two minutes after the agreed four hour response time. The crew requested paramedic assistance as the patient was presenting with severe sepsis. A Fast Response Unit (FRU) staffed by a paramedic was dispatched to the call at 01:59 and arrived on scene at 02:10. The paramedic stated that intra-venous (IV) access was considered to administer fluid therapy but this was discounted owing to the close proximity of the hospital. The patient was conveyed to hospital at 02:20 following the pre-alert procedure and handed over at 02:27.
Immediate risk mitigation:	Early conversations identified key people involved in the case and a Multi –Disciplinary Team (MDT) meeting took place.
Findings of investigation:	A review of the call process was carried out on the 29 August 2017 and concluded that the call was handed correctly. The automatic transfer of the call to NETS was correct. The NETS allocator manually transferred the call to the geographical dispatch group B5 as a Non-Emerg4 as there were no NETS crews available to respond to the call. The Non-Emerg4 category would have made it appear that the call had already received a clinical assessment. Since the implementation of the Ambulance Response Programme (ARP) this practice has ceased and the calls are sent from NETS with the original call determinant. An allocator viewed the call at 20:19 but did not assign a vehicle. There is no further evidence that the call was viewed again until 22:30 when a different allocator took over. OP 23 (Procedure for the Dispatch of Resources by Emergency Operations Centre (EOC) gives no clear guidance on how often, or in what situations resources should be searched for. Additionally there is no quality assurance process with

recognised key performance indicators (KPIs) in place to guide dispatch decisions.

The second allocator searched on five occasions for a vehicle to respond. Owing to the demand and the two on-going RTC incidents requiring fifteen resources, they were unable to find an available vehicle.

The allocator said that they always consider conducting a welfare call to the patient but could not, given how busy they were. This was contrary to the instructions in the Surge Red procedure; however it is clear that the allocator was extremely busy during this period. Further to this, the allocator said they believed that the Deployment and Distribution Desk (DDS) and Clinical Hub (CHUB) normally conduct welfare calls.

The CHUB does not routinely monitor HCP calls with a time frame of 4 hours unless the call is highlighted by a call taker due to concern. In addition the Non-Emerg4 category would have made it appear that the call had already received a clinical assessment. The allocator did not request support from the CHUB or DDS desk.

It was confirmed that the GP advised the care home staff to re-contact EOC should the patient's condition deteriorate and this did not happen.

On discovering the patient's condition, the St John Ambulance crew acted appropriately by administering oxygen therapy, requesting support and preparing the patient for rapid transportation to hospital.

The paramedic did not administer fluid therapy due to the close proximity of the hospital and the time critical nature. The clinical opinion determined that in severe sepsis aggressive fluid therapy is required within the first six hours of diagnosis. Establishing IV access en-route to hospital to deliver fluid therapy in sepsis patients should be considered by the paramedic in future practice.

Owing to the time elapsed since the call the LI is unable to conclude if there was a radio problem at the time however, it was concluded that this

	did not affect the time taken to convey the patient to hospital and to receive definitive care.
Recommendations:	a. Calls being transferred from NETS to the relevant dispatch group should maintain their original category and not revert to a Non-Emerg4 category b. OP23 should be reviewed to support allocators when holding calls due to lack of resources. c. A quality assurance process with associated key performance indicators (KPIs) is currently being developed and should be implemented when complete. d. The second allocator should be made aware of their welfare ring back responsibilities whilst at Surge Red. e. Shared learning with the care home should be undertaken to ensure re-contact take place where a patient deteriorates. f. Clinical reflection should take place with the paramedic to highlight the importance of establishing IV access en-route to hospital to deliver fluid therapy in sepsis patients. g. The St John Ambulance crew actions should be acknowledged and commended.

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
5 (catastrophic)	2 (unlikely)	10

Action plan/owner:

Review of Surge Management Plan to include HCP calls:
Owner: Practice Learning Manager Control Services

Calls being transferred from NETS to a dispatch group should not revert to a Non-Emerge4

Owner: Deputy Director of Operations - Control Services

Implement Quality Assurance for the dispatch process

Owner: Practice Learning Manager Control Services

Feedback to the Allocator regarding requesting assistance

	Owner: Practice Learning Manager Control Services A meeting should be arranged with the care home to share learning and advise of best practice: **Owner:** Quality Governance and Assurance and Manager (NW) Clinical Team Leader to arrange appropriate feedback: **Owner:** Clinical Team Leader, Brent (completed) Thank you letter to be sent to St John Ambulance crew **Owner:** Staff Officer to Medical Director

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/22222 **Datix reference: 11192**

Date of Incident: 12.05.17 **Date report: 30/11/17**

Incident description:	The patient jumped over a wall from a building site, and sustained an obvious fracture / dislocation to his ankle and lower leg. An ambulance was called and the patient was conveyed to the nearest emergency department. Later the same morning, a critical transfer was undertaken to transport the patient from the same local emergency department to a Major Trauma Centre; the patient had sustained traumatic injuries including a pneumothorax, and a lumbar fracture leading to cauda equina. The patient was treated as an inpatient in hospital and subsequently discharge home.
Immediate risk mitigation:	On initial review of the circumstances, and then from meeting the lead paramedic, there were no immediate concerns identified for fitness to practice or patient safety.
Findings of investigation:	The ambulance crew who attended the patient failed to fully appreciate the potential seriousness for injury in this patient, and as a result, failed to immobilise the patient in the pre-hospital phase, as per current expected guidelines and practice. The clinical opinion suggests that it is unlikely that this inaction caused any harm to the patient or indeed worsened any injury. The patient was not treated as per current guidance leading to a delay in reaching definitive care. Paramedic A has demonstrated honest and open learning, as is expected of the reflective professional.
Recommendations:	That the ambulance crew receive a focussed locally facilitated learning session. The Trust to consider the requirement for a thematic audit of pre-hospital immobilisation for trauma patients, and the care that is being delivered.

Current Risk Score:	**A: Potential impact / severity (1-5)**	**B: Likelihood of recurrence at that severity**	**C: Risk (C = A x B)**
	4 (major)	2 (unlikely)	8

Action plan/owner:	• Provide Paramedic A and EMT A focused clinical learning facilitated by an appropriate clinical lead. Owner QGAM North Central • Conduct a thematic review / Audit as part of the Trust 'forward plan' for 2018 / 19. Owner Medical Director

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/22232 **Datix reference: 11197**

Date of Incident: 18.05.17 **Date report: 18.11.17**

Incident description:	On 18 May 2017 the LAS were called to attend a 30 year old male who had potentially been assaulted and had fallen. This call was categorised as a R2 requiring a response within 8 minutes on 75% of occasions. A double crewed ambulance (DCA), comprising of a paramedic (Paramedic A) and Apprentice Paramedic, was dispatched to the call. The patient was assessed by Paramedic A and noted to be initially stable however during the assessment it was recognised that the patient had a low blood pressure. A pre-alert was placed to the nearest receiving Emergency Department (ED) The crew arrived at the hospital with a clinical handover of the patient being given to the hospital staff by Paramedic A. A second call was received regarding this patient requesting a critical transfer to a major Trauma unit as the patient had sustained; left rib fractures, left haemopneumothorax, and pulmonary contusions; The patient was admitted to the Major Trauma Ward following discharge from ED and was stepped down to Orthopedic Ward 6 days later. Patient was discharged home on 26th May 2017.
Immediate risk mitigation:	Both crew reflected on their practice before being interviewed as part of the investigation and acknowledged the decision to transport the patient to local ED was not best practice. Paramedic A also identified the need for more comprehensive documentation around patient assessment.
Findings of investigation:	• Paramedic A and Apprentice Paramedic both tried to gain as much history of these events as possible in line with what would be expected

	of them. There was limited information available, as to the level of assault that this patient had suffered. • Apprentice Paramedic was a student at the time of this incident and as such was being mentored by Paramedic A. • Paramedic A appropriately assessed the patient's chest. The under pinning knowledge at interview is of a level as to be expected. • Paramedic A did assess this patient's abdomen for signs of an internal bleed. During interview their underlying knowledge of what to assess and how was at the required standard. Later in hospital the patient was found to have an abdominal bleed. Without the patient's notes from the receiving hospital it is unclear as to whether this was found via imaging or direct patient assessment. • A transfer request was not made for several hours, the reason for this is unclear. • Paramedic A did not correctly assess this patient's pelvis and as such missed underlying injuries. The patient should have been assessed at skin level to be sure that any bruising would have been evident to the crew at the time of assessment. • Paramedic A and Apprentice Paramedic failed to act within trust guidelines by not adhering to the Major Trauma Decision Tree (MTDT). • Paramedic A and Apprentice Paramedic did not recognised the significance of a reduced blood pressure in relation to a concealed internal bleed and thus did not act on this accordingly.
Recommendations:	e. Paramedic A should receive further support at station level regarding medical clerking with particular attention to the documentation of physical assessment. f. Paramedic A should receive further training at a station level in triage and decision making relating to trauma, with particular attention to concealed bleeding, subtle trauma presentations and trauma assessment of a Pelvis. g. Paramedic A should undergo station based training surrounding the benefits of a team based approach to decision making to ensure that in a future event they discuss patient treatment plans with the rest of the crew or if necessary a more senior colleague h. Apprentice Paramedic should complete a reflective practice assignment to formalise the learning undertaken in relation to this incident which should form part of their student portfolio.

Current Risk Score:	**A: Potential impact / severity (1-5)**	**B: Likelihood of recurrence at that severity**	**C: Risk (C = A x B)**
	4 (major)	2 (unlikely)	8

Action plan/owner:	Training in Documentation and in completing full assessment **Owner:** Clinical Team Leader Further Training in particular attention to concealed bleeding, subtle trauma presentations and trauma assessment **Owner:** Clinical Team Leader To undertake station based training with reference to sourcing available resources (e.g. Clinical Hub, HEMS paramedic) **Owner:** Clinical Team Leader Apprentice Paramedic complete a reflective practice **Owner:** Clinical Team Leader

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/22242 **Datix reference: 11214**

Date of Incident: 11.08.17 **Date report: 29.11.17**

Incident description:	A call was received by the LAS for a 59-year-old male who had been unwell for a few days. The call was made by the patient's daughter. The patient had fallen but was getting up slowly. The call was triaged correctly initially but when new information was passed by the daughter during the instructions near the end of the call the Call Handler did not act on this leading to the call being incorrectly referred to 111. The patient self-presented to the local Emergency Department (ED) at 15:01. A transfer was received by LAS from the local ED requesting the patient to be transferred to a Heart Attack Centre (HAC) at 23:39 and there were delays responding to this call meaning that an ambulance did not arrive at the hospital until 03:07. The crew conveyed the patient to HAC at 03:46 with a pre-alert call to the hospital to advise that they were en route. The ambulance arrived at HAC at 04:15. The crew experienced delays of 54 minutes handing over the patient as the staff were observing and assessing the patient.
Immediate risk mitigation:	Feedback was given to the Emergency Medical Dispatchers (EMD) EMD A who triaged the initial call and the EMD B who incorrectly managed the Estimated Time of Arrival (ETA) calls from the hospital and EMD C who missed a change in patient's condition, ECG showing an ST Elevation MI
Findings of investigation:	The root cause of this incident was an inappropriate triage of the initial call to LAS leading to a referral to 111.

Recommendations:	EMD A EMD B and EMD C have already received feedback and support from the QA department and their management team. The LAS has a recruitment plan already in place to address the staffing and resourcing issues. This is on the Trust Risk register (TRR 533).

Current Risk Score:	**A: Potential impact / severity (1-5)**	**B: Likelihood of recurrence at that severity**	**C: Risk (C = A x B)**
	4 (major)	2 (unlikely)	8

Action plan/owner:	EMD A , EMD B and EMD C to receive feedback and support from the QA department and their management team **Owner**: QA Manager/Watch Manager To continue with the Trusts recruitment plan. **Owner**: Assistant Director of Operations (ADO) North East Sector

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Business and Financial Planning Update			
Agenda item:	15			
Report Author(s):	Key leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Presentation to the Executive Leadership Team in correspondence			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides an update for the Trust Board on progress at Q3 with delivery of the Business Plan deliverables that were agreed in May 2017.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

This report contains an overview of the progress, and risk to delivery, of the 67 objectives agreed to deliver the Trust's four organisational goals but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐
Ensure safe, timely and effective care	☒

Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Business and Financial Planning Update

1. On 25 May 2017, the Trust Board signed off the London Ambulance Service Business Plan 2017-19. The business plan was developed through extensive engagement with the Executive Leadership Team and introduced four new organisational goals:

   Goal 1: Patients receive safe, timely & effective care
   Goal 2: Staff are valued, respected & engaged
   Goal 3: Partners are supported to deliver change in London
   Goal 4: Efficiency & sustainability will drive us

2. Beneath these four goals, 67 objectives were agreed, all with delivery dates by the end of 2017/18. As part of the Business Plan, it was agreed that a six monthly status update would be presented to Trust Board and regular updates provided thereafter. This report provides an update as at Q3.

3. The Executive has also taken stock of the key priorities that must be delivered in 2017/18 and this report confirms those objectives which will be carried forward for completion in 2018/19 or closed because circumstances have superseded them.

4. The tables below confirm which objectives have been completed, will complete by 31st March 2018, will be carried forward to 2018/19 or are closed. In summary 51 (76%) deliverables have either completed or will complete by 31st March, 12 deliverables (18%) will carry forward and 4 deliverables (6%) are closed.

5. The report shows that substantial delivery has been achieved in our plans to ensure Patients receive safe, timely & effective care (Goal 1) with 14 out of 15 deliverables expected to be completed this year and supporting Partners to deliver change in London (Goal 3) with 14 out of 16 relevant objectives expected to complete this year. For Goal 2, staff are valued, respected and engaged, 7 out of the 17 deliverables will be carried forward and Goal 4, 2 out of the 15 relevant objectives will be carried forward. This reflects the Executive view of the need to have more time to plan their effective delivery, especially where the deliverables require change in our culture. Finally within the 51 deliverables that will complete this year, 25 or just under half by their nature cannot be judged to have completed until the year end even though these have been substantively delivered to date.

6. The final part of the report sets out the key headlines for our approach to Business Planning and Financial Planning for 18/19 which summarises some of the assurance work that has been considered by the Finance and Investment Committee to date and is for information.

Summary Position Goal 1 – Patients receive safe, timely and effective care

Ref	Deliverable	Completed	By 31st March 2018	2018/19	Closed	Executive owner
1.1	We will create a learning framework which involves patients in gaining feedback and service development	√				TB
1.2	We will strengthen our clinical governance processes, supported by a restructured Quality Assurance Directorate	√				TB
1.3	We will implement an annual plan of Clinical Education updates for all clinical supervisors		√			FW
1.4	We will strengthen the patient voice through the delivery of an annual patient engagement work plan	√				TB
1.5	We will ensure we have the right safe staffing levels in place, to fill our rosters to meet demand			√		PG
1.6	We will undertake and implement a Trust-wide review of rosters to better meet the needs of our patients (first tranche September 2018 second tranche September 2019)		√			PW
1.7	Learning from feedback will be routinely incorporated into all education programmes	√				FW
1.8	We will deliver improvements in Infection Control and the management of safeguarding issues	√				FW
1.9	We will deliver the second phase of medicine management improvement	√				FW
1.10	We will support delivery of pan London care pathway redesign for: fallers; patients with mental health needs; urgent care referrals; and End of Life Care	√				FW
1.11	We will improve our care for cardiac arrest, stroke and STEMI patients by reducing on-scene time		√			FW
1.12	We will improve our performance for patients with low acuity needs by reducing the waiting time for treatment	√				PW
1.13	We will improve our emergency control rooms and despatch processes	√				PW
1.14	We will deliver agreed CCG performance levels so that we have more consistent performance across London	√				PW
1.15	We will introduce new annual leave arrangements to better match patient needs and demand across the year		√			PG

Summary Position Goal 2 – Staff are valued, respected and engaged

Ref	Deliverable	Completed	By 31st March 2018	2018/19	Closed	Executive owner
2.1	We will agree our new multidisciplinary skill mix model, supported by annual recruitment plans to deliver the changes required	√				FW
2.2	We will establish a pipeline for our future Workforce, either via the LAS Academy, through University or other pipelines		√			PG
2.3	We will implement new rest break and end of shift arrangements to support frontline staff	√				PW
2.4	By July 2017 we will introduce a new Occupational Health Service to support staff to keep staff healthy	√				PG
2.5	We will address the three top causes of sickness: Stress; muscular skeletal injuries and Mental Health		√			PG
2.6	We will improve staff engagement, creating time and space to listen and act on staff views and feedback		√			JO'H
2.7	We will define our desired culture, introducing a behaviours framework and annual corporate management actions to set expectations and improve consistency			√		PG
2.8	We will deliver the actions outlined in our Workplace Race Equality Scheme action plan to improve the experience of BME staff and to make the Trust more representative of London's diversity			√		PG
2.9	We will complete our phase four actions to tackle bullying and harassment		√			PG
2.10	We will further improve the quality of appraisals to ensure all staff support delivery of corporate objectives		√			PG
2.11	We will set new autonomy, accountability & decision-making frameworks throughout the management tiers of the Trust			√		PG
2.12	We will design and implement new Talent Management arrangements to improve retention and succession planning			√		PG
2.13	We will put in place a clear Leadership Development Pathway across the Trust	√				PG
2.14	We will roll out hand held devices, so that our frontline crews have better information to treat patients and join up care		√			RF
2.15	We will move to vehicle-based equipment and drugs bags so that vehicles are consistently equipped			√		LB
2.16	We will introduce a Business Partner model to ensure that Corporate Services are actively engaged and support frontline operations			√		LB
2.17	We will strengthen our Corporate & Operational Management structures to improve support and accountability			√		PG

Summary Position Goal 3 - Partners are supported to deliver change in London

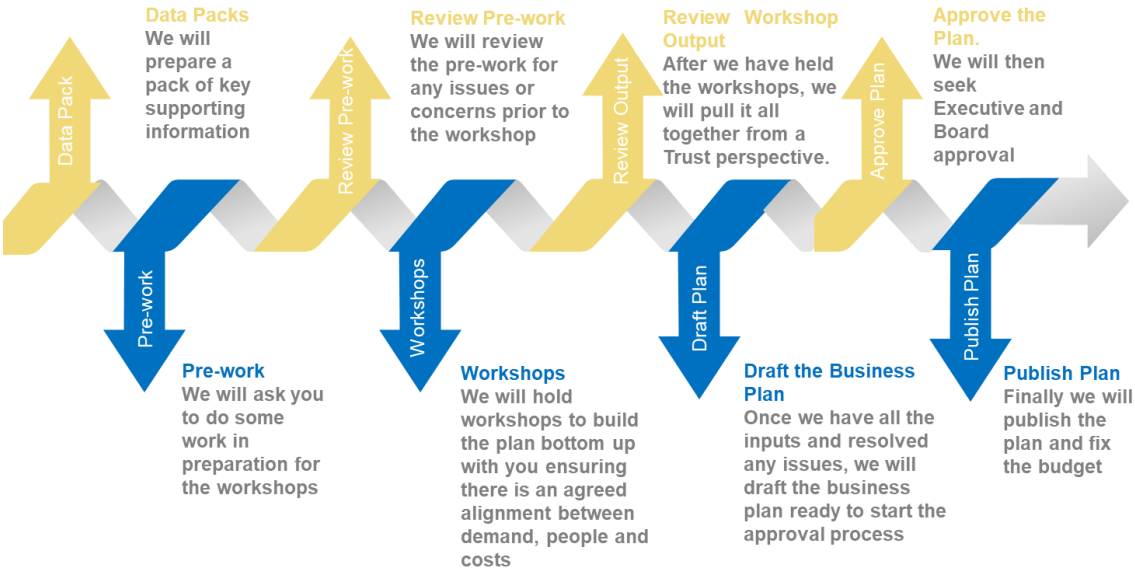
Ref	Deliverable	Completed	By 31st March 2018	2018/19	Closed	Executive owner
3.1	We will work with health partners to improve referrals between 111 and 999 services	√				FW
3.2	We will work with health partners to improve services to support frequent callers to 999	√				TB
3.3	We will work with health partners to improve support required by Care Homes in London	√				TB
3.4	We will work with health partners to improve referrals from healthcare professionals	√				FW
3.5	We will review our conveyance rates & set targets to ensure patients are referred to the most appropriate setting of care		√			PW/ FW
3.6	We will work with NHS Improvement & NHS England to reduce time lost through hospital handover delays	√				FW
3.7	We will expand the corresponding pilot with blue light partners to reach our sickest patients quicker (deliver under business as usual)	√				FW
3.8	We will secure an additional 111 service in London	√				AF
3.9	We will begin to roll out access to special patient notes for crews on scene	√				RF
3.10	We will transform the way we run our 111 service, improving integration with 999		√			PW
3.11	We will undertake monthly analysis of patient and health data and use this to support STPs to improve London's health system	√				JMc
3.12	We will produce a Data Quality Framework to ensure that high Quality, accurate data is available and well managed throughout the Trust	√				JMc
3.13	We will put in place a revised set of indicators specifically related to quality of care and patient engagement		√			JMc
3.14	We will review Value for Money opportunities with partners to define collaboration and procurement priorities for the Trust		√			LB
3.15	We will maximise value for money through back office collaboration with NHS partners			√		LB
3.16	We will review control room usage and future opportunities with Blue Light partners			√		AF
3.17	We will expand the corresponding pilot with blue light partners to reach our sickest patients quicker				√	PW

Summary Position Goal 4 – Efficiency and sustainability will drive us

Ref	Deliverable	Completed	By 31st March 2018	2018/19	Closed	Executive owner
4.1	We will achieve all targets in the financial plan		√			LB
4.2	We will deliver in full all the elements of the CIP programme: - Frontline efficiency: £7.5m - Corporate Pay: £1.4m - Non-pay: £4.1m - Income Generation: £2.0m - Other Opportunities: £2.8m			√		LB
4.3	We will design a rolling programme and process to ensure CIPs are identified and delivered for future years	√				LB
4.4	We will agree a transformation methodology and structure to ensure transformation across the Trust		√			AF
4.5	We will transform how we operate and deliver care - Programme one of the transformation programme				√	AF
4.6	Programme two of the Transformation Programme will redesign the culture our organisation				√	PB
4.7	Programme three will transform and simplify our business processes to improve organisational efficiency				√	LB
4.8	We will build IM&T Operating and Governance models and embed new IM&T management processes and tools to support a resilient organisation		√			RF
4.9	We will design and implement an IM&T assurance framework to provide assurance on IM&T performance and the resilience of services		√			RF
4.10	We will deliver our CAD resilience strategy and year 1 actions from the Resilience review focusing of the stability of the CAD environment		√			RF
4.11	We will deliver a linked programme of new system and enhancement initiatives to deliver digital enablers for the Business Plan		√			RF
4.12	We will deliver a linked programme of technology refreshes to ensure the Trust has a stable and sustainable technical infrastructure it can rely on		√			RF
4.13	We will outline our fleet requirements in a new five-year Fleet Strategy and commence the implementation of our year one actions		√			LB
4.14	We will launch our People & Organisational Development Strategy	√				PG
4.15	We will launch our refreshed five-year Strategy		√			AF
4.16	We will put in place a programme to secure opportunities that arise from fleet and estates improvements		√			LB
4.17	We will define our Estates requirement for the next five years and commence the implementation of our year one actions			√		LB
4.18	We will have piloted an electronic response vehicle to support the Mayor's pledge to clean up London's air		√			LB

Business Planning 2018/19

7. The Trust launched the business planning process in early December outlining the approach and process through which operational directorates would be engaged in developing their business plans and supporting financial plans through January and February with a view to presenting a draft plan in February and final plan for approval by FIC and Board in March. The process is set out diagrammatically below:



8. The Trust executive is working on the development of the Financial Plan for 2018/19 including a high-level assessment of the overall savings requirement for next financial year. The business planning approach will emphasise the need to work within a cash limited budget with appropriate triangulation of quality and performance deliverables within that, as well as being underpinned by a robust and deliverable Cost Improvement Programme.

9. A number of unknowns still remain at the time of writing including:

   - the outcome of national pay negotiations,
   - the impact of cost pressures such as business rates increases,
   - the resource impact of the recently introduced ARP as current performance suggests that we are delivering within existing resources,
   - and levels of demand led activity growth remain uncertain at this time.

10. NHS Improvement is yet to publish guidance relating to their planning requirements for Trusts for 2018/19. The Trust continues to prepare its 2018/19 Business Plan in line with the agreed process and timetable.

11. There are a number of work-streams that continue to run concurrently to ensure we are in a position to continue to refine the financial plan through the business planning process. These include:

- Operations are working to establish the potential impact of ARP on overall resource requirements through ORH
- External benchmarking through the Carter work and local benchmarking undertaken by external consultants is being used to inform CIP development
- Fleet and Logistics, Operations and Finance are working through the potential impact of both ARP and the Introduction of the ULEZ on the Trusts existing fleet.
- Contracting are working with Commissioners to agree the contract variation of 2018/19 including expected activity levels and agreement of CQUIN. The Association of Ambulance Chief Executives have written to NHS England highlighting the need for Commissioners to consider the cost impact of ARP on Trusts following the publication of the national contract variation.

12. LAS will be required to submit a refreshed financial plan for 2018/19 that:

- Delivers national performance standards introduced in November 2017 under ARP
- Delivers the agreed financial control total in 2018/19 (subject to planning guidance)
- Establishes a robust and deliverable savings programme for 2018/19 and beyond in line with the increased focus from NHS Improvement.
- Establishes a system wide risk reserve of 0.5% that remains uncommitted throughout 2018/19
- Ensures the Trust remains within its allocated ceiling for agency staff £7.04m.
- Delivery of financial and operational targets ensures LAS will receive £2.0m of STP funding.

Recommendation

13. The Board is asked to note this report

Lorraine Bewes
Director of Finance and Performance

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Connecting our Board with our workforce			
Agenda item:	16			
Report Author(s):	Angie Patton, Assistant Director of Communications			
Presented by:	Jamie O'Hara, Director of Strategy and Communications			
History:	N/A			
Status:	☐	**Assurance**	☒	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

Following their re-inspection in June 2017, the Care Quality Commission (CQC) reported that the London Ambulance Service recognised that more work needed to be done to reduce the disconnect between the Executive Leadership Team and frontline staff. This paper sets out a proposal to address this. The key objectives are to:

- raise the visibility of the leadership team within the organisation
- provide the 'frontline' with a direct link to the Board
- provide opportunities for Board members to increase their engagement with staff, to ensure the strategy and vision is embedded in the organisation's culture, and the views of staff are heard (CQC recommendation, June 2017)
- address the disconnect between the Board and the workforce as identified by the CQC inspection in June 2017.

Recommendation(s):

The Board is asked to agree the approach set out in the report.

Links to Board Assurance Framework (BAF) and key risks:

The CQC identified the disconnect between the leadership team and frontline staff as an area for improvement.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☒
Governance and Well-led	☒

Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Connecting our Board with our Workforce

Background

1. Following their re-inspection report in June, the CQC reported that the Service recognised more work needed to be done to reduce the disconnect between the executive team and frontline staff.

2. Issues that were raised included 'staff not feeling fully engaged with the Trust's strategy, vision and values, and staff feeling unsettled with the constant changes in the executive team and seeking more stability'. In addition, 'staff did not feel fully consulted and engaged in the trust change agenda and reported the leadership as having a top down approach. Remoteness of ambulance stations further added to the feeling of disconnection'.

3. The CQC found that nearly all the frontline staff they spoke to 'said the executive team was target driven and this sometimes took away the 'human factor' side of leadership'. In their report the CQC said: 'It was clear the executive team needed more engagement with staff to allay their fears and gain their support and participation in leading the service forward'.

4. The CQC also stated that the visibility of the executive team had not improved. Staff told the CQC that 'they rarely saw managers above Band 8, with the exception of the medical director and director of operations'.

5. This paper sets out a proposal to connect the wider Board with our workforce.

6. Since the CQC visited in February last year, a number of senior appointments have been made to the Executive, including the arrival of a new Chief Executive. Steps have already been taken to improve dialogue between senior management and frontline staff, including a series of staff roadshows across the service which will double in size in 2018, to run twice a year (end April and October). This has been supplemented by regular "all staff" emails directly from the Chief Executive and other communications engagement.

7. This proposal builds on that approach and sits alongside the programme for local Quality Assessment visits, which executive and non-executive directors will participate in during this year.

Objectives

8. This paper has the following objectives:

   - Raise the visibility of the leadership team within the organisation.
   - Provide the 'frontline' with a direct link to the Board.
   - Provide opportunities for Board members to increase their engagement with staff, to ensure the strategy and vision is embedded in the organisation's culture, and the views of staff are heard (CQC recommendation, June 2017).
   - Address the disconnect between the Board and the workforce as identified by the CQC inspection in June 2017.

Approach

9. Although the activity to date has improved visibility of the Trust's senior management team (particularly the Chief Executive via the Roadshows) it is still felt more needs to be done to raise the visibility of the wider executive and non-executive team.

10. It is therefore proposed that members of the Board are aligned with specific functions within the Service, the aim being that they spend time getting to understand the business within their allocated area and take the opportunity to engage with staff on both corporate and local issues.

Aligning Executive and Non-Executive with Front Line Operations

11. To date some non-executives have been aligned to work more closely with specific sector areas, principally in relation to STP engagement. However, given the relatively large size of the combined executive and non-executive team, it is felt that there is an opportunity to more closely align specific members of the team at group station, rather than sector level.

12. The key proposal in this paper is therefore that we identify a specific executive or non-executive director to take responsibility for Board level visibility in each of our 18 group stations. This person would then be able to form a more direct relationship with the local group station management and staff, for example attending meetings, holding "surgeries" or open sessions to explain more about the work of the Board and, of course, go on ride-outs and/or spend time with crews in mess rooms, A&Es etc., to increase visibility and awareness.

13. This would be in addition to rather than instead of the existing STP level responsibilities of some Board members. Effectively we would be creating a small executive/non-executive team that would collectively take a greater interest in a sector area and who could work closely with the sector management team and, if necessary, substitute for one another.

14. Obviously there would be an opportunity to align these arrangements to some extent to take account of home/work locations to minimise the travel involved in fulfilling any area Board commitments.

15. Board members are requested to give their views and support to the proposed way forward.

Jamie O'Hara
Director of Strategy and Communications

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	30 January 2018			
Report title:	Quality Improvement Plan and CQC Preparation			
Agenda item:	17			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	QIP Programme Board			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides an update on the current actions in Quality Improvement Plan and Care Quality Commission (CQC) Preparation Plan for the next Well-Led CQC inspection.

Recommendation(s):

The Board is asked to review and comment. The QIP plan includes CQC must Do/Should Do actions.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☒

Quality Improvement Plan Update

Summary of Progress

1. The CQC Routine Provider Information Request (RPIR) was completed with 186 questions answered, with a further supporting 39 Documents returned to CQC by the deadline of 30 November 2017. CQC Inspectors have also observed the November Trust Board and staff focus groups in December.

2. Mock Inspections were held on the 29/30 November 2017 using 32 external inspectors. The analysis of the results has been completed, with 24 high priority actions to be managed to resolution by business as usual process and actions reviews during January.

3. The Station quality assurance reviews have been completed with a number of issues identified, which are being resolved by local management in conjunction with the high priority actions from the Mock Inspections by the end of January 2018.

4. Preparation and training for Board member interviews has commenced, with full Mock interviews scheduled to take place 31 January/2 February 2018.

