



**MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO
BE HELD IN PUBLIC ON TUESDAY 27 FEBRUARY 2018 AT 09:00-13:15
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/17/169 Oral	Welcome and apologies To welcome attendees and note any apologies received.	HL	
09.05	2.	TB/17/170 Oral	Patient Story To hear about the experiences of a patient treated by the Trust.	TB	Information
09.35	3.	TB/17/171 Oral	Declarations of interest To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	4.	TB/17/172 Attachment	Minutes of the meeting held in public on 30 January 2018 To approve the minutes of the meeting held on 30 January 2018.	HL	Decision
	5.	TB/17/173 Attachment	Matters arising To review the action schedule arising from previous meetings.	HL	Information
09.45	6.	TB/17/174 Attachment	Report from the Chair To receive a report from the Chair.	HL	Information
10.00	7.	TB/17/175 To follow	Report from Chief Executive To receive a report from the Chief Executive (CEO).	GE	Information
STRATEGY & PLANNING					
10.15	8.	TB/17/176 To follow	Business Plan 2018/20 To receive an update on the development of the Business Plan 2018/20.	LB/GE	Discussion
10.30	9.	TB/17/177 To follow	Annual Financial Plan 2018/19 To receive an update on the development of the Financial Plan for 2018/19.	LB/GE	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
10.45	10.	TB/17/178 Attachment	Risk Management Strategy and Policy To approve the Trust's Risk Management Strategy and Policy.	TB	Decision
10.55	11.	TB/17/179 To follow	Data Quality Strategy To receive an update on the Trust's approach to ensuring the quality of its data.	JMcG	Discussion
QUALITY, PERFORMANCE AND ASSURANCE					
11.10	12.	TB/17/180 Attachment	Logistics and Infrastructure Committee Assurance Report To receive the report of the Logistics & Infrastructure Committee meeting on 06 February 2018.	TdP	Discussion
11.20	13.	TB/17/181 Attachment	People and Organisational Development Committee Assurance Report To receive the report of the People and Organisational Development Committee meeting on 08 February 2018.	JM	Assurance
11.30	14.	TB/17/182 Attachment	Audit Committee Assurance Report To receive the report of the Audit Committee meeting on 12 February 2018.	TdP	Assurance
11.40	15.	TB/17/183 To follow	Finance and Investment Committee Assurance Report To receive the report of the Finance & Investment Committee meeting on 22 February 2018.	FC	Assurance
11.50	16.	TB/17/184 To follow	Integrated Quality & Performance Report To receive the integrated quality & performance report.	LB/JC	Discussion
12.10	17.	TB/17/185 Attachment	Board Assurance Framework, Corporate Risk Register and Risk Appetite Statement To receive the Board Assurance Framework, Corporate Risk Register and proposed risk appetite statement.	PH	Assurance
12.20	18.	TB/17/186 Attachment	Serious Incident Management To note declared and closed Serious Incidents.	TB	Discussion
GOVERNANCE					
12.30	19.	TB/17/187 Attachment	Quality Improvement Plan and CQC Preparation	TB	Discussion

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
			To receive an update on the progress of the Quality Improvement Plan and the CQC Preparation Plan.		
12.40	20.	TB/17/188 Attachment	Trust Board Forward Planner To receive the Trust Board forward planner.	PH	Information
12.45	21.	TB/17/189 Oral	Questions from members of the public	HL	Information
13.00	22.	TB/17/190 Oral	Any other business	HL	Information
13.05	23.	TB/17/191 Oral	Review of the meeting To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
13.15	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 March 2018 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.					
Additional reports, circulated for information only: TB/17/192 Quality Report					



TRUST BOARD: Public meeting – Tuesday 30 January 2018

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
Amit Khutti	AK	Associate 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
Heather Gava	HG	Interim Corporate Secretary
Patricia Grealish	PG	Director of People and Organisational Development
Philippa Harding	PH	Director of Corporate Governance
Benita Mehra	BM	Director of Strategic Assets and Property
Jamie O'Hara	JO'H	Director of Strategy and Communications
Apologies		
Jayne Mee	JM	Non-Executive Director
Robert McFarland	RM	Non-Executive Director

1. Welcome and apologies (TB/17/144)

- 1.1. The Chair welcomed all to the meeting and noted the apologies that had been received.
- 1.2. Amit Khutti (Associate Non-Executive Director) and Benita Mehra (Director of Strategic Assets and Property) were welcomed to their first Board meeting.
- 1.3. It was noted that papers for future Board meetings would be circulated via Convene, a meetings application currently being trialled within the Trust.

2. Declarations of interest (TB/17/145)

- 2.1. There were no declarations of interest.

3. Minutes of the meeting held in public on 28 November 2017 (TB/17/146)

- 3.1. The minutes of the Trust Board meeting held in public on 28 November 2017 were approved as a true and fair record of that meeting, subject to the following amendments:
 - 3.1.1. The final sentence of minute reference TB/17/125, paragraph 8.3 should read "...it was likely that the Trust would have to rely on its existing performance reporting....".
 - 3.1.2. The final sentence of minute reference TB/17/130, paragraph 13.2 should read "It was noted that further thought needed to be given to the articulation of BAF risk 07...".

4. Matters arising (TB/17/147)

- 4.1. The actions arising from the previous meeting were noted.
- 4.2. Board members reviewed progress against the action log and it was noted that a call-handling action plan, and a recruitment and retention plan with a focus on the Emergency Operations Centre (EOC) were now in place. Vacancies within the EOC were currently running at 20% of agreed establishment, compared with a national average of 15%. The disappointing conversion rate of applications into appointments had also been investigated, and online assessments were to be piloted in the next recruitment round. The 111 service enjoyed a higher conversion rate and their approach was being examined. It was confirmed that the English assessment test which formed part of the overall assessment process had also been reviewed, following concerns expressed by the Chief Nursing Officer for England in relation to nursing staff, and was not deemed to be a significant factor.

5. Staff Story (TB/17/148)

- 5.1. The Board received a presentation from Gemma Walsh (GW) on the role of the Advanced Paramedic Practitioner (APP). The presentation set out the background to the APP programme, and outlined the roles of clinicians within the service, and the recruitment process and training programme. It was noted that effective working relationships had been established with GPs and other clinicians both in the community and in acute settings.
- 5.2. The presentation included details of how cases attended by the APPs (Urgent Care) between March and December 2017 had been handled, and it was noted that the highest percentage – 34% - had been dealt with at the scene without requiring transport to an emergency department or referral to a GP. It was expected that this percentage would increase as APPs gained experience and additional skills. The APP service also had a very low re-contact rate compared with London crews as a whole.
- 5.3. Two case studies were presented to illustrate the work of the APPs, and it was noted that a further cohort of eight trainee APPs had been recruited recently. This would facilitate wider deployment as current resources were centred on Croydon. The longer term plan was for APPs to be embedded in all five sectors. The presentation concluded with examples of positive feedback received from patients.

- 5.4. A number of questions were asked about the APP (Urgent Care) role and programme. It was noted that whilst the programme did not necessarily generate net savings to the Trust, there were believed to be wider savings across the local health economy in terms of admissions to hospital that had been avoided. Deployment of APPs was controlled by having an APP in the Control Room, and was becoming more effective with experience. In addition, APPs were included in auto-dispatch responses to cardiac arrest calls. Levels of support during training had been very good, and were welcomed by the APPs. The team had experienced some initial difficulties referring patients on to other parts of the NHS, in particular to specialist services, but this was improving. The restructure of the Operations Directorate would include a dedicated role for oversight of APPs. There was a brief discussion about the role of APPs and the service provided by Paradoc, and it was noted that differences between the two services meant that no direct meaningful comparison could be drawn. Utilisation rates for APPs were around 40%, which each APP attending 5-6 cases per day, and the key benefit to the Trust was the reduction in the number of conveyances, which was being evidenced via the Performance Review process. APPs had been issued with iPads but, due to technical issues, were currently unable to access Coordinate My Care. There was a brief discussion about the role of APPs in relation to elderly patients, this being a significant group in the context of inappropriate referrals to Accident and Emergency departments and hospital admissions. It was noted that APP training included a rotation with the Home Team based at Guys and St Thomas' NHS Foundation Trust, but that there was a wider focus of care, as evidenced by the case studies outlined in the presentation.
- 5.5. The Chair, on behalf of the Board, thanked GW for her informative presentation and GW left the meeting.

6. Report from the Chair (TB/17/149)

- 6.1. The Chair noted with pleasure that the appointment of BM to the post of Director of Strategic Assets and Property meant that the Executive Leadership Team (ELT) was now complete. She asked the Board to agree that BM should become a member of the Logistics and Infrastructure Committee.
- 6.2. In addition to the information set out in her report, the Chair informed the meeting that the milestones for implementing the national rebanding of paramedics were on track to be met, and no significant risks to implementation had been identified. She confirmed that the People and Organisational Development Committee would be monitoring progress on behalf of the Board.
- 6.3. The Chair also shared her thoughts from visits paid to Bow and Oval & Deptford stations, along with feedback from staff. It was noted that meetings with the Mayor of London, and with the National Director of Mental Health Services NHS England, had been constructive.
- 6.4. There was some discussion about the proliferation of apps available for use by NHS staff, and in particular by paramedics. It was felt that there was a lack of strategic direction generally in this area and that a strategy session for the Board looking at the digital agenda and linking it to the Trust's wider business planning process would be valuable.

ACTION: RF to arrange a Board session on digital strategy.

- 6.5. There was also a discussion about the setting up of a Clinical Council within the Trust, to draw together the various strands of clinical strategy and ensure a common direction of travel. It was agreed that the Council's Terms of Reference should be amended to allow for the inclusion of external expertise, and that its place within the Trust's governance framework required clarification.

ACTION: FW to amend the Clinical Council's Terms of Reference to allow for the inclusion of external expertise, and FW/TB/PH to clarify the Council's place within the Trust's governance framework.

- 6.6. The Board noted the report of the Chair.

Resolved:

- 6.7. The Board resolved to add the post of Director of Strategic Assets and Property to the membership of the Logistics and Infrastructure Committee.

7. Report from the Chief Executive Officer (TB/17/150)

- 7.1. The CEO presented his report on progress and key issues, events and activities since the Board meeting in November. In addition to the matters covered in the report, the CEO noted the formal award, in early January, to the Trust's 111 service of the East London Health and Care Partnership contract for integrated urgent care services.
- 7.2. The Board noted the Trust's strong performance following the implementation of the Ambulance Response Programme (ARP) standards, with only one other ambulance trust achieving comparable results across the board. Performance over the Christmas and New Year period had been particularly pleasing and represented a significant improvement over the previous year.

ACTION: PH to organise letters of thanks from the Chair to all those who had contributed to the Trust's strong performance over the Christmas/New Year period.

- 7.3. Non-Executive Directors asked a number of questions. It was confirmed that the major upgrade to finance systems referred to in the report was routine rather than in response to particular problems. There was a discussion about the roles of the Trust and of STPs in relation to frequent callers, and it was noted that the transfer of responsibility to STPs was being actioned, but at a slow pace, and that the ELT would be considering a business case for the management of frequent callers at its meeting on 14 February.
- 7.4. It was noted that occupational health had been a significant issue at staff roadshows. Changes in the way physiotherapy services were provided had been well received by staff, with access to counselling services being the only major area requiring significant further work, and this was in hand.
- 7.5. The Board noted the report of the Chief Executive Officer.

8. Sustainability and Transformation Partnerships Engagement Update (TB/17/151)

- 8.1. JO'H presented this report, which outlined the Trust's approach to STP engagement. It was noted that one of the 2017/18 CQUINs looked at how the Trust engaged with STPs in support of STP delivery plans and demand management activity. Funding through the CQUIN was directly linked to attendance at meetings, and this had proved problematic because STPs were complex, multi-level collaborative units and were still in the process of finding their feet. Communications could be disjointed, and this had resulted on occasion in Trust representatives not being invited to STP meetings.
- 8.2. There was some discussion about the degree of fit between the Trust's long term strategy and that of the STPs, and it was acknowledged that the Trust was uniquely placed to provide a London-wide perspective. As such it was in a position to influence STP strategy and it was important for all engagement with STPs to communicate a consistent message.
- 8.3. The Board noted the update on engagement with STPs.

ACTION: JO'H to put arrangements in place to ensure that Non-Executive Directors are briefed about key STP meetings, and to collate feedback from meetings.

ACTION: GE and JO'H to develop regular reporting to the Board in this area.

9. Integrated Quality and Performance Report (TB/17/152)

- 9.1. LB introduced this report, which related to performance during December 2017. The report provided an executive summary of the Trust's performance in relation to quality, operations, workforce and finance. Individual members of the ELT also provided detailed 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.
- 9.2. The overall picture was one of improving resilience, with performance over the Christmas and New Year period being better than in 2017/18. The level of planning that had supported this achievement needed to be maintained through January. Performance against ARP standards had been good overall, although there were some challenges in relation to category 2 patients and this was being investigated. The number of serious incidents had fallen. There were no new issues to report on financial performance, and the Trust was still on course to achieve its control total for the current year, or better. Financial planning for 2018/19 was underway, and was taking account of failures to deliver Cost Improvement Programme (CIP) projects in the current year by adopting a project management methodology.
- 9.3. There was a brief discussion about the comprehensive roster review which was due to be undertaken on a rolling basis during 2018/19 with a target completion date of 31 March 2019. The previous review – in 2014 – had taken 18 months to complete. The timescales reflected the need for staff engagement. Board members expressed concern about the timescales, given the need to meet ARP targets for category 2 patients.

ACTION: PW to report back to the Board with a plan for meeting ARP C2 and C3 targets.

ACTION: PW to ensure that the rostering review is completed and implemented within 2018/19, with a plan being brought to the Board in March.

- 9.4. It was noted that the Trust's 111 service (for South East London) had been busier than anticipated during December but had performed well, especially in relation to abandoned calls, where performance had been the best in the country at just under 1%.

ACTION: PH to organise letters of thanks from the Chair to all those who had contributed to the 111 service's strong performance at a time of pressure.

- 9.5. FC, in the absence of the Chair of the Quality Assurance Committee, flagged up two areas of risk which had been discussed at the Committee's meeting on 09 January 2018. The first related to the Trust's training capacity and capability, and the second to EOC recruitment and retention. It was suggested that an external review of training should be undertaken. The latter risk was being addressed by a range of measures and would be considered more fully by the People and Organisational Development Committee at its meeting on 08 February 2018.

ACTION: FW to commission an independent review of the Trust's training arrangements.

- 9.6. The detailed financial aspects of the report were considered, and it was noted that early estimates for 2018/19 were predicting the need to achieve £21.5m of savings in order to meet the Trust's control total. This would be challenging, especially given that all significant non-recurrent savings had been taken in 2017/18. A robust approach to CIP planning and delivery would be required. It was also noted that a significant underspend against the current year's capital budget was forecast and there was a short discussion about 2018/19 projects which it might be possible to bring forward into the current year.

- 9.7. The Board noted the integrated quality and performance report.

10. Quality Assurance Committee Assurance Report (TB/17/153)

- 10.1. The report was noted; FC had provided (in the absence of the Committee Chair, RM) an overview of the meeting of the Quality Assurance Committee on 09 January 2018 during the Board's consideration of the integrated quality and performance report.

11. Finance and Investment Committee Assurance Report (TB/17/154)

- 11.1. The report was noted; FC, as Chair of the Committee, had provided an overview of the Finance and Investment Committee on 16 January 2018 during the Board's consideration of the integrated quality and performance report.

12. Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Review (TB/17/155)

- 12.1. PW presented this report, which provided the Board with an overview of the EPRR assurance process and the results of the assessment for 2017/18. The report also explained the relationship between the EPRR review and the inspection undertaken in December 2017 by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.
- 12.2. For the EPRR review, the Trust had submitted its RAG-rated self-assessment against core standards to NHS England in September 2017, together with supporting evidence. An assurance meeting with NHS England had been held in November 2017, to review the self-assessment and agree any actions required. The Trust had rated itself amber in the three areas set out in the report and NHS England had concurred. This had resulted in an overall assessment of substantial compliance and an action plan was agreed with NHS England to address the areas of non-compliance. PW informed the meeting that all agreed actions were currently on target to be completed within agreed timescales.
- 12.3. It was noted that the NARU inspection was undertaken separately as a one-off review and did not contribute towards the overall EPRR compliance rating. It had focused on NHS strategic assets and national capabilities. The inspection had taken place in December and the final report had been received on 18 January 2018. This would be brought to the Board at its February meeting, along with the accompanying action plan. The areas covered by the action plan were acknowledged by management as being in need of improvement.
- 12.4. The Board noted the report on the EPRR annual assurance review.

13. Board Assurance Framework and Corporate Risk Register (TB/17/156)

- 13.1. PH presented the Board Assurance Framework (BAF) for the Board's consideration. It was noted that, whilst there were seven risks on the BAF with a rating of 15 or above, the ELT recommended closure of three of them (40, 43, and 48), and de-escalation from the BAF for a fourth (7). There had also been some discussion about the articulation of risk 49 at the most recent meeting of the Finance and Investment Committee, and the revised wording of this risk was highlighted and noted.
- 13.2. Risk 7 concerned the possibility of avoidable harm to patients during shift changes and had a current rating of 16. Monitoring of performance against ARP standards had identified some variation over the 24 hour period, but no significant variation at times of shift changeover, and the number of serious incidents had fallen overall. It was agreed that risk 7 should be re-rated as 12, with the proviso that management would flag it up to the Board if it needed to be re-escalated in future.
- 13.3. Risk 40 concerned the possibility that the Trust might not be able to recruit sufficient core front line staff. The ELT had broken this down into four risks, each relating to a specific staff group. It had concluded that recruitment to only one group – EOC staff – constituted a BAF level risk, and this was already set out in risk 47. It was agreed therefore that this risk should be closed.

- 13.4. Risk 43 concerned the possibility that the management of bank workers might not be being undertaken to the same standard as the permanent workforce. It was noted that all the mitigating actions had been completed and the ELT had recommended that this risk should therefore be closed. The Board agreed to accept this recommendation.
- 13.5. Risk 48 concerned the possible impact of recent changes in the taxation arrangements for lease vehicles equipped with blue lights on the Trust's ability to respond effectively to major or significant out of hours incidents. It was noted that this risk had not crystallised and that a range of mitigating strategies was being investigated. The ELT did not feel that this was a BAF level risk and the Board concurred that it should be closed.
- 13.6. The Board also considered the two potential BAF risks identified by the ELT and noted that the risk to the deployment of sufficient numbers of ambulances was scheduled for discussion at the forthcoming meeting of the Logistics and Infrastructure Committee. It was also noted that the risk that the Trust might not have sufficient training capacity had been considered by the Quality Assurance Committee at its last meeting. A full training review was underway and an initial report would be made to the Quality Assurance Committee at its meeting in March.
- 13.7. The Board noted the report on the Board Assurance Framework, and the Corporate Risk Register which had been provided for information.