5. The Quality Improvement Programme (QIP) initial burndown process has completed with all 135 actions closed.

CQC Inspection Date

6. CQC have confirmed that they will carry out a provider level inspection of 'well led' on 21-22 March 2018. At some point prior to the inspection of "well led", they will also carry out:

    - An unannounced inspection of at least one core service.
        - We can expect a phone call approximately 30 minutes prior to the team arriving.

    - A short notice inspection of at least one core service.
        - We can expect to be notified of this inspection via a phone call in advance.

7. As part of the inspection the following will be interviewed as a minimum:
        - The Trust Chair
        - The Chief Executive
        - Medical Director
        - Chief Quality Officer
        - Chief Operating Officer
        - Director of Finance/Chief Finance Officer
        - A sample of Non-Exec Directors (the NED for safety and risk is a priority.)
        - A sample of Governors, where appropriate
        - Director Infection Prevention and Control
        - Freedom to Speak Up Guardian

Provider Information Request (PIR)

8. The CQC Routine Provider Information Request (RPIR) was completed and returned to CQC by the deadline 30th November. As well as completing the Trust Self-Assessment, 186 questions were answered with a further 39 documents provided. It is expected that further information/document requests will be made by the CQC in the run-up to/during the inspection.

Quality Assurance Visits

9. The purpose of the quality assurance review was to measure each of our stations against the Key Lines of Enquiry (KLOEs) (focusing on Well Led) as part of the re-introduction of ongoing quarterly visits. All the stations have now been visited including both EOCs, NHS111 and the Logistics Centre.

10. There has been a marked improvement on last year's observations, with any issues identified being raised with the GSM and where necessary logged in Datix for urgent resolution and ongoing management. The target is to have completed all actions by the end of January.

11. The Quality Assurance visits will now continue as business as usual checks, with all stations/locations being visited on a quarterly basis.

12. A sector by sector review will be held in February to confirm the status of all actions and ensure that any outstanding actions have a completion plan.

Mock Inspections

13. The Mock Inspections are part of a range of activities aimed at ensuring the Trust is well prepared for the upcoming CQC Inspection and covered the Well Led domain and Warning Notice. Unannounced Mock Inspections took place 29th/30th November using 32 'Mock Inspectors' from a number of organisations including:

    - Patient Forum
    - NHSI
    - NHSE
    - SECAMB
    - Isle of Wight NHS Trust
    - Various London CCGs
    - Parliamentary and Health Services Ombudsmen
    - NEL Commissioning Support Unit

14. Over the two days the Mock Inspectors visited 30 sites including:

    - 9 Ambulance HQs Stations
    - 10 Ambulance Satellite Stations
    - Emergency Operations Centre (Waterloo and Bow)
    - Clinical Hub
    - 6 Hospital Emergency Departments
    - 111 Centre (Croydon)
    - Logistics Centre (Deptford)

15. Various problems were identified ranging from minor local issues to common issues across a number of Stations. The analysis of the results has been completed, with 24 high priority identified actions to be managed to resolution by business as usual process and final sprint actions during January.

16. Many of the problems raised were 'hygiene' issues i.e. 'business as usual' fixes, requiring everybody to be accountable, taking responsibility for their environment and actions. Much of this will be achieved by improved management visibility, reminders, training and regular quality assurance. The problems will be managed by regular reviews with sector ADOs commencing in February.

17. The 24-high priority identified actions to be managed to resolution by business as usual process and final sprint actions during January.

Final Sprint from Mock Inspections

High Priority	
Category	
Equipment	2
Estates	
Fleet	2
Health & Safety	2
IM&T	
IPC	2
Med.Mgt.	5
People & OD	6
Process	1
Rest Breaks	
Security	2
	24

Kit Bags | Blankets | Make Ready

Vehicle Checks | Fire Safety | H&S Contact

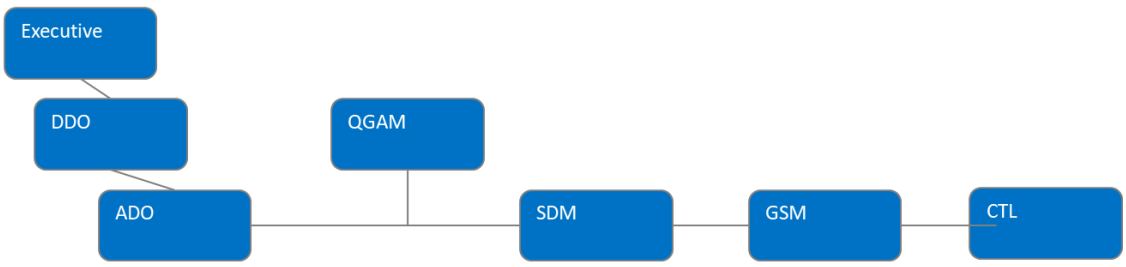
Sharps | Clinical Waste | Drug Storage

Drug Security x2 | CD Records | Med Mgt. Policy

Action Plan – Bank x5 | Equal Opportunity | Safeguarding

Patient Records | Leavers Process

Maintaining Focus



CORPORATE

- CQC inspection
- People & OD
- Stat Man Training
- IPC
- Health & Safety
- Staffing
- Equipment
- Vehicles
- Make Ready
- EOC / 111

SECTOR

- Risk registers
- Incident reporting
- Sickness
- Attendance
- Station security
- Staffing
- Vehicles
- Equipment
- RIDDOR reporting

STATION

- Appraisals
- StatMan Training
- Drug Safes
- Sharp Bins
- Notice Boards
- Medicine & Equipment Ordering

Quality Improvement Plan (2017-18)

18. The Quality Improvement Plan is the consolidated actions from the original CQC Plan and Well Led gap analysis which is aligned to the Business Plan objectives.

19. An agile approach was used to manage these 135 actions over a 6-week period with all of the actions either being completed or with an approved plan to achieve closure. Five of the actions although completed have not yet provided the relevant evidence for full closure.

20. A comprehensive staff communication plan has been developed with the following objectives:

- Focus on Senior Managers, putting the onus on them as drivers of change and the delivery of the Trust's strategy and QIP;
- Ensure that all staff know who is responsible for managing their areas and have regular opportunities of meeting with them;
- Enable responsive two-way communications through which staff at all levels can feel genuinely connected with the leadership and engaged in the Trust's change agenda;
- Recognise, celebrate and share achievement in an engaging manner that enables all staff to feel valued and part of the bigger picture.

21. Various products are being developed and will be rolled out over the next month, including staff handbook, Board Handbook including Tier 1 and 2 Managers and a CQC Inspector's Handbook.

LAS Countdown Plan

22. A LAS Countdown plan (see separate document) identifying all the activities that need to be completed prior, during and after the CQC inspections has been developed and is tracking to plan. Activities in the plan have continued to ensure the Trust is ready for the Inspection and have been updated following confirmation of the Inspection dates.

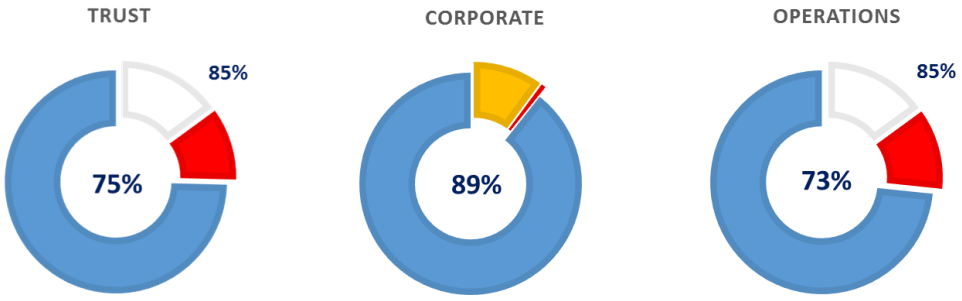
Statutory and Mandatory Training: Action Plan status on Requirements Notice

23. Improvement in the Statutory and Mandatory Training position has continued with Trust compliance now 75% as at the 31st December against the target of 85% by end of Mar-18.

24. Corporate compliance is 89% against a target of >90% compliance by end of Nov 2017 and Operations compliance is 73% at the end of December. Discussions are ongoing to look at the ability to roster staff to achieve 85% Operations compliance by the end of Feb 2018.

25. CSR 2017.2 was launched on 31 October 2017. An extra one-hour module for Health, Safety and Welfare has been included. One statutory training module, Equality, Diversity & Human Rights has not been included in the CSR 2017/18 programme and current discussions are looking at adding this to CSR in 2018.

Status as at 31st December



26. A new Bank contract has been finalised. A review of bank workers and their training has been undertaken. 167 Bank Workers have not completed a CSR course in the last rolling year and from November these bank workers have been moved into a 'do not use' status.

27. This left the Trust with 171 on the register until others either complete one of the current CSR courses and evidence on-going training from another Trust or complete both CSR courses if they have no evidence of on-going training from another Trust.

Progress against CQC /Should Dos (aligned to Business Plan objectives)

28. The latest Impact KPIs against the various domains have been updated and are presented in the Appendix.

29. All of the actions are now complete or have an approved plan to complete.

Staff are Valued, Respected, and Engaged (Should Do)

30. Focus on Statutory and Mandatory training has continued to ensure that staff complete all required training. (See previous section for more information)

31. Work in relation to Bullying and Harassment is on-going including diagnostic work, training round table champions and supporting informal resolution of Bullying and Harassment cases.

32. The new Rest Break policy was implemented in December, and is undergoing a further review following the implementation of ARP and operational winter pressures.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	**27 (27)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	**0 (0)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (0)**
Deliverable is on target to meet due date	**1 (1)**
Assurance Status (Evidence from Burndown w/c 4th December)	**27**

Patients Receive Safe, Timely and Effective Care (Should Do)

33. The Quality Improvement and Learning framework was presented and approved at the November Board meeting.

34. Funding to train a core group of staff in each station on Quality Improvement methodology is currently being sought from external funding mechanisms. Although key staff will be trained in Level 1 and 2 Quality Improvement approaches it is envisaged that the majority of staff should participate in improvement programmes within and across sectors as part of an annual cycle of improvement programmes.

35. Development of the Datix system continues with a quality assurance forum implemented. The quality Assurance visits are now part of business as usual and implementation of Health Assure is scheduled for completion in early 2018.

36. The roll-out of hand held devices, continues on track and is targeted to be completed by the end of March. The review of sites to agree solutions to ensure safe storage of drugs continues as part of the second phase of the medicines management programme.

37. LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target. New patient 'tagging' priority has been rolled out with positive feedback.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	**20 (16)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	**0 (1)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (0)**
Deliverable is on target to meet due date	**0 (3)**
Assurance Status (Evidence from Burndown w/c 4th December)	**20**

Efficiency and Sustainability Will Drive Us (Should Do)

38. The implementation of ARP was successfully achieved on the 1st November and response targets continue to be met.

39. A dedicated project team, led by the Medical Director, is focused on improving handover delays and is working closely with NHS Improvement. Full Job Cycle (JCT x MAR) was 104.2 minutes against a trajectory of 99.8. This is also better than September last year by 5.8 minutes.

40. A rapid review investigating shortage of equipment has been completed. There are two items of equipment which are in short supply. The Lifepak 1000 defibrillator and Manger Elk lifting cushion. There are sufficient Lifepak 1000's to equip all the frontline operational fleet. There are also supply issues with the provision of the Manger Elk lifting cushion. Three different version of the cushion have been manufactured by the supplier. There are interchangeability problems with these units, as the version two and three on-board chargers cannot be used with version one. Spare parts are also no longer available for the oldest units. This potentially impacts on 170 ambulances. Wherever possible the local Vehicle Preparation teams will seek to marry up correct units with chargers.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	**5 (0)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	**0 (0)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (2)**
Deliverable is on target to meet due date	**1(4)**
Assurance Status (Evidence from Burndown w/c 4th December)	**5**

Progress against Well Led domain (Should dos)

41. The new Director of Strategy & Communication started late November. The Director of Asset Management has been appointed and will start in January. The Interim director of Finance has been appointed into the substantive role following a recruitment process.

42. Board and Executive development is an on-going and is continually reviewed / addressed by the Chief Executive's Office and our Chair. Our Chair leads on Well-Led Development for our Board, Executives and Non-Executives.

43. Local questions relating to staff morale, leadership and engagement and the staff survey action plan will be added to the Q2 (June) staff friends and family test to support the qualitative data already collated in June each year. Staff focus groups were held on 15th December. The output is being collated and will be shared during January.

44. Reference Case information has been used in 'Our Strategic Intent'. Reference Case Phase 1 has been shared with Trust Board. Reference Case Phase 2 is still in development. This is being developed in line with the strategy for publishing early 2018.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	**50 (27)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	**0 (11)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (0)**
Deliverable is on target to meet due date	**3 (9)**
Deliverable date to be confirmed	**0 (6)**
Assurance Status (Evidence from Burndown w/c 4th December)	**50**

Risks and Issues

45. The issues from last month have been closed, and a new risk have been raised.

Programme	Risk/Issue	Comment	Status of Risk
All	CQC Interviewees may not present a joined up/ understanding of areas outside of their immediate directorate	QIP Project team will develop materials and arrange joint sessions to ensure all well informed and have supporting materials	**NEW**

Dr Patricia Bain
Chief Quality Officer

Appendix: Impact KPI's Scorecard (Must Do/Should Do and Well-Led Domain) November '17

Domain	Measure	RAG	Trend
	Sickness/Absence - All Staff	●	▲
	Sickness/Absence - Frontline Staff	●	▲
	BME% Starters	●	▼
	Controlled Drugs: LIN reportable	●	◀▶
	Job Cycle Time (mins)	●	▲
	Avg. Hospital arrived to Patient Handover (mins)	●	◀▶
	Avg. Patient Handover to Green (mins)	●	◀▶
	Controlled Drugs: Non LIN reportable incidents	●	◀▶
	Sickness/Absence - Long-term	●	▼
	Incident Reporting - No Harm *(Reported incidents to NRLS - 12 month rolling)*	●	▲
	Incident Reporting - Low Harm *(Reported incidents to NRLS - 12 month rolling)*	●	▼
	Statutory & Mandatory Training: Trust compliance	●	▲
	Statutory & Mandatory Training: Corporate	●	▲
	Statutory & Mandatory Training: Operations	●	▲
	Missing equipment incidents as % of all reported incidents	●	▼
	Failure of device/equipment/vehicle as % of all missing incidents	●	▼
	Sickness/Absence - Short-term	●	▲
	BME% Leavers	●	▲
	Bullying & Harrasment cases resolved within 28 days	●	◀▶
	Serious Incidents breaching 60 days	●	◀▶
	Infection, Prevention & Control: Hand Hygiene compliance	●	▲
	Rest Breaks - DCA		▶▶
	Rest Breaks - FRU		▶▶
	Statutory & Mandatory Training: Bank compliance		▶▶

Legend					
●	Target is not being met. Position has deteriorated since last month.	●	Target is not being met / No Target Set Position improved / static since last month.	●	Target is being met.
Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement				▶▶	Fast forward. Trend not available

STAFF ARE VALUED, RESPECTED & ENGAGED

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

EFFICIENCY & SUSTAINABILITY WILL DRIVE US

WELL LED

Nov-17 Impact KPI's Scorecard

Domain	Measure	Baseline 2015/16	Baseline 2016/17	Benchmark	Target	Actual / Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	RAG	Trend	Dec-17	Jan-18	Feb-18	Mar-18
STAFF ARE VALUED, RESPECTED & ENGAGED	Statutory & Mandatory Training: Trust compliance				85%	Actual	67%	67%	66%	65%	66%	66%	70%	74%	●	▲	75%	75%		
						Trajectory							67%	69%			75%	80%	85%	87%
	Corporate				90%	Actual	58%	57%	58%	59%	66%	65%	76%	86%	●	▲	89%	89%		
	Operations				85%	Actual	68%	68%	67%	66%	66%	66%	70%	73%	●	▲	73%	73%		
	Bank MAST compliance				100%	Actual						tbc	tbc	tbc		▶▶				
	Sickness/Absence - All Staff			4.3%	5.0%	Actual	4.6%	5.0%	5.0%	5.4%	5.2%	5.1%	5.2%	5.4%	●	▲				
	Long-term		3.3%		3.0%	Actual	3.4%	3.4%	3.4%	3.3%	3.4%	3.4%	3.5%	3.4%	●	▼				
	Short-term		1.8%		2.0%	Actual	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%	2.0%	●	▲				
	Frontline Staff	5.6%			5.0%	Actual	5.1%	5.5%	5.5%	5.5%	5.6%	5.6%	5.5%	5.9%	●	▲				
	KF17. % of staff feeling unwell due to work related stress in the last 12 months	55%	51%	48%	Improve	Actual										▶▶				
	KF19. Organisation & management interest in & action on health & wellbeing	2.84	3.24	3.21	Improve	Actual										▶▶				
	BME% of workforce		13%	*BME% of London Population 45%*												▶▶				
	BME% Starters		22%	-	24%	Actual	11%	19%	22%	17%	23%	18%	20%	7%	●	▼				
	BME% Leavers		16%	-	14%	Actual	29%	14%	26%	14%	11%	22%	9%	11%	●	▲				
	BME Conversion rate shortlisting to appointment					Actual	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	▶▶				
	Staff Survey: BME response rate		12%	14%	13%	Actual										▶▶				
	KF20 % experiencing discrimination at work in last 12 months	30%	21%	Avg. 20%	26%	Actual										▶▶				
	KF21. % believing the org provides equal opportunities for career progression/promotion	60%	78%	Avg. 70%	73%	Actual										▶▶				
	Bullying & Harrasment cases resolved within 28 days					Actual	100%	80%	-	-	50%	-	-	-	●	◀▶				
	KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	38%	33%	Avg. 28%	27%	Actual										▶▶				
PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE	Serious Incidents breaching 60 days			0		Actual	7	9	5	0	1	0	0	0	●	◀▶				
	Incident Reporting - No Harm *(Reported incidents to NRLS - 12 month rolling)*			1200		Actual						1201	1290	1425	●	▲				
	Incident Reporting - Low Harm *(Reported incidents to NRLS - 12 month rolling)*			500		Actual						395	428	314	●	▼				
	Q13a % saying if they were concerned about unsafe clinical practice they would know how to report it	86%	90%	94%	Improve	Actual										▶▶				
	Q13b "I would feel secure raising concerns about unsafe clinical practice"	50%	59%	63%	Improve	Actual										▶▶				
	Q13c "I am confident that the organisation would address my concern"	34%	49%	50%	Improve	Actual										▶▶				
	Infection, Prevention & Control: Hand Hygiene compliance				90%	Actual	70%	85%	76%	87%	90%	93%	91%	98%	●	▲				
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean				90%	Actual	97%	97%	95%	94%	97%	96%	93%		●					
	Infection, Prevention & Control: Monthly Premises Cleaning				90%	Actual	96%	96%	97%	98%	79%	92%	98%		●					
	Controlled Drugs: Non LIN reportable incidents				<15	Actual	16	24	38	31	35	23	33	33	●	◀▶				
	Controlled Drugs: LIN reportable				0	Actual	0	0	0	0	0	0	1	1	●	◀▶				
	Missing equipment incidents as % of all reported incidents					Actual	3%	3%	3%	2%	2%	3%	4%	3%	●	▼				
	Failure of device/equipment/vehicle as % of all missing incidents					Actual	10%	12%	16%	9%	9%	8%	11%	8%	●	▼				
	Q4f "I have adequate materials, supplies and equipment to do my work"	32%	40%	52%	Improve	Actual										▶▶				
EFFICIENCY & SUSTAINABILITY WILL DRIVE US	Ambulance Response Programme: Cat 1	7 mins (mean) (15 mins 90th centile response time)				Actual								00:07:03		▶▶	00:07:24			
	Ambulance Response Programme: Cat 2	18 mins (mean) (40 mins 90th centile response time)				Actual								00:18:25		▶▶	00:24:12			
	Ambulance Response Programme: Cat 3	120 mins 90th centile response time				Actual								133 mins		▶▶	179 mins			
	Ambulance Response Programme: Cat 4	180 mins 90th centile response time				Actual								149 mins		▶▶	172 mins			
	Rest Breaks - DCA		13%			Actual								4.40%		▶▶	1.10%			
	Rest Breaks - FRU					Actual								83.50%		▶▶	68.50%			
	Job Cycle Time (mins)	88			78	Actual	82	82	81	81	80	81	82	88	●	▲				
	Avg. Hospital arrived to Patient Handover (mins)		19		15	Actual	20	20	19	19	19	20	20	20	●	◀▶				
	% Arrive at Hospital To Patient Handover Over 15 Mins					Actual	60%	60%	57%	57%	57%	58%	59%	58%						
	Arrive at Hospital to Patient Handover - Total Hours Lost > 15 Mins					Actual	5018	5422	4638	4757	4751	5172	5794	5605						
	Avg. Patient Handover to Green (mins)		17		14	Actual	18	18	18	18	18	18	18	18	●	◀▶				
	% Patient Handover To Green Over 14 Mins					Actual	58%	57%	57%	57%	57%	57%	57%	57%						
	Patient Handover to Green - Total Hours Lost > 14 Mins					Actual	4878	4965	4851	4906	4805	4735	5061	5142						
WELL LED	Exec / Non exec visits				Improve	Actual	27	14	27	14	13	19	78							
	Q8a "I know who the senior managers are here"	65%	72%	73%	Improve	Actual										▶▶				
	Q5b "The support I get from my immediate manager"	49%	63%	57%	Improve	Actual										▶▶				
	Staff survery response rate	35%	42%	41%	Improve	Actual										▶▶				
	Overall Staff Engagement *(the higher the score the better)*	3.13	3.40	3.41	Improve	Actual										▶▶				
	KF4. Staff motivation at work *(the higher the score the better)*	3.33	3.52	3.67	Improve	Actual										▶▶				
	KF7. Staff ability to contribute towards improvements at work %	37%	46%	48%	Improve	Actual										▶▶				
	KF1. Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.03	3.43	3.46	Improve	Actual										▶▶				

Legend

●	Target is not being met. Position has deteriorated since last month.	●	Target is not being met / No Target Set Position improved / static since last month.	●	Target is being met.

Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement

▶▶ Fast forward. Trend not available

London Ambulance Service NHS
NHS Trust

Quality Improvement Plan

KEY

Red	**= Will miss/has missed due date**
Amber	**= At risk of missing due date, but recoverable**
Green	**= On Target**
Blue	**= Complete**

Organisation ID: RRU01
CQC Ref:INS1-2918947652

8th January 2018

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	Nov-17	Dec-17	Status	**Comments**
MUST DO: (1) Mast training compliance: Governance : Owner Patricia Grealish Director of People and Organisational Development								
Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such information must be more efficient. Enhancing Governance	1.01	Update all MAST training material/information contained in induction materials and messaging to reinforce and ensure individuals understand their responsibility for completion	PG	30/09/2017			Complete	There is now a standalone session on corporate induction which discussed the completion of mandatory training, how to complete it and the time frame allotted to do this.
	1.02	A communication plan will be designed and implemented to embed the process, responsibilities and accountabilities for MAST compliance across all management groups	PG	31/08/2017			Complete	Communication Plan in place and regular communications to staff re. completing Stat/man training being rolled out
	1.03	Ensure that the full extent of bank workers and their use at LAS is investigated and a report brought to ELT to discuss next steps.	PG	31/08/2017			Complete	Stat/Man training update to ELT was submitted with the relevant analysis.
	1.04	Clearly define and implement a process to ensure that all bank workers can evidence compliance with LAS MAST training	PG	31/07/2017			Complete	A new Bank contract has been finalised. A review of bank workers and their training has been undertaken. 167 Bank Workers have not completed a CSR course in the last rolling year and from November these bank workers will be moved into a 'do not use' status. This will leave the Trust with 171 on the register until others either complete one of the current CSR courses and evidence on-going training from another Trust or complete both CSR courses if they have no evidence of on-going training from another Trust.
	1.05	Complete implementation of enhanced ESR Project so records are available on demand for managers at individual, team, sector and function level	PG	01/08/2017			Complete	The launch of MyESR has provided all staff with a training compliance dashboard. A workforce dashboard has been launched in Oct-17. Requirement for 100% corporate compliance with Statutory & Mandatory training by end of Nov-17 communicated
	1.06	Ensure that MAST compliance data is incorporated into the workforce report for the Board, split into corporate and clinical staff groups	PG	31/08/2017			Complete	We have prepared a paper with the CQC Support team which is intended to give the ELT an update on the status of Statutory Mandatory Training compliance across the Trust together with progress on the associated Action Plan (dated 28 June 2017) which aimed to address the CQC report 'Must Do' actions. This will be shared at the November Board meeting and with Commissioners.

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	Nov-17	Dec-17	Status	**Comments**
MAST Training (2) : Setting and Maintaining standards								
Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such information must be more efficient.	1.07	Carry out a review of the content of MAST training for clinical staff to include the method of delivery and skills of trainers	PG	31/08/2017			Complete	Review has been completed and action plan developed
	1.08	All managers to have an objective requiring them to ensure their teams are compliant for all accessible MAST training	PG	31/08/2017			Complete	Standard objectives drafted and sent out with a request to all staff cascade across Directorates. Unable to confirm if objectives have been added/included in all appraisals
	1.09	Agree compliance target and dates for clinical staff to recognise the Block training nature of their core skills refresher programme	PG	31/08/2017			Complete	
	1.10	Carry out review to agree consequences of non-compliance with MAST requirements and to investigate options to require new employees to complete training period between offer and starting work with LAS	PG	31/08/2017			In progress	Review of non-compliance consequences not completed. New employee option - Since implementation of MyESR, we are exploring through the ESR Central Team, the possibility of access to StatMan training between offer and start date. Priority is being given to use of ESR rather than these new initiatives
	1.11	The ELT will require all corporate staff to be compliant in current MAST modules which are currently accessible, by 31 August 2017. This focus will be supported by the communication plan.	PG	31/08/2017			Complete	
	1.12	The ELT will require all corporate staff to be compliant in new MAST modules accessible on ESR by 31 November 2017. Evidence of progress will then be submitted to CQC to lift the requirement notice.	PG	30/11/2017			Complete	Improvement in the Statutory and Mandatory Training position has continued with compliance now 75% against the target of 85% by end of Mar-18. Corporate compliance is 89% against a target of >90% compliance by end of Nov-17 and Operations compliance is 73% at the end of December. Discussions are ongoing to look at the ability to roster staff to achieve 85% Operations compliance by the end of Feb-18. CSR 2017.2 was launched on 31st October. An extra one-hour module for Health, Safety and Welfare has been included. One statutory training module, Equality, Diversity & Human Rights has not been included in the CSR 2017/18 programme and current discussions are looking at adding this to CSR in 2018.

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	Nov-17	Dec-17	Status	**Comments**
Sickness and Absence: Owner Patricia Grealish								
To continue working with staff to address the issues related to rosters, rest breaks, sickness and absence, Actions should demonstrate a fair and consistent approach to managing the demands of the service along with health and safety of staff	1.13	Complete implementation of agreed approach in relation to Rest Breaks	PG/PW	31/12/2017			Complete	Discussions with the unions in relation to rest breaks has now been successfully concluded and agreement of the new policy reached on 20th October 2017. The implementation of the new policy will start from December 4th 2017. A project team focusing on roster development is in place and currently revising these to support the implementation of ARP. ARP will be implemented on 31st October and rosters to reflect the changing pattern of response will be aligned at this point.
	1.14	Launch of People & OD - Wellbeing Matters strategy theme introducing proactive approach to health and wellbeing	PG	31/12/2017			Complete	The implementation plan for the P&OD Strategy is now being developed.
	1.15	Ensure the introduction of the Workforce Dashboard to time which will give managers dynamic information about their people, including vacancy rates, sickness rates and appraisal	PG	01/08/2017			Complete	The workforce dashboard has been launched via the CEO led Roadshows, this includes sickness and absence, turnover, recruitment and training KPIs to ensure that both corporately and operationally these can be monitored more closely. The data is allowing focused effort on staff on long term sickness and absence across the sectors.
	1.16	Review the Trust Policy on Sickness Absence in light of 1.14 above and implement any recommendations	PG	31/12/2017			Complete	
Leadership development								
Review the leadership and management styles of key staff with responsibility for managing emergency and urgent care ambulance crews.	1.17	Launch of People & OD, Leadership and Management Theme, central to which is the development and communication of management behaviours	PG	31/12/2017			Complete	The implementation plan for the P&OD Strategy is now being developed.
	1.18	Develop and deliver behaviours and professional standards frameworks, learning from NHS Leadership Academy GMC and NMC. Ensure that role descriptions and objectives set out the importance of role modelling values and behaviours.	PG	31/12/2017			Complete	The LAS Behaviour Model has been rationalised from 9 Behaviours to 4 to better promote and market clear expectations going forward which will be underpinned by people's professional registrations and codes of conduct. Once these behaviours are signed off (December 2017) they will be rolled out across the organisation with a clear communications plan and supported by E-Learning and input sessions (January 2018).
In addition identify further opportunities for the executive team to increase their engagement with staff, to ensure strategy and vision is embed in culture and that the views of staff are heard.	1.19	Design and deliver key communication and engagement activities, including 'town halls', management group away days and ,road shows to support face to face communication with people across LAS. Explore the value of standardised approaches such as Listening into Action.	PG	31/10/2017			Complete	Roadshows Held.