14. Serious Incident Management (TB/17/157)

- 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. In addition to the information contained in the report it was noted that a recent internal audit review by KPMG had resulted in an opinion of significant assurance.
- 14.2. There was a discussion about how incidents were categorised, as a number of incidents detailed in the report appeared to have been inappropriately classified as 'delayed responses'. It was noted that classification of incidents took place at an early point in the reporting process and that the apparently high level of 'delayed response' classifications could be attributable to the lack of familiarity with the ARP standards which had only just been introduced at the time the incidents occurred. There was also a discussion about the level of reporting of SIs by the Trust and whether this was comparable with other ambulance trusts. It was noted that reporting followed national guidelines but that the incident reporting framework for ambulance trusts was not consistent with that followed in an acute setting. The Trust was the first ambulance trust to be working with NHS Improvement to review the reporting framework.
- 14.3. The Board noted the report on serious incident management.

15. Freedom to Speak Up Quarterly Report (TB/17/160)

- 15.1. PH presented a brief summary of the quarterly report, which covered national and local developments. She then introduced Conal Percy, the Trust's Interim Freedom to Speak Up Guardian. CP had been appointed until March 2018 as a full-time replacement for Margaret Luce, who had previously undertaken the role of Guardian on a voluntary basis. Her contribution towards progressing the Freedom to Speak Up

agenda had been invaluable, but the voluntary nature of her role had meant that it lacked visibility within the organisation. A key part of CP's role was to explore options for creating a Freedom to Speak Up network within the Trust, with a move to a 'hub and spoke' model after March appearing to be the favoured option. It was noted that FC was the Non-Executive lead in this area.

- 15.2. CP made a short oral presentation to the meeting, outlining his role and responsibilities, and the advantages of having a full-time Freedom to Speak Up Guardian.
- 15.3. It was noted that two cases had been raised within the Trust during the second quarter of 2017/18, compared with about 1600 nationally as reported by 210 trusts. The Board expressed concern that this could be indicative of a low profile for the Guardian within the organisation. It was also noted however that raising one's case with the Guardian was the fallback route available to staff should other, better established, routes prove fruitless.
- 15.4. The Board noted the Freedom to Speak Up report, thanked CP for his informative presentation and thanked Margaret Luce for her efforts whilst Freedom to Speak Up Champion.

16. Business and Financial Planning Update (TB/17/158)

- 16.1. LB introduced this report, which provided an update, as at quarter 3 of 2017/18, of progress in achieving the 67 business plan deliverables agreed by the Board in May 2017. The report also provided a high-level view of the wider business planning process for 2018/19, which had drawn on lessons learned in 2017/18.
- 16.2. It was noted that 51 deliverables (76%) had either been completed or were scheduled for completion by 31 March, 12 (18%) would be carried forward into 2018/19, and 4 (6%) had been closed because circumstances had superseded them. Where a deliverable was currently incomplete but scheduled for completion by 31 March, evidence had been sought to support this position.
- 16.3. The deliverables were mapped against the Trust's four organisational goals, and it was noted that:
 - 15.3.1 In relation to goal 1 (patients receive safe, timely and effective care) and goal 3 (partners are supported to deliver change in London) the success rate in achieving deliverables was in the region of 90%.
 - 15.3.2 In relation to goal 2 (staff are valued, respected and engaged) it was noted that 10 of the 17 deliverables would be complete as at 31 March, with the remaining 7 being rolled forward into 2018/19. This reflected the need for a longer timescale where cultural change was required within the organisation.
 - 15.3.3 In relation to goal 4 (efficiency and sustainability will drive us), only 2 of the 18 deliverables had been achieved to date, with a further 11 scheduled for completion by 31 March.
- 16.4. The report outlined the business planning process for 2018/19. The key difference from the approach adopted in 2017/18 was the focus on active engagement with, and input from, directorate and corporate teams. This would be achieved via a series of workshops to be held in February. The plan would function at business unit level, and would incorporate key performance metrics, targets, and key deliverables.

- 16.5. The report also outlined the approach to financial planning for 2018/19. This represented a departure from the established approach and would emphasise the need to work within a cash limited budget. The Trust was on target to meet its 2017/18 control total whilst operating at lower staffing levels than allowed for in baselines, and this would also be factored in, but not at the expense of performance or patient safety.
- 16.6. Early estimates suggested that savings of £20m would be required in 2018/19 if the Trust was to meet its control total. Reference costs, which compared the Trust's costs against the average of other ambulance trusts, suggested that some £16m could be released through improved productivity, changes in skills mix, and improved estate utilisation. External and local benchmarking exercises were also being undertaken.
- 16.7. It was noted that one of the lessons learned from 2017/18 was the need to provide adequate support for programmes required to achieve efficiencies, and this was to be provided via the Programme Management Office. It was also noted that the one year plan for 2018/19 was the first step in developing a longer-term strategic view.
- 16.8. The draft financial plan was due to be discussed at an extraordinary meeting of the Finance and Investment Committee. It was planned to hold the meeting just before the Trust Board meeting on 27 February 2018, where the final version of the plan would be presented. It was agreed that invitations to the Committee meeting would be extended to other Board members.

ACTION: PH to ensure that an extraordinary meeting of the Finance and Investment Committee was arranged for 22 February 2018, with meeting invitations extended to other Board members.

17. Connecting our Board with our Workforce (TB/17/159)

- 17.1. JO'H presented this report. Following their re-inspection visit in February 2017 the Care Quality Commission (CQC) had reported that the Trust recognised that more work needed to be done to reduce the disconnect between the ELT and frontline staff. The purpose of this report was to put forward proposals designed to address the disconnect by building on initiatives that had already been introduced to improve the visibility of the senior management team. The proposals were wider in scope than required by the CQC, encompassing non-executive as well as executive engagement.
- 17.2. The main plank of the proposal was that all Board members and regular attendees at Board meetings, both executive and non-executive, should be assigned to one of the Trust's 18 group stations, taking account of home/workplace locations and existing STP commitments. The proposal was discussed and some concern was expressed about the level of time commitment required from non-executive directors if effective relationships at station level were to be formed and maintained. It was agreed that the proposal had merit but required further working up before it could be taken forward.

ACTION: HL, GE and JO'H to take this proposal forward, taking account of existing non-executive director time commitments.

- 17.3. The Board noted the report on connecting the Board with the Trust's workforce.

18. Quality Improvement Plan and CQC Preparation (TB/17/159)

- 18.1. TB presented this update on progress in implementing the Quality Improvement Plan (QIP) and the CQC Preparation Plan. It was noted that mock inspections and station quality assurance reviews had been completed in preparation for the CQC inspection in March, with issues arising being managed and actions scheduled for completion by the end of January. Briefing packs for Board members had been prepared and mock interviews were scheduled for 31 January – 02 February 2018. All QIP actions had either been completed or had an approved plan to achieve closure. Evidence was awaited for just two actions in order to confirm closure, and this was in hand. It was noted that there could be a focus on compliance with the fit and proper person test during the course of the CQC inspection, and that a recent internal audit review had resulted in an opinion of substantial assurance. It was also noted that the Health and Safety Executive would be meeting with the ELT on 07 March 2018 to carry out its assessment.
- 18.2. The Board noted the report on progress against the QIP and the CQC Preparation Plan.

19. Report from the Trust Secretary (TB/17/162)

- 19.1. PH presented this report, which provided information about the Trust's position in relation to regulatory formalities administered by NHS Improvement, namely enforcement undertakings, and compliance with the NHS provider licence.
- 19.2. It was noted that NHS Improvement had acknowledged in writing that a number of the enforcement undertakings had already been met and good progress had been made on others. Full details were set out in the report.
- 19.3. The report also set out details of the self-certifications required from the Trust to demonstrate compliance with the NHS provider licence. It was noted that the purpose of self-certification was to ensure that providers carried out assurance on whether or not they could confirm compliance. The most important aspect of the process was to demonstrate that the Board understood clearly whether or not the Trust could confirm compliance and that the Board could sign off to that end. The report set out the requirements of conditions G6 and FT4 of the provider licence, and detailed the evidence being relied upon to support a statement of compliance.

Resolved:

- 19.4. The Board resolved to approve the self-certifications of compliance with conditions G6 and FT4 of the NHS provider licence.

20. Trust Board Forward Planner (TB/17/163)

- 20.1. The Board considered the forward planner and noted that from April 2018 it anticipated a move towards alternating between formal Board business meetings and developmental/strategy sessions.

ACTION: PH to canvass for input into a programme of developmental/strategy sessions for the Board.

20.2. The Board noted the forward planner.

21. Questions from members of the public (TB/17/164)

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

21.1.1 LAS Strategy: Will the Board ensure that the LAS Draft Strategy is subject to formal public consultation before the final strategy is agreed by the Board?

21.1.2 Patient Recontact Audit: Will the Board ensure that the LAS undertakes regular clinical recontact audits of Hear and Treat patients and Ill patients (111 to 999 and 999 to 111)?

21.1.3 ARP: Is the Board satisfied that the standardisation of 2 and 3 hour waits under the ARP system (rather than 20 or 30 minutes) are not causing harm to patients?

21.1.4 EOC: What action will the Board take to deal with the severe recruitment problems in EOC?

21.2. The following answers were provided at the meeting:

21.2.1 Large parts of the LAS strategy will be about the internal workings of the organisation and would therefore be inappropriate for a public consultation. However, the Trust wants service users to ensure it is improving the outcomes and experiences of its patients. This will be done in different ways that best meet their needs, and will provide the richest feedback possible.

21.2.2 The LAS recontact audit looks at patients who recontact LAS within 24 hours of initial contact for the same condition. Some patients who initially contact 111 are advised to contact 111 for a further clinical assessment – a proportion of these patients will be referred back to LAS for an ambulance attendance – these are not recontact as they are part of the initial episode. When the second call indicates a significant deterioration in condition the case is referred to the Serious Incident Group for review. For 111 managed patients the standard is to review if a patient contacts 111 three times or more in 96 hours and LAS 111 remain compliant with this review.

21.2.3 Since the introduction of the new ambulance standards in November 2017 there is, for the first time, a 90th centile reporting standard for response rates for all categories of patients which ensures oversight of any long waits for responses. To maintain safety the clinical hub oversees the patients waiting in all categories and monitor for deterioration in condition.

21.2.4 The risks associated with the Trust's ability to recruit into the EOC and the actions in place to mitigate these have been included in detail in the Trust's BAF.

22. Any other business (TB/17/165)

22.1. There was no other business.

23. Review of the meeting (TB/17/166)

23.1. The Board considered inter alia the appropriateness of papers submitted for Board consideration and agreed that routine Health and Safety updates should be reported via the Quality Assurance Committee and not direct to the Board.

ACTION: PH to make the necessary amendments to Board and committee forward planners.

DRAFT

24. Meeting close

The meeting closed at 2.15pm. The next Trust Board meeting in public will take place at 9am on Tuesday 27 February 2018.

DRAFT

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates (i.e. why action is not resolved / completed)
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
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/17/124a	Friends and Family Test results to be reported to the Board regularly	Patricia Grealish	28/11/17	30/01/18	CLOSED	See performance reporting
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
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/17/149 para 6.4	A Board session on digital strategy to be arranged.	Ross Fullerton	30/01/18	27/03/18	On track	Board members will be presented with a proposed schedule for strategy/development sessions by the March Board meeting
TB/17/149 para 6.5	The Clinical Council's Terms of Reference to be amended to allow for the inclusion of external expertise.	Fenella Wrigley	30/01/18			Update to be provided
TB/17/149 para 6.5	The place of the Clinical Council within the Trust's governance framework to be clarified.	Fenella Wrigley/Trisha Bain/Philippa Harding	30/01/18			Update to be provided
TB/17/150 para 7.2	Letters of thanks to be sent from the Chair to all those in the EOC who had contributed to the Trust's strong performance over the Christmas/New Year period.	Philippa Harding	30/01/18		CLOSED	Letters sent w/c 12 February 2018
TB/17/151 para 8.3	Arrangements to be put in place to ensure that Non-Executive Directors are briefed about key STP meetings, and feedback from meeting is collated.	Jamie O'Hara	30/01/18	31/03/18	On track	Quarterly STP reports scheduled. Additional support for Board members attending meetings being arranged.

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates (i.e. why action is not resolved / completed)
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
TB/17/151 para 8.3	Regular reporting to the Board on STP engagement to be developed.	Garrett Emmerson/Jamie O'Hara	30/01/18		CLOSED	Quarterly STP reports scheduled.
TB/17/152 para 9.3	A plan for meeting ARP C2 and C3 targets to be brought to the Board.	Paul Woodward	30/01/18	27/03/18	On track	Scheduled for Board meeting on 27/03/18
TB/17/152 para 9.3	A plan for completing and implementing the rostering review within 2018/19 to be brought to the Board in March.	Paul Woodward	30/01/18	27/03/18	On track	Scheduled for Board meeting on 27/03/18
TB/17/152 para 9.4	Letters of thanks to be sent from the Chair to all those who had contributed to the 111 service's strong performance over the Christmas and New Year period.	Philippa Harding	30/01/18		CLOSED	Letters sent w/c 12 February 2018
TB/17/152 para 9.5	An independent review of the Trust's training arrangements to be commissioned.	Fenella Wrigley	30/01/18		On track	Scope to be discussed by Quality Assurance Committee and People and Organisational Development Committee meetings in March
TB/17/158 para 16.8	An extraordinary meeting of the Finance and Investment Committee to be arranged for 22 February 2018, with meeting invitations extended to other Board members.	Philippa Harding	30/01/18		CLOSED	Meeting arranged as required.
TB/17/159 para 17.2	The proposal for allocating each executive and non-executive director to a designated group station to be taken forward, taking account of existing non-executive director time commitments.	Heather Lawrence, Garrett Emmerson and Jamie O'Hara	30/01/18	30/03/18	On track	Work being undertaken to establish NED time commitments
TB/17/163 para 20.1	Input to be sought for a programme of developmental/strategy sessions for the Board.	Philippa Harding	30/01/18	27/03/18	On track	Board members will be presented with a proposed schedule for strategy/development sessions by the March Board meeting
TB/17/166 para 23.1	Board and committee forward planners to be amended to reflect the reporting of Health and Safety updates via the Quality Assurance Committee rather than direct to the Board.	Philippa Harding	30/01/18		CLOSED	Forward planners for the Board and Quality Assurance Committee have been updated.



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Chair's Report			
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

1. This month has seen a number of meetings both internal and external with key leaders and influencers in the NHS:-

Dr Sarah Wollaston, Chair of the Health Select Committee

2. I attended a small round table discussion with Dr Wollaston, hosted by NHS Providers. Dr Wollaston was keen to hear from us as to how it is in reality and said that she wanted to hear from those who can talk to her in 'plain speech'. As a former GP she understands the NHS well and relates to front line issues. Inevitable discussion was held with regard to winter pressures and capital availability as well as the view of participants on Sustainability and Transformation Partnerships (STPs), their future and their current effectiveness.

Steven Barclay MP, Minister of State for Health

3. The NHS Confederation arranged a small round table breakfast discussion with the new Minister of State for Health whose responsibilities are:-
 - finance, procurement and operational performance
 - workforce pay and pensions, contracts, and whistleblowing
 - setting the government's mandate for NHS England
 - transformation and provider policy
4. It was a refreshingly open conversation, as he sought to understand issues from Chief Executive Officers (CEOs) and Chairs alike. The meeting was held prior to the planning guidance for 2018/19 being circulated and so, whilst we had discussion about the future of STPs and the local government politics of this, he was unable to make any announcements. Like Dr Wollaston he too wanted to hear it as it is.

NHS Improvement (NHSI) Chairs advisory group

5. I attended the first meeting of Baroness Harding's advisory group. Ian Dalton, NHSI CEO joined us to hear of particular issues. In relation to the planning guidance he was clear with us that if there was clear evidence of an increase in activity then organisations should agree this with commissioners to avoid unexpected expenditure later in the year.
6. There will be ten Integrated Care pilots nationally and, if deemed successful, they will hold the budget for the economy and be held to account for both the planning and delivery within resources. In time it is probable these pilots will be rolled out and will then replace STPs.
7. Baroness Harding agreed with me that the Ambulance Trusts have a key role to play in solving the Accident and Emergency delays by introducing new models of care.

Steve Russell, London Director, NHSI

8. Garrett and I had our regular meeting with Steve to discuss our performance and forthcoming Care Quality Commission (CQC) inspection. Steve has had his interview with the CQC as part of our forthcoming inspection. He said he explained to the CQC that whilst we have more to do (C2 and C3 Performance / Rostering) he no longer considers us as a Trust in Special Measures.

9. He advised that he had been impressed with how the Service had handled winter planning and in particular praised both Fenella Wrigley and Paul Woodrow for the effective role they play in the daily sector telephone calls.

CQC Chair's Experience – Angela Greatly, Chair, Central London Community Healthcare NHS Trust

10. Further to the NHSI Chairs' meeting where Angela described her experience of the new CQC inspection (slides previously circulated to Board members), we met to discuss her experience as a Chair in more detail and I can update Board members as required, individually or together.

Chairs and CEO meeting

11. Garrett and I attended a meeting with the Chair and CEO of Barts Health and London Air Ambulance. We discussed what else we could do together and it was agreed that our respective CEOs would take this work forward.
12. Board members will have seen recent coverage of the remodelled Physician Response Unit (PRU), where a paramedic and a doctor attend calls together in a car.
13. There is also an interest in discussing how volunteering can be increased.

Meeting with NHSI and NHS Estates

14. I hosted a meeting with NHSI and NHS Estates with our CEO and Benita Mehra, Director of Strategic Assets and Property. The main aims of the meeting were to introduce both Garrett and Benita to the influential decision makers with regards to Estates issues and access to capital in the NHS and to share our emerging strategic plans and estate requirements.

Visits to Westminster and St John's stations

15. I visited Westminster and St John's Wood Ambulance stations and met with staff at both the stations and at St Mary's and St Thomas's hospitals. I met the Unison Health and Safety (H&S) officer who was undertaking H&S checks diligently. I spoke with several crews at both St Mary's Hospital and St Thomas Hospital.
16. The staff issues were common across the crews that I met, namely rostering and in particular the unpopularity of the relief roster where there is no opportunity to bond as part of a team, and it is lonely particularly for I-Paras. I took the opportunity to discuss how modern rostering might look and the importance of the role of 'team' in this. I was pleased to meet I-Paras who have recently gained promotion, one as an Advanced Paramedic and another as a Team Leader.
17. Team leaders have little control of their staff in the current system neither holding the budget nor having responsibility for rostering.
18. Most staff that I met knew about the Clinical update newsletter where learning from incidents is shared. They had also had an appraisal or had one planned.