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	Nov-17	Dec-17	Status	**Comments**
	1.20	Launch of People & OD, Engagement strategy theme, central to which is developing communication and engagement plans to support staff survey and see 2.20 below	PG	04/10/2017			Complete	The implementation plan for the P&OD Strategy is now being developed.
	1.21	Launch of People & OD, Engagement strategy theme, central to which (in addition to 2.19 above) is core management development interventions to support working proactively with TUs and communicating directly with our people	PG	31/12/2017			Complete	The implementation plan for the P&OD Strategy is now being developed.
	1.22	Undertake a Pulse Survey in January 2018 and an independent deep dive in Q1 18/19 to test the impact of leadership development, changing working practices and engagement activities on staff experience	PG	30/06/2018			Complete	Small focus groups held in December, further groups to be held during 2018.
Bullying and Harassment and BME; Owner Patricia Grealish								
Continue to build on the programme of work to improve the culture around perceived bullying and harassment. Push forward with the measures it has identified and already established to increase a more diverse and representative workforce with greater numbers of black and ethnic minority staff.	1.23	To commission Consultant to complete Phase 4 of the work commenced in 2016/17	PG	31/07/2017			Complete	Initial diagnostic completed and work is now focused on embedding B&H capability in P&OD team
	1.24	To procure the services of an independent Mediator to support our approach for informal resolution and courageous conversations	PG	30/11/2017			Complete	Mediator recruited and in post
	1.25	To develop and launch the WRES Action Plan for 2017/18	PG	03/10/2017			Complete	LAS have submitted the WRES data to NHS England, the new WRES action plan which has been co-produced with BME staff it was reviewed and approved at the October board meeting
Allocation of resources : Owner Paul Woodrow								
Allocate ambulance personnel appropriately taking into account individual qualifications, experience and capabilities	1.26	A review will be undertaken of the Trust's allocation of ambulance personnel to vehicle resource against the Trust's skill mix matrix to determine levels of compliance.	PW	30/09/2017			Complete	Skills matrix in place and is reviewed on an ongoing basis.. No known breaches this year.
	1.27	The Trust's skill mix matrix will be reviewed on an annual basis to ensure it remains fit for purpose and clinically appropriate.	PW/FW	30/03/2018			Complete	The latest version of the skills matrix was published in July 2017. it is currently being reviewed and updated, and was ratified at the Operations Board in November.
Shift Patterns : Owner Paul Woodrow								
Ensure enough time is factored into shift patterns for ambulance crews to undertake their daily vehicle checks within their allocated shift pattern	1.28	The outcome of 4.01 and 4.02 will be considered as part of the Trust's roster review.	PW	31/03/2018			Complete	Duplicated with CQC1.29 below. Thus closed
	1.29	The outcome of 4.01 and 4.02 will be considered as part of the Trust's roster review.	PW	31/03/2018			Complete	This will be considered once the ARP has fully bedded in and the impact over an extended period is understood

STAFF ARE VALUED, RESPECTED & ENGAGED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Risk Management - Patricia Bain Philippa Harding								
Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly. Ensure staff report all incidents including low harm and near miss incidents and are encouraged to do so. Improve and Evidence how we learn from incidents, risks, feedback and external inquiries.	2.01	Undertake a baseline review of all local risk registers and complete a gap analysis	PB	01/09/2017			Complete	Complete
	2.02	Undertake regular monitoring / audit of risk registers and the Datix system to encourage proactive learning and risk mitigation. Undertake a Q3 deep dive to test the impact of changes on quality of risks being reported and effectiveness of the risk management approach	PB	ongoing			Complete	Complete
	2.03	Update and publish revised Risk Management Policy	PB	30/09/2017			Complete	At its meeting on 31 October 2017, the Board delegated authority to the Audit Committee to approve the proposed Risk Management Framework. It was considered at the Audit Committee meeting on 6 November 2017 and approved subject to a number of minor amendments. It will be re-circulated to the Board and published by 10 November 2017.
	2.04	Complete a strategic risk review of the Trust risk register and align local risk register to BAF	PB	01/08/2017			Complete	Due to be presented to 3rd October Board
	2.05	Raise awareness of incident reporting across the Trust through various mechanisms that include automatic feedback loops from Datix when an incident is reported. Ensure the Integrated Performance Report tracks the number of low harm and no harm incidents reported as well as total incidents reported	PB	30/09/2017			Complete	The Datix Risk Management System has been reviewed with an initial redesign and reconfiguration taking place on 1 October 2017 across LAS for Incidents. These improvements and future enhancements (to be made in Q3) will see the incident reporting process more robust and far more intuitive for staff, with a detailed feedback mechanism providing information to assist the learning and sharing relating to all clinical and non-clinical incidents. An e-learning package is being developed for all staff as part of mandatory training which will raise awareness of incident reporting, investigations and the sharing of lessons (to be launch in early 2018).
	2.06	Roll out updated risk management training for all operational managers for cascading to all staff, raising awareness of risk management processes	PB	01/10/2017			Complete	e-learning package to launch early 2018
	2.07	Redesign the investigation process to accelerate learning that includes training for core staff	PB	01/07/2017			Complete	Complete

STAFF ARE VALUED, RESPECTED & ENGAGED								
Proposed action	#Ref	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
	2.08	Develop a reporting and learning framework that includes events, communication at all levels in the Trust	PB	01/09/2017			Complete	A Quality Improvement and Learning framework has been developed with the support of corporate and operational staff. The framework will be presented to the Board in November. A key aspect of the Quality Improvement work going forward is the development of Quality Champions at group station/sector level. These staff will be the key link to the QGAMS to drive forward quality improvement and ensure that learning is shared in a more timely and meaningful way from Board to frontline.
	2.09	Develop the Datix system to ensure it captures and can report risks and incidents in a way that supports proactive learning	PB	ongoing			Complete	Datix web training e-learning platform tool has been launched with further training programmes on Datix and risk management in the new year. Development of the Datix system continues and implementation of Health Assure is under way.
Improving incident reporting - Sandra Adams								
Review and improve Trust incident reporting data Address under reporting of incidents including the perceived pressure in some departments not to report some incidents	2.10	Review incident reporting awareness tools	PB	01/08/2017			Complete	
	2.11	Develop DatixWeb training and implementation plan for roll out	PB	ongoing			Complete	e-learning platform tool was rolled out 1st October Trust Wide
	2.12	Design a plan for staff communication to ensure they understand the Trust updated incident management processes, following the implementation of DatixWeb	PB	01/09/2017			Complete	
Improving safety: Fenella Wrigley								
Ensure ongoing robust plans to tackle handover delays	2.13	Continue to implement system wide hand over project	FW	31/03/2018			Complete	LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target. New patient 'tagging' priority has been rolled out with positive feedback.
	2.14	Monitor Monthly at ROG	FW	monthly			Complete	Now being reported at ROG meetings

STAFF ARE VALUED, RESPECTED & ENGAGED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Improve the oversight and management of infection prevention and control practices. This includes ensuring consistent standards of cleanliness in the ambulance stations vehicles and staff adherence to hand hygiene practices	2.15	Recruit to IPC agreed Resource	FW	30/08/2017			Complete	Offer made and accepted but due to notice period will not join LAS until January 2018
	2.16	Continue to develop and implement Perfect Ward app	FW	ongoing			Complete	Perfect Ward now rolled out across Service and used across all sectors on a daily basis
	2.17	Increase IPC Audit at stations and A&E	FW	ongoing			Complete	All the stations have now been visited including both EOCs, NHS111 and the Logistics Centre. The Quality Assurance visits will now continue as business as usual checks, with all stations/locations being visited on a quarterly basis.
Ensure continued monitoring and improvements are made in medicines management so that safety procedures are embedded in everyday practice and sustained by staff	2.18	2nd phase of medicines management improvements to be implemented	FW	end 2017/18			Complete	Bulletins, FAQs, etc. provided by lead for secure drugs rooms which is in pilot phase across London. Training also under way.
	2.19	Continue development and roll-out of Perfect Ward App	FW	end 2017/18			Complete	Year one of the clinical strategy has been presented to QAC and all deliverables on track to be completed. One of the main deliverables being the roll-out of hand held devices, this is on track for completion in December.
	2.20	On-going auditing of estate to ensure drugs stored securely	FW	end 2017/18			Complete	All the stations have now been visited including both EOCs, NHS111 and the Logistics Centre. The Quality Assurance visits will now continue as business as usual checks, with all stations/locations being visited on a quarterly basis.

EFFICIENCY & SUSTAINABILITY WILL DRIVE US								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Fleet / Vehicle Preparation - Lorraine Bewes								
Ensure performance targets are met for high priority patients	4.01	Implement the Ambulance Response Programme in line with national guidelines and timescales	PW	04/10/2017			Complete	APR was successfully implemented overnight 31st October/1st Nov with no problems and all targets are currently being met.
	4.02	Finalise and implement the new system for rest breaks	PW	30/09/2018			Complete	Discussions with the unions in relation to rest breaks has now been successfully concluded and agreement of the new policy reached on 20th October 2017. The implementation of the new policy will start from December 4th 2017. A project team focusing on roster development is in place and currently revising these to support the implementation of ARP. ARP was implemented on 31st October and rosters now reflect the changing pattern of response will be aligned at this point.
	4.03	Reduce job cycle time (JCT) to 78 minutes	PW	30/03/2018			In Progress	A dedicated project team, led by the Medical Director, is focused on improving handover delays and is working closely with NHS Improvement. Full Job Cycle (JCT x MAR) was 104.2 minutes against a trajectory of 99.8. This is also better than September last year by 5.8 minutes.
	4.04	Undertake robust planning for winter 2017/18	PW	01/09/2017			Complete	Winter Plan agreed at ELT 30th August
	4.05	Reduce delays in hospital handovers	PW	30/11/2017			Complete	LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target. New patient 'tagging' priority rolled out with positive feedback.
	4.06	Produce robust workforce demand and capacity model	PG	03/10/2017			Complete	

EFFICIENCY & SUSTAINABILITY WILL DRIVE US								
Proposed action	#Ref	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Further improve the provision and monitoring of essential equipment availability for staff at the start of their shift	4.07	Understand the types of equipment in short supply and root cause. Address supply chain and distribution issues and ensure a robust audit process is in place to monitor impact	LB	30/11/2017			Complete	There are two items of equipment which are in short supply. The Lifepak 1000 defibrillator and Manger Elk lifting cushion. There are sufficient Lifepak 1000's to equip all the frontline operational fleet. There are also supply issues with the provision of the Manger Elk lifting cushion. Three different version of the cushion have been manufactured by the supplier. There are interchangeability problems with these units, as the version two and three on-board chargers cannot be used with version one. Spare parts are also no longer available for the oldest units. This potentially impacts on 170 ambulances. Wherever possible the local Vehicle Preparation teams will seek to marry up correct units with chargers. The Vehicle Preparation hubs complete and record a comprehensive vehicle inspection every 24 hours. This lists all equipment and consumables held on a vehicle. From their equipment store they will replenish missing items. A log of equipment issued, and to which vehicle, is regularly maintained. The Logistics Support Unit replenishes equipment issued by the hubs, also keeping a log.

WELL-LED								
Proposed action	#Ref	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Is there leadership capacity and capability to deliver high quality sustainable care - Garrett Emmerson & Patricia Grealish								
W1.1 Do leaders have the skills, knowledge, experience and integrity that they need - both when they are appointed and on an ongoing basis?	W0	Complete recruitment to remaining Executive team vacancies	GE	31/10/17 - Garrett to sense check			Complete	Director of Strategy & Communication started late November. Director of Asset Management has been appointed and will start in January. The Interim director of Finance has been appointed into the substantive role following a recruitment process.
	W1	Specify and commission a programme of Board and Executive development once the Executive recruitment is in place	GE	31/12/2017			Complete	Board and Executive development is an on-going and continually reviewed / addressed by the Chief Executive's Office and our Chair. Our Chair Heather Lawrence leads on Well-Led Development for our Board, Executives and Non-Executives.
	W2	Ensure Board meetings include some time for reflection on how effective they are and identify areas for improvement and there is an agreed timescale in place for re-looking at the dates of Board sub-committees to improve the flow of information to Board	PH	31/08/2017			Complete	
	W3	Ensure all Executive and Non Executive Directors (including secondees) have a personnel file which is compliant with the Trust Fit and Proper Person Policy	PG	31/10/2017 needs to match W0 date set by GE			Complete	An audit has been completed and any missing data is being requested/sought.
W1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions to address them?	W4	Ensure the actions relating to CQC February inspection and the well led gap analysis are reflected in Executives objectives and cascaded to their teams	GE	31/08/2017			Complete	All Executives have objectives relating to CQC actions and subsequent plans
	W5	Get consensus amongst the Executive on the top corporate risks to ensure alignment with the Business plan objectives and current strategic issues. Propose refreshed BAF to Board.	PH	31/10/2017			Complete	Risk evaluation is an ongoing item at every board. The BAF refresh has been presented to the Audit committee and tabled to go to the board 21st November for final agreement
	W6	Director of Operations to chair the weekly Service Delivery Group	PW	31/08/2017			Complete	It was agreed that the meeting would continue to be chaired by the chair of Performance
	W7	Explore with Mike Davidge the potential for information for improvement support into the performance function	GE	31/08/2017			Complete	This was considered and deemed not required
	W8	Strengthen visibility of the Business Continuity work programme amongst the Executive Team and ensure the Board receives an assurance report before end October	PH	31/10/2017			Complete	Business Continuity was addressed as an agenda item at ELT on 20th September 2017 with a further business continuity update to be provided to ELT in six months' time. The Business Continuity Steering Group will monitor the progress of the business continuity programme ensuring that on-going actions are completed within the agreed timescales. This group meets bi-monthly and reports into the Risk Compliance and Assurance Group which in turn reports to ELT.

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
	W9	Ensure the loop is closed on a number of areas where the Board has asked for further assurance - workforce resilience including safe staffing (PG), mandatory training compliance (PG), the impact of CIPs on quality (LB) and the impact of demand on patient quality and safety (FW,TB)	PH	31/10/2017			Complete	
	W10	Agree an Executive lead responsible for maintaining a register of external reviews and ensuring they are reported to Board. This includes the Health and Safety Review (July 2017) and the NARU assurance review (Dec 2017)	PH	01/08/2017			Complete	
	W11	Agree a definition of 'key business cases' to submit in the PIR and collate the information needed for the return	LB	30/11/2017			Complete	Proposal is to define key business cases for the PIR as any cases that within the scheme of delegation require ELT sign off and above
	W12	Ensure that there is a programmed local staff survey in June each year reported up to Board through the Workforce Committee to provide leaders with a more live sense of staff morale, views of leadership and engagement and assess the effectiveness of the action plan developed in response to the national staff survey released in January each year.	PG	31/03/2017			Complete	Local questions relating to staff morale, leadership and engagement and the staff survey action plan will be added to the Q2 (June) staff friends and family test to support the qualitative data already collated in June each year.
	W13	Undertake a specific pre CQC staff survey and / or mock focus groups before re-inspection and share findings with the Board and senior Corporate and Operational leaders. This should include questions on appraisal quality and quality of management support. Take advice from the equalities lead on the most effective mechanism for obtaining BME staff views	PG	31/01/2018			Complete	Focus Groups held on 15th December and output is being collated and will be shared during January.
	W14	Ensure all Executive Directors, the NEDs on the Quality Committee and the Trust Chair have a good understanding of the 17/18 financial and CIP plans and how they are supporting the quality agenda in the trust	LB	31/10/2017			Complete	This can be localised if required using question logic.
W1.3 Are leaders visible & approachable?	W15	Reinstate a formal programme of diarised Executive and Non Executive visits to services and a mechanism for collecting and reporting data to the Programme Board, ready for the PIR	PG	01/09/2017			Complete	
	W16	Ensure there is a clearly articulated written approach to staff engagement and collated evidence of those activities, ready for the PIR	PG	31/11/2017			Complete	Summary data will be provided to the People & Organisational Development committee and Trust board in July each year.
W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership and is there a leadership strategy	W17	Cross check the draft People and OD strategy and the implementation plan to ensure the KLOEs are explicitly addressed. This includes a clear statement the trust will use values based recruitment.	PG	31/08/2017			Complete	The implementation plan for the P&OD Strategy is now being developed.
	W18	Brief ELT on progress of the leadership development programme and agree the staff groups to be covered in each wave, including which staff could have training before Operations restructure is completed	PG	30/09/2017			Complete	

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
or development programme which includes effective selection, development, deployment and support processes and succession planning	W19	Finalise the 'key people' risk assessment and mitigations document	PG	31/08/2017			Complete	
	W20	Ensure the consultation documents and proposed structure diagrams for the Operational restructure have been shared with the wider Executive team for comment	PW	03/08/2017			Complete	The operational re-structure is being presented to ELT on 25th October and to the Board on 31st October. Once agreed this will then be taken forward with operational teams to implement. The implementation of the re-organisation will take place during 2018 Q1.
Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services and robust plans to deliver - Garret Emmerson, Karen Broughton & Angela Flaherty								
W2.1 Is there a clear vision and set of values with quality and sustainability as the top priorities	W21	Complete the quality strategy and implement a communications plan to share it with staff and partners	TB	31/08/2017			Complete	A Quality Improvement and Learning framework has been developed with the support of corporate and operational staff. The framework will be presented to the Board in November. A key aspect of the Quality Improvement work going forward is the development of Quality Champions at group station/sector level. These staff will be the key link to the QGAMS to drive forward quality improvement and ensure that learning is shared in a more timely and meaningful way from Board to frontline.
W2.2 Is there a robust, realistic strategy for achieving the priories' and delivering good quality, sustainable care	W22	Complete the refresh of the trust over-arching strategy and ensure the staff roadshows clarify the timetable and opportunities for staff engagement	GE	Garrett to suggest			Complete	The outline strategy will be presented to the Board by the end of the year. A stakeholder mapping exercise is under way to ensure that all key stakeholders are engaged with the strategy and that all relevant meetings are attended by appropriate level of representation from LAS. Revised date now due to be presented to Trust Board in March.
W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services and external partners	W23	Ensure that evidence is being collated on who has been involved in developing the overarching strategy and how, ready for the PIR	GE	30/11/2017			Complete	Workshops planned to involve staff in developing strategy • Hand written attendee sheets for all workshops • Excel spreadsheet identifying all workshops and other engagement activities • These products are still being updated whilst engagement activities continue.

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
W2.5 Is the strategy aligned to local plans in the wider health and social care economy and how have services been planned to meet the needs of the local population?	W24	Ensure there is a clearly articulated reference case for the over-arching strategy which can be supplied to CQC as evidence	GE	30/11/2017			Complete	• Reference Case information has been used in 'Our Strategic Intent' • Reference Case Phase 1 has been shared with Trust Board • Reference Case Phase 2 is still in development This is being developed in line with the strategy for publishing early 2018.
W2.6 Is progress against the strategy and local plans monitored and reviewed and is there evidence to show this?	W25	Provide quarterly progress updates on clinical strategy implementation to Board and a mechanism for communicating progress to staff	FW	30/09/2017			Complete	
	W26	Programme quarterly updates to Board for other significant approved Trust strategies	PH	30/09/2017			Complete	
Is there a culture of high quality sustainable care - Fenella Wrigley & Trisha Bain								
W3.4 Is action taken to address behaviour and performance that is inconsistent with the vision and values regardless of seniority?	W27	Collate the learning from the NE London intensive support programme as an exemplar for changing culture and agree what the model should be the trust will use across London	PW	30/11/2017			Complete	
	W28	Refresh the Management of Change Policy	PG	Patricia to advise			Complete	
W3.5 Does the culture encourage openness and honesty at all levels of the organisation including with people who use services in response to incidents ? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution and is appropriate learning and action taken as a result of concerns raised?	W29	Ensure the private part of the board receives a quarterly report on Whistleblowing and the work of the Speak up Guardian. Implement a mechanism for collating the information needed on whistleblowing for the PIR.	TB	31/10/2017			Complete	
W3.8 Are equality and diversity promoted within and beyond the organisation ? Do all staff, including those with a protected characteristics under the Equalities Act feel they are treated equitably?	W30	Ensure the gap analysis on equalities and diversity has visibility within the organisation and progress is monitored quarterly at board sub-committee level	PG	30/09/2017			Complete	
W3.7 Is there a strong emphasis on the safety and well being of staff?	W31	Ensure the Health and safety external review is presented to Board and assurance to QAG includes progress updates	TB	31/10/2017			Complete	Following a comprehensive review of health and safety compliance, a robust action plan is in place and being monitored via ELT and the Board.

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
Are there clear responsibilities, roles and systems of accountability to support good governance and management - Garrett Emmerson and Lorraine Bewes								
W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality sustainable services ? Are these regularly reviewed and improved ?	W32	Ensure there are up to date organisational structure charts and visual representations of the governance arrangements, including Board to floor assurance on quality and safety	PG, PH	30/11/2017			Complete	
	W33	Confirm the timetable for business partnering arrangements to be in place and the shape of the HR and Finance support	LB, PG	30/09/2017			Complete	The plan for Finance HR Business Partnering was presented to complete ELT in November with formal consultation commencing in early 2018.
W4.2 Are arrangements with third party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care	W34	Request a rapid review of third party provider monitoring, with particular emphasis on quality oversight	LB	30/11/2017			Complete	
W4.3 Do all levels of governance and management function effectively and interact with each other appropriately?	W35	Introduce standardised agendas and action logs for local risk and governance meetings and ensure these are Quality checked	TB	31/10/2017			Complete	Standard templates for all committees has now been developed and shared, with the review of Board sub committee's terms of reference and agendas now complete.
	W36	Implement minute taking training for admin staff taking minutes at Board, ELT, and sub-committees to improve the quality of evidence recording and ensure there are core templates for papers, action plans, minutes and action logs	PH	01/11/2017			Complete	
Are there clear and effective processes for managing risks, issues and performance - Trisha Bain and Philippa Harding								
W5.4 Are there robust arrangements for recording and managing risks, issues and mitigating actions ? Is there alignment between the recorded risks and what staff say is on their worry list?	W37	Agree a process for risks identified through the Operational and Corporate performance meetings to feed through to the corporate risk register and the BAF	GE	Garrett to suggest			Complete	The BAF has undergone a review and is aligned to the Risk Management strategy, the process will be further developed over the next few months.
	W38	Re-instate the quality assurance visits to core services to identify risks and ensure actions are being taken. Set out the reporting lines for intelligence from the visits	TB	31/10/2017			Complete	Station Quality Assurance review have started across all stations
	W39	Ensure papers for ELT, Board and sub-committees have a properly completed cover sheet to highlight their implications for risk and the risk appetite	PH	30/09/2017			Complete	

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
	W40	Review how the metrics being measured through the IPR could be used to inform the BAF paper at Board e.g. by prompting discussion of new risks, the scoring, completion dates or list of mitigating actions	PH, JP	31/10/2017			Complete	
W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored ? Are there examples of where financial pressures have compromised care?	W41	Review the current QIA process in use and ensure there is a mechanism in place to assure FIPC of any risks to quality relating to the CIP	LB	30/11/2017			In progress	Paper outlining proposed QIA process to be prepared for ELT/FIC/QC/Trust Board for Nov cycle.
Is appropriate and accurate information being effectively processed, challenged and acted upon - Jill Patterson and Ross Fullerton								
W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant ? What action is taken when issues are identified	W42	Finalise the data quality strategy and business case. Sign off the priorities for improvement in data quality and the reporting lines for progress against the strategy	JP	31/08/2017			Complete	The Data Quality strategy was presented to the Audit committee in September and recruitment of staff to support the development of the data quality strategy completed.
W6.6 Are there effective arrangements in place to ensure that data or notifications are submitted to external bodies as required	W43	Ensure that the Trust is submitting data correctly to STEIS and NRLS	TB,FW	31/08/2017			Complete	
W6.7 Are there robust arrangements (including external and internal validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Are lessons learned when there are data security breaches ?	W44	Consider bringing forward the annual information governance assessment to Q3 so the results and action plan are available at the point of reinspection. Ensure there is evidence collated to demonstrate learning from IG breaches	PH	31/10/2017			Complete	
Is there leadership capacity and capability to deliver high quality sustainable care - Garrett Emmerson & Patricia Grealish								
W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include people in a range of equality groups?	W45	Develop a clear narrative on the approach and mechanisms for staff engagement. Assess whether there is value in introducing some standard tools e.g. listening into action sessions	PG	30/09/2017			Complete	

WELL-LED								
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Due date**	**Nov-17**	**Dec-17**	**Status**	**Comments**
W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of the challenges within the system and the needs of the relevant population and to deliver services to meet those needs	W46	Clarify the mechanism for recording and sharing local engagement activity led by SEMs and CIOs	PG	31/08/2017			Complete	
Are there robust systems and processes for learning, continuous improvement and innovation - Angela Flaherty and Trisha Bain								
W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	W47	Clarify which, if any, accreditation and peer review schemes the trust is part of to enable this section of the PIR to be completed	FW	30/11/2017			Complete	
W8.2 Are there standardised improvement tools and methods and do staff have the skills to use them?	W48	Confirm a provider and specification for board to floor leadership for improvement / quality improvement training and commission the work (75k available from special measures which needs to be spent)	AF	31/08/2017			Complete	
W8.3 How effective is participation in and learning from internal and external reviews including those related to mortality? Is learning shared effectively and used to make improvements?	W49	Collate evidence from internal audit deep dives, SIG and the new mortality meetings. Have a clear statement of the mechanisms outside Insight magazine which are being used to share learning	TB	31/12/2017			Complete	Motility review is chaired by Neil and reports to Fenella. Governance team feed into training departments (EOC and Ops) to deliver learning from incidents training to clinical and control room staff.
W8.5 Are there system in place to support improvement and innovation work including objectives and rewards for staff, data systems and process for evaluating and sharing the results of improvement work?	W50	Set out clearly the infrastructure available to support quality improvement including the links between the Service Improvement Team in Operations and Corporate transformation team	AF	31/10/2017			Complete	The Quality and Learning Framework includes the overarching structure for learning, the tools and methodologies and the governance, assurance and performance management across the organisation to ensure learning is embedded and improvement is being delivered. This final draft document went to the Board on 28th November 2017 for ratification. Local learning plans will be agreed in early 2018.
	W51	Collate information on awards the trust has been nominated for or received in the preceding 12 months ready for PIR	PG	30/11/2017			Complete	Information collected and submitted as part of RPIR

CQC Countdown Plan

week ending

November				December					January				February				March					April			
05-Nov	12-Nov	19-Nov	26-Nov	03-Dec	10-Dec	17-Dec	24-Dec	31-Dec	07-Jan	14-Jan	21-Jan	28-Jan	04-Feb	11-Feb	18-Feb	25-Feb	04-Mar	11-Mar	18-Mar	25-Mar	01-Apr	08-Apr	15-Apr	22-Apr	29-Apr

Key Dates

- PIR received
- PIR submission
- Assumed — *Initial Staff Survey Results*
- Assumed — Regulatory Planning Meeting
- Possible — *Unannounced Inspection date*
- Half Term
- Assumed — Unannounced Inspection date
- Assumed — Staff Survey Results
- Site visit core services
- Confirmed — Announced Well Led Review
- Easter
- Assumed — Initial Findings Letter

12 weeks

PIR

- PIR management
- Additional Information Requests
- Agree resource cover
- Information Requests during inspection
- Additional Information Requests
- Handover to Bau

Quality Assurance

- Mock inspection preparation
- Mock Inspections
- Analysis & report from Mock
- Exec / Non exec visits agreed
- Exec / Non exec visits

Maintaining Focus

- Distribute Mock Inspection Actions
- Sign off approach to be agreed
- Sector review of status against CQC actions
- Daily ADO CQC action review

CQC logistics

- Confirm room for CQC PMO support
- Procedure for unannounced CQC visit
- Define Information Hub
- Presentation Rooms booked
- IT Support agreed
- Confirm plan & logistics with CQC
- Confirm key meetings to CQC
- Agree CQC support team (WL review)
- Information Hub running
- Response to initial findings letter
- Manage preparations for responding to draft CQC report
- Define improvement activities post inspection aligned to Business Plan & Strategic objectives

Communications

- Exec Posters
- Senior Mgt Posters
- Pre production of Handbooks
- Z Cards and Handbooks sign off
- Z cards and Handbooks to print
- QIP/ CQC Comms Support
- QIP/ CQC Comms Plan

Stakeholder communications

- Create stakeholder map
- Create stakeholder plan
- Manage preparations for Quality Summit

Board preparation

- QIP Programme Board
- QIP Programme Board
- QIP Programme Board
- Briefing Notes
- Mock Interviews
- Define the Quality Improvement road map
- QIP Programme Board
- QIP Programme Board
- QIP Programme Board
- QIP Programme Board
- QIP Programme Board
- QIP Programme Board

Legend

- Activity
- Key Activity
- Key Dates
- Ongoing
- Not started
- In progress
- Complete
- Overdue

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	30 January 2018			
Report title:	Freedom to Speak Up Quarterly Report			
Agenda item:	18			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:
This report provide the Board with an update on Freedom to Speak Up activities since October 2017.
Recommendation(s):
The Board is asked to note the update provided in this report.
Links to Board Assurance Framework (BAF) and key risks:
N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Freedom to Speak Up Quarterly report

Background

1. As Board members will be aware, it is a requirement in the standard NHS contract that NHS Trusts nominate a Freedom to Speak Up Guardian. Guardians can be approached by any member of staff in their organisation to discuss concerns about any risk, malpractice or wrongdoing which they believe is harming the service.

2. Whilst the LAS is generally considered to have made a good start on introducing Freedom to Speak Up, with all the appropriate processes in place, very few concerns have been raised with the Freedom to Speak Up Guardian. At its meeting on 31 October 2017, the Board considered and endorsed an interim arrangement to enable the Trust to make greater progress in relation to encouraging staff to engage with Freedom to Speak Up. A full time interim Freedom to Speak Up Guardian has now been appointed and a number of activities are being planned to raise the profile of Freedom to Speak Up across the organisation.

3. This report provides the Board with information about the Freedom to Speak Up activities that have taken place nationally and within the LAS since the last Board update.

National Guardian's Office (NGO):

4. In October 2017 the NGO published its first Freedom to Speak Up case review of Southport & Ormskirk Hospital NHS Trust. The main points were:

    - The review found evidence that the culture, policies and procedures of the trust did not always support workers to speak up, including evidence of a bullying culture.

    - Persistent failure by the trust to feedback to staff regarding any actions it had taken in response to workers' speaking up, creating a widespread belief among staff that the trust did not take their concerns seriously

    - The review also found that the trust did not appropriately support the needs of its black and ethnic minority workers, including a failure to respond to multiple and serious concerns raised by many of those workers.

    - Many workers regarded most of the trust's senior leaders as invisible and inaccessible

5. The NGO published their first Annual Report in November 2017. The full report can be seen here:
   https://www.england.nhs.uk/wp-content/uploads/2017/11/07-pb-30-11-2017-national-guardian-annual-report.pdf.

6. The Annual Report contains a case study from North West Ambulance Service where, on a particularly busy night in June 2017, 420 emergency calls – which should have received call backs - were abandoned. An investigation found that the call-back process had become too lengthy and time consuming. A new procedure was implemented six weeks after the issue was raised with the Freedom to Speak Up Guardian, and the people who spoke up received a personal "thank you" from the Director of Operations.

7. This is a good example of how staff who identify an issue, supported by their Guardian, and with an executive management team willing and able to listen, can make a timely, practical change to improve the quality and efficiency of a service.

8. Organisations with a Freedom to Speak Up Guardian are now required to provide quarterly data to the National Guardian's Office. Key headlines from the Q2 national data (July – September) are as follows:

    - 1,611 cases were raised with Freedom to Speak Up Guardians / ambassadors / champions.
    - 551 of cases included an element of patient safety / quality of care.
    - 733 included elements of bullying and harassment.
    - 75 related to incidents where the person speaking up may have suffered some form of detriment.
    - 365 anonymous cases were received.
    - 23 trusts did not receive any cases through their Freedom to Speak Up Guardian.
    - 210 out of 233 Trusts (over 90%) sent returns. Over 90% of trusts have provided data this quarter, up from 62% for Q1 (April – June).

9. In response to feedback, the National Office has introduced weekly advice surgeries for Guardians.

10. In December 2017, two members of the LAS Public Education Team provided basic life support training (including CPR and defibrillator, stroke and choking) to the NGO team at their team away day, following a direct request from Dr Henrietta Hughes.

11. The NGO has requested to meet with the current Guardian in advance of the CQC re-inspection in March.

National Ambulance Network of Guardians:

12. The National Ambulance Network of Guardians meets quarterly to share good practice and provide mutual support. The meetings are held in different geographical areas and include an element of CPD as well as an opportunity to network and share information.

13. The most recent meeting (December 2017) was held at North East Ambulance Service and included a CPD session on supervision. The Chief Executive of NEAS attended for part of the meeting to have an informal conversation with members of the group.

Update on LAS activities:

14. Margaret Luce, who previously acted on a voluntary basis as the LAS Freedom to Speak Up Guardian has now stepped down. Margaret has been instrumental in the progress that the LAS has made in relation to Freedom to Speak Up and the Trust is very grateful for her contribution as Guardian. Conal Percy has been appointed to replace Margaret on a full time interim basis until the end of March 2018, following his foundation training by the NGO.

15. Conal's priorities and activities between now and end of March 2018 will include:

    - Completing the outstanding actions from the KPMG 2017/18 internal audit recommendations.
    - Devising a process to establish and recruit to the Freedom to Speak Up Guardian position.
    - Developing a comprehensive communications plan including:
        - Input from LAS staff on how to promote the speaking up process.
        - Explore options for creating a Freedom to Speak Up network within the LAS, such as the 'hub and spoke' model employed at Yorkshire Ambulance Service.
        - Update speaking up pages on the Pulse

- Developing a reporting template to ensure that the Board is kept up-to-date with the issues and themes that have arisen in relation to Freedom to Speak Up.
- Reviewing the Trust's Freedom to Speak Up Policy, with additional guidance notes covering consistency of recording and how support can be assured to all staff when a concern is raised.