Heather Lawrence OBE Chair



Report to:	Trust Board			
Date of meeting:	27 February 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. Throughout January, the London Ambulance Service NHS Trust (LAS) continued to perform well against the new Ambulance Response Programme (ARP) standards, despite continued winter pressures across the healthcare system in London, high volumes of influenza and norovirus, and periods of low temperatures. Performance for the Category 1 mean response time currently stands at 7 minutes and 9 seconds for the month (01/01/2018-31/01/2018) against the 7 minute standard, and remains fairly consistent week on week. Category 1 90th percentile for the same period is well within the 15 minute target, at 11 minutes and 45 seconds, showing that our most critical patients are being responded to quickly.
2. Following the introduction of the ARP in November 2017, the Operations directorate has been undertaking a review of our initial observations since 'go live' based on two months' worth of full data. The key issues that have been identified include, the higher volume than expected of Category 2 calls and the estimated time of arrival (ETA) calls coming in to the 999 system, whether determinants Card 21 (haemorrhage), Card 12 (fitting) and pregnancy/maternity calls are coded appropriately within the new categories. These identified issues have been raised by the Trust as part of a national feedback exercise in readiness for the national ARP Spring Review which takes place on 20 February to assess the impact of ARP since its introduction.
3. In the meantime, further work is underway to address our response to Category 2 and 3 incidents and an improvement plan will be presented to the Board in March 2018. The Operations directorate is awaiting modelling which will indicate the number of double crewed ambulance (DCA) and fast response unit (FRU) hours (and the corresponding number of whole time equivalents) required to deliver performance against the national targets. We do know that we require fewer FRUs to meet the new standards and so we are reducing FRU levels and overtime incentives are being directed towards DCA shifts. To ensure that the Trust has the right mix of DCAs and FRUs along with the requisite number of staff hours in the right place at the right time, new rosters are currently being designed working collaboratively with trade unions and frontline staff. Ten group stations (the first tranche) will go live with new rota patterns in September 2018 with the second tranche (8 group stations) going live in March 2018. The Operations directorate is also working with fleet to increase our number of double crewed ambulances and meet the demand of delivering the new transport response model required post-ARP.
4. The Operations directorate has invested in a product called 'Signals from Noise' (SfN) which went live in January 2018 and enables the Trust to monitor initially the compliance of EOC in the pre-triage sieve/nature of call (NOC) by individual call handlers so that we can maximise the early predict of Category 1 calls and provide the quickest response to this group of patients. This product will be developed further over the coming months and will support the performance management process within EOC.
5. To further improve productivity, the Operations directorate is scoping new efficiency measures for 2018/19 which includes increasing the number of patients seen by patient facing clinicians per shift and a reduction in conveyance rates. These measures will form new KPIs which will be managed through the monthly performance reviews cycle.
6. As was reported last month the following actions were being implemented to increase the number of rest breaks allocated:

- Moving five identified DCAs per hour, and per sector, onto an 'out of service' code so that it is only possible for their breaks to be interrupted by a Category 1 call
 - Identifying between 15 and 30 ambulances to provide extra DCA shifts to cover 11:00/23:00 (bridging shifts) so that additional cover is in place over the peak rest break window period which will in turn protect the allocation of breaks
 - The development of a clear clinical safety process will be made available to support dispatch staff at times of reduced DCA availability.
7. I can now confirm that these actions are live from the week commencing 12 February 2018 while the end of shift working group will present their plan for new end of shift arrangements later this month.

Finance & Performance

8. As reported in detail elsewhere on the agenda the overall financial position for the Trust is £2.7m ahead of the internal plan at Month 10, 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.
9. The latest forecast is that the Trust will deliver a £1.1m deficit for 2017/18 against a control total deficit of £2.4m which is a significant achievement in the current financial environment across the NHS. The 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.
10. Capital spend is £12.2m against a YTD plan of £18.2m, £6.0m behind plan. The current forecast is to spend £20.3m vs the plan of £24.6m.
11. Business planning for 2018/19 is currently underway with well attended engagement workshops of the top 200 managers held across corporate and operational divisions early in February. National planning guidance and revised control totals were also issued to providers at the beginning of February and the Trust is working through the impact of these and the outcome of discussions with commissioners on the Business and Financial Plan for 2018/19, which will have been discussed at an extra-ordinary meeting of the Finance & Investment Committee. The Trust's draft operational and financial plan is due for submission on 8 March 2018 and final submissions are now required by the end of April.
12. The Performance team have continued to focus on reporting with attention placed on the new ARP Ambulance Quality Indicators (AQIs). The Business Intelligence team is working with colleagues to implement initiatives to allow for accurate and confident recording and reporting of the more complex aspects of operations, as per the NHSE AQIs. Meetings have been productive with agreements reached on the Heathrow Airport post arrival recording, coding of clinically closed calls, and the reporting of CHUB re-categorisation. Various teams are now working collaboratively to fulfil their obligation to make the required changes, including: the IM&T data warehouse team who are writing the necessary logic; the CAD support team who are assisting with practical changes; and the Data Quality team (in conjunction with BI) who are writing and working through the agreed rules by exception. Additional work is being undertaken by the Contracts team to identify commissioned and non-commissioned events.

13. Business Intelligence prepared for the National Ambulance Information Group (NAIG) peer review held on the 12 February 2018. The peer review will be testing, checking, and providing assurance to the Trust that the recording of data is correct and in the spirit of the AQI guidelines. A detailed report will be shared with the Executive Leadership Team.
14. As we begin to approach a new financial year, the Forecasting & Planning team are working with the Contracts team in order to create activity projections and understand the future requirements not only of the Trust but of our stakeholders and commissioners. These projections for 18/19 need to consider the new operational service delivery for ARP and will be aligned with our strategic intent.
15. Focus has also now turned to Easter with the Forecasting & Planning team working with Operations and Scheduling teams to provide activity and capacity forecasts for the bank holiday weekend and the lead up to it, allowing time for any necessary action to be taken and to offer assurance around any plans.
16. The Performance scorecards continue to evolve, and in the new financial year greater focus will be placed on benchmarking and customer satisfaction. New draft scorecard templates have been shared at the business planning workshops and have been well received. These scorecards are part of a wider integrated approach to performance management which will include CIP, QEP and Carter review metrics.
17. A key outcome from last month's Performance Reviews was the extra focus on assuring risks captured on Datix with resultant actions – every directorate was able to demonstrate that they had reviewed their risks and actions a week prior to the Performance reviews. An additional challenge was presented to all stakeholders to improve appraisal compliance rates, a key areas of focus in the February reviews. We continue to develop and refine WRES metrics within the People and OD directorate; greater granularity has been requested to understand not only where BME staff are positioned in term of their Agenda for Change banding, but also if training opportunities and engagement can be demonstrated.
18. Additionally, the Performance Directorate has recently developed a Data Quality Assurance Framework, with a detailed Strategy paper being presented to the Executive Leadership Team for discussion. This paper is shared with the Audit Committee for final agreement.

IM&T

19. During January IM&T continued to provide reliable and highly available services with no critical service Incidents in the month. During the Secretary of State's visit to LAS the Chief Information Officer, Ross Fullerton, explained the positive impact of funding from Department of Health which has been used to provide ambulance crews with 4G connected tablets. The Secretary of State was particularly impressed with the patient impact of providing crews with electronic access to patient data to inform better quality decision making.
20. Ross presented to the London NHS CIO Council on the LAS Strategic Intent and outlined some of the healthcare system interoperability challenges of implementing electronic patient records in London. LAS will require support from across the London healthcare system to access existing patient data and to electronically transfer care from LAS to other providers in London. The presentation was well received with several trusts expressing an interest in supporting our work.
21. LAS hosted the AACE IM&T national leads for a 2-day workshop. Ahead of the event Ross Fullerton and Vic Wynn attended an information sharing day at EMAS who's CEO,

Richard Henderson, is the AACE lead for IM&T. The event included an update on the Ambulance Radio Programme, back-office efficiencies and Carter benchmarking, several NHS Digital programmes and how each trust is managing cyber risks.

22. During late December and early January all of London's 111 providers successfully implemented version 14 of NHS Pathways. These upgrades required a considerable level of effort from LAS to ensure each provider's system was able to safely and reliably send requests to the LAS999 CAD system. A workshop will be held in February with colleagues from NHS England and other providers to learn lessons from this process which would have benefitted from better coordination and planning.
23. The IM&T project management office has been established as a core part of the new IM&T operating model. This function will work closely with the Trust-wide PMO to manage the delivery of IM&T led changes as well as the IM&T aspects of trust-wide initiatives. The PMO is improving the quality of project documentation and governance with a set of best practice materials to be used for all projects.
24. Delivery has commenced for the IM&T requirements of the North-East London Integrated Urgent Care contract. The Connecting Clinicians project continues on-target with the deployment of iPads and scoping has commenced for the ePRF project mentioned above. Road-testing of the replacement Satellite Navigation and Mobile Data Terminal solution has commenced with positive user feedback received. Site visits were undertaken to Crown Commercial Services datacentres in preparation for the implementation of new CommandPoint infrastructure during 2018.
25. Considerable progress has been made towards achieving Cyber Essentials accreditation with an external assessment scheduled for February by Dionach on behalf of NHS Digital. We continue to action all NHS CareCERT cyber alerts in a timely manner. Patching to mitigate the highly publicised Spectre and Meltdown vulnerabilities announced by Intel and others is underway and scheduled to complete in early February.

Strategy

26. Over the past month we have carried out further detailed modelling for our five proposed pioneer services (Urgent Care Paramedics, Maternity, Falls, Mental Health & End of Life Care). We have worked closely with the subject matter experts and held a 'clinical challenge' session. The next steps for this modelling and service specification is to have discussions at ELT and Trust Board to agree the specific pilot services that we will run, and where they should be tested.
27. We have been working with a core team of representatives from across the organisation to explore key elements of a Blueprint for moving to an Integrated Urgent & Emergency Care model or 'Single Point of Access'. Building on sessions in early January focusing on understanding our shared vision and agreeing a high level operating model option, we are currently thinking through the implications and benefits of the future SPA and Integrated Urgent and Emergency Care model at 3 levels:
 1. Initial access (i.e. the channels through which people access LAS services)
 2. Contact handling and initial triage
 3. Complex triage and resolution.
28. During recent weeks we have held further sessions focused on the complex triage and resolution level and the detailed role requirements for the future Clinical Assessment Service (CAS). A further session is planned for this week to focus on the contact handling and initial triage level and in particular we would like to explore the benefits of a more integrated model at this level.

Quality Improvement

29. A wide range of communication material has now been distributed to staff to prepare them for the CQC visits over the next 2 months including personal messages from me. CQC have attended sector group quality meetings and the corporate Quality Oversight Group, both with positive feedback.
30. Senior leadership teams have participated in mock interviews, supported by NHSI improvement. Weekly meetings with operational teams and our Chief Quality Officer (CQO) are held to maintain focus on areas where trajectories need to be met e.g. safeguarding training, appraisals, and incident reporting and station environmental checks.
31. A project team to deliver the Quality Improvement and Human Factors training met on 26th February. The team will develop the overarching Quality improvement Plan which will incorporate all quality improvement programmes aligned to the quality and efficiency plan and will include systems and process development, training and support for staff, further improvement of assurance processes to ensure that continued learning and improvement is embedded across the organisation. The Risk management Strategy and Policy that includes an implementation plan will be submitted to the Audit Committee. Health Assure is now being rolled out with evidence to support Well-led and Safe domains and will be fully uploaded by March and the remaining KLOEs by the end of April.
32. A presentation was given in relation to Mental Health training and awareness amongst call handlers. Three sessions were held with staff at Waterloo and Bow to give them a confidential space to raise concerns and discuss challenges. Actions arising include:
- Revised role of the Registered Mental health Nurse to intercept calls if on the line for >10 minutes
 - Devise questions using co-production with our expert patient reference group to for call handlers to use to support safe call termination.
 - Call handler course to be revised to include a focussed section on MH calls
33. The mental health response car test shift has been completed to ensure the processes are working correctly. Four patients were seen in 5 hours and none conveyed, a review is underway to assess the implementation of a full roll out. In February training in managing patients with Dementia in the North Central sector took place to increase staff awareness of communication skills, 78.48% of staff have completed CSR dementia friends training. A business case to increase capacity to the frequent caller team is underway, this should bring a significant positive impact both financially and in terms of reducing demand on the service, whilst resolving issues for these patients more rapidly.
34. Audits are currently being undertaken in relation to safeguarding to assess the increases in paediatric Mental Health referrals and to review the increase in referrals relating to parental mental health. The team have worked with P&OD teams to ensure that our systems and processes for checking DBS are up to date and cover all appropriate staff groups. Safeguarding training has been given a strong focus with operational teams and trajectories set to meet the >90% target by the end of March.

Medical Directorate

35. Along with providing senior clinical support to the Trust efforts in managing held calls and maintaining clinical safety during the winter period the Medical Directorate have provided support to the vehicle based bag trial being rolled out in North West London.

36. We have recruited 2 experienced clinicians to undertake a 2 year secondment within the team. These staff will lead to enhance how we share learning from experience by using innovative methods in order to engage staff. They will also be working to improve the availability of Appropriate Care Plans across London and it is envisaged the roll out of personal electronic devices will support this.
37. CARU continue to publish monthly and quarterly audits on time in order to improve and enhance the care provided to patients. There are a number of Clinical Trials underway with several others in development including the care provided to Diabetic patients and the triage of patients using the Medical Priority Dispatch System.
38. Recruitment to the Infection Prevention and Control (IPC) team has been completed providing additional capacity within the department to improve understanding of Infection Prevention & Control requirements and the level of reporting across the organisation.
39. The Head of IPC has been working closely with our Occupational Health provider to evaluate the vaccination status of our staff and to ensure a program for improvement where gaps are highlighted.
40. Clinical Education and Standards have been progressing talks with the Mulberry Technical College to encourage students to pursue a career in the ambulance service. Partnership working with Anglia Ruskin University has further progressed to increase the number of potential candidates who will one day join the Ambulance Service.

People and Organisational Development

41. As at 15 February 2018, Trust compliance is 77.2%. Corporate compliance is 90.7% and Operations compliance is 76%. CSR.2017.2 compliance is being monitored weekly with reports sent to DDOs which is followed up by ADOs in their sectors with compliance leads chasing completions.
42. The ESR Project Team met with Emergency Planning to review the records held for EPRR Operational & Tactical Commander. The team completed an upload of all courses/attendance into ESR which has resulted in accuracy of reporting against compliance for Operational Commander (31% to 77%) and Tactical Commander (46% to 70%).
43. The establishment of a joint Learning and Education Group is underway which will include approval and forecasting of StatMan training requirements and ensure effective evaluation of training material and delivery. In addition commissioning of an independent review of training provision across the trust is underway.
44. The final report from Jim Timpson, Director of NHS Elect covering the interviews held with ELT and the Chair will be delivered in February 2018. A cultural analysis report (including Staff Survey outputs) and presentation has been drafted for review in advance. Following discussion with the Executive team it is envisaged that this will be jointly presented at ELT on 7 March 2018 and to the March Trust Board. This will allow this piece of work that commenced early in 2017 to be closed out with the focus then moving to engaging widely on our emerging values and associated behaviours.
45. The behaviours developed will be aligned to our values once confirmed using the original behaviour framework designed from outputs from staff at the Bullying and Harassment Workshops and the Supportive Leadership and Management Behaviours Modules.

46. The Trust's Leadership Development Pathway has been designed to offer a range of training and education interventions for different groups of employees and managers which is aligned to the NHS Leadership Academy/Korn Ferry Hay Healthcare Leadership Model and its 9 dimensions and 4 leadership levels.
47. The Pathway is offered across five key areas:
- Leaders of Tomorrow for aspiring leaders to support skills development and progression of our identified future leaders
 - Management Essentials is for bands 4-6 and as refresher sessions for all Leaders and will form part of a Management Induction programme
 - The Engaging Leader intended for Bands 6-7/8
 - The Visible Leader intended for Bands 8-9
 - The Transformational Leader intended for VSM-ELT Leaders
48. Each of the levels have been designed to allow us to develop and map skills and knowledge alongside the Trust's Behaviour Model, completing the Attitude Skills and Knowledge (ASK) Model at each level in order to build robust performance and competence frameworks as we move forward.
49. The Pathway identifies internal training provision as well as external provision available to us via the LAS Bursary Scheme, NHS Leadership Academy, NHS Elect and NHS Employers some of which we have already accessed and delivered to groups of managers.
50. Management Essentials will run as the main toolkit for managers equipping them with the skills and knowledge to work effectively at the LAS. This already has elements that are run across the organisation and will be centralised to ensure consistency and regularity of delivery as well as enable us to establish competence with accredited workshops. HR Masterclasses are currently being scheduled and PDR Appraisal Skills is being run for both the Appraiser and Appraisee. Other courses are in development and will be launched alongside the entire Pathway launch.
51. Whilst a series of communications have been sent out during January and February to emphasise the importance of ensuring quality appraisals take place, improving the quality of the appraisal 'conversation' has been the foremost consideration. To support an appraisal audit will take place in March 2018 with semi-structured interviews across selected areas. The interviews will be supported by a questionnaire that will be sent to all staff. The results of both will be analysed with recommendations on future activity being made in April 2018. Appraisal training for both managers and staff is being delivered throughout February and March 2018.
52. The Engaging Leader continues to be run through the NHS Leadership Academy's Mary Seacole Local Programme. The LAS became an early adopter in December 2016 and we are coming towards the end of a two year licence so will shortly begin the evaluation as to whether this programme will continue at the LAS beyond December 2018. Cohort 3 is part way through and the NHSLA Quality Assurance lead visited their workshop on 8 January 2018; a second visit is planned for their next workshop. Cohort 2 will be having an additional workshop on 8 March 2018 and successful delegates from Cohort 1 will be presented with their certificates.
53. The Visible Leader has been collaboratively designed with NHS Elect who will deliver the programme with input from the Trust's team. This has been designed with the recognition that these bandings have not had any or minimal development in recent years. Due to the large numbers requiring training involved coming out of the Operations restructure discussions this month with Paul Woodrow will focus on the numbers, delivery methods and timings.

54. We have expressed an interest in delivering the new NHS Employers/Zeal/EMAS designed course specifically for ambulance trusts the Healthy Workplace Leadership Development Programme (based on the previously delivered Supportive Leadership and Management Behaviours which was well received and attended by staff).
55. To continue Cathe Gaskill's work, new Bullying and Harassment Workshops are being scheduled during February and March as well as design of an element to be included in Induction which will incorporate Freedom to Speak Up input from our FTSU Guardian, Conal Percy.
56. A coaching and mentoring steering group has been formed. Terms of Reference have been agreed, the key criteria being to provide strategic and operational direction for coaching and mentoring within the Trust in line with the P&OD Strategy and, to identify and share best practice around coaching and mentoring. The first meeting will take place in February 2018. "Coach to Lead", which is a foundation programme for managers, will start on 1 March 2018 and is designed to equip managers with the skills to manage using a coaching style.
57. Sponsorship Mentoring for BAME staff (a leadership development and inclusion initiative working in partnership) is a programme designed to enable greater access for BAME staff at Bands 2 - 7 to more senior roles across the organisation with the support of a Sponsorship Mentor. This will be piloted and evaluated between May 2018 and September 2019.
58. The Learning and Development team are exploring two options for pilots for Reverse Mentoring another leadership development and inclusion initiative working in partnership. Through a paired relationship of a senior member of staff with a more junior member of staff within the BAME workforce it seeks to enable opportunities to "walk in the shoes" of BAME colleagues and identify some of the barriers that may exist in the organisation which prevent BAME staff from progressing within the LAS. It can also be set up more widely so that a more junior member of staff mentors a senior member of staff to support sharing mutual knowledge and experience and improving service performance and staff morale as a result.
59. A stakeholder meeting was held late January to look at developing an improvement plan for our Clinical and Corporate Induction. It has been identified that there is a need to host inductions in a central location as well as to rationalise the number of induction events (from current frequency of weekly to monthly). There have been historical challenges to combining clinical and non-clinical inductions to form one Corporate Induction, however there are significant benefits to doing this, for example, better employee experience, less call on Subject Matter Expert (SME) time to allow better support for SME subjects covered.
60. Our Occupational Health Provider, PAM have added a further 63 physio associates following our request. We have also requested recommendations from staff on preferred physios in locations where PAM have less coverage. This will reduce time required for staff to attend physio appointments and reduce their travel to and from appointments. This has also allowed us to make recommendations to PAM of physios that LAS staff are happy with being referred to, which has been well received.
61. The immunisation project is over 50% complete and is forecast to be completed by mid-March, however we are currently ahead of schedule. Alongside the paper review of staff immunisation records, we are booking staff in for their vaccinations into regular clinics but are also commencing clinics at specific sites (e.g. Control Rooms) with the support of local management teams. This will ensure that we identify staff requiring immunisations and get everyone appropriately vaccinated to protect both staff and patients and that we are fully compliant with our obligations.

62. There has been ongoing liaison with key management teams within LAS to support better understanding of the OH offer. Following a meeting with Jules Lockett, weekly drop in clinics will be arranged for EOC for both physio and counselling (on alternate weeks) at Waterloo and Bow. The sessions will be 15min “drop ins” and will be coordinated locally. This will be an opportunity to build trust with staff and give confidence in PAM services. It will support staff engagement, sickness absence and also staff perception of the Trust’s support of their wellbeing (CQUIN).
63. To provide a simple solution for staff who may not be aware of their immunisation status, an immunisation card has been produced to allow all staff to have a personal record of their immunisation status. This is available at all times and held on their person in the event of a possible exposure and will mitigate concern in the event of an incident and allow staff to access timely treatment where required.
64. The Equality committee met on 9 February, with discussion areas including Gender pay Reporting, Sickle Cell project, sector based recruitment activities, and the Workforce Disability Equality scheme. There was also discussion about and commendation of a volunteer outreach charity project for homeless people In London which has been established and is led by a long standing member of our staff. The committee was well attended by our staff, Trade Union reps and Patients Forum representatives.
65. The Trust’s LGBT Network hosted the national LGBT meeting on the 8 February at Bow which I attended to welcome representatives from all Ambulance Trusts.
66. The national BME Meeting was held on 1st February 2018, at Yorkshire Ambulance. The Trust were represented by Agatha Nortley-Meshe and Melissa Berry. The national meeting was to formulate a work plan, which will include focus on the WRES and relaunch the National BME Ambulance Network. It is planned to hold a national conference towards the end of 2018. The Network plans to more actively engage with AACE and wants to encourage more members nationally.
67. The 8 January saw the start of our community engagement events at Westfield (East), The Stratford Centre and Barking and Brent Cross shopping centers. The Trust were there for 7 days in total with many expressions of interest. These events will continue until the end of March at which time an evaluation will take place of their impact and effectiveness in attracting a diverse group of candidates to roles at the Trust.

Communications

68. A series of communications have been sent to the LAS Workforce during January and February 2018 around appraisals. The communication emphasised the importance of quantity and quality of appraisal. In order to support quality, it has been agreed that an appraisal audit will take place in March 2018. This will comprise of semi-structured interviews which will take place across selected areas. The interviews will be supported by a questionnaire that will be sent to all staff. The results of both will be analysed and recommendations will be made in April 2018. Appraisal training for both managers and staff is being delivered throughout February and March 2018.
69. Joan Ryan MP for Enfield North visited the Service in mid-January meeting Peter Rhodes, Assistant Director of Operations, North Central London and went on a ride-out from Edmonton station.
70. I have continued my engagement with London’s Sustainability and Transformation Partnerships. I attended the South West London STP Programme Board and met with Sarah Blow, Senior Responsible Officer for the STP. I also met with Angela Bahn from Bromley CCG, she is also the responsible officer for the South East London urgent and emergency care network.

71. Media stories of note:

- Cardiac arrest survivor raises money for defibrillators: we worked with the Evening Standard to secure coverage about jogger Neil Cole who raised more than £6,000 to buy defibrillators for eight London parks. Neil collapsed after running his second 5k ParkRun in January 2015. He was treated by fellow runners who performed CPR until our paramedics arrived and resuscitated him.
- 999 call during Finsbury Park mosque attack: National press and broadcast media referenced the call made to us during last June's attack after it was played at Woolwich Crown Court during the trial of accused attacker Darren Osborne.
- Staff assault: An assault on four of our frontline staff attracted coverage in the Evening Standard and Croydon Advertiser in January.
- Channel 5 documentary: A documentary 'Eight years old and smuggling drugs' featured an interview with Clinical Adviser to Legal Services Kirstie Smith. The programme looked at how children were being used by drug mules to transport drugs and the violent crimes committed while people are on these substances. Kirstie spoke about the variety of violent incidents she had attended, such as stabbings and shootings and how the patients are often youngsters.
- Fire at Holland Park Gardens: We received substantial regional and national media interest following a fire at Holland Park Gardens in which one person died.
- Physician response unit: BBC National News broadcast a report on the unit which is run as a collaboration between London Ambulance Service, London's Air Ambulance and Barts Health NHS Trust, and aims to reduce avoidable A&E admissions by providing much of the care and tests given in hospital to people in their homes or communities. Data from the first 111 days of the expanded service shows overall savings for local health services are estimated to be £410,938. In that time 67 per cent of patients have avoided a hospital trip and been treated within the community. BBC Health Editor Hugh Pym went on a ride out with the team for this report.

72. We have responded to three enquiries from the Health Service Journal over the past couple of weeks. In the first of these enquiries, the publication asked all ambulance trusts how much winter funding they had received and we confirmed our total was £3,728,000 for 2017/18.

73. Secondly, we provided a comment on an issue flagged in our risk register concerning changes to personal tax liability for on-call ambulance staff using lease cars with blue lights. We explained that this tax change was a national issue and also agreed and provided a national statement from AACE.

74. Finally, the HSJ also asked us about handover delays at Northwick Park Emergency Department which were also highlighted in our risk register. We provided some basic background information and emphasized that we are working closely with A&E departments and the rest of the healthcare system to manage capacity in all parts of London. We are still waiting to see if any of these enquiries result in specific stories or coverage

Garrett Emmerson
Chief Executive Officer



Report to:	Trust Board		
Date of meeting:	27 February 2018		
Report title:	Business Plan 2018/20		
Agenda item:	08		
Report Author(s):	Lorraine Bewes, Director of Finance and Performance Kevin Tallett, Discidium		
Presented by:	Garrett Emmerson, Chief Executive and Lorraine Bewes, Director of Finance & Performance		
History:	Executive Leadership Team 14/02/18; Finance and Investment Committee 22/02/18		
Status:	☒	Assurance	☒ Discussion
	☐	Decision	☒ Information
Background / Purpose:			
The purpose of this document is to provide an update on the process including the timescales and the current actions for the completion of the 2018- 2020 Business Plan.			
Recommendation(s):			
The Board is asked to review and comment. The Business Plan includes the CIPs that must be achieved during 2018/19.			
Links to Board Assurance Framework (BAF) and key risks:			
Links to BAF risk 49 in relation to the delivery of CIPs.			
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	☒

Business Planning Update

Introduction

1. The purpose of this paper is to introduce the attached Business Plan (to follow) which is presented as work in progress for confirmation from FIC that the proposed content and process meets the Board's requirements for assuring that the plan will deliver resources, both people and budget, that are capable of delivering the contractually and mandated quality and safety outcomes and that the financial, workforce and operational plans are fully integrated and internally consistent.
2. The content of the Business Plan document is set out for ease of reference below. We are taking a different approach to previous Business Plans by looking to move away from top down planning to a team-based co-production process. We will Build a Business Plan comprising of the following to cover the next three-year time horizon and to deliver the Trusts goals:

Business Plan Section	Status
Executive Summary	1 st draft complete
Our Vision, Purpose & Values	Complete using current version with new version included in appendix at present
Strategic Goals and Objectives	Strategic Goals defined (4P's). ELT to define a set of objectives aligned to the goals
Long Term Direction and Strategic Intent	Drafted, awaiting latest update
2018/19 Financial Planning	Latest updates included, directorate level budgets being confirmed
Trust Improvement Plan	Key Trust programmes identified, quality priorities undergoing review, efficiency project undergoing evaluation
Strategic Risks Assessment	Draft completed
Operational Plan: Activity, People and Finance	1 st draft being produced and validated
Capital Plan	High level envelope identified and will be validated against project portfolio

Context

3. The Business Plan sets out how we intend to deliver the Trust's strategic objectives around the pillars of our four strategic goals:
 - Provide outstanding care for our patients
 - Be a first-class employer, valuing and developing the skills, diversity and quality of life of our people
 - Partner with the wider system to optimise health care provision across London
 - Provide best possible value for the taxpaying public, who pay for what we do.

4. The Business Plan will be underpinned by a number of outcome deliverables and improvement plans which outline in more detail how we will achieve this across quality and safety improvement, people capability and use of resources.

Quality and Safety

5. The Quality Improvement Methodology Framework will be incorporated into all improvement programmes, not just quality related i.e. efficiency programmes aligned to the Carter review. The current development of a programme management office will further support the consistent delivery of improvement across all portfolios. Capacity and capability in quality improvement methodology is currently very limited, however, there is a plan to increase this capacity and to support the development of a continuous learning and improvement culture. LAS will also align their quality systems and processes to the regulatory framework as set out by the Care Quality Commission (CQC 2017) new frameworks. This is particularly important as the new inspection regime will involve on-going monitoring throughout the year, not just a 'one-off' inspection. Building systems and processes that allow the assessment against these standards to become 'business as usual' is therefore imperative
6. The assurance processes described will ensure that all tools, governance systems and processes link to this framework. Quality Assurance sector reviews, a new reporting system (Health Assure) will be introduced, alongside the re-structuring of the Datix system, to support this and provide the whole organisation with regular self-assessment reports both at sector and corporate levels to enable constant identification of risk and improvement opportunities. This will be further strengthened by the review of corporate governance and risk management frameworks.

People Capability and Capacity

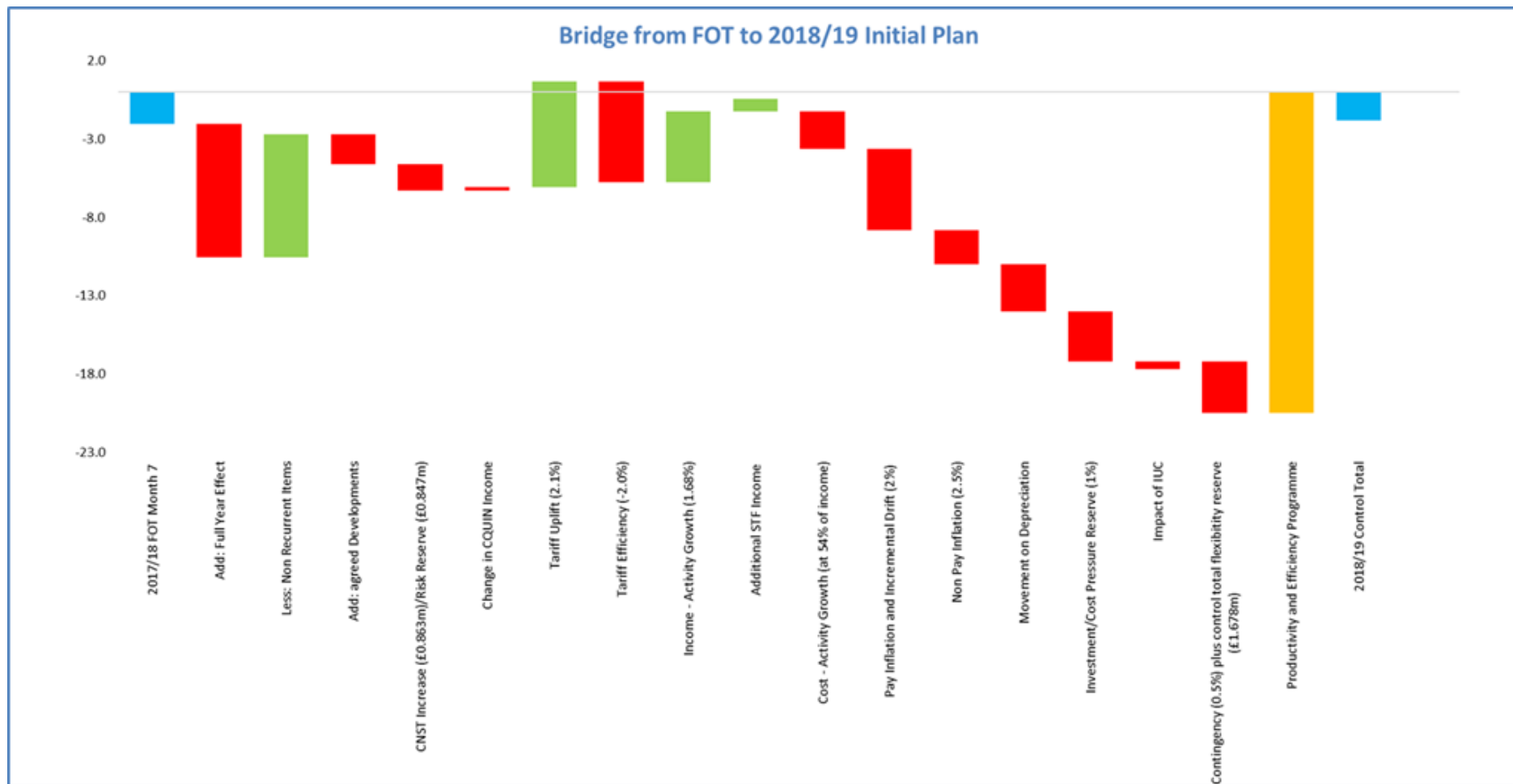
7. In setting out our Strategy for People and Organisational Development we have taken into consideration the work and input of other Trusts, of our external partners and of our people. Our work will not just focus on the short or medium term, but importantly seek to work with other organisations within the health and education sectors to tackle the future supply of paramedic skills.
8. We know that there is an increasing demand for our services and that we are working towards providing integrated urgent care services so that our people who have typically worked within a specific part of the business may be required to work across the LAS and health system boundaries. We understand that the future will see a decrease in 'dispatching and conveying, and an increasing focus on skills in 'hear and treat' and 'see and treat', extending the scope and practice of our Advanced Paramedics and allied healthcare practitioners. Last, but not least, technology will play an increasing and pivotal part in the work that we do and our people will need to be increasingly technology enabled and literate.

Use of Resources

9. We have a constrained financial budget envelope within which to work that requires us to make a significant efficiency savings while improving our services.
10. LAS is required to submit a financial plan and budget for 2018/19 that:
 - Delivers resources that are capable of delivering contractual and mandated quality and capability outcomes (note: An Operational Capacity plan for 18/19 vs 17/18 will be included in the final draft of the business plan to show key capacity

outcomes such as hours available, utilisation and efficiency assumptions, staff numbers and skill mix, ambulance hours, following receipt of the report from ORH on post ARP operating plan. This will enable the Board to gain assurance around the Trust's ability to align resources, efficiencies and quality.

- Delivers national performance standards introduced in November 2017 under ARP
 - Delivers the revised financial control total of £1.564m deficit in 2018/19
 - Ensures the Trust remains within its revised allocated ceiling for agency staff £5.990m which represents a reduction of £1.047m from the current allocated ceiling of £7.037m
11. Delivery of financial and operational targets ensures LAS will receive £2.728m of provider sustainability funding (previously STF) this represents an increase of £0.788m from 2017/18.
12. An initial high-level assessment of the financial plan and underlying assumptions has been carried out and is shown in the figure below:



13. In producing the Business Plan, we have opted to take a co-production approach, working both top down and bottom up in defining the business plan to gain maximum benefit and buy-in from our people. This approach allows the directorates and most importantly, the sub-divisions to generate ideas for improvement and efficiency.
14. We have engaged staff through a number of workshops (3 workshops with 2 more to go at the time of writing), and so far, 130 staff have developed a list of circa 600 ideas for delivery. These ideas are in the process of being consolidated, evaluated and valued. We are grouping ideas into those that can be delivered within one year (quick wins) and those that will take longer to be fully delivered running into years two and three.
15. The first tranche of those ideas will be delivered in 2018/19 through the use of traditional and agile techniques, managed through the Programme Management Office (PMO). Alongside this we will be developing projects that are the output of our initial benchmarking work and further enhanced by working with NHSI on developing the Model Ambulance opportunities in the sector. There will also be a number of projects with significant savings from strategic decisions the Board will need to make over the coming 6 months. These projects will again be managed through the PMO in a structured and controlled way utilising gateway methods and traditional project management techniques with the PMO team providing assurance of the delivery of actions required to ensure we have the best chance of success in delivery, working independently of Finance.
16. Therefore, we can group our key project focus as follows:
 1. Agile delivery of immediate actions (quick wins) within 2018/19 to deliver efficiency savings
 2. Productivity savings led by sector benchmarking through NHSI Model Ambulance which will involve both quick win projects and longer-term programmes, in order to achieve at least the average cost of other ambulance trusts and where it is appropriate, to achieve upper percentile.
 3. Strategic and Quality projects to deliver a sustained financial position and improve patient outcomes

Developing priorities for year 1 (position after 3 of 5 workshops)

17. The table below gives an overview of the number of individual ideas generated in the workshops held so far, split by delivery directorate. The ideas will have an element of overlap and will also need to be reviewed and combined with the early work done on CIP's to give a consolidated view of ideas for efficiency savings. The immediate next step is for the ELT to set the direction of the Trust priorities by agreeing a set of objectives, based on the projects, to align with the 4 P's strategic goals.
18. Each directorate will develop a set of 'must do' deliverables, these will be agreed with the rest of the ELT 'obtaining buy-in' to achieve. Further discussions will be then held to agree additional deliverables both local Directorate and Trust Wide based on resources available – financial and people, as well as fit with the Trust's Strategic Objectives and operational requirements.

Idea Values by Directorate				
Directorate	Do	Discuss	Not Yet	Total (£'000)
Central Operations	1,664	301	0	1,965
Quality	2,106	101	0	2,207
Finance				
People & OD	4,256	779	300	5,335
IM&T	469	199	1	669
Operations	2,194	331	5	2,530
EOC/111	61	0	0	61
Medicine	641	167	0	808
Governance	59	0	0	59
Strategic Assets	6,932	57	5	6,994
Strategy & Communications	1,303	271	500	2,074
	19,685	2,206	811	22,702

19. The embryonic PMO Portfolio 'weighting' criteria have been used to give an initial view, breaking the ideas down into 3 tranches:

Do – those with a weighting that, based on the input from the front-line teams' members who participated in the workshops, identifies them as 'attractive' and 'achievable'.