16. Two cases have been raised since the last Board update in October, one with Margaret Luce and the other with Non-Executive Director, Fergus Cass. The first relates to bullying and harassment in a team within the Service, and is still under investigation. The second one will be discussed by the Board in its private meeting, including a summary report, action plan and lessons learned.

17. It is proposed that future reporting to the Board initially follows the structure of information requested by the NGO and the Care Quality Commission:

    - Number of incidences
    - Any themes drawn from analysis of these
    - Any actions taken as a result of the investigations into these incidences
    - Any areas of the service that have featured more than others in whistleblowing incidences.

18. As there have been so few incidences of concerns being raised under Freedom to Speak Up over the past year, it has not been possible to report on these in the manner outlined above; however we anticipate an increase in the number of incidences with increase communication and engagement activity.

Conclusion

19. The LAS continues to have a high level of engagement with the NGO, the National Ambulance Network and the London Region Network of Guardians.

20. The NGO's recent publications and data are beginning to really demonstrate the value of the Guardian role.

21. The LAS now has an opportunity to develop and increase the capacity within the role, by appointing a full time interim Guardian to take forward the necessary activities in order to get the maximum benefit from this additional source of support for staff.

22. Whilst numbers of recorded cases within the LAS remain low, it is anticipated that these activities will increase the numbers of people coming forward with concerns.

23. The Board is asked to note the contents of this report.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Report from the Trust Secretary			
Agenda item:	19			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the information with action taken by the Chair in relation to the agreement of Enforcement Undertakings with NHS Improvement and provides the Board with assurance on progress against these.

Recommendation(s):

The Board is asked to note the report and comment on the questions relating to the Trust's compliance with the NHS provider licence.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report from the Trust Secretary

Enforcement Undertakings

1. NHS Improvement (NHSI) has required the Trust to enter into formal undertakings to support its progress with its operational recovery and sustainability, quality challenges and key strategic issues, in line with its Single Oversight Framework (SOF). These enforcement undertakings and other more draconian regulatory measures are usually related to the imposition of Special Measures. As the imposition of Special Measures on the Trust occurred under the NHS Trust Development Authority, undertakings were not formally agreed at that time. The proposed undertakings were under negotiation with the Executive Leadership Team for some time and required agreement before the end of 2017. In light of this and the fact that the draft undertakings had already been reflected in the Quality Improvement Programme, the Chair decided to use the authority allowed her in the Trust's Standing Orders to authorise the agreement of these undertakings.

2. In writing to the Trust, NHSI acknowledged that a number of the undertakings have already been met and others have made good progress. The undertakings will provide a foundation for further developing the Trust in key areas needing improvement. Progress against these undertakings should be monitored by the Board. Annex A to this report provides more detail about the undertakings and the progress against them that has already been made,

Self-certification of compliance with the NHS provider licence

3. For the first time both NHS trusts and NHS Foundation Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution).

4. NHS Foundation Trusts have been required to self-certify since Monitor began issuing the NHS provider licence in 2013. Whilst NHS trusts are not formally subject to the NHS provider licence, directions from the Secretary of State require NHS Improvement to ensure that all NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

5. Furthermore, NHS Improvement's Single Oversight Framework (which assesses performance against the five themes of quality, operational performance, finance and use of resources, strategic change and leadership and improvement capability) is underpinned by the NHS provider licence and compliance with the licence will be the basis for any formal intervention action taken by NHS Improvement.

Self-certifications required

6. NHS Trusts are required to self-certify after the end of the financial year that they are in compliance with Conditions G6(3) and FT4(8) of the NHS provider licence:

   Condition G6(3) – The Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution
   Condition FT4(8) – The provider has compliance with required governance arrangements

7. The purpose of self-certification is to ensure that providers carry out assurance on whether or not they can confirm compliance. How providers undertake this process is for them to decide. The most important aspect of any process is to demonstrate that the Board understands

clearly whether or not the provider can confirm compliance and that the Board can sign off to that end.

Condition G6

8. The details of condition G6 of the NHS provider licence can be found at Annex B to this paper (together with a summary of the general licence conditions with which all NHS Trusts and NHS Foundation Trusts are expected to comply). Essentially, it requires that providers must have in place processes and systems which:

   a. Identify risks to compliance with the NHS provider licence; and
   b. Take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

9. Providers must annually review whether these processes and systems are effective.

10. The following mechanisms have already provided the Board with assurance with regard to the requirements of G6:

    - Preparations and publication of an Annual Governance Statement which sets out the mechanisms of control and risk management for the Trust;
    - The Head of Internal Audit Opinion has confirmed that the organisation has an adequate and effective framework for risk management, governance and internal control;
    - External audit opinion;
    - Corporate Risk Register and Board Assurance Framework updated on a regular basis and reported to the Board;
    - Self-assessment and various external reviews, including a CQC inspection focussing on Well Led;
    - Quality Improvement Programme and monitoring of progress against Enforcement Undertakings;
    - Monitoring by NHS Improvement and additional improvement support provided;
    - Compliance with laws and regulation

11. Having considered the assurances provided, is the Board content to approve the self-certification that the Trust is compliant with Condition G6 of the NHS provider licence?

Condition FT4

12. The detail of condition FT4 of the NHS provider licence can be found at Annex C to this paper. Essentially, it requires that providers must:

    a. review whether the governance systems they have in place achieve the objectives set out in the licence condition (i.e. are compliant with “those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS”); and
    b. set out any risks identified to good governance and mitigating actions taken to avoid these risks.

13. The mechanisms set out above as providing assurance to the Board with regard to the requirements of G6 also provided assurance with regard to the requirements of FT4.

14. Having considered the assurances provided, is the Board content to approve the self-certification that the Trust is compliant with Condition FT4 of the NHS provider licence?

Philippa Harding
Director of Corporate Governance

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
Quality	1.1.1	Mandatory training to meet the Trust's current target. There is a lack of staff awareness of infection prevention and control measures in addition to inconsistent compliance with these measures.	PG	• Reporting in place showing compliance levels. Overall Trust compliance for Stat & Man training is at 75%. Corporate is 89%, Operations at 73%. (December 17) Safeguarding L1 compliant, L2 EOC 58% (YTD). • A flagging system is in place for 'vulnerable patients through 'Co-ordinate My Care'. Compliance with IP&C training (combined) is 89.01%. Recording now on ESR and reported to QIP and to the Trust Board. • Where compliance levels are not appropriate, action taken to improve staff uptake of training	30/03/18	Compliance rates have improved and are being tracked regularly through the QIP

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
1.1.2	Timely safety checks and repairs on both vehicles and equipment, consistent with the Trust's safety policy	LB, TB	• The maintenance for all equipment is set in accordance with the manufacturer's requirements as a minimum. • All key items of equipment should be inspected by staff prior to use at the start of shift, and defects reported as necessary. • The VP process will clean, inspect and re-equip equipment for the safe use of that equipment on a daily basis (all DCAs currently). A comprehensive daily Vehicle Inspection record is maintained for all prepared ambulances. • Defects are notified according to policy OP25 (The Procedure for Scheduled Maintenance and Exchange of Ambulance Equipment) and a replacement item provided. • All associated inspections and audits are subject to weekly performance monitoring within the team and monthly KPI reporting through to the exec via the monthly performance report.	30/03/18	An audit of safety checks and repairs is being carried out as part of a regular audit programme.
1.1.3	Safe staffing levels and appropriate skill mix and experience on DCAs	PW, PG	• Skill Mix Matrix approved July 2017 and circulated to sectors.	30/03/18	A rota review is being undertaken as part of the Pan London Rota Review 18/19 project. This reports monthly with actions completed by March 2019.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
1.1.4	Reporting incidents and near misses to national standards	TB	• Reporting in place providing information about the total number of low or no harm incidents • At the end of December there were 1,957 No-harm incidents (YTD against a target of 1200) and 220 low-harm incidents (target 30). • As a proportion of total incidents the No-harm/Low-harm increased to 92% up from 42% and is above the national benchmark. • The LAS now the second highest reporter to NRLS of ambulance trusts. • 281 staff trained in DATIX web since June 2017 including grading of incidents.	30/03/18	Data is presented in the monthly Quality Report where the proportion of Low/No-Harm/ Moderate and Severe incidents is monitored to ensure adequate levels of reporting are achieved.
1.1.5	Learning from incidents and near misses shared and embedded	TB. FW	Policy redesigned and approved Dec 2017 to include section on Learning Lessons • In the last 6 months approximately 20 incidents have resulted in changes to practice through CSR training. Examples include spinal injuries, management of STEMIs, paediatric pain management, VF AED protocol and forced extubation for tracheostomy patients.	30/03/18	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No		Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	1.1.6	Action taken in response to the independent health and safety review	TB	• A total of 59 actions (categorised as high/medium priority) were recommended following the independent review. A total of 31 actions have been completed, 22 actions are in progress and currently underway, and 2 actions are overdue. • Re-assessment to take place form independent reviewer in early Feb 2018. • Monthly trust wide and sector wide scorecards linked to action plan available to all staff and monitored via governance system.	30/03/18	Report presented to ELT with oversight from the CCG. The Health & Safety Executive will be returning to the Trust in 2018-19l to review compliance.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
1.1.7	Medicines management, including tracking and audit, and safe storage arrangements for controlled drugs in place, consistent with the Trust's medicines management policy	FW	• Medicines management incidents continue to be tracked and audited. • The overall trend in medicine management incidents is still up although down from the peak in November. • Unaccounted losses for controlled drugs remain consistent and stable with previous months. Themes including staff retention documentation errors and broken ampoules. • There has been a reduction on the number of non-controlled drugs. Themes include drug stock discrepancies, access codes written on walls and poor storage facilities.	30/03/18	Board approval of secure drugs rooms business case on 28 November 2017. Monthly update reported to ELT and Board with issues feedback to each Sector.
1.1.8	Continued progress on EPRR as evidenced by the NARU independent review.	PW	• Assured through NARU review • November 2017 Trust graded as 'Substantial' compliance for EPRR. Response plan being updated over 2- year period in order to achieve 'Full' compliance.	30/01/18	
1.1.9	Improved staff appraisals in line with the Trust's appraisal policy	PG	• In December 2017 Appraisals 52%. • An action plan with a trajectory is in place and is reported to the Executive Leadership Team.	30/03/18	Compliance rates have improved and are being tracked regularly.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No		Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	1.1.10	Resource action plan for consistent ARP performance across STP regions and LAS stations	TB	Evidence same as 1.2.1 (below) • October last month of old ambulance reporting saw A8 Ambulance Performance 68.9% (6.7% below trajectory). Red 1 – 73.5% (2.5% above trajectory). Demand 96,549 (2,7% above plan) • New Ambulance Response Programme (ARP) introduced 1/11/2017 -saw Trust meet C1 and C4 categories in December but miss C2 and C3 due very high operational demand.	30/03/18	
	1.1.11	Improved uptake of equality and diversity training to meet the Trust's current target	PG	• Improved self-assessment indicator in WRES e.g. BME leavers 11% (against a target of 14%) • 61% E&DH&R training January 2018	28/11/17	Achieved and reported to the Board on 28 November 2017.

		Organisational wide learning from complaints and incident reporting	TB	• The organisation has historically shown good learning from incidents and this has continued. Examples include incidents involving VF arrest, forced extubation of tracheostomy patient and use of diazepam PGD which have been incorporated into CSR2017.2 training. These and others are shared with staff via Clinical Update magazine. • Patient Experiences Team produce regular reports with learning from complaints highlighted in the Quality Report and shared with both QGAMs and the staff involved. • Lessons learned are also included in Clinical Update or Insight magazine which is disseminated across the Trust. • Examples are shared with the national Ambulance network with themes and changes to practice being shared with all UK Ambulance Services at regular network meetings as well as on an informal advisory basis. • Where an issue is identified that has implications for practice for other agencies, these are shared across the wider health and social care economy. Case examples are available on our Trust website	30/03/18	Risk mitigation measures are put in place immediately after a Serious Incident is declared both for staff, patients and the Trust.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
Efficiencies & MHA	1.2.1	Improved operational performance and demand management, including handover delays at hospitals, job cycle time and multiple attendance ratios.	PW	• Meet target efficiencies agreed with stakeholders. • October was the last month of the old-style ambulance reporting and saw A8 Ambulance Performance at 68.9% (6.7% below trajectory). Red 1 – 73.5% (2.5% above trajectory). Demand was 96,549 (2.7% above plan). • The new Ambulance Response Programme (ARP) introduced 1/11/2017 -In December high operational pressures saw the Trust meet 2 out of 4 call categories.	30/11/17	LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target. New patient priority 'tagging' system, based on NEWS Scores has been rolled out with positive feedback.
	1.2.2	Improved understanding by staff of MHA, particularly in EOC and EPRR	PW, FW	• Evidenced by internal audit • Mental Health Act update included in *Clinical Update* with training compliance at 80%. Mental Health assessments have risen from less than 70% to above 90% in most Sectors.	30/11/17	Covered by EOC Intensive Support Programme. This is included in the monthly Quality Report for the Board.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
Continuity & workforce	1.3.1	Business impact assessments in place for all functions and a comprehensive business continuity plan, including service delivery, control services and demand management systems across LAS, independently assured through the NARU review.	PW	• Incident Response Procedures (September 2016) being updated December 2017 following recent incidents. Currently under review. • November 2017 Trust graded as 'Substantial' compliance for EPRR. Response plan being updated over 2- year period in order to achieve 'Full' compliance.	30/03/18	
	1.3.2	Workforce strategy which addresses recruitment and retention, supports new models of care and underpins the ARP. Supported by an implementation plan showing progress with actions.	PG, PW	Short-term plan for 18/19 and 19/20 due to be in place by 30/03/18. Strategic workforce planning approach/framework being developed, which will inform review of 18/19 and 19/20 to ensure alignment to the strategy, once approved. This will then be used for longer term planning.	30/03/18	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
Governance	2.1.1	Effective board, committee structures and reporting lines, including: • Recruitment of substantive executives to replace interim appointments and vacancies • Board and executive team development programmes in place • Deloitte well led review in February 2017 recommendations addressed • Behaviour framework and leadership pathway designed and implemented	GE, PH, PG	• Majority of ELT now substantive. Director of Strategic Assets & Property started 15/01/2018. Only Chief Information Officer remains interim. • Executive development programme started January 2018. Deloitte Well Led review recommendations addressed through QIP. • A review of Clinical Governance has been completed by the Chief Quality Officer. The number of quality groups have been reduced from 70 to 20 with new ToRef, agendas , membership and key issues reports from sub groups disseminated up to Board via Quality Oversight Group. • The Director of Corporate Affairs has reviewed and introduced a standardised format for all corporate meetings. • Behaviour work is part of the People and Culture Strategy approved by the Board in November 2017. Implementation plan due for publication in January 2018.	30/03/18	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No		Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	2.1.2	Accurate, comprehensive, timely and up to date information for board and committee decision-making, including a comprehensive BAF to: • Manage risks to compliance with the conditions of the Licence • Review and approve the risk management policy and BAF and manage risks • Manage, monitor and embed at all levels within the organisation, the quality improvement plan to rectify the concerns raised in the CQC report	PH, TB	• Risk Management Framework signed off by the Audit Committee, using delegated authority from the Board at its meeting on 06 November 2017. • BAF being used to drive agendas and discussions at Board Assurance Committees, RCAG operation being refreshed and new risk training being implemented across the organisation. • Integrated Performance report agreed used by ELT and Board. • The Risk Policy will be approved by the Board in March. • A risk management improvement plan is in place which includes training, re-designing of Datix, risk registers as part of the Quality and Assurance Directorate improvement activities.	30/03/18	
	2.1.3	Board approval of the Trust's overarching strategy	GE, JO'H	Currently engaging widely on the Trust's Strategic Intent. The Draft Strategy and delivery plan is due to be considered by the Board at its meeting on 29 January 2018, with final sign off of these at February Board meeting.	30/03/18	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No		Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	2.1.4	Timeline to refresh the Trust's supporting strategies	JO'H	• Strategic Intent 2018/19 -2022/23 outlines directorate priorities over the next 4-5 years. Operational plans being developed in readiness for the new financial year. This is supported by plans from People & OD, Finance, Clinical Strategy, Assets and Property (for review) IM&T and the Quality & Learning Framework.		
	2.1.5	Board approval of the people and organisational development strategy and implementation plan showing progress with actions	PG	• Board approved P&OD Strategy on 03/10/17	01/11/17	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No		Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	2.1.6	Consult and engage with staff to: • Implement flexible rostering, rest break policy, leave policy and flexible working practices; • Manage sickness absence • Tackle bullying and harassment in line with phase two of Trust's plan • Deliver staff survey action plan and >50% response rate in the staff survey • Increase engagement score in the staff survey from the 2016 baseline	PW, PG	• The average rest breaks allocated for all staff has risen from 8% to 34.8% in December, although further work needed with Double Crewed Ambulances (1.1%) • Sickness all staff 5.4%. Short term 2.0% & frontline sickness 5.9%. • No cases reported since Aug 2017 when 50% cases met Trust target. April 2017 100% cases managed according to time scale. • Staff survey response rate 53.6% better than 2016/17 (42%) and higher than average for other Ambulance services (47%).	30/03/18	New Rest Break Policy implemented on 04 December 2017 and will be reviewed quarterly. Further work will continue with the unions to re-review the policy and align it to the end of shift times. Consultation on other working practices has been completed and agreed. Completion of B&H implementation plan due Q4, will then transition into BAU. Staff survey action plans undertaken and actions implemented as appropriate, reported back through roadshows, Board meetings and ELT. Response rate to staff survey above 50%. Awaiting confirmation of engagement score.
	2.2	Work with the Improvement Director to support the quality improvement programme, as appointed by NHS Improvement	TB	• Confirmation of Improvement Director involvement in QIP	TBA	Improvement Director attends Trust 2 days per week and based there during 2017. During 2018 attends on average 1 day per week but maintains contact via email and telephone.

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
	2.3	Undertake a well led framework review and address the findings	PH	• Further review was completed by Discidium PMO in September, with the actions incorporated into an Agile / Burndown process and completed. • All plans are now incorporated into the Quality Improvement Plan.	30/09/18	
	2.4	Complete the review of IT governance and processes and ensure sufficient capacity and capability is in place	RF	• Review completed • Action plan in place responding to findings of the review • Tracking of progress in place to ensure achievement of action plan. • Resilient service being provided	27/06/17	Report on the New Year's Day 2017 CAD system outage presented to the Board on 27 June 2017, together with action plan, which has received regular Board and Exec oversight ever since.
Buddy Trust	3.1	Will co-operate and work with any partner organisations (this may include one or more 'Buddy Trusts') who may be appointed by NHSI to support and provide expertise	TB	• Agreed with NHSI not to adopt Buddy scheme. However, Service works with other organisations via the NHS Improvement Director to adopt best practice.	Complete	
	3.2	Will work with any such partner organisation on such terms as may be specified by NHSI	TB	• As 3.1 above	Complete	

ANNEX A: London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	No	Summary of undertaking	Exec Owner	Evidence	Date(s)	Commentary
Prog mgmt	4	• Sufficient programme management and governance arrangements in place to enable delivery of these undertakings • Programme management structure in place and widely understood • Board signed off enforcement undertakings • Clear action plan in place to ensure achievement of enforcement undertakings Tracking of progress against enforcement undertakings a standing item at Board	MK	• Enduring PMO approved at ELT service currently provided by Discidium until end March 2018 or until post holders appointed. • QIP has been in place since October 2017 and has been reporting to the Board since then. Part of the Quality Assurance Framework. • Undertakings to be circulated to the Board ahead of meeting January 2018. • All actions above are covered by plans overseen by the Board. • Reporting on progress against action plan can take place from next formal Board meeting (29 January 2018)	30/03/18 Ongoing	
Meetings & Reports		• Will attend meetings, conference calls as required by NHSI • Will provide reports as NHSI require	TB	• Improvement Director involvement in QIP • NHSI Improvement Director sits on ELT. Any reports prepared for that committee are then available to be shared with NHSI. • The new Director of Strategy & Communications is developing and external engagement strategy.	Ongoing	Improvement Director attended Trust 2 days per week being based there during 2017. During 2018 will attend on average 1 day per week but maintains contact via email and telephone.

Annex B

Condition G6

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
    a. the Conditions of this Licence
    b. any requirements imposed on it under the NHS Acts, and
    c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
    a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b. regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

Summary of the general licence conditions with which all NHS Trusts and NHS Foundation Trusts are expected to comply

- (G1) **Provision of information** - This condition requires licensees to provide Monitor/NHSI with any information required for licensing functions
- (G2) **Publication of information** - This condition contains an obligation for all licensees to publish such information as Monitor/NHSI may require, in a manner that is made accessible to the public
- (G3) **Payment of fees to Monitor/NHSI** - The Health and Social Care Act 2012 gives Monitor/NHSI the ability to charge fees and this condition obliges licence holders to pay fees if requested
- (G4) **Fit and proper persons** - This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions)
- (G5) **NHSI Guidance** - This condition requires licensees to have regard to any guidance that NHSI issues
- (G6) **Systems for compliance with licence conditions and related obligations** - This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements
- (G7) **Registration with the CQC** - This licence condition requires providers to be registered with the Care Quality Commission and to notify if registration is cancelled
- (G8) **Patient eligibility and selection criteria** - This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner

- (P1) **Recording of information** – Under this condition, Monitor/NHSI may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor/NHSI
- (P2) **Provision of information** – Having recorded any information in line with P1, licensees can be required to submit this information to Monitor/NHSI
- (P3) **Assurance report on submissions to NHSI** – This condition allows Monitor/NHSI to oblige licensees to submit an assurance report confirming that the information they have provided is accurate
- (P4) **Compliance with National Tariff** – This licence condition imposes the obligation to charge for NHS health care services in line with the National Tariff
- (P5) **Constructive engagement concerning local tariff modifications** – This licence condition requires licensees to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor/NHSI for a modification
- (C1) **Patient choice** – where the system allows for choice, then patients should be provided with information about that choice at the points in the system where it is available
- (C2) **Competition oversight** – the licensee shall not enter into agreements that distort/restrict competition to the extent that it is against the interests of health care users

(IC1) **Enable the provision of integrated care** – the licensees shall not do anything that could reasonably be regarded as detrimental to enabling integrated care

ANNEX C

Condition FT4

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
    b. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
    d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
    e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
    f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
    g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
    h. to ensure compliance with all applicable legal requirements.

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	20			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an updated forward plan for Board meetings until the end of the 2018/19 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas.

This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.

Recommendation(s):

The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2018/19 financial year.

This report relates to the following Board Assurance Framework (BAF) or other risk:

Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	2017/2018 February - Tuesday 27 February 2018
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Patient Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	Audit Committee Assurance Report
	RM	
	JM	People & OD Committee Assurance Report
	FC	
	TdP	Logisitics & Infrastructure Cttee Assurance Report
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
	PW	
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	
	LB	
	PG	
Governance	TB	Quality Improvement Plan Update
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	
	PH	
	PH	FTSUP Quarterly Report
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	March - Tuesday 27 March 2018
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Staff Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	
	RM	Quality Assurance Committee Assurance Report
	JM	People & OD Committee Assurance Report
	FC	Finance & Investment Committee Assurance Report
	TdP	
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
	PW	Rest Break Policy implementation review
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	Quarterly Streategy Update
	LB	Business and Financial Plan
	PG	Staff Survey Results and Actions
Governance	TB	Quality Improvement Plan Update
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	Approval of Information Goveranance Toolkit
	PH	Annual Corporate Governance Review
	PH	
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

Trust Board forward planner: 2017/18 + 2018/19

		2018/2019	
Area	**Lead**	**April**	**May - Tuesday 29 May 2018**
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		
Annual Reporting	LB, PH		Annual Report and Accounts (incl AGS)
	PH		Self Certification of Compliance with Provdier Licence
	JJ		Audit Committee Annual Report
	TB		Health & Safety Annual Report
Strategy & Planning	GE		
	LB		Business and Financial Plan
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		
			Infection Prevention and Control Annual Report
			Safeguarding Annual Report
			Mental Health Annual Report

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	June	July - Tuesday 31 July 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		Rest Break Policy implementation review
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		
			Patitent Experience Annual Report
			Patient and Public Involvement Annual Report
			Public Education Annual Report

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	August	September - Tuesday 25 September 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	October	November - Tuesday 27 November 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		Logisitics & Infrastructure Cttee Assurance Report
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		
	LB		Business Plan progress review
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	December	January - Tuesday 24 January 2019
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	February	March - Tuesday 26 March 2019
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	30 January 2018			
Report Title:	Update on Health and Safety Action Plan			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Ayodeji Adeyemi, Head of Health and Safety			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	Executive Leadership Team			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

This report provides an update on the current status of the actions recommended in the Health and Safety Independent Review Report, and to provide assurance/highlight issues that may impact the successful implementation of the recommended actions. The report is supported by the following documents:

Appendix 1: Updates on actions 'In Progress and on schedule'

Appendix 2: Health and Safety Scorecard – providing an overview of the Trust's health and safety performance from Q1 to Q3 (December 2017)

Recommendation(s):

The Board is asked to note the report, and support the H&S Department to address the barriers highlighted within the report.

Links to Board Assurance Framework (BAF) and key risks:

Links to Datix risk 676 – relating to the lack of Trust-wide compliance with statutory health and safety requirements. Risk Rating: 20

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Health and Safety Update

Introduction & Background

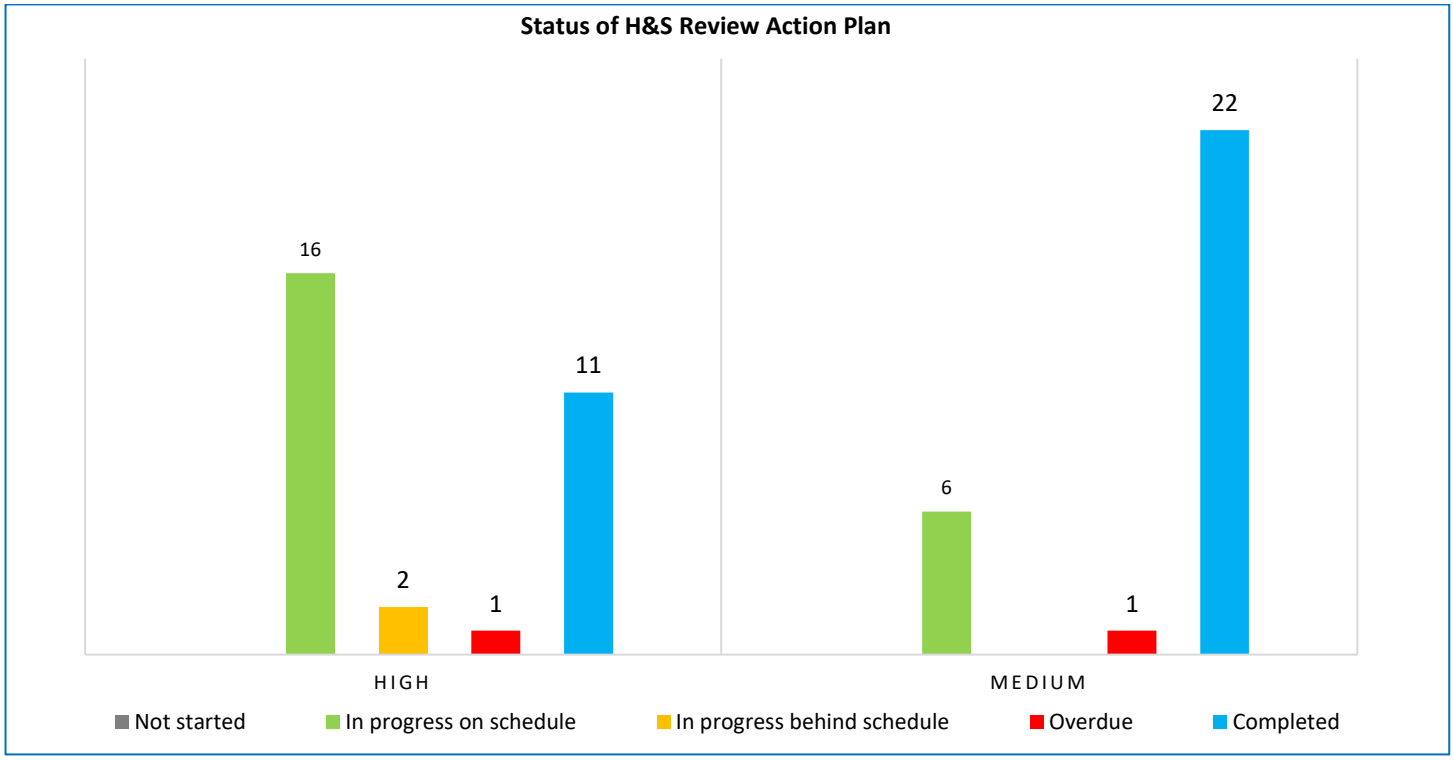
1. An independent review of the Trust's arrangements for health and safety was undertaken in June 2017 with the objective of assessing the level of the Trust's compliance with health and safety legislation/statutory requirements. The report from the review highlighted key risks and areas of non-compliance across the Trust, and recommended key actions that need to be completed to improve compliance. The review report and action plan was received by the ELT in August 2017.

2. This report aims to provide an update on the current status of open actions (yet to be completed) recommended in the Health and Safety Independent Review Report, and to provide assurance/highlight issues that might impact the successful implementation of the recommended actions.

Highlight of actions recommended

3. A total of 59 actions (categorised as high/medium priority) were recommended following the independent review. A total of 33 actions have been completed, 24 actions are in progress and currently underway, and 2 actions are overdue.

4. A breakdown of the current status of the actions is provided below:



Updates on the H&S Review Action Plan

5. **Overdue actions:** Two actions are currently overdue on the Health and Safety Review Action Plan. Action updates have been provided in the section below.

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
3.7	Confirm refresher period requirements for driver training.	Med	Mark Crouch	Paul Woodrow	There is currently no legislation that specifies the refresher period for driver training however, the Trust is aware that one is being drafted. As best practice, other emergency services have adopted and implemented a 5 yearly driver refresher training programme for all their regular/blue light drivers. It is recommended that the Trust adopts this best practice standard implemented by the other emergency services pending the announcement of the driving standards/training legislation. The Head of Driving Standards and Clinical Education Department are reviewing the options for implementing the 5 – year driver refresher training programme.	31/12/2017	Overdue
8	Undertake review of bariatric provision across the Trust – with aim of reducing manual handling risks to staff.	High	Kevin Bate	Paul Woodrow	The Trust now has 3 bariatric vehicles available and on contract from St Johns Ambulance. The use of these vehicles are currently under review with the aim to ensure that they are utilised only for the transportation of Bariatric patients. In order to enable this, a specific call sign has been implemented and a process for flagging addresses is also being considered. A service-wide review is also on-going to assess the viability of providing the bariatric service in house. The DDO for Central Operations will be presenting an options paper to the ELT before the end of January 2018.	31/12/2017	Overdue

6. **Actions in progress but are behind schedule:** Two actions are currently 'In progress behind schedule' on the Health and Safety Review Action plan. Action updates have been provided in the section below.