Discuss – those are either slightly less 'attractive' or have a more difficult level of 'achievability'

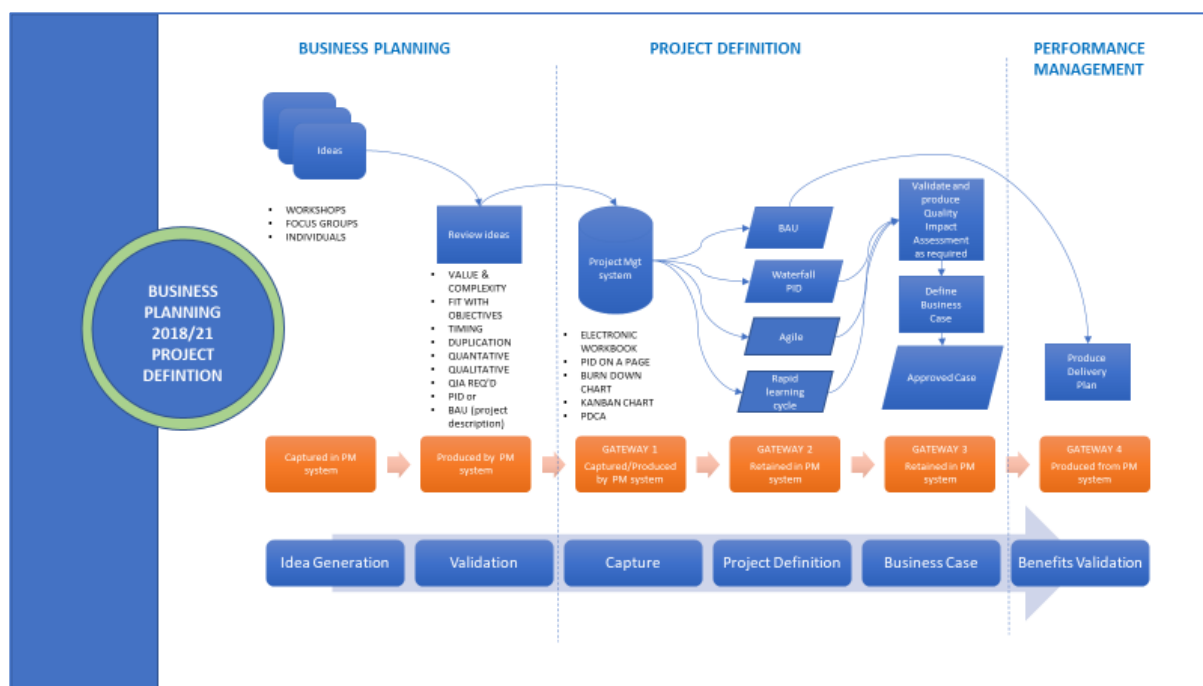
Not yet – those that are either the least 'attractive' or are considerably more difficult to achieve.

20. Each idea in these categories will be captured and validated and then defined as projects which can be assured, monitored and control for delivery. The split by weighting and initial estimated value is shown below:

Attractive	2	£170k	£12,255K	£7,163k
	1	£256k	£2,036k	£267k
	0	£5k	£550	£0
		0	1	2
Achievable				
		£19,685k	Do	
		£2,206k	Discuss	
		£811k	Not Yet	
		£22,702k	Total	

Process

21. As the ideas are validated, and combined with the early CIP ideas, already identified at high level, they are captured to ensure they can be quantified and the most appropriate method of delivery assigned to each one to become a portfolio of defined efficiency projects which will fit alongside the Trust Quality Priorities and Strategic Programmes. Once the projects have been defined and move into delivery they will be monitored through the Trust's Performance Management processes, which will include the use of Trust and Directorate level balanced scorecards and KPI's/Deliverables.
22. These score cards are currently being defined with the Directorates and will be incorporated into the updated version of the plan which will submitted to Trust Board on 27th February.
23. The process overview for idea generation through project definition and propose gateways is shown below:



Timeline

24. The timescale for achieving delivery of the Business Plan is very tight but is achievable. The plan below identifies the key milestones leading to submission of the plan, over the next 6 to 8 weeks, to be well positioned for the final submission of the plan to NHSI by 30th April. The engagement to date has been excellent and this will need to continue through March.

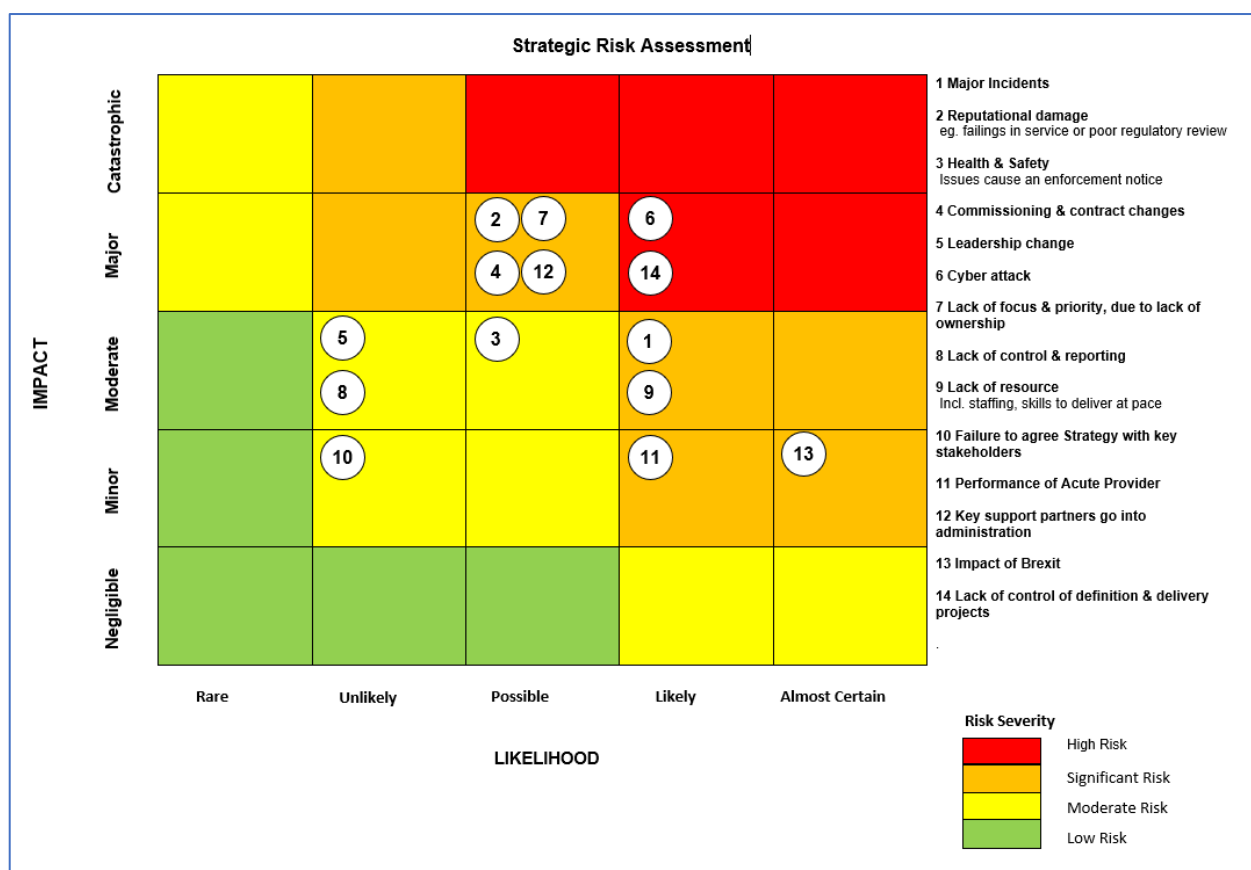
Task	Due Date	Owner	w/c 12/02	w/c 19/02	w/c 26/02	w/c 05/03	w/c 12/03	w/c 19/03	w/c 26/03	w/c 02/04	w/c 09/04	w/c 16/04	w/c 23/04	w/c 30/04
Business Plan Key Meetings/Dates														
Draft Business Plan to ELT	14/01/18	LB	◆											
Draft Business Plan to FIC	22/01/18	LB		◆										
Draft Business Plan to Trust Board	27/01/18	LB			◆									
Business Plan to ELT	07/03/18	LB				◆								
Business Plan to FIC	13/03/18	LB					◆							
Business Plan to Trust Board	27/03/18	LB						◆						
Draft 2018/19 Organisational Operating Plans submitted to NHSI/NHSE	06/03/18	LB				◆								
Final Board approved Organisation Operating Plan submitted NHSI/NHSE	30/04/18	LB												◆

Risk

25. The risks identified will be managed through the Trust Risk Management process and also through the independent PMO assurance processes. These processes will seek to ensure the projects have been set up to succeed from the start and will be used to assure the projects during their delivery.
26. The process to capture, validate and define the projects will also be used to identify resource and capability constraints (and recommend how to overcome them) together

with identifying the cost to achieve to ensure we remain within the budget envelope while delivering with focus and the requisite amount of pace.

Risk	Impact	Likelihood
Major Incidents	Moderate	Likely
Reputational Damage, for example failings in service or a poor regulatory review	Major	Possible
Health & Safety issues cause an enforcement notice	Moderate	Possible
Commissioning and contract changes	Major	Possible
Leadership change	Moderate	Unlikely
Cyber attack	Major	Likely
Lack of focus and priority due to lack of ownership	Major	Possible
Lack of control and reporting	Moderate	Unlikely
Lack of resource including staffing including skills to deliver at pace	Moderate	Likely
Failure to agree Strategy with key stakeholders	Minor	Unlikely
Performance of Acute Providers	Minor	Likely
Key support partners go into administration	Major	Possible
Impact of Brexit	Minor	Certain
Lack of control of definition and delivery projects	Major	Likely



Next Steps

27. The next steps are:

- ELT to set direction and agree Trust objectives aligned to the 4 P strategic goals
- Update the Trust Board on progress to date, timetable and process for submission of the Business Plan
- Complete definition of the Trust, Directorate and Sub-division scorecards which will form part of the business as usual performance management process
- Confirm directorate and sub-division budgets within the overall Trust budget.
- Hold directorate level 'deep dive' workshops where these are needed to validate the scope and benefits of the efficiency ideas for projects
- Define the Trust portfolio of projects and the delivery approach for each project
- Estimate resourcing and costs to achieve the efficiency projects and Trust Programmes
- Define the individual business cases
- Establish governance, control and assurance processes for project delivery
- Create the Capital Plan including cost to achieve the delivery of the projects
- Overlay year 2 and 3 planning assumptions and the currently known efficiency schemes which will run into year 2 and 3 together with the full year effect of current schemes. This will also include the NHSI planning assumptions for years 2 and 3.



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Annual Financial Plan 2018/19			
Agenda item:	09			
Report Author(s):	James Corrigan, Interim Deputy Finance Director			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Consideration by the Finance and Investment Committee at its meeting on 22/02/18			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The purpose of this paper is to update the Trust Board on the development of the Financial Plan for 2018/19 including a high level assessment of the overall savings requirement for next financial year, provide an update on recently issued planning guidance and control total changes and ongoing contract discussions with Commissioners. Since the January update, Joint Planning Guidance from NHS Improvement and NHS England was published on 2 February 2018, Revised control totals were issued to Trusts on 6 February 2018 and the London Ambulance Service NHS Trust (LAS) has received a formal response to its original contract proposal from Commissioners. A number of unknowns still remain at the time of writing this report including: the outcome of national pay negotiations although recently issued joint guidance has confirmed that any costs above the existing planning assumption of 1% (excluding incremental drift) will be funded centrally, the resource impact of the recently introduced Ambulance Response Programme (the outcome of external modelling review by ORH is urgently required to confirm the new level of safe staffing and fleet hours and the extent to which 17/18 pay underspends in particular are recurrent), and levels of demand led activity growth remain uncertain at this time.				
Recommendation(s):				
The Board is asked to note progress on the development of the Financial Plan for 2018/19. The draft financial plan has been reviewed at the Finance and Investment Committee and an update is included within the Committee update.				
Links to Board Assurance Framework (BAF) and key risks:				
The establishment of a robust Financial Plan for 2018/19 is critical in ensuring resources are deployed to ensure maintenance of effective, safe and good quality services and are sufficiently and sustainably resourced to meet the expected demand pressures. The Trust is required to deliver the Control Total agreed with NHS Improvement as part of its two-year plan (£1.564m Surplus). Key BAF risks covered are: 37,40,42,44				

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	☒

Annual Financial Plan 2018/19

1. The purpose of this paper is to update the Committee on the development of the Financial Plan for 2018/19 including a high level assessment of the overall savings requirement for next financial year, provide an update on recently issued planning guidance and control total changes and ongoing contract discussions with Commissioners.
2. Since the January update,
 - Joint Planning Guidance from NHS Improvement and NHS England was published on 2 February 2018
 - Revised control totals were issued to Trusts on 6 February 2018
 - The London Ambulance Service NHS Trust (LAS) has received a formal response to its original contract proposal from Commissioners
3. A number of unknowns still remain at the time of writing this report including:
 - the outcome of national pay negotiations although recently issued joint guidance has confirmed that any costs above the existing planning assumption of 1% (excluding incremental drift) will be funded centrally,
 - the resource impact of the recently introduced Ambulance Response Programme (ARP). The outcome of external modelling review by ORH is urgently required to confirm the new level of safe staffing and fleet hours and the extent to which 17/18 pay underspends in particular are recurrent.
 - and levels of demand led activity growth remain uncertain at this time.

Joint planning guidance summary

4. NHS Improvement and NHS England jointly issued planning guidance for 2018/19 at the beginning of February. The key headlines relating to LAS are as follows:
 - The Sustainability and Transformation fund is to become the Provider Sustainability Fund (PSF) with total funding of £2.45bn (up currently from £1.8bn).
 - There will be no additional winter funding in 2018/19. Systems are required to produce a winter demand and capacity plan with actions and proposed outcomes. Further guidance on submitting these will be available by March 2018.
 - Trusts accept that their control totals remain exempt from the existing contractual performance fines in the NHS Standard contract.
 - If control totals are not accepted, it will trigger action under the Single Oversight Framework and providers will not qualify for any discretionary capital allocations.
 - Funding allocations announced include an allowance for 2.3% growth in ambulance activity in 2018/19 and the guidance calls for STPs, CCGs and Trusts to review and update the trends and assumptions underpinning their expected rates of growth and move towards a shared set of agreements regarding growth.
 - Plans should ensure that ARP standards are met by September 2018 and Handovers should not exceed 30 minutes.
 - The guidance emphasises that it is essential that 2018/19 pay costs in planning returns are an accurate reflection of costs of current pay assumptions as these will be used to model nation pay agreements.
 - Workforce plans should be detailed and well modelled and align with both finance and service activity plans to ensure the workforce levels are affordable, efficient and sufficient to deliver safe care to patients
 - Providers should not assume any capital resource above internally generated capital unless NHSI or NHSE has specifically agreed additional funding.

- The 0.5% CQUIN risk reserve has been withdrawn in 2018/19 and 0.5% has been added to the STP engagement CQUIN which will now become 1%
- Plans should include appropriate phasing profiles to reflect seasonal changes in demand, particularly related to winter and ensure efficiency savings are not back loaded into the later part of the year.

Revised financial control total for 2018/19

5. NHS Improvement issued revised control totals and agency ceilings to providers in early February. The changes to the control total are set out in the table below.

	£m
Current 2018/19 control total (including allocated STF)	1.011 Surplus
Net impact of CNST income and spend changes	-0.836
Risk Reserve (available for deployment)	-0.847
Additional STF allocation	0.788
2018/19 control total (including allocated STF) before flexibility	0.116 Surplus
Control Total flexibility changes made if 2017/18 control total (excluding STF) is delivered	-1.680
Revised 2018/19 control total	-1.564 Deficit

Current STF allocation (from £1.8bn STF General Fund)	1.940
Additional STF allocation (from additional £650m STF)	0.788
Total allocated STF - the enhanced provider sustainability fund	2.728

Agency ceiling 2017/18	7.037
Agency ceiling 2018/19	5.990
Movement on agency ceiling	-1.047

Update on progress

6. 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 and the initial outputs are due for review by the end of February 2018.
 - External benchmarking through the Carter work and local benchmarking undertaken by external consultants is being used to inform CIP development, as reported in the efficiency saving section of the business plan.
 - Fleet and Logistics, Operations and Finance are working through the potential impact of both ARP and the introduction of the Ultra-Low Emissions Zone on the Trust's existing Fleet.

- Contracting team is working with Commissioners to agree the contract variation of 2018/19 including expected activity levels and agreement of CQUIN.
- Business planning workshops have been held with both operational and corporate divisions to identify efficiency and improvement opportunities across the organization.
- ELT meetings to confirm priority of strategic objectives for Yr. 1, 2 and 3 and Directorate level scorecards and detailed budget meetings are being arranged between now and end March.

Process and Timetable

Key Milestones	Description	Deadline
Budget Setting Guidance	Contracting Timetable confirmed and agreed. High level Business Planning guidance issued to all key stakeholders	November Early December
High Level Business Planning	High Level Income & Expenditure, Capital and Cash Plans agreed with key stakeholders (e.g. Divisional Directors, FIC, Capital Programme Group) confirming with Tier 1: 1. Operational performance targets 2. Transformation change agenda 3. Overall financial envelopes for I&E & capital	Launch 06/12/17 December workshops
Initial Planning Sign Off and Submission	Board, FIC/ ELT Review and approve high level plans	FIC 16 th January
Detailed Level Business Planning	Details of Income & Expenditure, Capital and Cash Plans discussed and agreed with key stakeholders (e.g. Divisional Directors,).	December/January / February Regular on-going reviews by Business Planning Group
Final Draft Detailed Planning Sign Off and Submission	Board / ELT Review and approve draft detailed plans for concluding contract income	Board 28 th February
Final Business Plan	Tier 1 Business Plan Workshop to communicate outcome	Early March
Finalise Detailed Budget Position	Final reviews to close any remaining budget gaps mitigate risks and finalise CIP plans.	Board 27 th March
Final Draft Detailed Planning Sign Off and Submission	Board / ELT Review and approve final detailed plans for submission to the NHSI. All individual budgets are signed off by their respective leads.	End March – 30 April April Submission to NHSI
Budget Upload	The Budget will be uploaded to the Ledger following the year end close down of the ledger in late April.	Early May

James Corrigan
Interim Deputy Director of Finance



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Risk Management Strategy and Policy			
Agenda item:	10			
Report Author(s):	Jason Ramchurn, Interim Head of Quality Intelligence Dr Patricia Bain, Chief Quality Officer			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	Quality Oversight Group membership (virtual approval); Audit Committee meeting on 12 February 2018 (ref: AC/17/72)			
Status:	☐	Assurance	☐	Discussion
	☒	Decision	☐	Information

Background / Purpose:

Over the last year work has progressed against the key priority area outlined in the Quality Improvement Plan in relation to Risk Management Strategy and Policy. The attached strategy document brings together all of this work into one overarching policy framework. The purpose of the Risk Management Strategy and Policy is to provide the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the London Ambulance Service NHS Trust (the Trust) is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to on-going operational activities.

The Trust is therefore committed to:

- Adopting best practice in the identification, evaluation and cost effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practical.
- Maximising opportunities to achieve the Trust's objectives and deliver core services provisions.

The Trust acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risk where this occurs. This is set out in our risk appetite.

The Trust's overall strategic aim is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system in place which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. Including but not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

Recommendation(s):
The Board is asked to approve the Risk Management Strategy and Policy to take forward for full implementation.
Links to Board Assurance Framework (BAF) and key risks:
All Board Assurance Risks relating to quality governance and risk frameworks.

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	☒

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NHS

London Ambulance Service

NHS Trust

Risk Management Strategy and Policy January 2018



Risk Management Strategy and Policy 2018-19

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Appendices

1	Model Risk Matrix
2	Risk Appetite Statement (2017)
2a	Risk Appetite Statement (Good Governance Institute)
3	LAS Assurance Framework
4	Risk Management Training Matrix
5	Roles and Responsibilities
6	Risk Reporting, Accountability and Escalation
7	Definitions
8	Structure for Risk Reporting and Escalation/De-escalation
9	Risk Management Policy Monitoring Dashboard
10	Risk Management Programme Plan 2017 / 2018

Risk Management Strategy and Policy

Key messages

- All staff must ensure that they identify all clinical and non-clinical risks to the delivery of safe, effective and high quality services.
- All staff must ensure that risks are assessed as soon as is reasonably practicable, identifying controls to mitigate negative impacts.
- When risks are identified and are unable to be controlled effectively, then staff have a responsibility to ensure that they are escalated to appropriate individuals for further review and consideration of how risks will be managed and recorded.
- The Trust Board have set the 'risk appetite' for the organisation and risks identified within risk registers must be assessed to ensure that they meet the thresholds set.
- Staff with identified responsibilities for managing risk in the organisation must ensure that they receive training that is appropriate to their level of accountability and responsibility.

Summary

London Ambulance Service (The Trust) Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity and openness

The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors.

This strategy and policy describes a consistent and integrated approach to the management of all risk across the Trust.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the board and management is not surprised by risks that could, and should, have been foreseen.

Strategy and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

Scope

Risk Management activities applies equally to all staff and individuals employed by the Trust including; contractors, volunteers, students, locum, agency and staff employed with honorary contracts.

1 Purpose

Risk management is both a statutory requirement and an indispensable element of good management.

1.1 Strategy Statement:

The purpose of the Risk Management Strategy is to provide the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that London Ambulance Service (the Trust) is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to on-going operational activities.

The Trust is therefore committed to;

- Adopting best practice in the identification, evaluation and cost effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practical.
- Maximising opportunities to achieve the Trust's objectives and deliver core services provisions.

The Trust acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risk where this occurs.

The Trust's overall strategic aim is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system in place which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. These arrangements are set out in the following documents; Standing Financial Instructions, Scheme of Delegation and Authorisation from the Board of Directors, Standing Orders from the Board of Directors.

The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. Including but not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

The Trust has the following risk management objectives;

- Minimise the potential for harm to patients, all staff and visitors to a level as low as reasonably practicable.
- Protect everything of value (such as high standards of patient care, staff safety, reputation and assets or income streams).
- Anticipate and respond to changing circumstances (social, environmental, legal, financial etc.).
- Maximise opportunity by adapting and remaining resilient to changing risk factors.
- Ensure that risk management is clearly and consistently integrated and not managed in silos.
- Consider compliance with health and safety regulations, insurance, accreditation and legal requirements as a minimum standard.

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- Inform policy and operational decisions by identifying risks and their likely impact.

These objectives will be achieved by;

- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management.
- Including risk management issues when writing reports and considering decisions.
- Demonstrating the application of risk management principles in all activities of the Trust.
- Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust.
- Maintaining a comprehensive risks register (Datix) of both clinical and non-clinical risks and reviewing the same on a periodical basis.
- Ensuring controls are in place, effective to mitigate the risk and understood by those expected to apply them.
- Ensuring gaps in control are rectified and assurances are reviewed and acted on in a timely manner.
- Maintaining documented procedures, within Datix (the Trust's Integrated Risk Report), of the control of risk and provision of suitable information, training and supervision.
- Preparing contingency plans to secure business continuity where there is a potential for an event to have a major impact upon the Trust's ability to function.
- Monitoring all arrangements continually and seeking continuous improvement.

1.2 Policy Statement:

The Board of Directors is committed to the active management of risk, providing better care and a safer environment for patients, staff and other stakeholders. The aim is to achieve this without compromising flexibility, innovation and best practice in the delivery of patient diagnosis, treatment and rehabilitation.

The purpose of the Risk Management Policy is to identify the proactive systems used by The Trust to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

The Trust recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incurs risks.

The Trust accepts its corporate responsibility to provide the highest standards of patient care and staff safety and as such, the process of risk management is viewed as an essential component in maintaining and improving standards in the Trust.

The objective of the Policy is to ensure that the Trust has an effective system for identifying and managing risks with the aim of;

- Achieving its objectives
- Protecting patients, staff and members of the public; and
- Protecting assets.

2 Introduction

- 2.1 The Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, operating premises and managing finances all involve risk. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

The Trust is committed to;

- Adopting best practice in the identification, evaluation and cost effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practical.
- Maximising opportunities to achieve the Trust's objectives and deliver core service provisions.

The Trust however, acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risks where this occurs.

- 2.2 The aim of this strategy and policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.
- 2.3. This strategy and policy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels, and they are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.
- 2.4 The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined herein, escalating any risks where required.
- 2.5 Risk management is both a statutory requirement and also an integral part of good governance. It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff. It is expected that all risk management activities in the Trust will follow the process described within this document.
- 2.6 The Trust has adopted an integrated approach to the overall management of risk, irrespective of whether the risks are; clinical, organisational, environmental or financial.

3 Framework

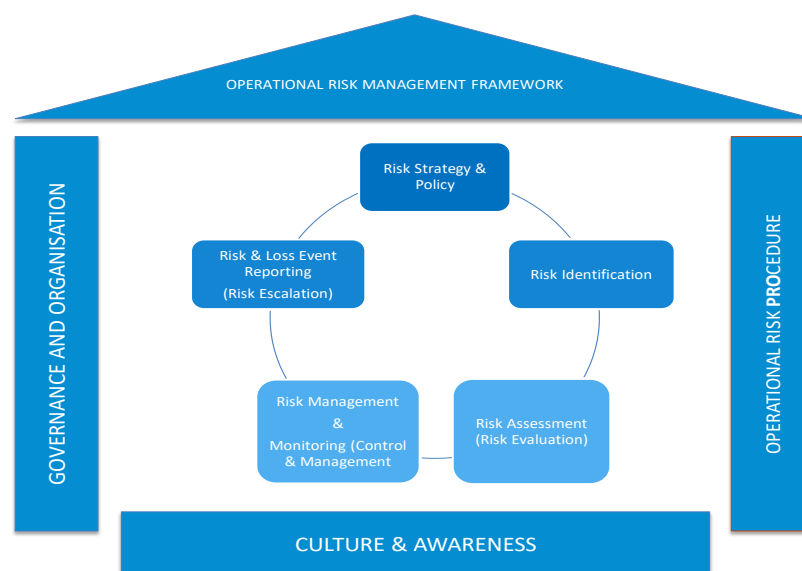
- 3.1 This section describes the broad framework for the management of risk. Operational instructions for risk management, health and safety risk assessments, investigation of incidents and learning from incidents and central alerts systems management are detailed in separate procedural documents.

The Risk Framework below depicts the process for how risk is managed by The Trust.

Fig 1: Risk Management Process



Fig. 3: Governance Framework 2017



Adapted from Operational Risk Management Framework (Soneri Bank) 2017

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3.2 Risk Matrix

- 3.2.1 To evaluate the likely impact/consequence of a risk occurring the risk should be scored with the use of the Risk Matrix. Please see Appendix 1

4 Risk Appetite

4.1 Risk Appetite Description

- 4.1.1 The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an initial evaluation. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite".
- 4.1.2 Risk appetite is therefore 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' (HMT Orange Book definition 2005) It can be influenced by personal experience, political factors and external events.
- 4.1.3 Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance and its reputation.
- 4.1.4 It is important for the Trust to know about its about risk appetite because if the organisation's collective appetite for risk is set at a certain level and the reasons for it is not known, then this may lead to erratic or inopportune risk taking, thereby exposing the organisation to a risk it cannot tolerate. Conversely an overly cautious approach can be taken which may stifle growth and development. If the leaders of the organisation do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected.
- 4.1.5 The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The risk appetite review will consider:
- Risk leadership
 - People
 - Risk strategy and policy
 - Partnerships
 - Risk management process
 - Risk handling
 - Outcomes

4.2 Risk Appetite Statement

- 4.2.1 The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:
- The nature of the risks to be assumed

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- The amount of risk to be taken on
- The desired balance of risk versus reward

4.2.2 On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

- Quality/Innovation/Outcomes Risks
- Financial/Value for Money (VFM) Risks
- Compliance/Regulatory Risks
- Reputational Risks

4.2.3 The statement will also define the Board's appetite for each risk identified for the achievement of strategic objectives for the financial year in question.

4.2.4 Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

4.2.5 The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk (please see Appendix 2).

5 Risk

5.1 Risks to patients

- 5.1.1 The Trust recognises that there is inherent risk as a result of being ill or injured, and that the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible.
- 5.1.2 The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good health care and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery.
- 5.1.3 In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

5.2 Organisational risks

- 5.2.1 The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial and health and safety etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.
- 5.2.2 The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance arrangements whilst maximising our performance in line with value for money.
- 5.2.3 A programme of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

5.3 Reputational risk

- 5.3.1 The board of directors models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment.
- 5.3.2 The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

5.4 Opportunistic risks

- 5.4.1 The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in business plans, whilst respecting and abiding by its statutory obligations.
- 5.4.2 Taking action based on the Trust's stated and agreed risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure that safety and quality is maintained.

6 Risk Management Process

- 6.1.1 Risks are adverse events that may happen, which if they were realised, could stop the Trust achieving its objectives or negatively impact upon its success. Risk management also addresses those issues that have happened, which were not planned, and have had an adverse outcome. These issues also require management action.
- 6.1.2 Regardless of whether a risk is clinical or non-clinical in nature The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and, where appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

6.2 Risk Management Cycle

- 6.2.1 The Trust's risk management cycle ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:
- Clarifying objectives
 - Identifying risks to the objectives
 - Assess and score the risk.
 - Identify controls and their effectiveness.
 - Identify and record actions to mitigate the risk
 - Regularly review and monitor the risk
 - Escalation and de-escalation of risks

6.3 Governance structure to support risk management

- 6.3.1 There are different operational levels ensuring the governance of risk in the Trust:
- Board of Directors
 - Executive Team
 - Operational Management Teams
- 6.3.2 Risk management by the board is underpinned by a number of interlocking systems of control. The board reviews risk principally through the following three related mechanisms.
- **The Board Assurance Framework (BAF)** sets out the strategic objectives of The Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the board agenda.
 - **The Corporate Risk Register (CRR)** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
 - **The annual governance statement** is signed by the Chief Executive as the accountable officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

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- 6.3.3 Additionally, the Audit and Risk Committee and other board sub-committees exist to provide assurance of the robustness of risk processes and to support the Board of Directors.
- 6.3.4 Each division will have a management forum where risk is discussed, including their risk register, actions, and any required escalation
- 6.3.5 Risk Management Structure

Please refer to **Appendix 3** for details of the various committees involved in The Trust's governance of risk.

7 Horizon Scanning

- 7.1.1 Horizon scanning focusses on identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business.
- 7.1.2 Horizon scanning helps identify positive areas for the Trust to develop its business and services and provides a steer toward taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.
- 7.1.3 By implementing formal mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a planned, structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.
- 7.1.4 The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:
 - Legislation
 - Government white papers
 - Government consultations
 - Socio-economic trends
 - Trends in public attitude towards health
 - International developments
 - NHS Improvement publications
 - Local demographics
 - Seeking stakeholders views
 - Risk Assessments
- 7.1.5 All staff have a responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.
- 7.1.6 Board members have the responsibility to horizon scan and formally communicate matters in the appropriate fora relating to their area of responsibility.

8 Risk Management Activities

- 8.1.1 The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by on-going training including:
- Risk Management Procedure
 - Policy for the Management of Incidents and Serious Incidents requiring Investigation
 - Health and Safety Policy and Procedures
 - Complaints Policy and Procedure
 - Information Governance Policy
 - Corporate Business Continuity Policy and Plan
 - Policy for the Management of Conduct and Capability
 - All policies and procedures associated with Healthcare Acquired Infections
 - The Management of Violence and Aggression and Harassment of Staff
 - Safeguarding policies and procedures (Adult and Child)
- 8.1.2 The Trust's systems of internal control are based on its on-going risk management programme that aims to:
- Identify principal risks to the achievement of goals set out in the Annual Plan;
 - Evaluate the nature and extent of risks;
 - Manage all risks effectively, efficiently and economically;
 - Enable the completion of the Annual Governance Statement.

9 Delivering the Strategy

- 9.1.1 The strategy aspect of this Risk Management Strategy and Policy will be delivered by focussing on key themes of activity, linking the Trust's overarching commitments, strategic objectives outlined in the Annual Plan and local objectives agreed within Operational/ Corporate Directorate service/governance plans.
- 9.1.2 Executive Directors, Senior Management Teams and Departmental / Operational Managers within the Trust will:
- Be clear about the Trust's quality priorities and strategic objectives;
 - Promote awareness and understanding of the benefits of proactive risk management, therefore developing a positive risk and patient safety culture;
 - Manage risk through their own; Departmental, Directorate, Operational structure by; identifying, assessing, controlling, monitoring and reviewing risks. Ensuring the controls and action plans are SMART and fully implemented;
 - Distribute and disseminate, to their teams results of complaints, incidents, serious incidents, audits and lessons learned;
 - Support compliance with appropriate legislation and standards including national Risk Management Standards and CQC requirements
- 9.1.3 The Trust will:
- Ensure corporate ownership and accountability throughout the organisation of risk management and the need to mitigate risk along with the mechanisms for reporting and sharing learning across the organisation;

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- Promote and support the development and implementation of risk management strategies and policies in general practice;
- Provide training and on-going support to ensure that all risks are reported and that all staff are aware of mechanisms to report incidents and near misses.
- Ensure that all staff receive training in conducting health and safety risk assessment;
- Establish and implement a plan to develop and strengthen the organisation's risk management culture.

9.1.4 The Strategy will be reviewed annually by the Board according to good governance practice.

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10 Risk Management Specialists

- 10.1.1 The Trust has risk management specialists who possess and maintain appropriate qualifications and experience sufficient to ensure that competent advice is available to staff. The specialists are responsible for creating, reviewing and implementing policies, procedures, protocols and guidelines for the effective control of risk. Key risk management leads for the Trust are as follows:
- 10.1.2 The Director of Corporate Governance is the corporate governance lead for the organisation. The Director of Corporate Governance supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Board of Directors, for maintaining the Board Assurance Framework that defines the principal risks to achieving the Trust's strategic objectives together with associated controls, sources of assurance and action plans
- 10.1.3 Chief Quality Officer is the quality governance lead for the Trust. The Chief Quality Officer is responsible for the Trust Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. The Chief Quality Officer is accountable to the Chief Executive and is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The Chief Quality Officer is also responsible for notifying the Medical Director of risks identified through incidents, risk assessments, risk profiling and other triggers.
- 10.1.4 The Deputy Director of Quality Governance and Assurance is responsible for supporting the implementation of the Trust Risk Management Strategy and Policy and supporting procedures. The Deputy Director of Quality Governance and Assurance is accountable to the Chief Quality Officer and is responsible for promoting and supporting the implementation of Trust-wide systems of governance and risk. This includes establishing dynamic risk management systems and processes that form an integral part of routine organisational and departmental activity
- 10.1.5 Where responsibilities are assigned within the following roles the Trust shall regularly review the training needs analysis to ensure that competence sufficient for the discharge of any duties is acquired and maintained by the duty holders
- 10.1.6 Details of other Trust risk management specialists are provided below.

Trust Risk Management Specialists Specialist/ Advisor

Specialist/ Advisor
Caldicott Guardian
Chief Pharmacist/Accountable Person Controlled Drugs
Director for Infection Prevention and Control (DIPC)
Head of Quality Assurance
Head of Health and Safety
Head of Legal
Head of Patient Experience
Information Governance Manager
Fire Safety Officer
Local Counter Fraud Specialist
Local Security Management Specialist (LSMS)
Responsible Person, Legionella
Senior Information Risk Owner (SIRO)
Waste Manager

11 Roles and Responsibilities for All Staff

- 11.1.1 **Awareness:** Staff should have an awareness and understanding of the risks that affect patients, and staff.
- **Risk identification:** Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.
 - **Accountability:** Staff will be identified to own the actions to tackle risks.
- 11.1.2 **Communication:** There will be active and frequent communication between staff, stakeholders and partners.
- **Competence:** Staff will be competent at managing risk.
 - **Training** – staff have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities have this provided internally. The training matrix for staff is found at Appendix 4
 - **Board Training** – the Trust Board receives training every **two years**, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed Regulations.
- 11.1.3 **Management:** Activities will be controlled using the risk management process and staff are empowered to tackle risk.
- **Risk assessment and management** – risks are assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans are put in place where required.
 - **Process** - the process for managing risk is routinely reviewed to ensure continual improvement. This is integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.
 - **Measuring performance** - exposure to risk is measured with the aim of reducing this over time. The culture of risk management is also measured and improved where applicable.

12 Responsibilities and Accountabilities

12.1 Individual responsibilities

- 12.1.1 Risk management is the responsibility of **all staff**. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day activities conducted by members of staff.
- 12.1.2 The following sections define the organisational expectations of particular roles or groups.

12.2 Risk Management Roles

- 12.2.1 See Appendix 5 for a full list of roles and responsibilities

12.3 Risk Lead

- 12.3.1 All corporate areas, sectors, programme and project teams must have an identified Risk Lead.

The risk lead will be responsible for:

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- consulting with teams to identify and assess risks and determine mitigating actions;
- the on-going maintenance of a risk register for their area of Trust business;
- ensuring risk registers undergo regular review and quality assurance;
- promoting the risk management Policy and procedure and best practice within their area of Trust business;
- communicating changes to the risk management strategy, policy and risk procedure to staff within their area of the Trust;
- sharing information and knowledge on risks within their area of Trust business, directorate and those on the Corporate Risk Register through membership of the clinical governance monitoring committee; and
- being the key contact for the quality and assurance support department on the management of risk and compliance with this strategy and policy.

12.4 Risk Owner

- 12.4.1 All risks will have an identified risk owner recorded on the Trust's integrated risk management system (Datix). It may not be the same person as the action owner (see below). The risk owner is responsible for ensuring the risk is managed, including ongoing monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk, and reporting on its overall status. It is the responsibility of the risk owner to escalate risks where appropriate in line with local governance arrangements and the risk reporting, accountability and escalation process described in appendix 6.