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
1.2	Ensure human factors including fatigue, alcohol, drugs, night-working and stress are considered in the risk assessment process	High	Ayodeji Adeyemi	Trisha Bain	A proposal is being put together by the Head of Health and Safety to create a Stress Management task and finish group which will review the Stress Management Policy, process for undertaking stress risk assessments as well as develop arrangements for identifying, monitoring and escalating workplace stressors in line with the HSE Stress Management Standard. The LAS is also working in liaison with UCL to train 5 people who will support the Trust in Human Factors. Risk assessments relating to Human factors will be incorporated into the site specific risk assessments which will look at how specific staff groups work as well as the risks they are exposed to. Implementation of site assessment process to commence in 2018.	31/01/2018	In progress behind schedule

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
1.10	Complete and implement assessments for facilities i.e. site specific risk assessments. This should consider traffic flows and location of equipment such as pressure gauges.	High	Ayodeji Adeyemi	Trisha Bain	Process and templates for completing site specific risk assessments developed. In order to mitigate the current capacity issues within the H&S Team, support is being sought from the Union Health and Safety Representatives in order to facilitate the completion of the Site specific risk assessments across 83 sites by March 2018.	31/03/2018	In progress behind schedule

Manual Handling:

7. Key practical manual handling training was delivered to 44 Clinical Tutors in December 2017. Additional sessions have been planned for 36 tutors (including tutors from HART and NETs) and will be completed by 31/01/2018. The training will enable the delivery of practical manual handling refresher training to all frontline operational staff from CSR 1 – April 2018.

8. Following the recent increase in the number of manual handling incidents reported involving the Ferno Track Chairs, Manger Elks and Tail Lifts, the Fleet and Logistics division will be implementing a 12 – weekly maintenance programme (including 6 – weekly visual inspections) for the above equipment from January 2018.

9. Manger Elks – A new business case is being developed to replace the current stock of Version 1 elks, which are now obsolete. 140 of the Elks are due to be replaced with version 3 models as part of the roll-out of new ambulance vehicles which is currently ongoing. The business case is for replacing the remaining 174 Version 1 Elks with newer Version 3 models, as well as for replacing the charging points within current vehicle stock to enable either the Version 2 or 3 to be interchangeable.

10. As part of the short term solution to minimise the compatibility issues, all Mangar Elk equipment will be marked/labelled from the end of January 2018 in order to ensure that compatible products i.e. charging leads, pumps and hoses can be processed together by the Vehicle Preparation Team and made available on the vehicles.

Management of Health and Safety Risks:

11. The average timelag for reporting RIDDOR incidents during Q3 was 37 days. 35 out of the 59 RIDDOR incidents reported during the quarter were reported out of time. RIDDOR reporting compliance currently exceeds the statutory reporting timeline of 15 days for most RIDDOR incidents.

12. Trust-wide Display Screen Equipment arrangements have been reviewed. Agreed processes to be implemented Trust-wide in Q4.

13. Regular monitoring of Health & Safety trends/issues through the monthly Quality Report.

14. A further meeting is being organised at the request of the HSE with the CQO and the ELT to discuss how the Trust manages health and safety issues especially relating to manual handling and stress. Meeting to be arranged for March 2018.

15. The Health and Safety Department are working with the Estates Department as well as external consultants to address the gaps identified relating to the Trust's compliance with fire requirements.

Training:

16. The Health and Safety Department are aiming to provide DSE Assessor as well as Fire Marshall training to nominated staff across the Trust who will help with undertaking fire drills, fire inspections and DSE risk assessments.

17. The compliance rate for the mandatory Health, Safety and Welfare training in December 2017 was 62%.

18. The Managing Health and Safety Course for Managers is being re-launched in order to make it mandatory for Managers as well as to incorporate other safety elements such as incident investigation, risk management and infection control e.t.c.

Barriers/Issues

19. The Terms of Reference and membership of the Corporate Health and Safety Committee is yet to be agreed due to outstanding queries regarding the allocation of seats to the two recognised Trade Unions.

    Action: This issue has been escalated to the Chief Quality Officer and Director for People and Organisational Development.

20. Reduced capacity of the Health and Safety team due to long-term staff sickness/absence.
    Action: The recruitment of additional resources to support the Health and Safety Department is ongoing.

21. Concerns have been highlighted about the implementation of action 2.5 and how random drugs and alcohol sampling of staff will be implemented fairly across the Trust. Clarification and agreement is sought from the ELT about the process for effectively implementing this process across the Trust.
    Action: HR Manager (Action Lead) is putting together a paper for the ELT highlighting key requirements and concerns.

Conclusion

22. All Directorates and Action Leads have been actively engaged with progressing and implementing their respective actions, and a lot of work is being done to ensure that these actions can be completed and embedded to improve the Trust's compliance. The effectiveness of the Corporate Health and Safety Committee is critical for ensuring that efficient systems can be put in place to maintain Trust-wide Health and Safety Compliance however, the Committee will not be able to achieve this or provide the required level of scrutiny and leverage if the Terms of Reference and Membership is not agreed.

23. An overview of the Trust's health and safety performance from Q1 to Q3 (November 2017) is provided in the Health and Safety Scorecard (Appendix 2).

Ayodeji Adeyemi
Head of Health and Safety

APPENDIX 1 - Updates on actions 'In Progress and on schedule'

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
3.3	Ensure systems are implemented to monitor staff competence after training and to ensure that training requirements are achieved and maintained.	High	Peter McKenna	Paul Woodrow	Process for monitoring staff competence to be incorporated into the OWR process for frontline staff from April 2018. Clinical Education Department - working with H&S Department to ensure that training requirements are achieved and maintained.	31/03/2018	In progress on schedule
3.6	Develop system for and maintain clear records associated with training in use of equipment	High	Tina Ivanov	Fenella Wrigley	A system has been implemented for reporting on MAST training however, system for recording equipment training and competency assessments is being developed/incorporated into work being done by Clinical Edu. Department.	28/02/2018	In progress on schedule
3.15	Implement monitoring regime to verify effectiveness of training provided to staff.	High	Peter McKenna	Paul Woodrow	Process for monitoring staff competence to be incorporated into the OWR process for frontline staff from April 2018. Qualitative feedback from staff following training sessions is collected and reviewed by the P&OD Department.	31/03/2018	In progress on schedule
1.11	Complete and implement risk assessments for activities undertaken in Fleet Workshops.	High	Justin Wand	Lorraine Bewes	Process and templates for completing site specific risk assessments to being developed by Fleet Contracts team. Freight Transport Association advising on content and potential split of assessments between consultants and Fleet team.	31/03/2018	In progress on schedule
4.7	Review Daily Vehicle Check LA(1) form to confirm all checks required, and ensure appropriate facilities are provided to allow staff to achieve the checks in time.	High	Justin Wand	Lorraine Bewes	LA1 forms as well as process for completing these are currently under review.	31/01/2018	In progress on schedule
2.5	Review alcohol and drugs policy and consider more detailed advice on limits and need for testing regime where appropriate.	High	Andrew Buchanan	Patricia Grealish	Action under review: Options paper produced for the ELT regarding the random sampling of staff. Clarification and agreement is required from the ELT regarding the process for effectively implementing this process across the Trust.	31/01/2018	In progress on schedule

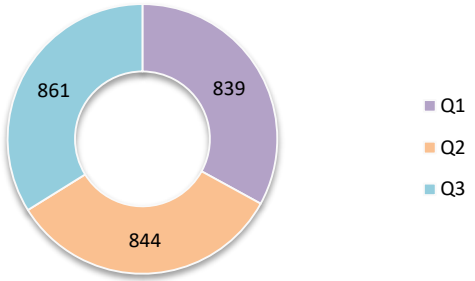
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
1.9	Complete and implement assessments for HART activities (This was not assessed as part of the review).	High	Marc Rainey	Paul Woodrow	H&S Department currently reviewing risk assessments for HART Activities. Visit to HART facilities scheduled for February 2018.	28/02/2018	In progress on schedule
1.13	Ensure appropriate risk assessments are completed under COSHH and DSEAR for hazardous and flammable substances used across the Trust including in workshops and by HART	High	Justin Wand	Paul Woodrow	Process and templates for completing site specific risk assessments to be developed by Fleet Contracts team. Freight Transport Association advising on content and potential split of assessments between consultants and Fleet team.	01/03/2018	In progress on schedule
4.11	Audit procedures in place in HART and bring into line with wider LAS HS&S systems.	High	Marc Rainey	Paul Woodrow	H&S Department currently reviewing risk assessments for HART Activities. Visit to HART facilities scheduled for February 2018.	28/02/2018	In progress on schedule
1.1	Review process for identifying, assessing and managing health and safety risks in line with legislation and statutory requirements.	High	Ayodeji Adeyemi	Trisha Bain	Process under review – to be incorporated into revised Trust-wide H&S Policy.	31/03/2018	In progress on schedule
1.3	Ensure staff completing health and safety risk assessments are competent	High	Ayodeji Adeyemi	Trisha Bain	Proposal to make the Managing Safely Course Mandatory as well as incorporate other key safety elements e.g. risk management, incident management and investigation etc. has been sent out to relevant departments for their review. The aim is to re-launch training in April 2018.	31/03/2018	In progress on schedule
1.6	Complete and implement assessments for lone working and security risks	High	Ayodeji Adeyemi	Trisha Bain	Lone working policy and risk assessments completed. Updated policy to be presented for approval at 29/01/2018 Corporate H&S Committee Meeting.	31/01/2018	In progress on schedule

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
2.1	Update Health & Safety Policy document in line with good practice and clearly define responsibilities for Directors, HS&S team, Heads of departments and managers.	High	Ayodeji Adeyemi	Trisha Bain	Health & Safety Strategy approved by Trust Board in November 2017. Draft H&S Policy to be produced during Q1 - 2018.	28/02/2018	In progress on schedule
2.2	Review policy for lone workers and ensure it considers process for monitoring lone workers, emergency procedures and any restrictions.	High	Ayodeji Adeyemi	Trisha Bain	Lone working policy and risk assessments completed. Updated policy to be presented for approval at 29/01/2018 Corporate H&S Committee Meeting.	31/01/2018	In progress on schedule
3.12	Ensure HS&S training identified in Core Training Policy is implemented. This includes risk awareness training for senior managers, manual handling, investigation of incidents, slips trips falls.	High	Ayodeji Adeyemi	Trisha Bain	Proposal to make the Managing Safely Course Mandatory as well as incorporate other key safety elements e.g. risk management, incident management and investigation e.t.c has been sent out to relevant departments for their review. The aim is to re-launch training in April 2018.	31/03/2018	In progress on schedule
3.14	Define and communicate requirements for PPE maintenance and replacement. This should include head protection, fall protection and stab vests.	High	Ayodeji Adeyemi	Trisha Bain	Trust-wide PPE policy is currently under review - to be completed by 31/03/2018.	31/03/2018	In progress on schedule
2.4	Clarify and document responsibilities of committees where HS&S is discussed, and of boundaries between HS&S, QGAM, Estates, People & Organisational Development and Fleet. This should consider what is appropriate for the HS&S Committee and what meetings HS&S should attend. (Suggested guidance is included at Appendix 15)	Med	Ayodeji Adeyemi	Trisha Bain	Trust Governance and Committee meeting structure agreed and implemented. Changes to H&S Management Structure will be reflected in the updated Health and Safety Policy	28/02/2018	In progress on schedule

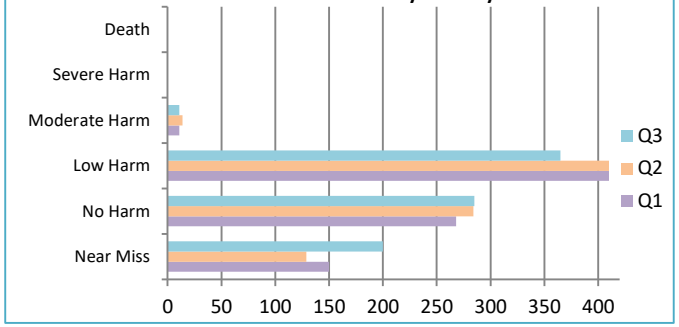
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status
3.9	Provide guidance and training to staff on how to effectively use Datix	Med	Nathan Colman	Trisha Bain	E-learning package has been developed for all staff and will form part of the Mandatory training requirement. The package will be launched in Q4 2017.	31/03/2018	In progress on schedule
3.10	Include guidance and training on Datix in induction sessions for new staff.	Med	Nathan Colman	Trisha Bain	E-learning package has been developed for all staff and will form part of the Mandatory training requirement. The package will be launched in Q4 2017.	31/03/2018	In progress on schedule
3.13	Develop standard for HS&S Notice boards in all locations.	Med	Ayodeji Adeyemi	Trisha Bain	To be completed during review of site specific risk assessments - to commence in November 2017.	31/03/2018	In progress on schedule
4.10	Implement system of internal audits	Med	Ayodeji Adeyemi	Trisha Bain	Programme of internal audits to be implemented from March 2018.	31/03/2018	In progress on schedule
4.14	Implement independent assurance regime to verify robustness of systems in place.	Med	Ayodeji Adeyemi	Trisha Bain	This will provide independent assurance to the ELT and Board regarding the effectiveness of the Health & Safety Department in implementing and maintaining appropriate arrangements to ensure compliance with Health & Safety requirements. Independent audits of Trust-wide compliance to commence in 2018/19.	31/03/2018	In progress on schedule

Health & Safety Scorecard – Q3 (December 2017)

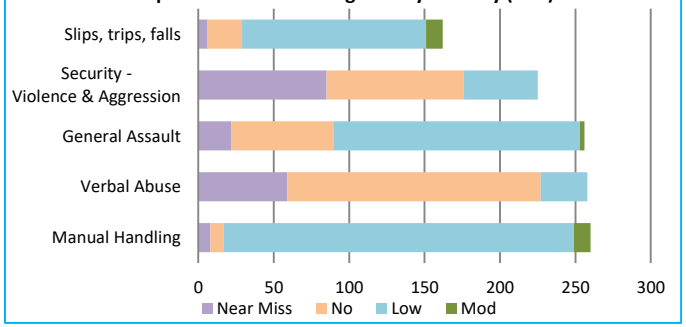
Number of H&S incidents by Quarter



Accidents & Incidents by Severity



Top 5 Incident Sub-Categories by Severity (YTD)



2544 health and safety related incidents have been reported during 2017/18. 91 additional incidents (covering Q1 & Q2) were identified during Q3. Total YTD H&S incidents account for 40% of all incidents reported Trust-wide during the year.

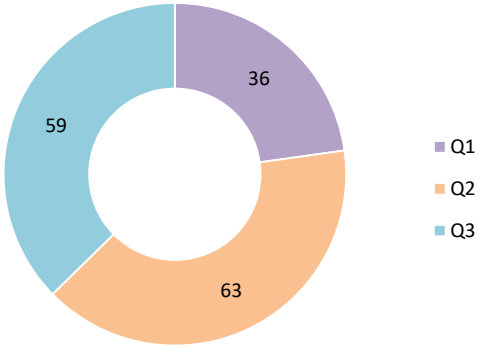
1192 (46.8%) of the H&S related incidents reported during 2017/18 resulted in low harm. 36 (1.4%) incidents resulted in Moderate Harm. 1316 (52%) of the incidents were reported as 'No Harm/Near misses'.

Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

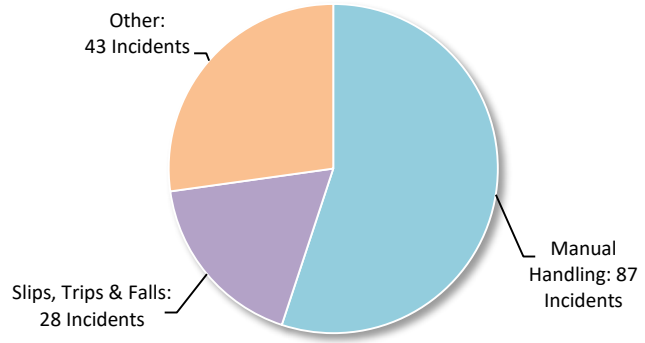
Key Updates:

1. Key training in practical MH commenced on 04/12/2017 for 44 Clinical Tutors. Additional sessions have been planned for 36 tutors and will be completed by 31/01/2018.
2. Practical MH refresher training will be provided for all frontline operational staff from CSR 1 – April 2018.
3. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Color categorization of Mangar Elks to commence by end of January 2018. 12 weekly maintenance plan has been implemented for all equipment including tail lifts and track chairs. This will be supported by 6 weekly visual inspection checks to identify and rectify faults/defects.
4. No trends identified with increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
5. Prototypes of the proposed integrated Vehicle based ALS and first response bags to go on trial from 22/01/2018.
6. Dynamic Risk Assessment Training rolled-out to all frontline staff as part of MAST training during CSR 2 – 2017.

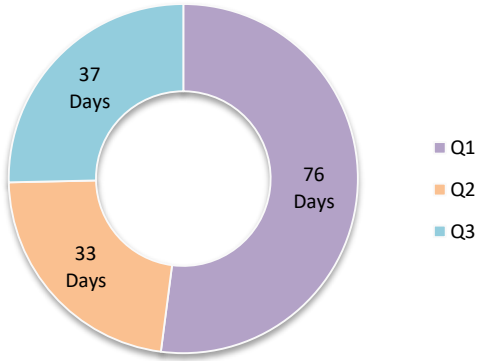
RIDDOR Reportable Incidents by Quarter



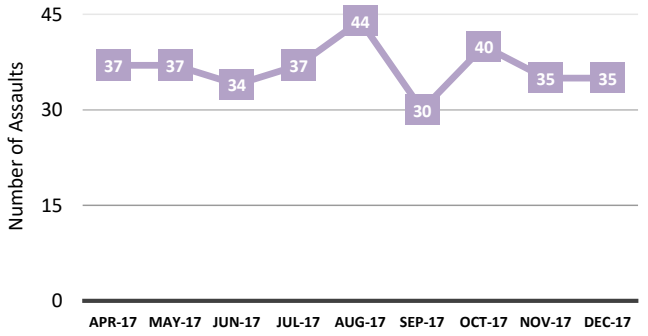
RIDDOR Reportable Incidents by Cause



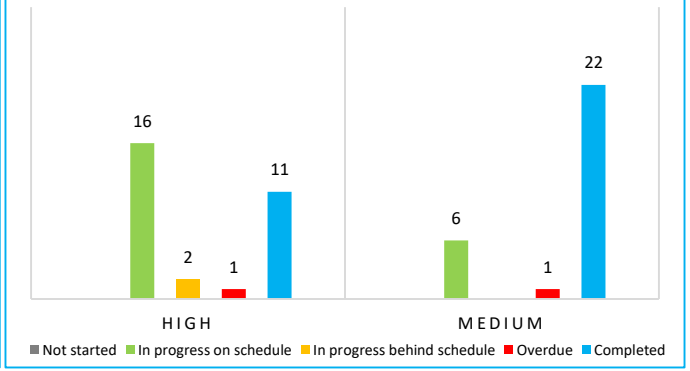
RIDDOR Reporting Timelag (Average Days)



Assaults on Staff by Patients



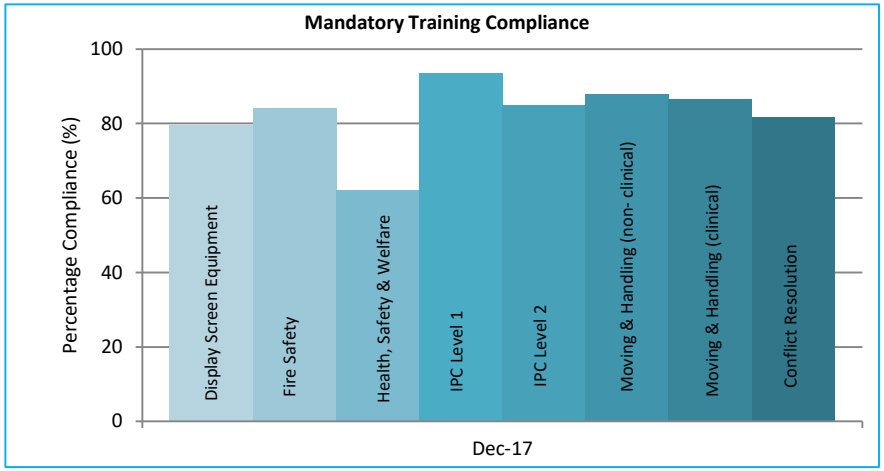
Status of H&S Review Action Plan

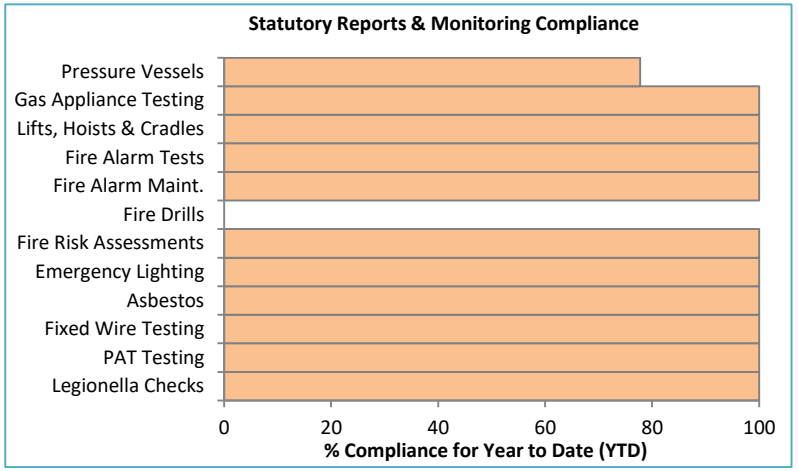


7. The average time lag for reporting RIDDOR incidents across the Trust in Q3 was 37 days. This exceeds the average time lag of 33 days during Q2 as well as the statutory reporting timeline of 15 days for most RIDDOR incidents. **In Q3, 35 out of the 59 RIDDOR incidents were reported out of time.**

8. Assaults on staff by patients make up 31% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required.

9. 33 of the 59 actions recommended have been completed.
   - 24 actions are currently in progress with 5 actions due to be completed by 31/01/2018.
   - **2 actions are overdue.**





Trust-wide compliance in December 2017 for 5 out of the 8 mandatory health and safety training courses was below 85%.

The H&S Dept. is reviewing arrangements to improve the inconsistent practice and Trust-wide compliance with statutory fire drills. All sites have been asked to nominate fire marshals who will be trained in Q4 to support the department with maintaining compliance.

The H&S Team are also liaising with an external contractor regarding the review of fire risk assessments and maintenance of equipment.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating						Target Risk Rating	Key changes/updates since last review
						Q2			Q3				
						Jul	Aug	Sep	Oct	Nov	Dec		
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	15	15	9	Key training in practical MH has been provided to Clinical Tutors in December 2017. Training to be completed in January 2018. Practical MH refresher training to be provided from CSR 1 – April 2018. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – to be tabled for approval at January H&S Committee meeting.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	3	The average time lag for reporting RIDDOR incidents across the Trust in Q3 is **37 days.** There are still inconsistencies in RIDDOR reporting however, these are reviewed with the relevant Managers in order to address the gaps.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Risks approved by H&S Committee and RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q4, 2017-18.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is currently under review.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	30 January 2018			
Report title:	Quality Report – January 2018			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Various			
Presented by:	Dr Patricia Bain, Chief Quality Officer Dr Fenella Wrigley, Medical Director			
History:	Quality Assurance Committee			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The purpose of this paper is to provide assurance to Board of the standards of care provided by the London Ambulance Service during the month to which the data in this report relates (unless otherwise stated). For those instances where aspects of care are identified as having fallen below acceptable standards the actions and assurances required to prompt an improvement are clearly detailed. The report also highlights areas of good practice and areas where progress has been made.

Recommendation(s):

The Board is asked to note the report (information from which has been incorporated into the integrated Quality and Performance Report).

Links to Board Assurance Framework (BAF) and key risks:

BAF Risk 7 - Performance falls at staff changeover time - this report evidences a decrease in the number of declared Serious Incidents at the shift changeover time

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service
NHS Trust

Quality Report

January 2018

All data pertains to December 2017 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

Legend
- Above Target
- Within 5% of Target
- Over 5% from Target

Executive Summary: Exception Report (Positive)

Safety

- Reduction in number of non-controlled drugs incidents
- Confirmation from Education Manager that the learning shared by SW Ambulance Service to raise awareness about Sudden Death in Epilepsy (identifying risk factors to help minimise risk) will be used in the Trust's training programme.
- The Trust Medical Director and Chief Quality Officer co-chaired twice daily Safety Huddle conference calls with managers from directorates across the organisation. These meetings were aligned to daily performance cell meetings but maintained a clinical safety and quality oversight focus. Incidents of note were brought to the group for discussion and escalated where appropriate. Assurance was provided by the Clinical Hub and Operations that staffing levels were adequate in order to provide a safe service for the following shift enabling shortfalls to be proactively managed.
- LAS is currently the second highest reporter to the NRLS across the ambulance trusts. It should be noted No & Low harm patient safety incident reporting has increased from 42% to 90% which is well above the national benchmark

Actions & Assurance

- Ongoing monitoring via Datix system
- Training plan to be agreed with Education and Training Senior Manager and rolled out by end of Q4
- The next training session has 15 managers attending
- All incidents of note were collated on a spread sheet and will be included in the clinical safety review being undertaken by the Medical Director.

Effectiveness

- Multi-professional team debrief undertaken with LAS staff and Homerton Hospital ED and Maternity staff following a breech birth at home
- The Trust provided a weekly bulletin to Acute Trusts detailing expected demand, upcoming events, weather related impact on service delivery, hospital breach data and reiterating the need for hospitals to prioritise the release of ambulance crews by facilitating a rapid handover either through hospital led nurse cohorting or the 'Fit to Sit' initiative

Actions & Assurance

- CPD event to be undertaken in January 2018 at Homerton Ambulance Station to provide shared learning event with Homerton Hospital midwives
- Feedback was received from Imperial Heath stating the weekly bulletin was found to be accurate, gave relevant information and became a useful source of information

Caring

- Letter of thanks received from the Senior Coroner for Inner London South on the comprehensive response to the PFD report sent on 20th November 2017.
- A maternity service user is represented on the Maternity Differentiated Workstream and is keen to be part of working with LAS on a user engagement event.

Actions & Assurance

- Draft proposal for procurement of external facilitation team for maternity engagement event "whose shoes" – Transformation Team to provide support

Executive Summary: Exception Report (Improvement Required)

Safety

- There has been an increase in the number of morphine ampoule breakages.
- Clarification around the maximum time that a crew can wait on scene, awaiting the arrival of a midwife
- Ongoing review of the ARP categories for Maternity Calls
- Despite escalation and weekly reminders actions from serious incident investigations continue to breach the assigned deadline
- In December the Trust moved to REAP 3 (Severe Pressure) resulting in all CTLs being fully operational in order to support service delivery. This meant a reduction in the number of OWR's being conducted and therefore fewer submissions of hand hygiene compliance data

Actions & Assurance

- Monitoring of incidents via Datix and procurement of ampoule racks for CD safes. It is thought the increase could also be a result of a change in presentation whereby ampoules are individually wrapped and may be breaking as staff are opening the packaging
- Agree LAS Policy with Operations Team and Medical Directorate – March 2018 Deadline
- Daily Datix incident reviews for any delays impacting upon maternal, fetal or neonatal outcomes
- Consideration being made to the deadlines assigned to serious incident actions under the new investigating process to ensure the time frame is realistic and achievable
- The Governance team will continue to escalate overdue actions to the responsible manager and ELT where required
- The Trust has now moved to REAP 2 (Moderate Pressure). This will see OWR's resume. The Head of Infection Prevention & Control has requested any outstanding submissions for December be sent as a priority in order for the data to be updated

Effectiveness

- Procurement of newborn thermometers outstanding
- Procedures for checking equipment, dealing with broken equipment, requesting replacement equipment & obtaining electronic or manual staff confirmation of procedures remains ongoing

Actions & Assurance

- Update on costing's to be reviewed
- Feedback awaited from Deputy Director of Fleet & Logistics.

Caring

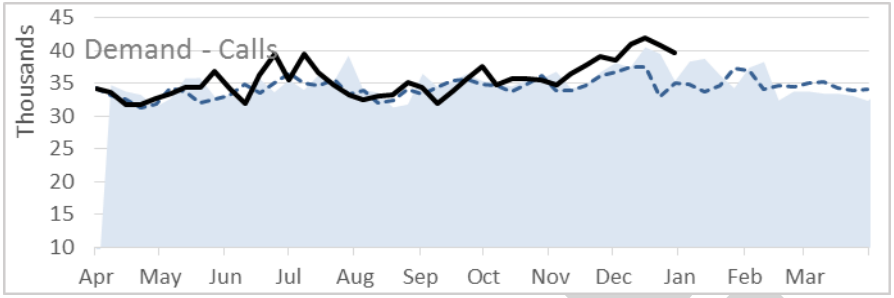
- Safeguarding Adults & Children level 2 (EOC) training at 42% against a target of 58%

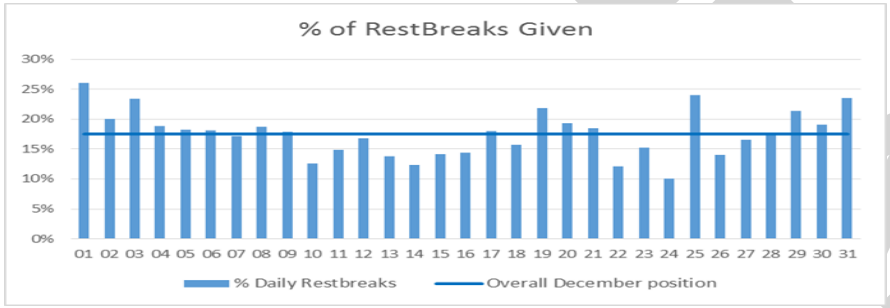
Actions & Assurance

- Head of Safeguarding & Prevent to work with EOC managers to understand the reasons for lower than anticipated completion rates

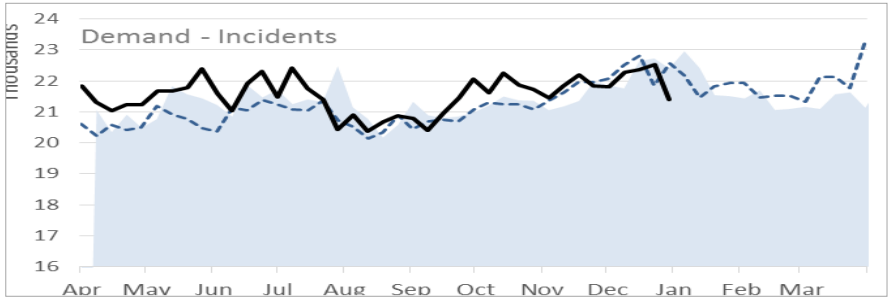
Performance Pressure

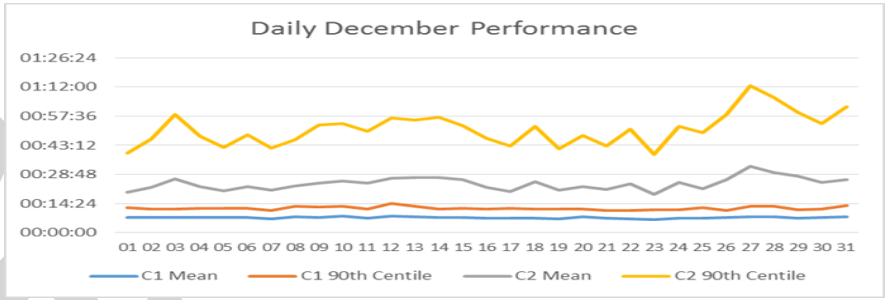
Pressures





Performance





- As forecast for the festive period, December saw an surge in demand for Emergency and Urgent Care calls across London. This was further compounded by pressures in the health system as a whole resulting in an increase in the number of patient handover delays at hospitals. In order to manage this demand and mitigate the risk to patients awaiting a response a number of initiatives were implemented by the Trust with the support of NHS England;

  Winter Room – A senior manager from the Trust was based in the NHSE Winter Room. This ensured the LAS was represented face-to-face when strategic decisions were made

  Safety Huddle – The Trust Medical Director and Chief Quality Officer co-chaired twice daily conference calls with managers from directorates across the organisation. These meetings were aligned to daily performance cell meetings but maintained a clinical safety and quality oversight focus. Incidents of note were brought to the group for discussion and escalated where appropriate. Assurance was provided by the Clinical Hub and Operations that staffing levels were adequate in order to provide a safe service for the following shift enabling shortfalls to be proactively managed.