12.5 Action Owner

- 12.5.1 All risks have action owner(s) to whom the risk owner delegates responsibility for ensuring the delivery of a task or activity that will help mitigate the identified risk, and to provide regular reporting on progress.

12.6 Quality Governance Department (QGD)

- 12.6.1 The QGD supports the organisation and the Board of Directors by providing a risk management function that facilitates and monitors the implementation of effective risk management practices by operational management, and assists risk owners in defining the target risk exposure, and in reporting adequate risk-related information throughout the organisation.
- 12.6.2 Specifically, the department supports all areas of the Trust to produce risk reports in an agreed format to facilitate ward to Board governance and where necessary, escalation, of risks. The department also supports executive management of risk by managing the Corporate Risk Register and reviewing the wider Trust risk register to provide assurance on the compliance with the Risk Management Strategy and Policy, and procedure. The department also provides support and guidance to the Trust's corporate office in the maintenance of the Trust BAF, ensuring a clear relationship between BAF risks identified by the Board (top down) and those recorded in the Trust risk register (bottom up).
- 12.6.3 In addition to its central risk management function, the department also provides a compliance and assurance function providing positive assurances as well as monitoring specific risks to non-compliance with regulatory quality and safety standards defined by the Health and Social Care Act 2012 and its associated regulations. The QGD's role will not be limited to this regulatory framework alone.

12.7 Health and Safety Risk Assessments

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- 12.7.1 Risks for inclusion on the Risk Register can be identified from a number of sources including audits, incidents/near-misses, inspections, complaints, enforcement action and **health and safety risk assessments**.
- 12.7.2 All areas of the Trust must proactively carry out health and safety risk assessments on their activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments are important because they help to identify and adequately address hazards and risks in order to prevent harm. Where a risk has been identified as a result of a health and safety risk assessment, which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally), the risk must be entered onto the Risk Register. Where a health and safety risk is entered onto the Risk Register, the health and safety risk assessment must be attached to the risk entry.

13 Assurance Framework

13.1 Assurance Structures

- 13.1.1 Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the Assurance Committees of the Board. The Trust Assurance Committees receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with milestones. The Trust Assurance Committees are responsible for providing assurance on the management of corporate risks to the Board of Directors and are identified at Appendix 3

14 Training

14.1 Training plan and support

- 14.1.1 To support the successful implementation and embedding of the risk management strategy, policy and risk procedure:
- 14.1.2 **Training** – an e-learning package 'Introduction to Risk Management' will be developed and available to all staff through the Trust intranet. Staff have access to comprehensive risk guidance and advice via the QGD department; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities have this provided internally. The training matrix for staff is found at appendix 4. Training compliance is reported to the Trust Board and Management Executive via the workforce committee.
- 14.1.3 **Board Training** – the Trust Board will receive training every **two years**, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.
- 14.1.4 Attendance/participation records is co-ordinated centrally on the Trust's management system.
- 14.1.5 The Trust's Management Executive ensures monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management training for Board members and senior managers. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.
- 14.1.6 The Risk Management Training Matrix can be found at Appendix 4

15 Equality Impact Assessment

- 15.1.1 As part of the development of this Strategy and Policy its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact

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on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

16 Process for Monitoring Compliance with Strategy

- 16.1.1 The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed, through the annual review of the risk management system and the Internal Auditor's report on the effectiveness of the system of internal control.
- 16.1.2 A monitoring dashboard has been developed to facilitate the monitoring of the key elements of this strategy. The dashboard will be subject to annual review in support of the on-going monitoring process by the Deputy Director of Quality Governance and Assurance.

17 Implementation and Dissemination

- 17.1.1 This Strategy and Policy document is available to all staff via the Trust intranet and internet sites.
- 17.1.2 **Internally:** Notification of this document will be included in an all staff email bulletin, as well as through the Trust's other communication routes.
- 17.1.3 **Externally:** The reviewed Policy will be sent to the Trust's main commissioners and is freely available on request to Trust stakeholders

18 Review

- 18.1.1 This Strategy and Policy will be reviewed annually.

19 Risk Management Procedure

19.1 Risk Management Procedure

- 19.1.1 This Risk Management Strategy and Policy document is underpinned by a comprehensive Risk Management Procedural Document which describes the process for effectively identifying, assessing, evaluating and monitoring all Trust Risks whether they are clinical or health and safety related.

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21 Associated documents, legislation and references

21.1.1 NHS England – Risk Management, Policy and Process Guide (2015)

21.1.2 Health and Social care Act (2008)

21.1.3 Monitor Risk Assessment Framework (2015)

21.1.4 Health and Safety at Work Act (1974)

This strategy and policy should be read in conjunction with the risk procedural document 2017/18.

Equality and diversity statement

This document complies with the London Ambulance Service equality and diversity statement.

Disclaimer

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Document management

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Model risk matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table, then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Note: the Trust has adopted the NPSA risk matrix and descriptors without adaptation.

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Note: the Trust has adopted the NPSA risk matrix and descriptors without adaptation.

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Table 3 Risk scoring = consequence x likelihood (C x L)

Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the Trust has adopted the NPSA risk matrix risk scoring without adaptation.

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For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

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

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 1 (above) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Calculate the risk score the risk multiplying the consequence by the likelihood: $C \text{ (consequence)} \times L \text{ (likelihood)} = R \text{ (risk score)}$

Risk Appetite Statement (November 2017)

The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The statements below are a reflection of the Trust's current position in relation to the primary risk groupings as set by the Good Governance Institute (2012)ⁱ. This reflects the position of the Trust's risk appetite, relating to its strategy and associated quality plans. This statement will be reviewed no later than March 2018 by the Audit Committee and Trust Board, or following the next regulatory review of the Trust (Care Quality Commission or NHS Improvement).

Quality

The Board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the potential for consequent effects on patient safety, experience or outcomes are low and the potential for mitigating actions are strong.

Compliance/Regulatory

The Board has a cautious risk appetite when it comes to compliance and regulatory issues. It will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them. The Board is willing to take opportunities where positive gains can be anticipated and within the regulatory environment.

Innovation

The Board's risk appetite for innovation, strategic transformation and developing effective external relationships and alliances is broad, depending on the nature of the innovation being proposed. It has a flexible view of innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other innovations will be limited to only essential developments and with decision making held by senior management.

Reputation

The Board has a mainly cautious approach to the management of the Trust's reputation. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions.

Financial

The Board will adopt a flexible approach to financial risk and is prepared to invest in resources that deliver improvements in quality and patient safety. Financial decisions impacting on quality and patient safety will be subject to rigorous quality impact assessments. The Trust has a more cautious approach to commitments other than those related to quality, patient safety and improve the patient experience.

Commercial

The Board has a flexible view of commercial risk, aligned with its appetite for innovation. It will support lower-risk opportunities in established business areas and markets and in areas where it has significant commercial strength over its competitors and/or wishes to secure continuity to the benefits and outcomes to the Trust's patients and the wider community it operates in.

ⁱ Bullivant J & Corbett-Nolan A (2012) Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking accessed from <http://www.good-governance.org.uk/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/> on 5 April 2017

Risk Appetite for NHS Organisations

A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012



Risk levels ▶	0	1	2	3	4	5
Key elements ▼	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM)	Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VFM is the primary concern.	Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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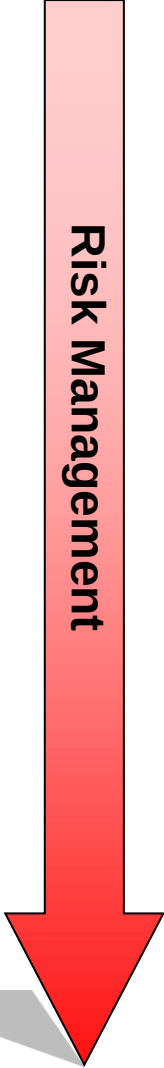
www.good-governance.org.uk

LAS Assurance Framework

TO INSERT

Appendix 4

Risk Management Training Matrix

Risk Management	Key stages of the patient pathway	Level of Training	Agenda for Change Grades	Aims of Training	
	Identification, Assessment and Escalation	Level 1 Foundation Training	All Trust staff (Mandatory)	Personal and Professional Development Plans Positive Performance Management Further training and development as life-long learning	- For all Trust employees to understand what a risk is, - To undertake the relevant risk assessment (without formal form completion) - Identify any immediate risks to patient safety and correct them. - Appropriate escalation to senior staff to formalise risk assessment and undertake mitigations
	Risk Management and Escalation	Level 2 Intermediate Training	Band 6/7/8 Senior Management Teams (Identified through PDPR and Job Description)		- For all staff with responsibility for departments/ clinical areas/ wards to be able to identify and assess associated risks. - To undertake formal risk assessments and utilise risk management software (Datix) - To be able to action and document mitigations against risks, and evidence future actions required. - To be able to escalate risks when unable to control risks within own resources (including escalation to Corporate Risk Register via Candidate Risk Forms) - To understand the process of risk de-escalation in line with Trust policy.
	Strategic and Emerging Risk Management and Control	Level 3 Advanced Training	Executive Team (in line with Trust Policy and Licence Requirements)		- To be able to lead on the management of all Corporate and Strategic Risks - To undertake scrutiny of the Board Assurance Framework, ensuring appropriate mitigation is in place. - To ensure that any external and longer term risks are identified and managed in line with best practice. - To direct Trust staff in the management of de-escalated risks to Divisional level - To provide senior guidance to Trust staff in the identification and management of risk.

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Appendix 5

Roles and Responsibilities

Title	Risk Management Responsibility
Chief Executive	The Chief Executive is the Accountable Officer for the London Ambulance Service NHS Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation as outlined below. The Chief Executive chairs the Management Executive. The Management Executive, as the group responsible for the Corporate Risk Register, decide which risks require recording and managing corporately or escalated to the Trust BAF.
Director of Finance	Responsible for implementing financial systems of internal control including the reporting of fraud to NHS Protect. The Director of Finance is responsible for informing the Board of Directors of the key financial risks within the Trust, the actions being taken to control them, and providing written advice to the accountable officer on the content of the annual governance statement regarding financial risk. The Director of Finance also ensures that structures, systems and processes are in place and functioning to support the Trust's financial, IM&T and estates strategies.
Chief Quality Officer and Medical Director	The Chief Quality Officer and Medical Director are jointly accountable for the effective delivery of the Trust's quality Policy. They are responsible for ensuring the systems are in place to identify and assess the clinical risks to patients and that there are processes in place for effective planning, organisation, control, monitoring and review of preventive and protective measures.
Medical Director	The Medical Director is responsible for ensuring the clinical processes adopted within the hospital are appropriate and effective, that the Trust is compliant with national institute of clinical excellence (NICE) guidance, ensuring clinical involvement in and the delivery of the clinical audit programme, learning through national confidential enquiries and medical training, supervision, appraisal and revalidation. The Medical Director is responsible for informing the Board of Directors of the key risks emanating from clinical activity throughout the Trust, employment of doctors and their practice, training, supervision and revalidation, the actions being taken to control them and provide written advice to the accountable officer on the content of the annual governance statement in regards to the management of these risks. The Medical Director is the nominated director for infection prevention and control (DIPC). The Medical Director is also the Trust senior information risk owner (SIRO) with ownership and champion of the Trust's information governance policy together with risks relevant to the role of the Caldicott guardian.
Chief Quality Officer	The Chief Quality Officer is responsible for the executive leadership of risk management and compliance, and fulfilling the statutory duty of quality improvement including delivery of the key quality and patient experience objectives. The CQO is responsible for reporting on the Trust's achievement of essential quality standards and preparation and consultation of the Trust quality account. The CQO is the Executive Director responsible for

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Title	Risk Management Responsibility
	managing risks associated with the delivery of therapy services together with safeguarding children and adults. The CQO has joint overall authority for quality improvement and clinical governance and delegated authority for quality improvement, risk management, clinical governance, complaints and litigation, and is executive lead for child protection.
Director of Operations	The DoO is responsible for the performance of all operational services, emergency planning and business continuity risks. They provide written advice to the accountable officer on the content of the annual governance statement with regards to the achievement of key performance standards and readiness to respond to major events and maintenance of key services at these times. The chief operating officer also line manages all sector directors and associate directors of operations from a managerial performance perspective.
Chief Quality Officer/Head of Health and Safety	The CQO is the appointed executive director for health and safety and is responsible for ensuring there is an effective health and safety management system compliance with statutory requirements and is responsible for ensuring the Trust has access to competent health and safety advice and resources, and that health and safety is included in Board decisions and priorities. The CQO is responsible for ensuring systems are in place to identify and assess risks associated with health and safety to employees, patients, and those affected by the Trust's activities. The CQO ensures the development, implementation and monitoring of the health and safety policy and its arrangements and chairing the Health and Safety Committee.
Director of Strategy	The Director of Strategy and Major Projects is the appointed executive director to ensure that major projects, including those delivering on innovation and commercial impact meet the requirements of regulatory and statutory requirements. The Director of Strategy and Major Projects is responsible for ensuring that the Trust progresses those schemes that meet the Board's priorities and fit within the remit of the risk appetite for the Trust. The Director of Strategy and Major Projects is responsible for ensuring that project systems are in place to identify and assess risks with projects, innovations and commerce, ensuring that any impact on Trust patients, staff and activities are robustly investigated, and to not evidence negative outcomes in relation to quality and delivery of service.
Non-Executive Directors	Non-executive directors have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical) that support achievement of the organisation's Policy. In particular, members of the Audit Committee will review the adequacy of the risk management Policy, and receive regular monitoring information against the management of risks judged as significant within the Board assurance framework, and provide assurance to the Board of Directors on the effectiveness of systems within the Trust designed to manage risk.
Executive Directors	Executive Directors are accountable to the Chief Executive and Trust Board for the maintenance of effective systems of internal control within their areas of responsibility. Executive directors are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the BAF and any other identified significant risks.

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Title	Risk Management Responsibility
	Each Director is responsible for risk management leadership including the implementation of, and compliance with current Trust policies, and for ensuring sufficient resources have been allocated to undertake effective risk management. Executive directors are responsible for ensuring the Corporate Risk Register and BAF are reviewed on a monthly basis and that risk action plans from serious incidents and risks are implemented in a timely manner as agreed. Leading by example, executive directors are fundamental in establishing and sustaining an environment of openness on risk management within their directorates.
Director of Corporate Governance	The Director of Corporate Governance is the corporate governance lead for the organisation. The Director of Corporate Governance supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Board of Directors, for maintaining the Board Assurance Framework that defines the principal risks to achieving the Trust's strategic objectives together with associated controls, sources of assurance and action plans. The Director of Corporate Governance also advises the Board in relation to the decision-making regarding the Trust's annual Risk Appetite Statement. The Director of Corporate Governance works closely with the Chief Quality Officer in all matters relating to organisational governance and risk.
Chief Quality Officer	The CQO is the quality governance lead for the Trust and is responsible for the Trust Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. The Chief Quality Officer is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to clinical governance and risk, up to and including the Corporate Risk Register. The Chief Quality Officer works closely with the Director of Corporate Governance, and appropriate others, in all matters relating to organisational governance and risk. The CQO has a responsibility to ensure the delivery of appropriate training to Trust staff that enables the correct identification, analysis and scoring of risk, together with maintaining the Trust's electronic integrated system for risk management (Datix) .
Head of Quality Governance	The Head of QG is responsible for supporting the implementation of the Trust Risk Management Strategy and Policy and supporting procedures and is responsible for promoting and supporting the implementation of Trust-wide systems of governance and risk. This includes establishing dynamic risk management systems and processes that form an integral part of routine organisational and departmental activity. The Head of QG administers the Trust's Corporate Risk Register on behalf of the Deputy Director for Quality Governance and Assurance and training to staff on matters associated with: risk assessment; risk grading (and subsequent escalation or de-escalation); and the compilation of risk registers, day-to-day responsibility for the operation of the Trust's electronic integrated risk management system (Datix) and is also responsible for providing oversight for the Trust's incident reporting.

Quality and Assurance Support

Quality and Assurance Directorate

Title	Risk Management Responsibility
Sector ADOs/Deputy Directors of Ops	Sector Directors are responsible for ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk register; and ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.
Deputy Director of Operations	Managerially accountable to the Director of Operations for giving authority to Trust policies, allocation of sufficient resources, active involvement in and demonstrable leadership of risk management and have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this Policy and related documentation. They are accountable for ensuring clinical risks, health and safety risks, emergency planning and business continuity risks, relevant project and operational risks are identified and managed. They shall at all times ensure compliance with: national regulatory quality standards frameworks as defined by the Care Quality Commission (CQC); health & safety policies/procedures and all relevant legislation and regulation. Secotr/Directorate directors have a responsibility to ensure that risks are correctly identified, captured on local risk registers, and ensuring that risks are reviewed by an appropriate operational group at least monthly as part of performance monitoring, to consider and plan actions being taken. They must ensure appropriate escalation of risks from services or sectors/directorates to corporate level within the defined tolerances (see Appendix 5).
Senior Managers and Senior Staff	Senior Managers take the lead on risk management and set the example through visible leadership of their staff. They do this by: • Taking personal responsibility for managing risk. • Sending a message to staff that they can be confident that escalated risks will be acted on. • Ensuring risks are updated regularly and acted on. • Identifying and managing risks that cut across delivery areas. • Discussing risks on a regular basis with staff and other managers to help improve knowledge of the risks faced within their areas and the wider organisation. • Increasing the visibility of risk management and focusing on completion of agreed actions. • Both escalating risks upward in line with the agreed escalation and reporting framework (Appendix 5), and communicating with their staff what the top risks are, in a way that can be clearly understood by all staff. • Ensuring staff within their area of responsibility are appropriately trained in risk management. • Monitoring mitigating actions, ensuring risk and action owners fully understand their roles and what is expected of them. • Encourage the identification of risks and issues by fostering a fair blame culture, encouraging staff to manage those risks and actions within their capacity.

Quality and Assurance Support

Quality and Assurance Directorate

Title	Risk Management Responsibility
	• Incorporating risk management into staff personal development plans. Senior staff are expected to be aware of and adhere to the risk management best practice to: • Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation. • Identify risk owners with the seniority to influence and be accountable should the risk materialize. • Assess the rating of individual risks by assessing the likelihood that they will happen, and the consequence if they do. • Identify the actions required to reduce the risk and assign appropriate action owners. • Record risks on a risk register. • Check frequently on action progress, especially for high and significant risks. • Take responsibility for the ongoing maintenance and review of respective risk registers, implement a process for escalating risk as and when appropriate to their line manager/appropriate group, and sharing any lessons learned across each area. They shall at all times ensure compliance with CQC published standards; health and safety policies/procedures and all relevant legislation and regulation.
Head of Health and Safety	• Responsible for supporting the implementation of the Trust health and safety policies and procedures. The Head of Health and Safety is accountable to the Director of Workforce and is responsible for promoting and supporting the implementation of Trust-wide systems for health and safety. • The Head of Health and Safety is responsible for developing an effective health and safety management system that is compliant with statutory requirements. • The Head of Health and Safety is responsible for providing support and training to staff on matters associated with health and safety: risk assessment. • The Head of Health and Safety has day-to-day responsibility for the management and oversight of the Health and Safety Department.
All Employees (Permanent, temporary, voluntary, contract)	• All Trust employees including permanent temporary or contract have a duty and a responsibility to be 'safety aware' and co-operate in the identification and minimisation of risks. • Staff are responsible for ensuring they are familiar with significant local hazards and know and use safe systems of work. If staff identify hazards or risks in the workplace they are responsible for taking immediate action to reduce the risk, (for example wiping up a spillage, warning others or removing and reporting a piece of equipment identified as not working properly).