  Weekly Winter Briefing – The Trust provided a weekly bulletin to Acute Trusts detailing expected demand, upcoming events, weather related impact on service delivery, hospital breach data and reiterating the need for hospitals to prioritise the release of ambulance crews by facilitating a rapid handover either through hospital led nurse cohorting or the 'Fit to Sit' initiative

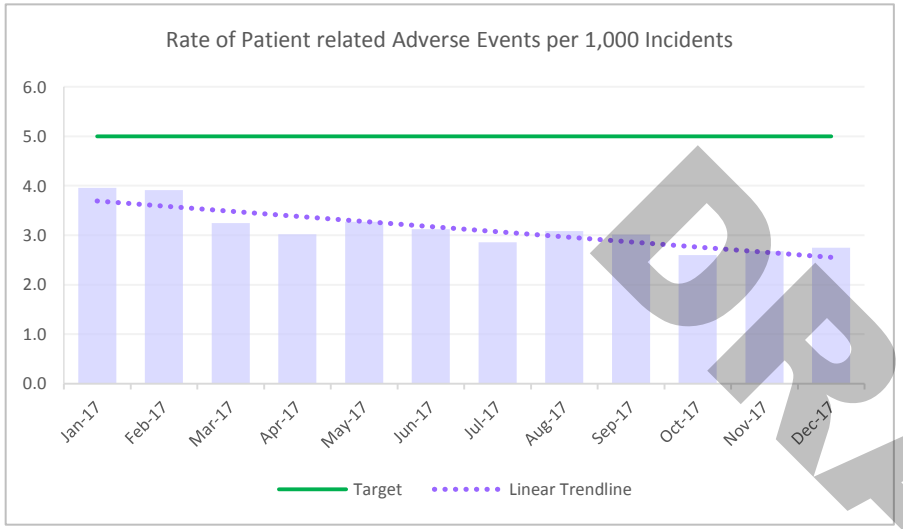
Patient Safety

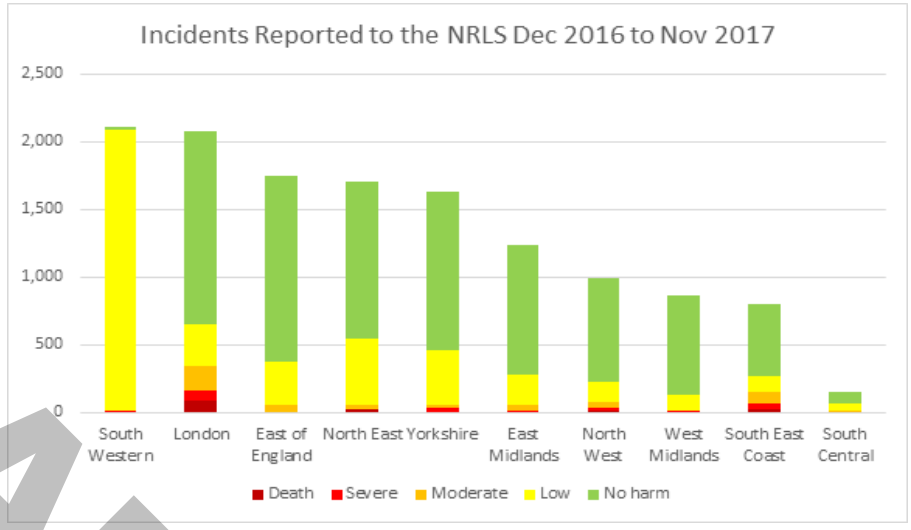
Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	83%	91.4%	98.0%	59.5%	↓			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	2.6	2.7	2.7	↑					
Patient related Adverse Events - NO HARM	1200	G	1957	204	187	178	↓					
Patient related Adverse Events - LOW	30	G	220	18	23	36	↑					
Patient related Adverse Events - MODERATE	25	G	147	13	21	28	↑					
Patient related Adverse Events - SEVERE			61	9	10	8	↓					
Patient related Adverse Events - DEATH			96	8	10	19	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.4	3.5	3.9	2.8	↓					
Staff related Adverse Events - **NONE**			1617	223	218	164	↓					
Staff related Adverse Events - **LOW**			1169	107	136	101	↓					
Staff related Adverse Events - **MODERATE**			58	11	11	8	↓					
Staff related Adverse Events - **SEVERE**			1	0	0	0	↔					
Controlled Drugs - Other Reportable Incidents			255	33	34	31	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	3	1	1	0	↓					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	95%	95%	97%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			285	23	37	39	↑					
Serious Incidents declared in-month			53	3	9	5	↓					
Serious Incidents breaching 60 days	0	G	24	0	2	0	↓					
Serious Incidents breaching 40 days	0	G	27	0	5	0	↓					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			5%	3%	6%	6%	↓					
Needle Stick Injuries as % of Staff Adverse Events			2%	3%	3%	3%	↓					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	3	0	0	0	↔			LQ25	✓	
Safeguarding Adults & Children Level 1 (3 Years)	90%	G	76%	88.0%	79.9%	92.1%	↑					
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	R	79%	76.4%	81.8%	83.8%	↑					
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	48.0%	42.6%	42.0%	↓					
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	57%	56.9%	76.9%	78.4%	↑					
Safeguarding Trust Board (3 Years)	90%	G	79%	78.6%	100.0%	100.0%	↔					
Total Inquests where LAS asked to give evidence - In-Month			53	4	6	4	↓					
Total Inquests where LAS asked to give evidence - Year to Date			268	43	49	53	↑					
Missing Equipment Incidents as % of all reported incidents			3%	4%	3%	4%	↑					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	11%	8%	9%	↑					
Number of NRLS uploads In-Month	1	G	9	1	1	1	↔			LQ21		

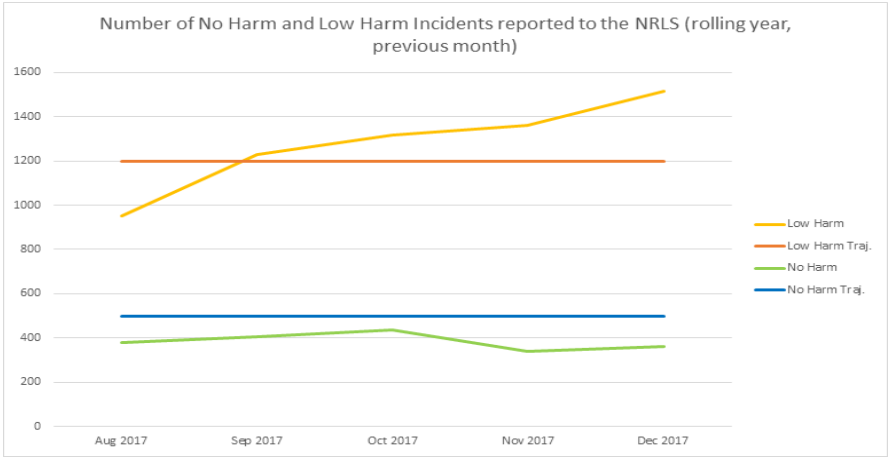
Patient Safety

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain





Actions and Assurance



National Reporting and Benchmarking

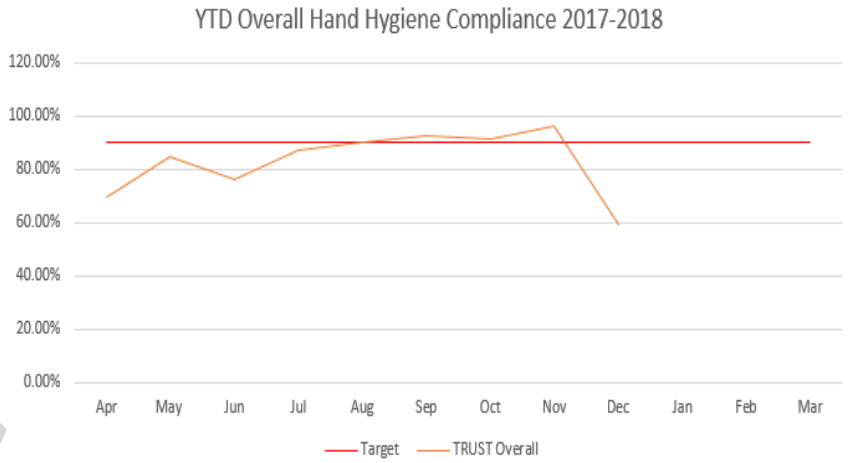
- Data is provided by the NRLS on the 18th of each month for a rolling year ending the month prior
- The LAS was the 2nd highest reporter to the NRLS for the rolling year ending November 2017.
- The number of low harm incidents has been above trajectory since the rolling year ending September 2017, and is continuing to increase (see left)
- The number of no harm incidents is currently under the trajectory and after a dip in November, is on the increase again and due to hit the trajectory in the rolling year ending February 2018
- Please note as at 9th January there are 88 patient safety incidents within Quality Check that need to be reported to the NRLS, which will increase the numbers
- It should be noted No & Low harm patient safety incident reporting has increased from 42% to 90% which is well above the national benchmark

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Hand Hygiene Compliance 2017 – 2018 (Trust Compliance target: 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
TRUST Overall	69.84%	84.54%	76.24%	87.20%	90.22%	92.78%	91.44%	96.33%	59.53%
North East	97.40%	90.60%	60.90%	57.00%	95.30%	100.00%	67.00%	95.66%	66.66%
North Central	100.00%	100.00%	48.90%	89.00%	100.00%	100.00%	96.70%	95.60%	83.33%
North West	56.00%	73.80%	92.00%	95.00%	100.00%	76.40%	97.50%	93.40%	56.00%
South East	33.30%	95.80%	95.80%	95.00%	62.00%	100.00%	96.00%	100.00%	66.66%
South West	62.50%	62.50%	83.60%	100.00%	93.80%	87.50%	100.00%	97.00%	25.00%



Performance

- Significant drop in the completion and submissions of Operation Workplace Reviews (OWR) of Clinical Practice by Clinical Team Leaders (CTLs) during December due to REAP 3.
- Analysis of aggregated data was based on 11 stations' submissions out of a possible 18 group stations. It has been challenging period for the front line staff to complete their OWRs
- Due to the poor completion and submission rate, the overall hand hygiene compliance has fallen significantly below the target for this month

Assurance

- QGAMs continue to focus on the quality of services; the OWR tool was amended and agreed, with an easier method of data submission to the IPC team, through a generic email address from January 2018
- With REAP downgraded to REAP 2 in January 2018, OWRs will resume and continue to be undertaken by CTLs
- Submissions and compliance rates of the numbers of audits streams in OWR will continue to be monitored by the IPC team with prompt feedback provided to sectors and stations management
- Increase team capacity since Q4 to support station management and staff with validation audits and local & A&E visits to facilitate and maintain improvements in practice
- IPC Hand Hygiene practical session re-introduced to the non-clinical Induction Day (using UV light) from January 2018, to ensure that ALL new employees in LAS understands the importance of hand hygiene and is able to hand wash with soap and water and use hand gel correctly; personal bottles of hand gels provided

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly IPC Training Compliance 2017 -2018 (Trust Compliance target: 90%)

IPC Training Compliance 2017- 2018 (Trust Target: 90%)

TRUST Overall	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Level 1 *	87.80%	88.18%	87.96%	88.50%	91.56%	91.88%	91.31%	92.53%	93.13%
Level 2 *	87%	84.92%	82.30%	78.28%	78.15%	79.73%	77.41%	83.05%	84.90%
Level 1 (No: trained)	4471/5093	4491/5093	4493/5108	4510/5096	4634/5061	4707/5123	4719/5168	4791/5178	4812/5167
Level 2 (No: trained)	3383/3887	3288/3872	3200/3888	3039/3882	3018/3862	3128/3923	3081/3980	3302/3976	3335/3928

Performance

IPC training figures for Llevel 1 and level 2 continues to be monitored via ESR; the system allows easy access to robust data in a timely way and is a huge improvement compared to a year ago

- Level 1 training continues to show compliance and the compliance rates is increasing month on month, achieving best yet figures at end of Q3 - 93.13%, equivalent to 4812 out of 5167 total staff

- Level 2 training achieved 84.90% at end of Q3, although missed the target of 90%, the compliance rate has continued to increased month on month
- 3335 out of 3928 patient facing staff have undertaken their Level 2 training

- To ensure IPC and hand hygiene remains high on the Trust agenda, all new employees are provided with IPC and hand hygiene training – new patient facing staff undertake Clinical Induction and non-clinical staff have a separate Induction session.
- IPC and practical Hand Hygiene was re-introduced to the Corporate Induction day in January with good feedback

Assurance

- Training compliance is monitored on a monthly basis via a Monthly Performance Scorecard by the IPC team
- Performance is shared at Sector Quality meetings and IPC Champions meetings, Quality Report
- Monitored quarterly at the operational Infection Control and Decontamination Group (ICDG) and assurance provided to the Infection Prevention and Control Committee (IPCC), and onwards to the QOG, and QAC and Executive Team as well as Commissioners

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly OWR BBE 2017-2018 (Trust target: 90%)						
	Jul	Aug	Sep	Oct	Nov	Dec
Compliance / submission	%	%	%	%	%	%
TRUST Overall	93	91.36	95.16%	97.71%	94.50%	59.53%
North East	98	95.3	100%	100%	98.33%	66.66%
North Central	90	100	93.33%	95.30%	96.66%	83.33%
North West	80	97.8	95%	97.50%	98%	56%
South East	97	66.7	100%	100%	100%	66.66%
South West	100	97	87.50%	95.75%	94.50%	25%

Performance:

Bare-below-the-elbow (BBE) compliance was monitored from July 2017 via the OWR tool by CTLs

- Excellent compliance with the target set in October and November 2017
- However, the OWR completion and submission rates dropped markedly in December due to REAP 3 and the challenges the Trust faced as a whole
- With nearly half of Groups Stations not undertaking and submitting their data to the IPC team, this has an overall impact on the compliance rates as analysis is based on aggregated data received from all Group Stations
- All sectors missed the 90% target as a result of REAP 3

Assurance:

- CTLs to recommence OWRs now that REAP level has decreased
- Compliance will be monitored by CTLs and the IPC team

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

6-Weekly Vehicle Deep Clean 2017-2018 (Trust target: 90%)									
	Apr	May	Jun	Jul	Aug*	Sep	Oct	Nov	Dec
TRUST Overall	97%	97%	94.80%	94.30%	96.80%	95.72%	93%	95%	95%
North East	95%	95%	97.80%	96.20%	96%	97.00%	98%	98%	98%
North Central	99%	99%	82.50%	91.20%	97%	97%	97%	90%	97%
North West	99%	99%	98%	98%	98%	96.00%	96%	93%	96%
South East	99%	98%	98.30%	95.50%	97%	98.00%	98%	96%	97%
South West	97%	97%	94%	94%	96%	98.00%	99%	97%	95%

Performance

- Vehicle 6 weekly deep clean compliance continues to do well.
- All 14 hubs are operational and Phase 2 is in progress

Assurance:

- The quality of the cleaning is being monitored by the Logistics VP Contract Manager and the Contractor using ATP testing – data is currently being analysed
- Monthly and Quarterly data submission for monitoring by the IPC team, Sector Quality Meetings, ICDG, IPCC
-

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Premises Cleaning 2017-2018 triangulated data from Estates, Stations and Contractor from Septe										
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	J
TRUST Overall	96%	96.58%	96.70%	98.20%	78.65%	84.25%	98.15%	87.67%	88.00%	
North East	92%	93%	95%	96%	97.30%	64.30%	96.60%	63.66%	63%	
North Central	99%	99%	96%	100%	66.70%	66.70%	100%	100%	100%	
North West	96%	95.40%	97%	98%	98%	94%	98%	77.80%	77.40%	
South East	97%	97%	97%	98%	33%	98%	97.66%	97.66%	98.85%	
South West	96%	98.50%	98.50%	99%	98.25%	98.25%	98.50%	99.25%	98.50%	

Performance

- The performance dipped in December due to lack of completion and submission of data as a result of REAP 3 and absence of Estates Contract Manager due to external commitment
- 2/5 Sectors achieved their targets
- IPC team has undertaken all 70 stations audits in the last 12 months and during the end of Q3, was focused on scrutinizing station action plans and ensuring their completion; supporting IPC Champions and Station management as far as practicable

Assurance:

- Increased IPC team capacity from Q4 will focused on validation audits and supporting station management and staff, Estates team in practical ways to enhance the standards in the environment including clinical waste management
- Cleanliness standards are monitored monthly by IPC team, who also attend Contract meetings with the Contractors
- Monitored at quarterly Sector, ICDG, IPCC

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

H&S Incidents by Sub-category	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Total
Exposure to bodily fluids	43	45	32	0	120
Incident involving broken ampoule or vial	11	11	16	0	38
Needle stick injury - Cannula (contaminated)	11	10	14	0	35
Razor injury (clean)	7	4	5	0	16
Needle stick injury - IM (contaminated)	3	1	7	0	11
Bit by a person	4	3	9	0	16
Needle stick injury - IM (clean)	0	3	2	0	5
Lancets injury (contaminated)	3	0	0	0	3
Needle stick injury - Cannula (clean)	0	1	3	0	4
Needle stick injury - sub-cutaneous (contaminated)	2	0	1	0	3
Contact with sharps (includes needle stick)	0	1	2	0	3
Lancets injury (clean)	2	0	0	0	2
Razor injury (contaminated)	1	0	0	0	1
Needle stick injury - sub-cutaneous (clean)	0	0	0	0	0

Performance:

- YTD incidents to Q3: 257 in total
- In Q3 – numbers for incidents involving broken ampoule/vials increased – these are managed by Medicine Management
- In Q3 - 32/91 (35%) incidents reported relate to body fluid exposure – a decrease from Q1 and Q2 data
- The data for Q3 is awaiting further detailed analysis for lessons

Assurance:

- All Datix incidents are reviewed by the Head of Infection Prevention and Control and feedback provided
- Lessons from analyses are shared and training content amended (Evidence Bulletins/Training packages)
- Collaborative working with Health and Safety team to ensure that all aspects are considered and acted upon
- LAS uses Safer needles
- Forging relationships and working closely with Workforce and Occupational Health; IPC support to OH Contract meetings from January 2018; Vaccination Status project is in progress (Workforce)
- Monitored monthly by IPC team, quarterly at Sector meetings, ICDG, IPCC

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

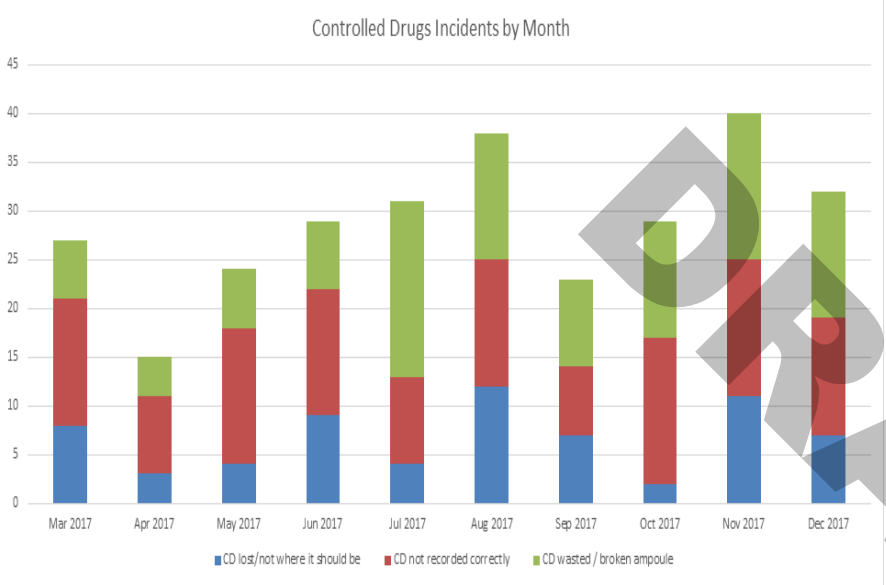
Exceptions

- Good practice
  - Compliance with 6 weekly deep clean compliance continues to perform well
  - IPC Training compliance rates continues to increase
  - IPC practical session of hand hygiene re-introduced into the non-clinical Trust Induction day in January 2018, with good feedback

- Development areas
  - Inconsistent adherence to basic principles of infection prevention and control - hand hygiene, including use of alcohol gel
    - Quality assure content and delivery of training sessions currently provided by non-IPC specialist
    - Increase IPC validation audits of practice, and support to change historical practice
    - Encourage personal accountability and responsibility regarding IPC standards by introducing IPC discussions at One-Ones and PDRs, team meetings, OWRs
    - Regular competency checks, role modelling by key influencers e.g. mentors, senior staff

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- One unaccounted for loss of 2x ampoules injectable morphine in Dec 2017.
- Total of 31 other controlled drugs incidents including the following
  - Morphine retained off-duty (n=3)
  - Paramedic drugs pack containing CDs lost (n=1)
  - Documentation errors (n=13)
  - Broken morphine ampoules (n=12)
  - CD safe left open (n=2)
- Other medicine management issues
  - Medicines in wrong location (n=3) or lost (n=4)
  - Cabinets not secure (n=5) or access code visible (n=1)
  - Confusion over glucagon expiry dates (n=1)
  - Overdoses of ibuprofen (n2), paracetamol (n=1) & ipratropium (n=1)
  - Adrenaline given in hypothermic cardiac arrest (n=3)
  - Wrong drug or dose administered (n=3)

Actions

- Bulletin explaining presence of two expiry dates on glucagon packaging (one relates to manufacturers date and one to shorter shelf life when removed from fridge and placed in LAS drugs packs.
- Implementation of new more comprehensive medicines audit procedures at LSU
- Increased focus on spot check audits by IRO team and LAS CQC team
- Purchase of morphine ampoule racks for use in CD safes to reduce incidence of breakages during transfer of ampoules in/out of safe
- E-learning CSR package during December 2017 emphasising cross checking of drugs prior to administration.

Assurance

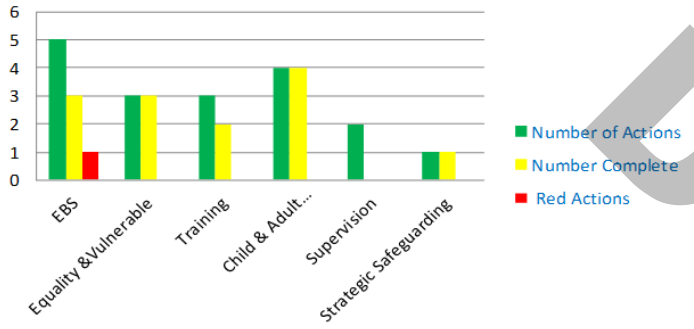
- Unaccounted for losses of controlled drugs remain stable and consistent with previous months for which data available.
- No reported PGD breaches during December 2017
- Reduction in number of non-controlled drugs incidents
- No incidents of incorrect dose with 1:1,000 adrenaline
- Progress of secure drugs on stations project will continue to further enhance medicines management within the Trust.
- It should be noted that the hypothermic cardiac arrests were not due to environmental factors (i.e. exposure to extremes of temperature) but were a natural result of death whereby upon review the patient had been deceased for longer than first thought

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

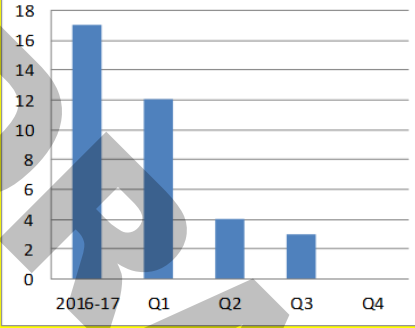
Safeguarding Score Card December 2017

Work plan 2017-18



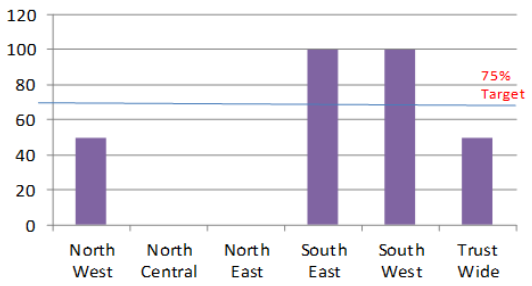
All progressing well except EBS 24/7 telephone referrals and taped line.

Safeguarding Allegations Against Staff 2017-18



Remains unchanged for December

Local Partnership Working % RRM Attended



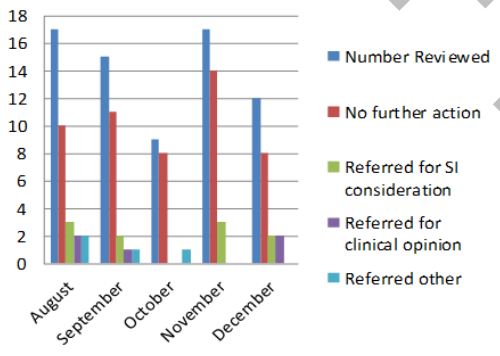
Currently running at 50% for YTD discussed with operational leads at Safeguarding Operational Group. Will discuss at Operations Governance Meeting. Also to address with QGAM/ADO North Central and North East who consistently do not achieve attendance.

Trust safeguarding referrals and concerns raised

	Adults Safeguarding	Adults Welfare	Children	Total Referrals	% incidents
Apr-17	406	595	715	1716	1.90%
May-17	366	680	753	1799	1.90%
Jun-17	385	708	787	1880	2.00%
Jul-17	379	656	735	1770	1.90%
Aug-17	366	666	622	1654	1.80%
Sep-17	369	623	667	1659	1.80%
Oct-17	421	666	732	1819	1.90%
Nov-17	420	671	692	1783	1.90%
Dec-17	464	767	674	1905	1.95%
Oct-17	421	666	732	1819	1.90%
Nov-17	420	671	692	1783	1.90%
Dec-17	464	767	674	1905	1.95%

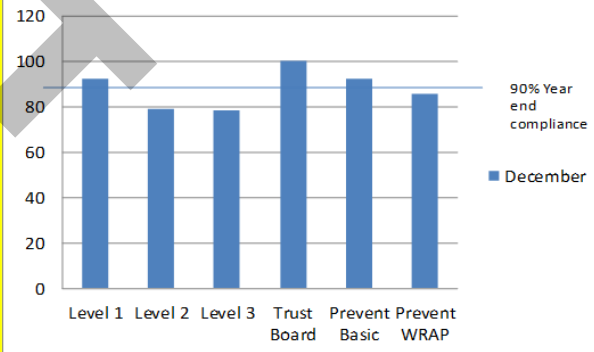
We have seen an increase to 1.95% of trust incidents. Biggest jump being in adult welfare concerns

Child Death



100% were processed within 3 weeks of receiving

Safeguarding Training December



Whilst figures look on track there is concern about level 2 due to current access problems staff are experiencing we may not reached commissioned target. Currently 83% operational staff compliant and 42% EOC staff

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

Health and Safety Risk Tracker				Initial Risk Rating	Current Risk Rating QTR2				Target Risk Rating	Key changes/updates since last review
Risk No.	Risk description	Risk Owner	Exec Lead		Aug	Sep	Oct	Nov		
63	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies notably MARAC Original Risk ID 426	Alan Taylor	Trisha Bain	12	12	12	8	8	8	Awaiting closure from RCAG as reached target rating
65	There is a risk that due to our inabilityto link safeguarding referrals Original Risk ID 458		Trisha Bain	12	12	12	4	4	4	Awaiting closure from RCAG as reached target rating
69	Compliant with safeguarding training requirements for clinical and non-clinical staff.		Trisha Bain	12	12	12	8	8	4	Trust has now moved to ESR for recording all training. Agreed to reduce risk but to keep open as ESR still not 100% reliable with names etc at present.
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made		Trisha Bain	12	12	12	12	12	6	Now 46% referral rate so some improvement but more required before closure. Specialists to discuss with IRO and APP to target keypeople to ensure someone makes the referral. Agreed further comms around youth violence and introduction of referrals to Red Thread re audit in Jan

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

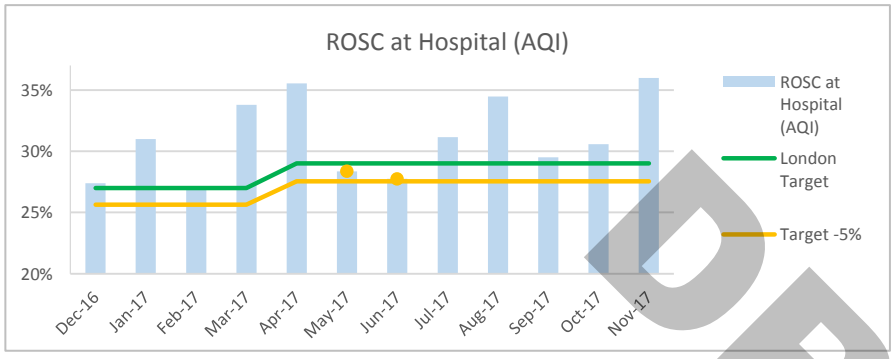
Measures	Target / Range	RAG	YTD 17/18	Sep-17	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	30%	31%	36%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	42%	42%	62%		↑			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	74%	74%	73%		↓			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	64%	60%	59%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:31		↓					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:41	00:40	00:36		↓					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	93%	92%	94%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	6.0%	9.9%	14.4%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.3%	97.3%	97.0%		↓		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	91.0%	92.0%	92.0%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	96.0%	96.0%	97.0%		↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%			↑		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%		97%		↔			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	90%	89%	87%	92%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						19%	30%	↑			LQ11	✓	

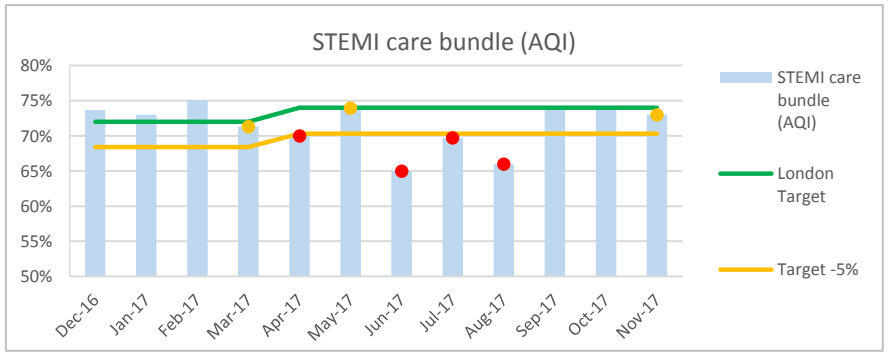
Assurance

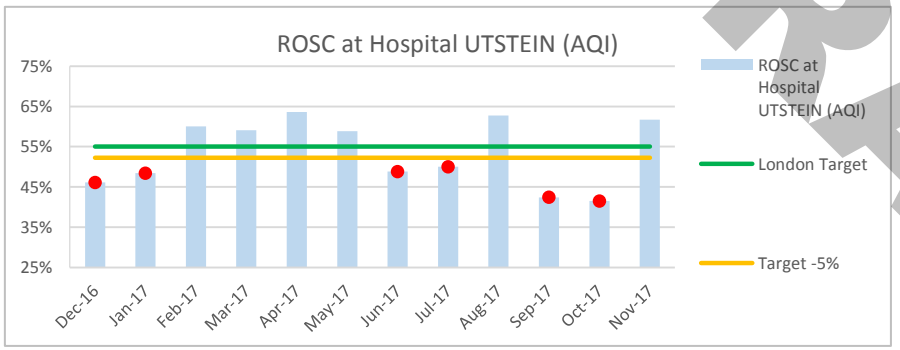
- In November, LAS CPI completion increased for the first time in three months. Team Leaders audited 49% of the PRFs available, with a further 44% audited by other members of staff. CARU trained eight members of staff on restricted duties on how to undertake CPI audits in November, as well as one Team Leader and one Team Coordinator. Five student paramedics from the LAS Academy were also trained on the CPI process and the content of the CPIs.

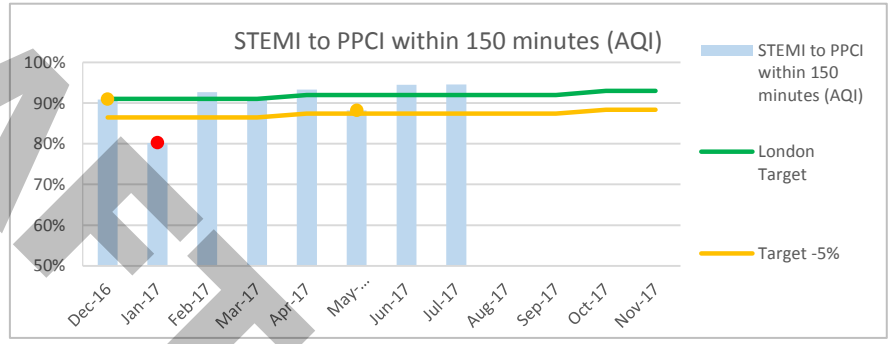
Effectiveness (Clinical AQIs)

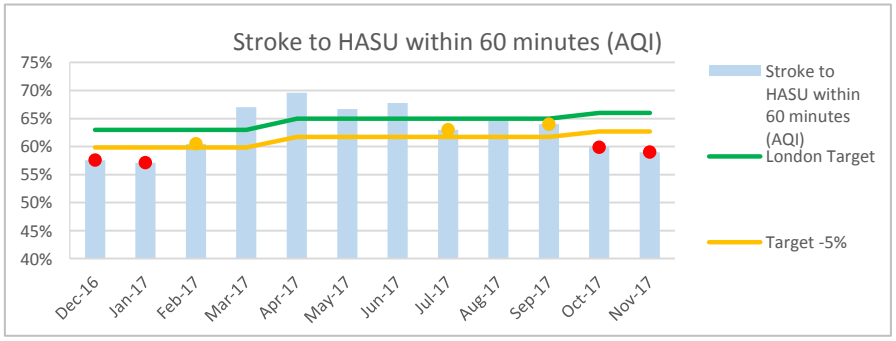
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

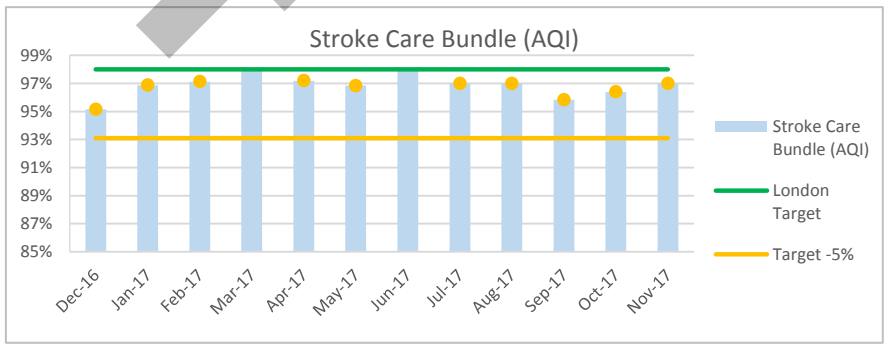








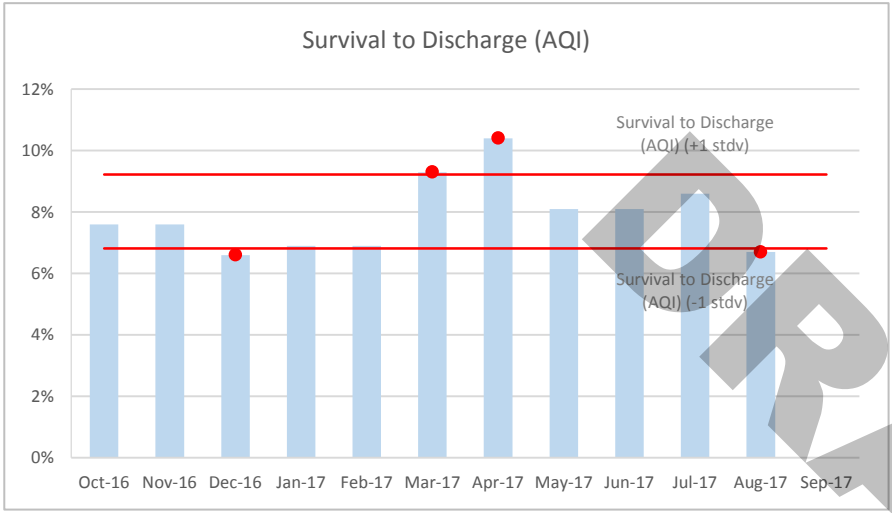


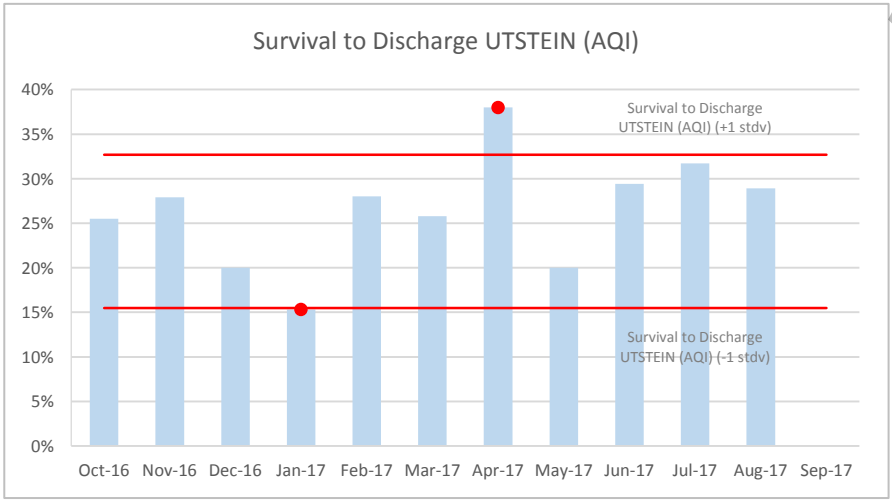


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Effectiveness (Clinical AQIs)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





AQI: Narrative

- ROSC sustained to hospital reached a high of 36% for 2017-18 in November for the Overall group. For the Utstein group, ROSC also increased compared to the previous few months.
- We saw a decline in survival to discharge for both the Overall Group and the Utstein Group in August compared to previous months*.
- Compliance to the STEMI care bundle remained consistent in November with on-scene times improving (36 minutes average); the lowest it has been this financial year, There was slight fluctuation in the percentage of patients who received PPCI within 150 minutes in August*.
- The percentage of Stroke patients who arrived at a HASU within 60 minutes dropped to 59% in November, however we spent less time on scene with these patients (31 minutes on average); the lowest this financial year. Compliance to the Stroke care bundle remained consistent in November.

*Please note there is a three month time lag to receive hospital outcomes.

AQI: Action

- Six FAST positive stroke patients were under-triaged in November and inappropriately taken to the ED rather than a HASU. The crews involved have all received feedback from their QGAMs.

AQI: Assurance

- An infographic reminding staff to consider analgesia was again included in the STEMI care pack available for Team Leaders to print and display on station
- The importance of documenting a full FAST was also highlighted in the infographic within the Stroke care pack sent to all complexes

* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Research Actions & Outcomes

RIGHT-2: 144 patients have been recruited since the beginning of the study (contractual target =180).

ARREST: The trial is due to start on the 15th January in Waterloo and Westminster. This trial aims to determine the best post-resuscitation care pathway for patients without ST-elevation on their ECG

Clinical Audit: Progress

Progress against the clinical audit work plan was formally reviewed in November at the Clinical Audit and Research Steering Group:

- The recognition, assessment and treatment of patients in hypovolaemic shock project has been abandoned due to the small number of cases available
- We are working on a further nine projects and facilitating four members of staff to undertake their own clinical audit projects. Five projects are yet to commence

Actions & Assurance

One clinical audit action was completed in November:

- All Adrenaline (1:1,000) teaching materials for the T/EAC and Academy programmes were confirmed as current.

There are no actions that have exceeded their due date.

As a result of our Continuous Re-contact Clinical Audit, in November and December:

- 38 crews were recommended for feedback (19 positive & 19 constructive)
- 26 EOC staff were recommended for constructive feedback (23 EMDs & 1 CTM)
- Two potential incidents were flagged on Datix, SIG deemed LAS decision making to be appropriate but both were flagged to the Independent Police Complaints Commission for further investigation

Caring

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	96%	67%	100%	↑			LQ27	
Friends and Family Test Response Rate			1.8	0.0	0.0	0.0	↔			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	116	19	15	24	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.81	1.0	0.9	0.9	↓			LQ29c	
Positive Feedback Compliments			838	91	90	80	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	8.0%	7.6%	6.6%	↓				
Mental Health related MPS calls as percentage of all calls			2%	2.2%	2.0%	1.7%	↓				
Mental Health related Incidents as percentage of all calls			5%	5.4%	4.9%	3.7%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.2%	↓				
Rate of Frequent Callers per 1,000 Calls			3.11	3.3	3.6	3.2	↓				
CMC records viewed			3012	291	778	1458	↑			LQ30	

Assurance

Since CMC app was included on iPads, the number of CMC records reviewed have continued to increase month on month and reached record 1458 in December 2018. With plans for CMC to be used Pan London endorsed by all 32 CCG and standardisation of PSPs, it is envisaged that records access will significantly improve for specialist patient groups.

Frequent Callers

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Frequent Caller Team (FCaT) updates:

- The national definition of a frequent caller: Any one aged 18 or over who:
  - calls 5 or more times in 1 month from a private dwelling, or
  - calls 12 or more times over a 3 month period from a private dwelling.
- New Frequent Caller Management Database (FCMD) is working well, allows earlier identification of Frequent Callers (FC's) & therefore early intervention. The functions of the database is being expanded making identification and reporting of frequent caller's easier.
- Last month the FCMD identified 586 new & existing frequent callers meeting the national definition. 99% of these patients are now matched with a NHS number. Where possible, patients are matched with a GP.
- The national Mental Health CQUIN relating to patients with mental health issues attendance at Emergency Departments is having positive effects. EDs are establishing 'Frequent Attender' forums. This also has the effect of a better conversation with other local agencies. It has been agreed for these care plans to be shared with the LAS.
- The Frequent Caller Team met with representatives from the SIM project (Serenity Integrated Mentoring). SIM proposes police officers joint work complex mental health patients with local mental health teams and are co-located, with a focus on patients who have multiple section 136s. Working together to establish consistent support and boundaries.
- A business case will be presented to the ELT in February 2018.

FCaT challenges

- A PSP related meeting is being held in January to review the PSP process and the management and review of 'care plans'.

Case study:

Typical Frequent Caller with complex care needs

Case one:

48 year old male with previous cardiac history (3 x cardiac arrests). Diagnosed with health anxiety and calling with chest pain. At its peak he was calling 50+ times a month and being conveyed to local hospital most times. Experiences ongoing chest pain thought to be anxiety-related. Also regularly self-presents at hospital.

Working with GP, local Community Mental Health Team and Emergency Dept consultant, we established a call strategy. Several multi-disciplinary meetings held with relevant Health & Social Care professionals. Caller was offered Cognitive Behaviour Therapy which he eventually engaged with. His calls have now reduced to under 15 a month. He is still engaging with mental health staff. His case is reviewed regularly.

Case two:

62 year old male known to social services. Calls LAS regularly with health anxiety complaining of catheter problems. Calling 70+ times a month.

Patient calls reviewed and FCaT approached local social services. Social worker assigned and case further reviewed by specialist local team. Calls now reduced to under 40 times a month.

FCaT continue to review calls and work with local social services to further reduce calls. LAS has provided evidence to social services of possible early signs of dementia becoming more apparent and life changing.

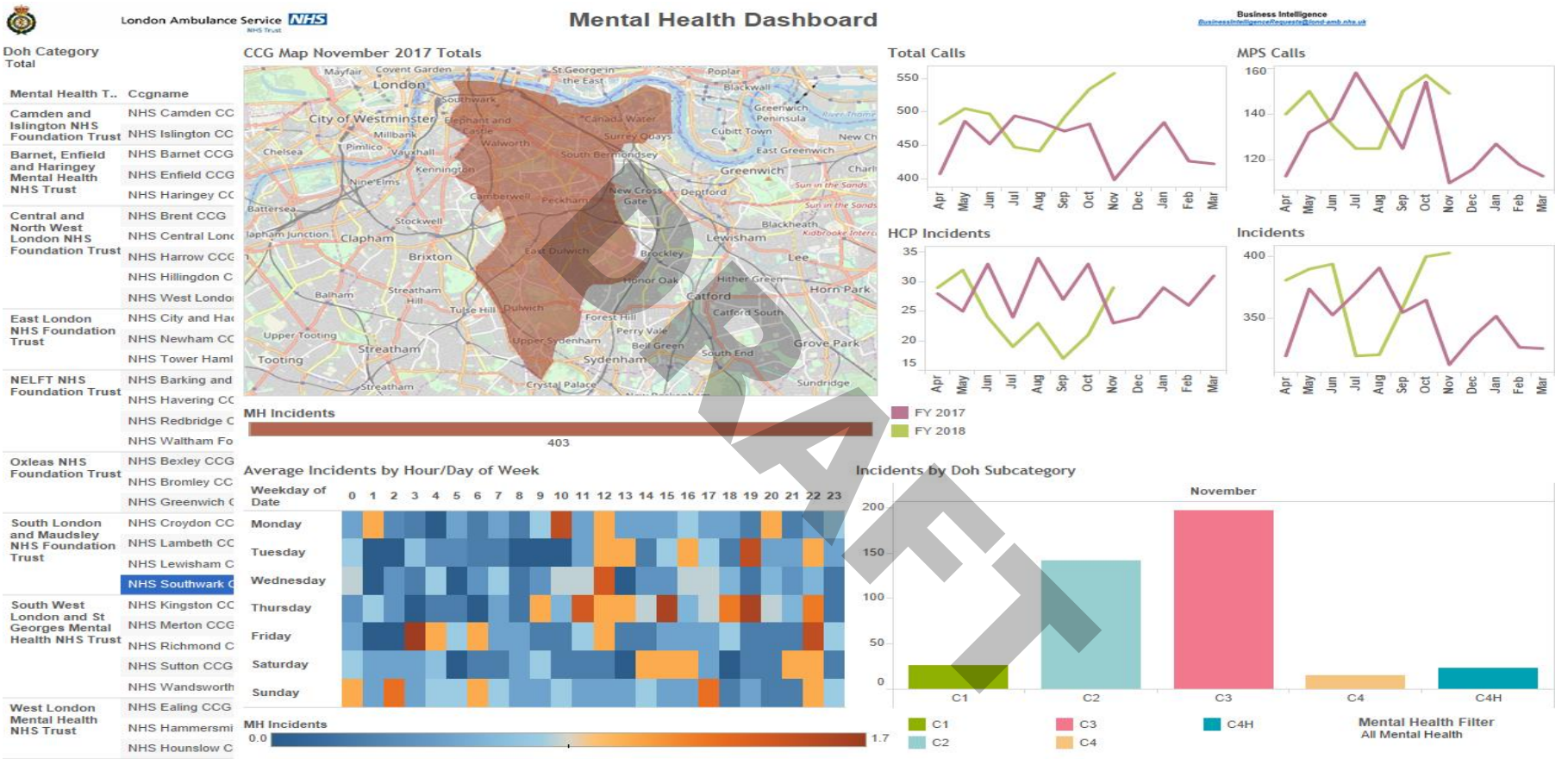
Frequent Callers

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Cluster	CCG	Patients	Calls last month	Calls last quarter	Calls last 12 months
NC	BARNET CCG	30	709	2032	6023
NE	CITY AND HACKNEY CCG	37	413	1168	3129
NW	EALING CCG	30	450	1163	3394
SE	SOUTHWARK CCG	24	197	728	2612
NC	HARINGEY CCG	30	350	895	2896
SE	GREENWICH CCG	16	162	483	1406
SE	LAMBETH CCG	22	191	546	1631
NW	HAMMERSMITH AND FULHAM CCG	21	210	534	1625
NC	ISLINGTON CCG	23	227	705	1973
NE	HAVERING CCG	12	263	634	1876
SE	BEXLEY CCG	15	102	322	1150
SW	CROYDON CCG	23	284	579	1678
NC	CAMDEN CCG	18	173	529	1349
NW	WEST LONDON CCG	16	160	570	1271
NE	TOWER HAMLETS CCG	18	222	426	1211
SE	LEWISHAM CCG	14	137	515	1476
NE	NEWHAM CCG	22	213	592	1349
NW	HILLINGDON CCG	18	205	538	1944
NW	CENTRAL LONDON (WESTMINSTER) CCG	15	141	478	1390
NE	WALTHAM FOREST CCG	16	251	818	2160
SW	WANDSWORTH CCG	13	146	421	1050
NW	HOUNSLOW CCG	15	156	410	2159
NE	BARKING AND DAGENHAM CCG	15	95	333	910
NW	BRENT CCG	17	218	492	1170
SW	SUTTON CCG	16	152	363	1068
NW	HARROW CCG	10	168	406	1031
SW	MERTON CCG	11	96	239	802
SE	BROMLEY CCG	16	106	313	870
NC	ENFIELD CCG	20	213	597	1129
NE	REDBRIDGE CCG	14	129	425	1043
SW	RICHMOND CCG	11	93	327	857
SW	KINGSTON CCG	8	60	132	384
	Top 5				
NC	BARNET CCG	M	403	1294	3931
NE	WALTHAM FOREST CCG	M	73	397	1152
NW	EALING CCG	F	87	252	1040
NE	HAVERING CCG	F	93	252	483
NW	EALING CCG	F	125	171	312

Mental Health

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain



Total Calls and Incidents increased significantly in December.

C3 (n=197) in November unlike previous months where C2 incidents were the highest month on month for MH followed by C2 incidents at 142 (significantly higher than the 41 for previous month), the rest of the sub categories also higher in October.

Number of calls support provided (Mental Health CHUB) for December was **547,** November: **643** and October: **722**

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Events on database	Events attended	Interested staff
19	12	1229

National Guardians Office CPR Information Session – 11th December 2017
"Thank you very much indeed for the first aid and CPR/ AED training. I really enjoyed it and the team told me that they felt much more confident in dealing with an emergency. It was great that everyone had the opportunity to practice CPR and to see how straightforward the defibrillator is. Also, the information and training on choking and stroke were invaluable.
As a medic, I am always keen that everyone is aware, able and ready to assist and your training really supported this for my team."
Junior Police Cadets 13th December 2017
"Very, very well received. Very poplar presenter. The BEST we have welcomed. All the cadets were engaged and included, even the quiet ones could not resist joining in."

Key Updates

- On 7th December we held an event for our Partnership Reference Group, which is made up of representatives from Healthwatch groups and voluntary sector organisations across London. We gave them an overview of our new strategy and invited their feedback on key areas. Their ideas and contributions are being fed into the final version of the strategy.
- We have updated the presentation we deliver to primary school children for their "Work Week" topic, and can now show images of our vehicles and equipment on the interactive white boards in their classrooms. For the teenagers we are constantly enhancing and updating the Knife Crime presentation we deliver to make it more interactive, and this has received positive feedback.

Staff Awards

- Incident Response Officer Andy Beasley received a commendation at the first ceremony celebrating the work of the 3 police forces serving London (Metropolitan Police Service, British Transport Police & City of London Police) recognising the efforts of officers, emergency service staff and members of the public. Andy was recognised for his bravery at the London Bridge terrorist attack for which he was one of the first people on scene and described working through gunfire whilst setting up a casualty clearing stations and command structure.
- A member of staff from the service recently joined a group of volunteers in a visit to India where they delivered lifesaving first aid training to people in several regions including 2 schools. Since returning from the trip the team received a commendation from the Asian Fire Service Association at an awards ceremony in Slough.

Staff Recognition

- An amazing 1,231 letters and messages of thanks were received by the Trust in 2017 – with some sent by people as far away as Japan and the United States of America.
- Senior Paramedic Ben Woodhart has been named #AuditHero for his work and involvement in research and clinical audit in particular the introduction of the Clinical Audit and Research Unit Engagement Facilitator in order to bridge the learning gap.
- The Archbishop of Canterbury visited the service in December to give thanks and to hear staff experiences following the major incidents of 2017. The Archbishop met frontline and control room staff along with members of the service Christian Fellowship.

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Performance January – December 2017

0	23	26	36	22	27	35	26	25	27	34	33	36	350
1	19	28	32	26	29	36	32	35	29	21	26	30	343
2	24	33	38	29	37	23	29	31	34	36	28	32	374
3	36	40	26	29	44	21	33	39	26	25	31	33	383
4	29	32	38	31	23	24	19	34	30	31	41	33	365
5	29	26	36	25	17	27	31	23	25	20	27	30	316
6	28	30	31	27	37	15	31	12	27	31	30	33	332
7	33	32	24	34	35	36	36	26	29	33	28	28	374
8	33	26	24	32	44	37	32	36	38	35	32	48	417
9	30	35	36	24	30	25	35	24	32	35	23	37	366
10	25	22	34	22	22	26	20	29	31	30	19	34	314
11	29	23	26	22	32	24	27	27	20	26	30	34	320
12	18	25	27	23	26	32	28	37	29	21	31	30	327
13	27	22	11	33	34	23	27	16	25	29	30	38	315
14	25	21	30	22	35	25	26	35	22	12	34	23	310
15	27	14	24	24	28	16	25	29	33	31	26	28	305
16	31	23	33	18	32	36	29	28	29	25	27	35	346
17	29	26	29	28	38	31	25	21	29	19	26	24	325
18	24	29	33	16	29	34	19	13	32	16	29	33	307
19	23	28	23	23	24	39	27	33	28	19	24	32	323
20	27	39	32	39	30	24	30	34	37	19	29	34	374
21	18	13	31	32	26	24	24	29	36	27	23	40	323
22	37	42	30	25	32	30	37	30	23	20	29	25	360
23	34	19	40	35	31	33	28	42	23	35	43	30	393
Grand Total	**658**	**654**	**724**	**641**	**742**	**676**	**676**	**688**	**694**	**630**	**699**	**780**	**8262**

In 2017 –
Imminent birth calls represent 27% to total calls
Conveyance rate for these calls 90%

397 Babies born
Breech Birth (baby being born bottom first) 29

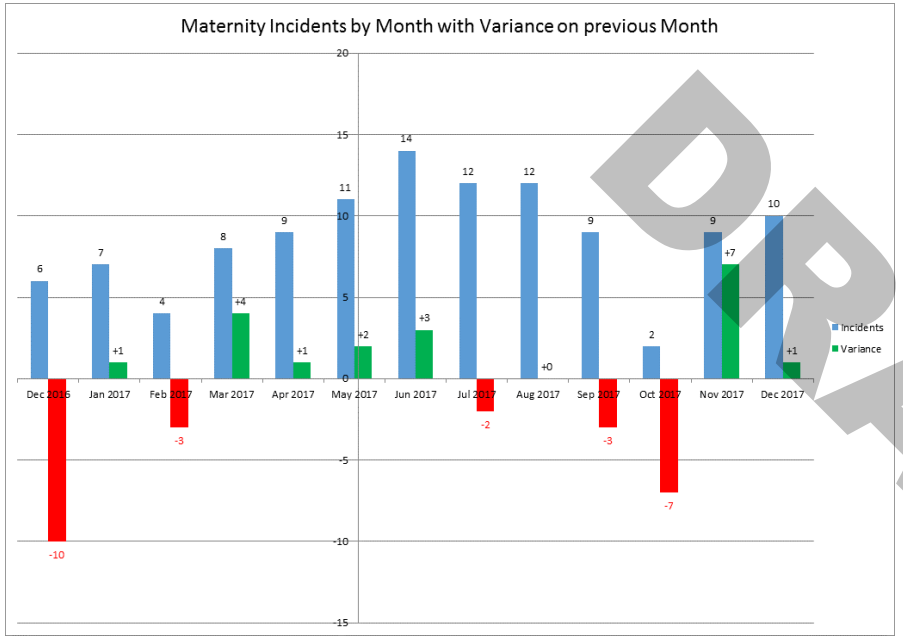
Antepartum bleeding after 20 weeks 33%

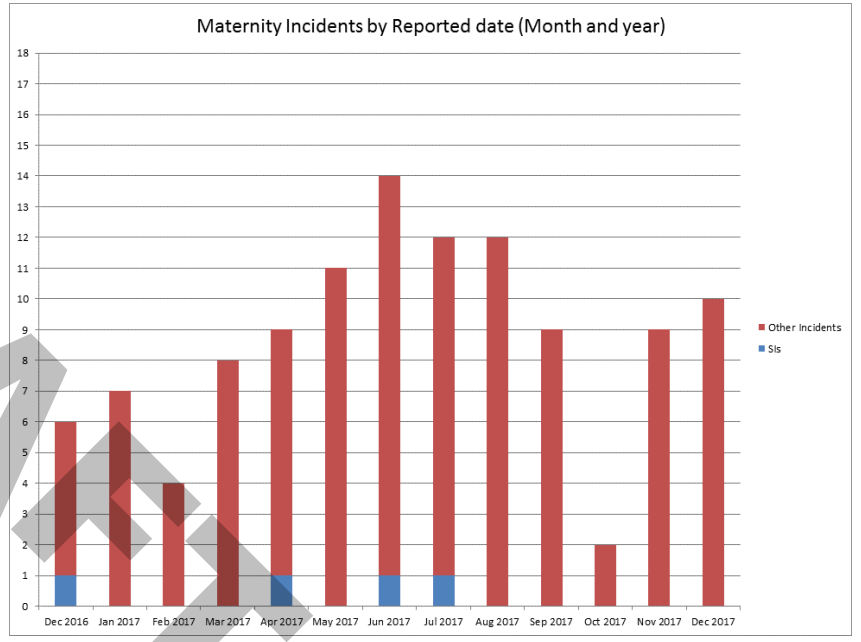
Calls managed by the Clinical Hub
Average 98 per month
Range of pregnancy gestations and minor disorders
Thematic analysis to be completed

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Maternity Risk 2017





Maternity Complaints

4 Complaints focussed around:

1. Care provided by acute hospital and LAS staff
2. Non conveying a sense of urgency
3. Request for information regarding a poor pregnancy outcome
4. Perceived length of time awaiting an ambulance response

Maternity Incidents December 2017

Incidents reported by staff highlight

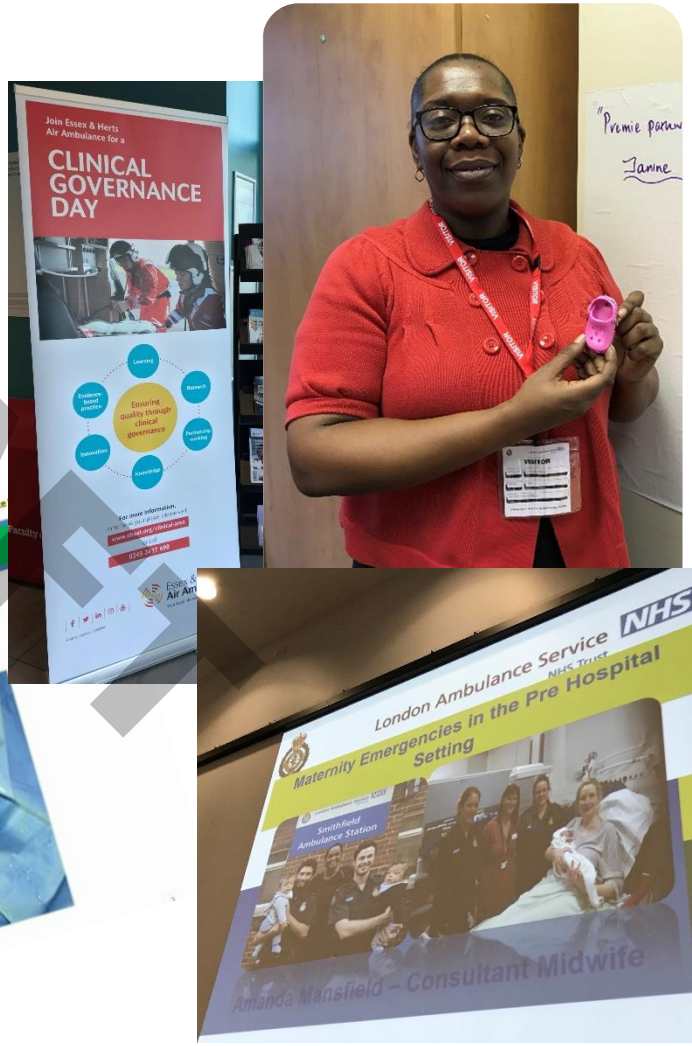
- Difficulties locating the appropriate area to handover a pregnant woman
- Maternity unit declining to send a midwife
- EOC assessment of a pregnant woman

Maternity

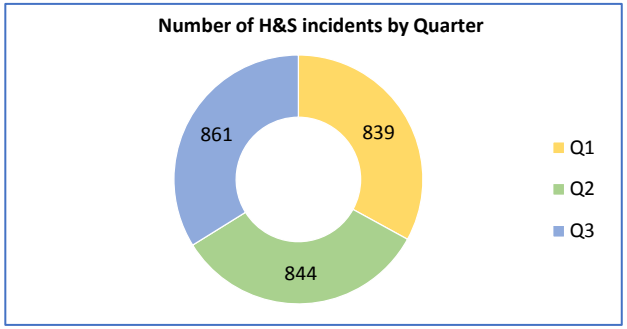
Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

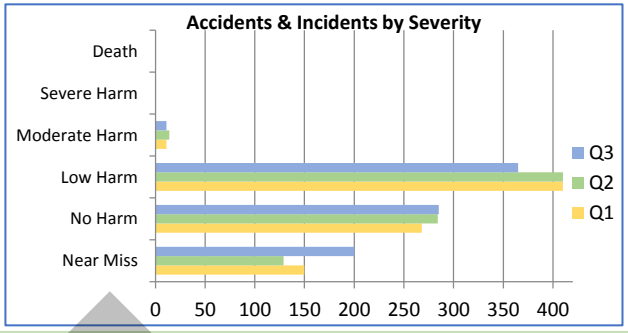
Success

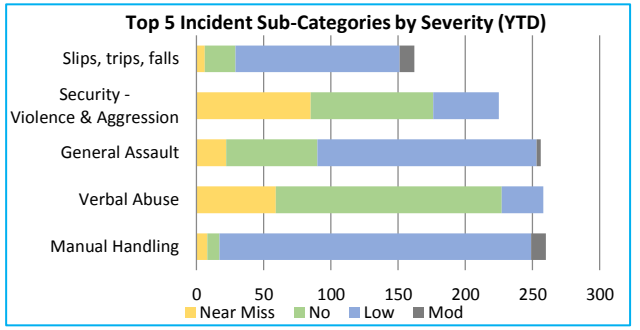
- Maternity Differentiated Clinical Pathway – Stakeholder and User engagement event
- Roll out of CSR3.17 Including the updated guidance focussed upon Newborn Transition and Newborn resuscitation
- Successful meeting with Northwick Park Hospital Senior Midwifery team – LAS to be able to attend local strategic meeting to improve working relationships
- "Map my Maternity" Project group, led by EOC staff and Paramedic to build and optimise the Maternity Unit information held on the MiDOS system on staff Ipads.
- Job description of Practice Development lead for Out of Hospital Maternity Care completed the job evaluation process
- LAS Presentation at Essex & Herts Air Ambulance Service



Health & Safety Scorecard – Q3 (December 2017)



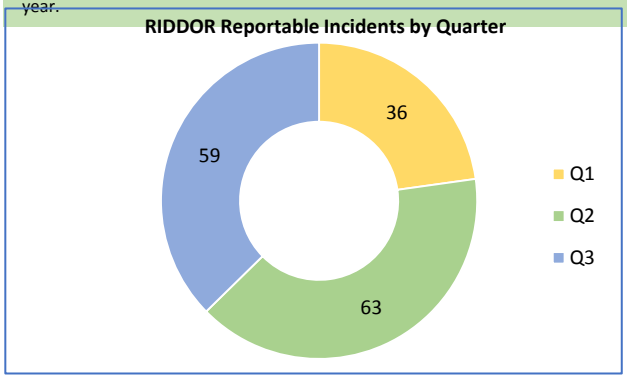


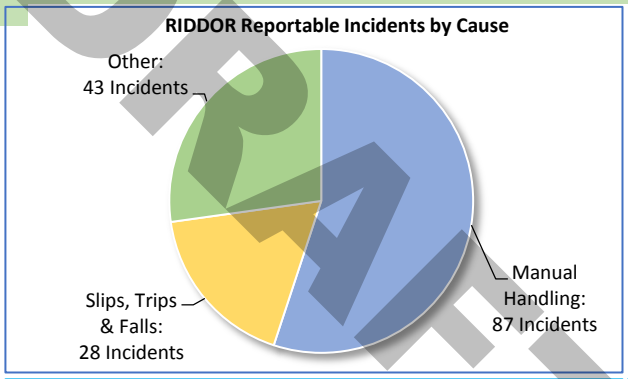


2544 health and safety related incidents have been reported during 2017/18. 91 additional incidents (covering Q1 & Q2) were identified during Q3. Total YTD H&S incidents account for 40% of all incidents reported Trust-wide during the year.

1192 (46.8%) of the H&S related incidents reported during 2017/18 resulted in low harm. 36 (1.4%) incidents resulted in Moderate Harm. 1316 (52%) of the incidents were reported as 'No Harm/Near misses'.

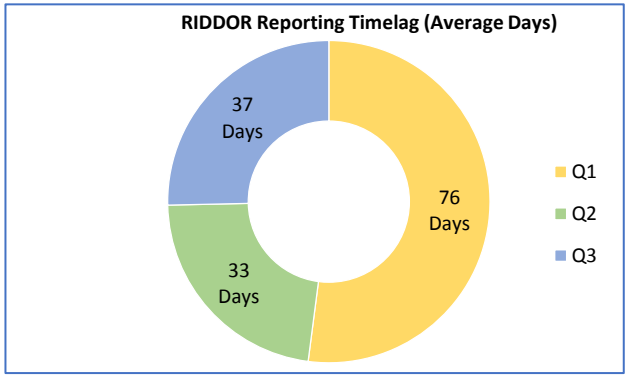
Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

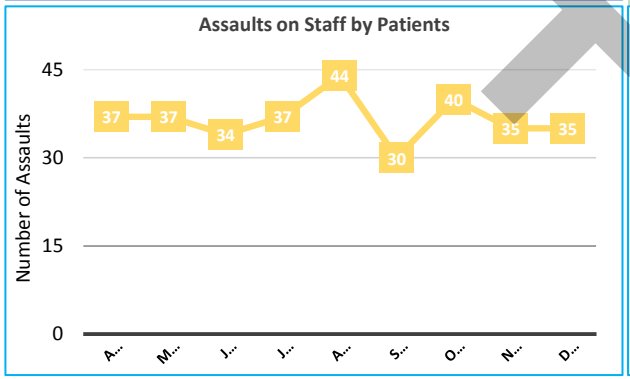


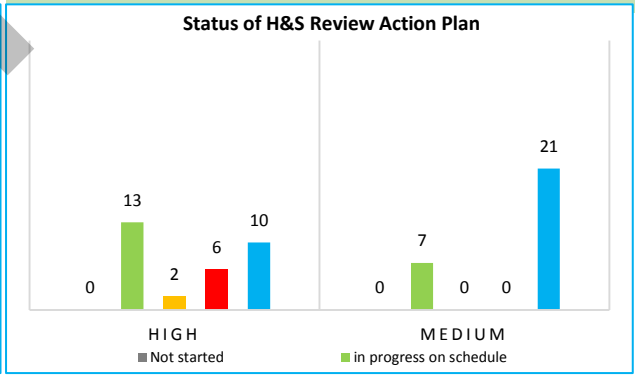


Key Updates:

1. Key training in practical MH commenced on 04/12/2017 for 44 Clinical Tutors. Additional sessions have been planned for 36 tutors and will be completed by 31/01/2018.
2. Practical MH refresher training will be provided for all frontline operational staff from CSR 1 – April 2018.
3. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Color categorization of Mangar Elks to commence by end of January 2018. 12 weekly maintenance plan has been implemented for all equipment including tail lifts and track chairs. This will be supported by 6 weekly visual inspection checks to identify and rectify faults/defects.
4. No trends identified with increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
5. Prototypes of the proposed integrated Vehicle based ALS and first response bags to go on trial from 22/01/2018.
6. Dynamic Risk Assessment Training rolled-out to all frontline staff as part of MAST training during CSR 2 – 2017.



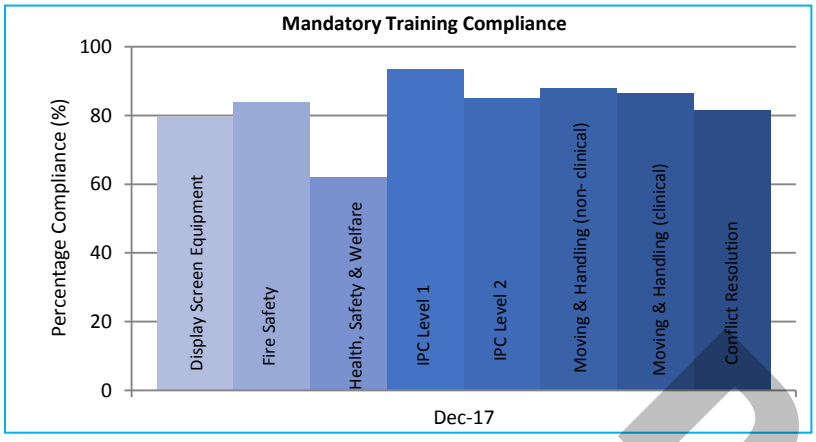


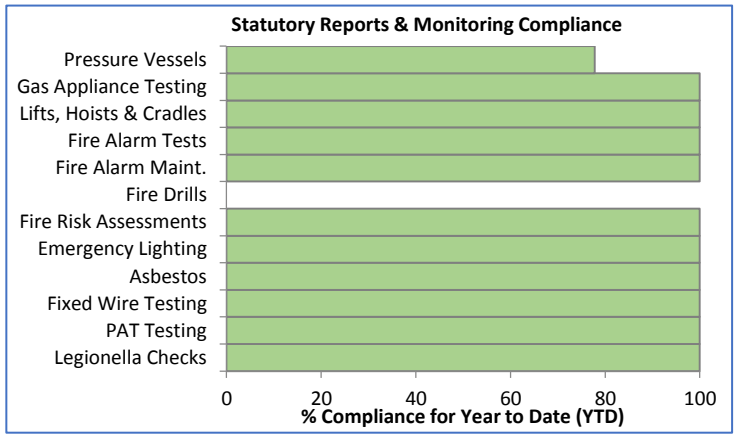


7. The average time lag for reporting RIDDOR incidents across the Trust in Q3 was 37 days. This exceeds the average time lag of 33 days during Q2 as well as the statutory reporting timeline of 15 days for most RIDDOR incidents. 35 RIDDOR incidents were reported out of time in Q3.

8. Assaults on staff by patients make up 31% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required.

9. 31 of the 59 actions recommended have been completed.
   - 22 actions are currently in progress with 5 actions due to be completed by 31/01/2018.
   - **2 actions are overdue.**





Trust-wide compliance in December 2017 for 5 out of the 8 mandatory health and safety training courses was below 85%.

The H&S Dept. is reviewing arrangements to improve the inconsistent practice and Trust-wide compliance with statutory fire drills.
All sites have been asked to nominate fire marshals who will be trained in Q4 to support the department with maintaining compliance.

The H&S Team are also liaising with an external contractor regarding the review of fire risk assessments and maintenance of equipment.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Target Risk Rating	Key changes/updates since last review
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	15	15	9	Key training in practical MH has been provided to Clinical Tutors in December 2017. Training to be completed in January 2018. Practical MH refresher training to be provided from CSR 1 – April 2018. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – to be tabled for approval at January H&S Committee meeting.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	12	3	The average time lag for reporting RIDDOR incidents across the Trust in Q3 is **37 days.** There are still inconsistencies in RIDDOR reporting however, these are reviewed with the relevant Managers in order to address the gaps.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Risks approved by H&S Committee and RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q4, 2017-18.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is currently under review.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.

Sector Heat Map: Quality Data

CQC		Key Performance Indicator	NW	NC	NE	SW	SE	Other	LAS Target	LAS Ranges
SAFETY		Hand Hygiene OWR compliance	56%	67%	83%	25%	67%		90%	
		Rate of Patient related Adverse Events per 1,000 Incidents	2.4	1.8	2.2	3.2	2.3		5	
		Rate of Staff related Adverse Events per 1,000 Incidents	1.5	2.7	3.2	2.4	3.8		3	
		Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0		0	
		Percentage of Incidents reported within 4 days of incident occurring	97%	97%	99%	97%	97%		85%	
		Potential Serious Incidents referred to SI Group	6	1	4	3	2			
		Serious Incidents declared in-month	0	0	0	0	0		0	
		Serious Incidents breaching 60 days YTD	0	0	0	0	0		0	
		Serious Incidents breaching 40 days YTD	0	0	0	0	0		0	
		Medication Errors as % of Patient Adverse Events	9.3%	4.0%	0.0%	2.4%	10.9%		0%	
		Needle Stick Injuries as % of Staff Adverse Events	3%	0%	5%	0%	4%		0%	
		Missing Equipment Incidents as % of all reported incidents	4%	3%	3%	2%	8%			
		Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	13%	8%	9%	16%	9%			
		Safeguarding Adults & Children Level 1	94%	97%	94%	97%	97%		90%	
		Safeguarding Adults & Children Level 2 - Clinical	89%	86%	87%	91%	92%		90%	
		Percentage of staff completing Core Skills Refresher 2017.1 (cumulative)	93%	95%	90%	88%	93%		90%	
EFFECTIVENESS	*	ROSC at Hospital (AQI)	37.8%	33.3%	31.4%	41.8%	36.6%			
	*	STEMI care bundle (AQI)	73.3%	71.1%	76.2%	73.5%	59.5%			
	*	Stroke to HASU within 60 minutes (AQI)	57.8%	49.5%	65.0%	64.2%	61.2%		65%	
	*	Stroke Care Bundle (AQI)	97.8%	96.1%	97.3%	96.7%	96.4%		98%	
	**	Survival to Discharge (AQI)	-	-	-	-	-			
	*	CPI - Completion Rate (% of CPI audits undertaken)	100%	86%	82%	100%	96%			
	*	CPI - Percentage of Staff receiving ONE Feedback Session YTD	45.3%	53.3%	47.5%	48.0%	43.2%			
	*	Documented Care - Cardiac Arrest Compliance (CPI audit)	97%	97%	97%	96%	98%		95%	
	*	Documented Care - Discharged at Scene Compliance (CPI audit)	97%	97%	97%	97%	97%		95%	
	*	Documented Care - Mental Health Compliance (CPI audit)	92%	93%	90%	94%	94%		95%	
	*	Documented Care - Severe Sepsis Compliance (CPI audit)	97%	97%	96%	98%	97%		95%	
	*	Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-		95%	
	*	Documented Care - Glycaemic Emergencies Compliance (CPI audit)	97%	97%	97%	98%	97%		95%	
CARING		Rate of Complaints per 1,000 Incidents	0.4	0.5	0.4	0.0	0.7			
		Mental Health Related Incidents	6%	7%	6%	7%	7%			
		Mental Health Related HCP Incidents	0.3%	0.4%	0.3%	0.4%	0.4%			
		Rate of Frequent Callers per 1,000 Calls	6.3	8.7	7.2	6.1	5.5			

* data shown refers to Nov-17
** data shown refers to Aug-17

Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Learning from Incidents

- An improving our service information guide has been produced and attached to payslips for distribution to all members of staff. This guide included a reminder and information on incident and positive incident reporting along with a focus on accurate grading of incidents submitted by staff.
- To improve the accuracy of incident grading across the service additional information has been embedded into Datix to assist staff in the definition of no, low, moderate and severe harm.

- Following on from last months report, the clinical decision making and safety netting article was published in the Clinical Update in December 2017.
- The Clinical Hub were issued with enhanced guidance to assist them in the use of Toxbase when assessing patient who have ingested medication over and above the recommended level (accidently or intentionally). Staff were also provided with a clinical scenario to complete.

Incidents

SI update	Incidents reviewed In December	SIs declared In December	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	41	6	20	7	13	0	7
Trend on previous month	↑	↑	↔	↑	↓	↔	↑

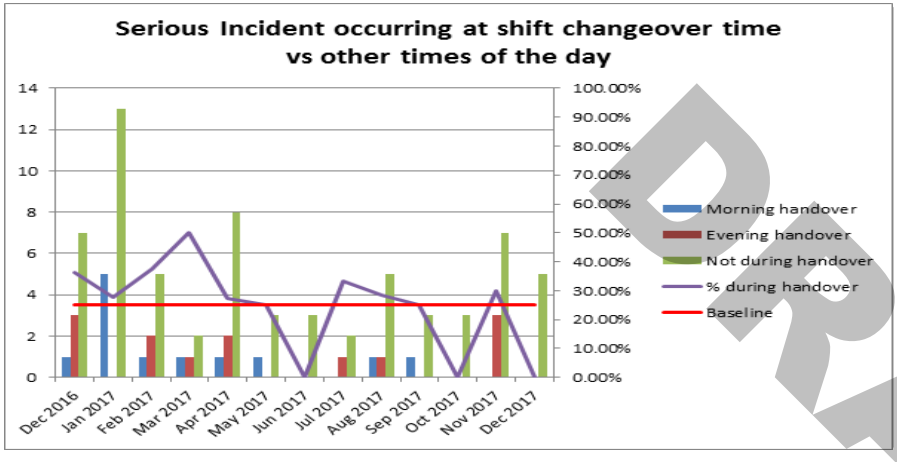
Serious Incidents & Incidents

- The 4th Lead Investigator training session is arranged for the 19th January. Currently 15 managers have confirmed there attendance.
- All incidents submitted within the Datix system have now been assigned a responsible manager
- Weekly overdue incidents and unapproved risks report has been shared with senior managers from November to date.
- Since the implementation of this report we have seen a reduction of overdue incidents and an increase in incidents requiring quality checking prior to closure.
- Completed incident investigations are referred back to the respective manager should the quality assurance identify gaps within the investigation process, a lack of assurance that the incident has been addressed and/or evidence of actions taken.

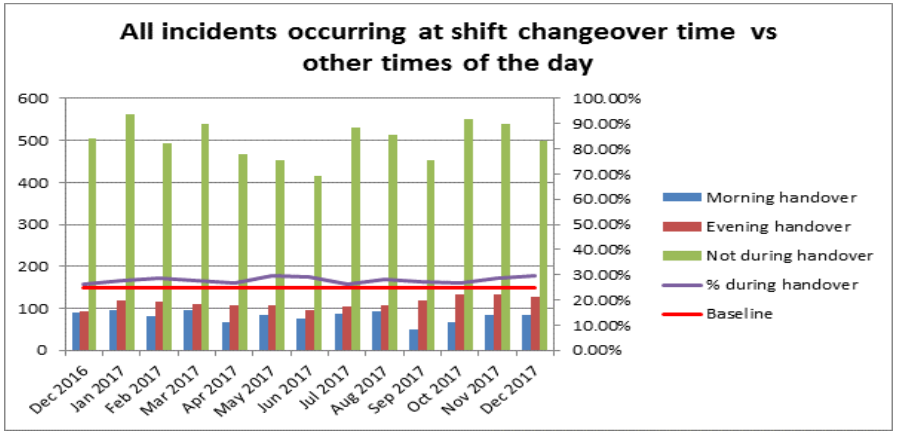
Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Serious Incidents occurring during shift changeover



All Incidents occurring during shift changeover



Actions relating to Serious Incident Investigations

SI action plan update (relating to closed overdue SI investigations):

- 28 actions are currently overdue (reduction of 15 from last month)
- Weekly reminder emails from the Governance Team continue and non-compliance continues to be escalated.
- Areas of concern that have been escalated to executive or Deputy Director level includes:
    - IM&T – eight overdue
    - EOC - eight overdue

- Reporting dashboards are available for the Senior Management Team in each sector to provide a clear and accurate overview of the outstanding actions within their teams.

Reported incidents relating to calls received during shift changeover

Six serious incidents were declared in December 2017. Of these one concerned a call that was received during the pre-determined handover period. There was a slight delay to the call which was categorised as a category 2. A preliminary review of the incident showed that the primary root cause of the SI was a potentially incorrect non-conveyance decision rather than directly related to the delay.

The chart to the left shows that around 30% of incidents have been reported that occurred during shift changeover, which is only slightly higher than expected (assuming a 25% baseline), and this figure has remained fairly level since DatixWeb was introduced.

Learning From Deaths, Inquests and Claims

Owner: Nicola Foad | Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

Inquests – figures and learning

- In the month of December, LAS were requested to attend Inquests to give oral evidence on 4 occasions, 2 less than for the month of November.
- No Prevention of Future Death (PFD) reports were received in December.
- An Inquest is listed for 15/16 January where medicine management concerns have been raised. The Trust has provided written evidence on the actions taken to ensure satellite stations do not run out of IV fluids and that regular top-up supplies are received before stocks are depleted.

Claims – figures and learning

- As at the end of Quarter 3 2017/2018 NHS Resolution had 45 claims against LAS open under their Clinical Negligence Scheme for Trusts & 70 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- Meeting scheduled for January 2018 with Head of Non-Clinical Claims for NHS Resolution to explore identification of learning and trends.

Inquests – figures and learning

The response to HM Coroner to the PFD received in September arising out of the death of a MH patient & sent to 9 organisations/individuals was sent on 20th November. The response outlined the following action taken/to be taken:-

- Individual feedback to Emergency Medical Dispatcher & Call Taking Manager;
- A further reminder in the next Quality Assurance bulletin to Emergency Operations Centre staff on the importance of triaging calls correctly & re-triaging the call when any change is reported in the patient's condition;
- Bespoke training currently being delivered to Control Services, NHS111, Clinical Team Leaders & Joint Response Unit on the Mental Health Act;
- Training in place with regard to the best practice of contacting the Clinical Hub for advice when dealing with patients in mental health crisis;
- Anticipated that all operational staff will have received training by the end of March 2018;
- Mental Health Transformation Board will discuss in January 2018 in a 'lessons learnt' section to agree what is needed to implement improved consistent pathways & processes pan-London.

Actions

Completed:

- carry chair & track – this recommendation has been acted on. Following actions taken: From January 2018, all carry chairs and track to be serviced every 6 weeks. When seen for the first time the gas strut will be replaced as standard. The equipment manufactures' to provide training for Workshop staff on maintaining equipment. CSR 2018.1 to include manual handling training including refresher training on the use of the carry chair & track. The equipment manufactures' to provide training video on correct use of carry chair & track to support CRS 2018.1 & will be available to view on Pulse.

Ongoing:

- LAS' reliance on the Intranet for the circulation of policies as reported in September – pending discussion between Chief Quality Officer & Director of Corporate Governance.
- Procedures for checking equipment, dealing with broken equipment, requesting replacement equipment & obtaining electronic or manual staff confirmation of procedures – feedback awaited from DD of Fleet.

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 key complaints themes : December 2016 to December 2017

Complaints by subject 2015/17	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Delay	19	36	16	27	21	17	16	14	26	9	22	33	19	275
Conduct	15	26	27	36	16	19	24	19	19	16	17	25	20	279
Road handling	8	7	9	16	12	11	13	14	10	7	14	9	7	137
Treatment	1	3	3	5	1	2	5	1	7	5	16	8	9	66
Non-conveyance	1	1	3	4	3	0	4	12	0	1	6	1	7	43
Total these subjects	44	73	58	88	53	49	62	60	62	38	75	76	62	800
Overall totals	58	90	74	105	66	70	76	73	86	51	94	85	84	1012

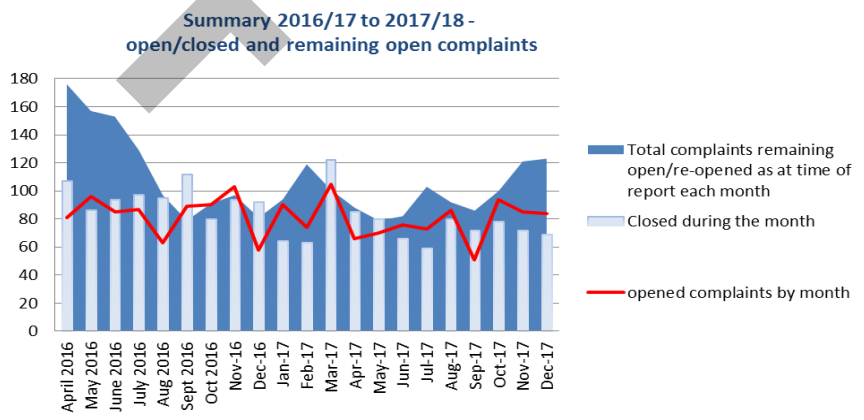
Complaint summary April 2017 to December 2017

- Of all the complaints received to 31 December 2017, 106 remain under investigation or have been re-opened.
- Of these, 24, were over 35 working days as at 03 January. Reduced staff numbers due to annual leave and sickness impacted on turnaround and complaint numbers have risen in recent weeks.
- Of the 84 complaints received in December, 64 remain under investigation, 13 were actioned or referred to other agencies, 6 were not upheld and 1 was partially upheld.
- The highest number of complaints by sector was EOC x 19 followed by South East x 13 and NHS 111 x 11.
- Winter measures remain in place and continue to impact on completion of QA reports, operational input and clinical reviews. It is anticipated that this will improve from 08 January
- Our revised trajectory for complaint totals based on current numbers is 930 for 2017/18
- We have noted that a number of complaints about driving standards relating to our Make Ready contractor using LAS vehicles has been received

Actions

- During December we received 84 complaints which included 6 from other Health Care Professionals on behalf of the patient
- This represents a slight decrease over November but a 31% increase over December 2016 (58 complaints).
- Since 01 November 2017, 7 complaint cases have been referred to the Serious Incident Group (one not declared – outcome of x6 awaited)
- During November to December we have been managing a number of Quality Alerts, of these 2 related to Cat 1 ARP, 6 to Cat 2 ARP and 2 Cat3/4.
- We are planning a launch of the Quality Alert process in April 2018, liaising with G&A and QGAM's and updating the website.
- Of the 104 complaints where the call was between 01 November to 31 December , the split of call categories was as follows:
- ARP Cat 1 x 7 complaints, ARP Cat 2 x 43 complaints, ARP Cat 3 x 17 complaints, ARP Cat 4 x 18 complaints, not CAD related x 18
- A summary report of complaints post ARP will be shared with G&A

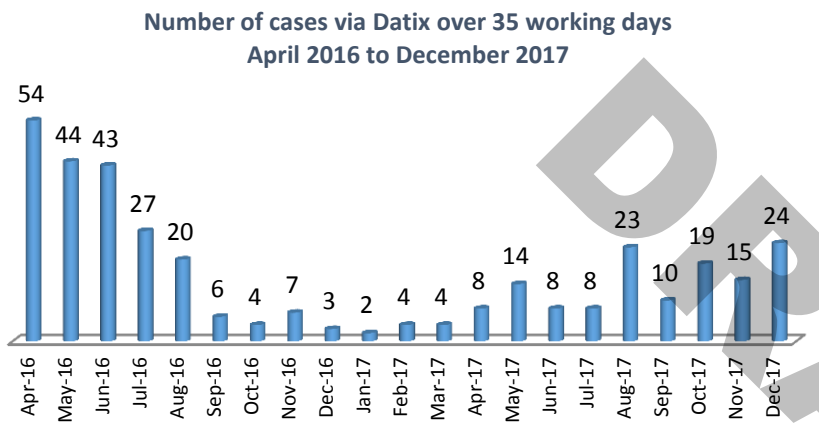
Assurance and learning



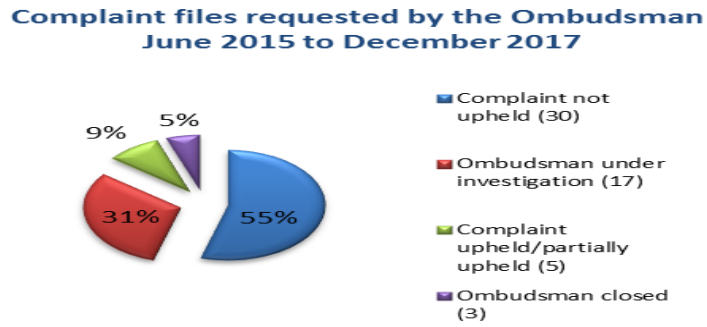
Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Performance against 35 day response target



Overview of Ombudsman cases 2015-2017



Assurance and learning – case examples

Case example one

Complaint hosted by Acute Trust from the patient who has raised concerns that the attending ambulance staff appeared to question why an ambulance had been called when he suffered an Achilles injury

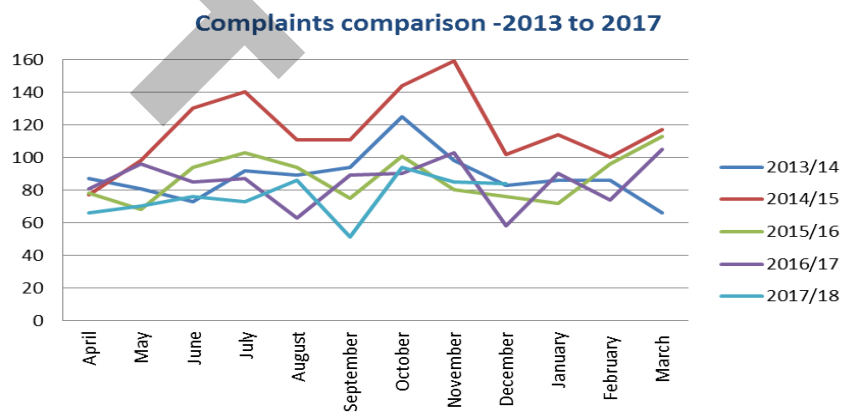
The paramedic acknowledged that he made a comment about it not being a ruptured Achilles tendon based on the fact the patient was not in acute distress and accepts that although he did not mean to be derogatory, this was inappropriate.

Case example two

Complaint from child's mother that she was declined an ambulance for her daughter despite her symptoms

The Quality Assurance evaluation concludes that the call handler made an error of judgement when applying the initial clinical triage protocol. Although call handlers do not have any clinical expertise, they are trained to ask a series of structured questions to progress through the triage process in order to assess the patient's condition and to determine the appropriate level of priority response. In this case, the 'Heart problems/AICD' protocol should have been applied which would have indicated a Category 2 priority, although priority would still have been given to patients determined at a higher categorisation.

Assurance and learning



Quality Account 2017-18 CQUINs

Exec Lead: Lorraine Bewes

National CQUIN	CQUIN Indicator descriptor UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status				Notes
					Qtr 1	Qtr 2	Qtr 3	Qtr 4	
N1a	Improvement of health and wellbeing of NHS Staff	£263,701	Final Period – Q4 17-18	0.08%	n/a	n/a	n/a	100%	Q3 Report due to be submitted to commissioners 23rd January 2018.
N1b	Healthy food for NHS staff, visitors and patients	£260,562	Final Period – Q4 17-18	0.08%	n/a	n/a	n/a	100%	Q3 Report due to be submitted to commissioners 23rd January 2018
N1c	Improving the uptake of flu vaccinations for frontline staff within providers	£260,562	Final Period – Q4 17-18	0.08%	n/a	n/a	n/a	100%	Q3 Report due to be submitted to commissioners 23rd January 2018. Cohort of staff agreed.
12	Reducing Ambulance Conveyance	£784,825	Final Period – Q4 17-18	0.25%	n/a	n/a	n/a	100%	Q3 Report due to be submitted to commissioners 23rd January 2018
STP 1	Supporting local areas - STP engagement	£1,569,650	Final Period – Q4 17-18	0.50%	n/a	n/a	50%	50%	Q3 Report due to be submitted to commissioners 23rd January 2018.
STP 2	National CQUIN: STF Delivery (Control Total)	£1,569,650	Final Period – Q4 17-18	0.50%	n/a	100%	n/a	n/a	Achieved, based on 16/17 control total. Confirmation provided to commissioners regarding ring-fencing of funding.

Local CQUIN	CQUIN Indicator descriptor UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status				Risk / Issue / Notes
					Qtr 1	Qtr 2	Qtr 3	Qtr 4	
L1	Mobile Devices	£3,139,299	Final Period – Q4 17-18	1.00%	n/a	n/a	50%	50%	Q3 Report due to be submitted to commissioners 23rd January 2018

Quality Risk Register

There are currently 12 open risks which have a quality impact on the Corporate Risk Register with a net rating of 12 and have clearly documented mitigating actions.

At the recent Risk Compliance & Assurance Group (RCAG) four risks which had a quality impact were discussed and approved:

- Datix ID risks 676 relating to lack of compliance with statutory health and safety requirements
- Datix ID 677 - Risk of musculo-skeletal injuries to frontline staff
- Datix ID 681 relating to the Trust meeting its statutory RIDDOR reporting requirements
- Datix ID 704 relating to recruitment & retention of EMD's into EOC.

Four risks which had a quality impact were approved for de-escalation at the RCAG meeting in November and therefore no longer appear on the Corporate Risk Register:

- Datix ID 339 relating to ring backs
- Datix ID 445 relating to delays in defibrillation for fine VF patients
- Datix ID 279 relating to the download of information from defibrillators.

Three risks relating to Safeguarding which continue to be regularly monitored (Datix ID 63,65 and 495). Additional staff have been recruited into the team with an administrator due to commence in January 2018. Along with implementation of the Escalation policy we should see improvements in the processing of request from MARAC which will enable all 3 risks to be closed and removed from the risk register.

Actions

A Risk Register deep dive and reconfiguration of Datix system activity was undertaken in November and December and is ready for Q4 implementation.

Assurance / Progress

All Directorate risks are currently being reviewed

Weekly overdue incidents and unapproved risk tracker reports are being circulated to ADOs, QGAMs and Sector Leads to improve the timeframe for reviewing unapproved risks.

Emerging risks scored at 10 and above are being flagged to RCAG monthly with strict timelines for submission stated.

Quality Assurance Committee has oversight of all quality risks rated greater than 10