Quality and Assurance Support

Quality and Assurance Directorate

Title	Risk Management Responsibility
	• At all levels, this will be best achieved by harnessing a culture of honesty and openness whereby any incidents involving acts or omissions which could otherwise have been prevented may be identified quickly and corrected in a positive and responsive way. • All Trust employees have a responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls.

Appendix 6

Definitions

Acceptable/tolerable Risk is the mitigated risk remaining after all reasonable controls have been applied to associated hazards that have been identified, quantified, analysed, communicated to the appropriate level of management and accepted after proper evaluation. Risks identified at operational level with an initial risk rating that does not require escalation will be the responsibility of the individual Division/CSU/Department to decide what level of risk is 'acceptable'. In respect of strategic and higher risks, it is the responsibility of the Chief Executive supported by the Executive Directors and other key individuals with delegated responsibility. Acceptability is defined in accordance with the Trust's defined risk appetite.

Adverse event is any event or harm or circumstance leading to unintentional harm or suffering.

Assurance is the means by which the organisation, Board of Directors, Trust senior leadership, manager, or clinical lead knows that the controls designed to manage/mitigate risks are effective and being properly implemented. Assurance can be defined as positive or negative, and internal or external. External assurance is generally considered of greater value due to its objective source.

Board Assurance Framework – The Assurance Framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Chief Executive's Annual Governance Statement.

Clinical Risk is the chance of something happening to a patient during NHS care that could have or did lead to unintended or unexpected harm, loss or damage. This is a broad definition that may range from dissatisfaction on the part of patients at having to wait so long for treatment or at lack of communication, to undergoing the wrong operation, or suffering permanent disability or death.

Consequence (Impact) is the level of harm that has, or may be suffered and is measured at the Trust on a scale of 1 to 5.

Controls are arrangements and systems that are intended to minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Controls Assurance is a holistic concept based on best governance practice which conforms with the Combined Code of Practice on Corporate Governance and the Turnbull guidance on Internal Control. It is a process designed to provide evidence that NHS organisations are doing their 'reasonable best' to manage themselves to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. Managers need to put in place control strategies that will offer the best chances of identifying and correcting errors at a reasonable cost.

Gap in control is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective. A negative assurance (a poor Internal Audit report for example) highlights gaps in control.

Gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective.

Hazard is something that has the potential to cause harm, such as substances, equipment, methods of work, and other aspects of work organisation.

Quality and Assurance Support

Quality and Assurance Directorate

Health and Safety risk assessment is proactive examination of the risks arising from work. This includes risks from activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments inform the risk register. Where a risk has been identified in the health and safety risk assessment, which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally), the risk must be entered onto the risk register. Where a health and safety risk is entered onto the risk register, the health and safety risk assessment must be attached to the risk entry.

Inherent or Initial Risk is the risk linked to the activity itself without the application of controls i.e. when first identified.

Inherent/Initial Clinical Risk is the permanent or currently unavoidable clinical risk that is associated with a particular clinical investigation or treatment. It is the risk from undergoing a particular procedure in ideal conditions and performed by competent staff using the most up-to-date research, equipment and techniques. It can be considered permanent or currently unavoidable when used for the purpose of risk assessment. The risk that should be targeted by clinical risk assessment is the risk that is added to the inherent or initial risk and results from, for example, a poor safety culture, poor communication and teamwork, inadequate supervision of inexperienced staff, unreliable equipment or an unsuitable environment.

Internal Control is the process effected by the Board of Directors designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations.

Likelihood is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Mitigated or Target Risk is the remaining risk when **all** reasonable controls have been applied – when the additional controls to mitigate the residual or current risk have been applied and are effective i.e. the point at which the risk it is judged that the risk can be closed or accepted. This may be described as the **tolerable risk**. The added benefit of additional controls must be weighed against the cost.

Patient Safety Incident is any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.

Principal (Strategic) Risks are those risks that can adversely affect the achievement of the Trust's corporate objectives and are identified, assessed and monitored by the Board Assurance Framework.

Residual or Current Risk is the risk remaining after the controls put in place to mitigate the inherent or initial risk are fully effective. The current risk status can be changed at any time if and when the controls change.

Risk is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Risks differ from their hazard in that the former is the calculated probability of the event occurring whilst the consequences or impact measure the effect of the risk being realised as a hazard. Put simply, hazards represent risks that have been realised.

Risk Appetite - at the organisational level, is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept/retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

Quality and Assurance Support

Quality and Assurance Directorate

Risk Assessment (see separate entry for Health and Safety risk assessment) is the process by which risks are prioritised and then categorised through the application of a 5 by 5 calculation to produce a composite score out of a maximum of 25. (25 being the most severe.) The risk assessment is based on the probability (likelihood) of a hazard occurring on a 1 to 5 scale, multiplied by its likely consequence or impact (severity) which is measured on a similar 1 to 5 scale. An account of the criteria for obtaining accurate measures of risk and severity of consequence or impact can be found in the Risk Management Procedure.

Risk Management is the systematic identification, assessment, treatment, monitoring and communication of risks. This process is followed by the application of current or planned resources to effectively control, monitor and minimise the overall likelihood (and in some instances, impact) of the identified risk.

Risk Owners – are throughout the organisation in accordance to the accountabilities and responsibilities. The Corporate Risk Register is owned by the Executive Directors of the Management Executive and the Board Assurance Framework is owned by the Trust Board of Directors.

Risk Register – is a management tool that allows the Trust to understand its comprehensive risk profile. It is simply a repository of risk information linking risks and controls for the whole organisation.

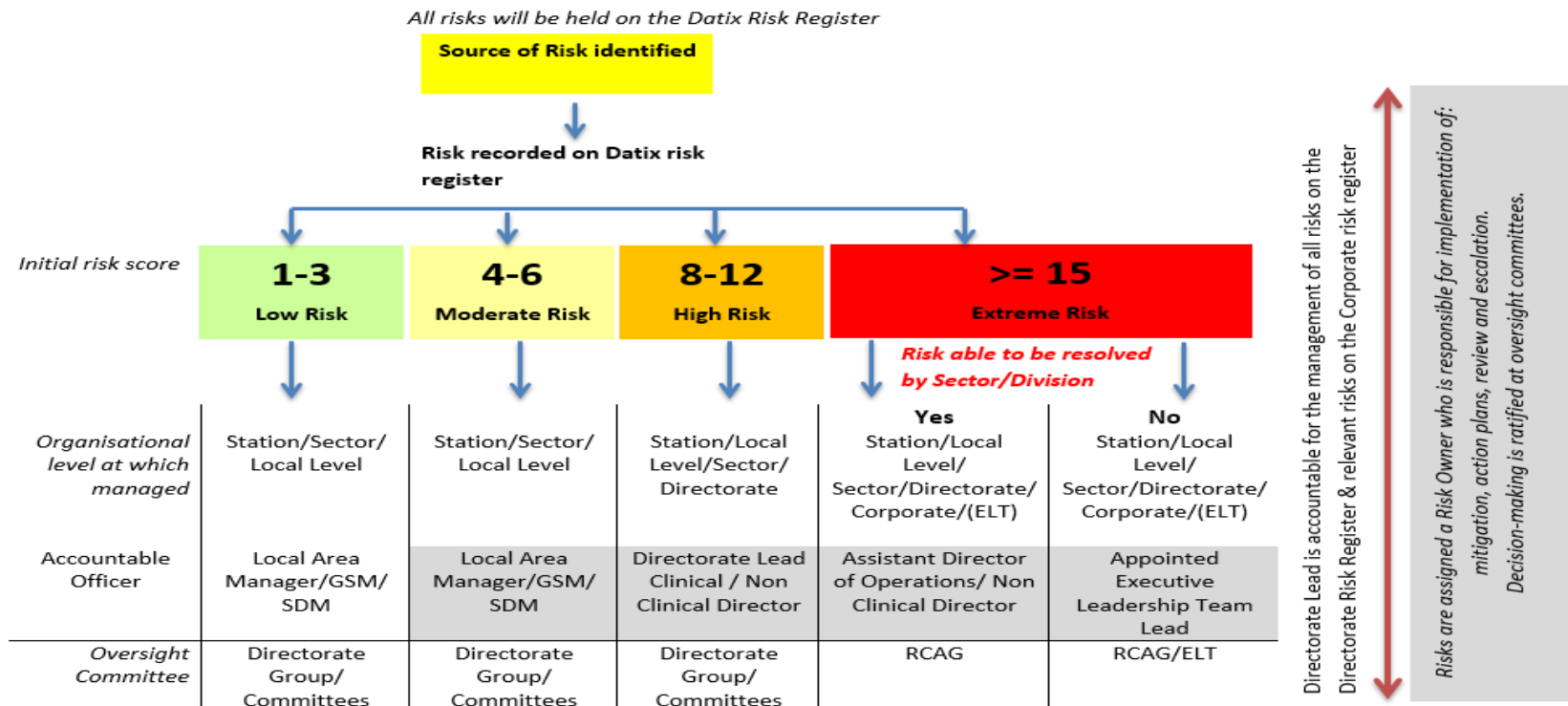
Appendix 7

- 1 • **Risk identification by station/sector/department/directorate** - clinical or non-clinical. Could be identified from various sources, such as: local risk assessments; business/project planning; incidents; complaints/PALs; claims; external audit/review; internal audit; regulatory standards framework; NICE framework; national/local alerts. These are examples and therefore this list is not exhaustive.
- 2 • **Risk entered onto Datix risk register by risk owner** after approval of risk articulation, grading, target risk, review date, key controls/mitigating actions to address identified gaps in control, by relevant manager (relevant manager to be locally determined, dependent on the area of the Trust). Assigned action owners(s) may not be the same person as the risk owner.
- 3 • **Level 1 risk:** Low risks (current risk score 1-3) are managed and reviewed by the station/department via local risk registers - minimum frequency monthly.
- 4 • **Level 2 risk:** Moderate risks (current risk score 4-6) are managed and reviewed locally but also recorded on the directorate/sector (or equivalent) risk register and reported monthly to the directorate governance and risk meeting (or equivalent).
- 5 • **Level 3 risk:** High risks (current risk score 8-12) will continue to be managed and reviewed locally (minimum frequency monthly) and reviewed monthly by the operational/governance and risk meeting/sector (or equivalent).
- 6 • **Level 4 risk - Divisional risk register gateway:** Significant (or 'red') risks (current score 12+) are considered at corporate level and a decision made as to **1:** accept the risk onto the divisional risk register **2:** submit as a candidate risk for escalation to the Corporate Risk Register **3:** de-escalate the risk back to the directorate for local management. All significant risks are reported monthly at the corporate governance and risk meeting (or equivalent).
- 7 • **Level 4 risks - Corporate Risk Register gateway:** Significant risks (current score 15+) are evaluated at monthly RCAG meetings as the gateway for review of level 4 (significant or 'red') clinical or non-clinical risks. The Executive Risk Group evaluates candidate risks for the Corporate Risk Register and/or Board Assurance Framework (BAF) and either accepts their escalation or de-escalate to the divisional risk register.
- 8 • **Level 4 risk - Corporate Risk Register:** Executive Risk Group reviews the Corporate Risk Register and BAF monthly to ensure they continue to represent the Trust's portfolio of risk.
- 9 • **Level 5 risk - Board Assurance Framework (BAF) - Risks impacting on Trust's strategic objectives.** The BAF is owned by the Trust Board and maintained by the Director of Corporate Governance. The BAF is a 'top down' risk register. Each BAF risk is assigned an executive 'risk owner'. Each risk on the BAF is monitored by the Trust Board and its committees, and scrutinised by the Audit Committee once a year for its effectiveness. The Trust Board also sets the Trust's risk appetite, and reviews this at least annually.

Risk Structure and escalation/de-escalation

Appendix 8

Structure for risk reporting, accountability and escalation/de-escalation



Quality and Assurance Support

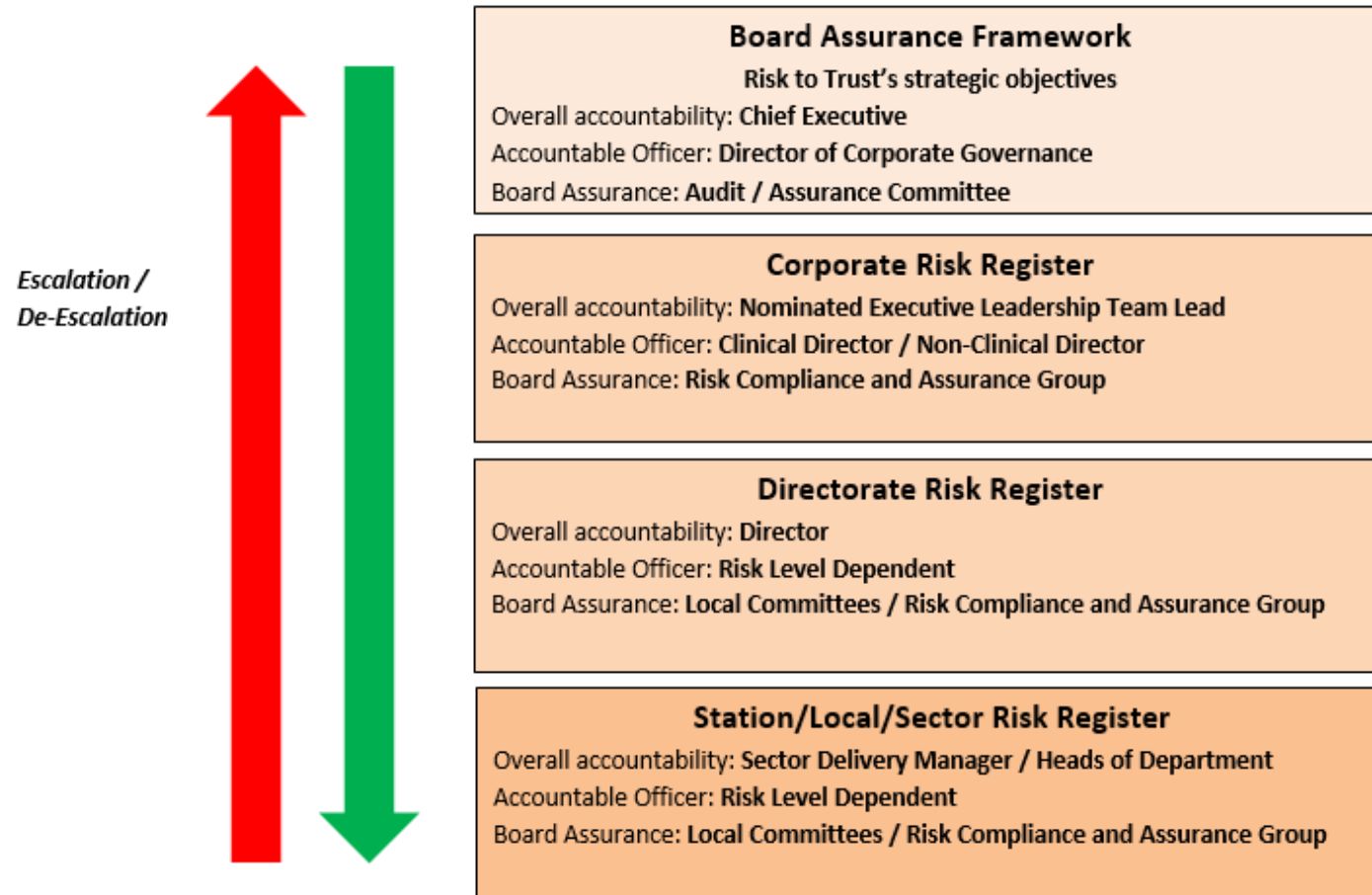
Quality and Assurance Directorate

Movement of risks

Escalation and De-escalation

What an effective system looks like

Risk can be managed locally and not escalated to the BAF even if the initial risk score is ≥ 15



Risk Management Policy Monitoring Dashboard

Minimum requirement to be monitored	Method of monitoring e.g. audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	Development of action plan	Monitoring of action plan and implementation
Identification and management of risk: <i>Board Assurance Framework Review</i>	Process Review	Director of Corporate Governance	Annually	Audit Committee	Director of Corporate Governance	Board of Directors (BoD)
<i>Chief Executive report to the Board of Directors re significant risks</i>	Review	Director of Corporate Governance	Monthly	BoD	Director for Clinical Quality	BoD
<i>Corporate Risk Register</i>	Review	Chief Quality Officer	Monthly	Executive Risk Committee/ Assurance Committees	Executive Risk Committee/ Assurance Committees	BoD

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Minimum requirement to be monitored	Method of monitoring e.g. audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	Development of action plan	Monitoring of action plan and implementation
Managing Risks Locally/Learning Lessons & Improvements: <i>Reporting of all incidents</i> <i>Reporting of incidents to all external agencies</i> <i>Local management of risk</i>	Internal Audit of risk and incident management system	Internal Auditors	Annual	Audit Committee	Director for Clinical Quality	Audit Committee
	SI reports	Deputy Director of Quality	Monthly	Serious Incident Management group	Deputy Director Quality	Quality Committee
	performance reports	Operational/Directorate Directors	Monthly	Monthly executive performance reviews	Operational /Directorate Directors	ELT/BoD
Training : <i>Risk Management Training for All grades of staff</i>	Annual Report	Deputy Director of Quality Governance	Annual	Audit committee/P&OD Committee	Dep Director Quality Governance Education and Training	ELT/BoD
Assurance Committees: <i>Reporting arrangements into the Assurance Committees and to the Board</i>	Self-Assessment	Director of Corporate Governance	Annual	BoD	Director of Corporate Affairs	BoD

Quality and Assurance Support

Quality and Assurance Directorate

Risk Management Programme Plan 2017 / 2018

Appendix 10

LAS Risk Management Programme Plan 2017 - 2018																									
Project Information						Gantt Chart (End of Week)																			
ID	Project Name	Owner	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
1	LAS Incident Module (round 1)	Jason Ramchurn	176	4-Sep	7-May	Scoping	Configuration																		
	LAS Incident Module (round 2)	Jason Ramchurn	86	8-Jan	7-May					Scoping															
	LAS Incident Module (Cloud Upgrade)	Jason Ramchurn		26-Feb	16-Jul																				
ID	Deliverable Name/Task Name	Assigned To	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
1	LAS Incident Module	Jason Ramchurn	81	4-Sep	25-Dec																				
1.1.1	Coding and NRLS mapping	Nathan Coleman																							
1.1.2	Identify Stakeholders	Nathan Coleman																							
1.1.3	Determine scope, objectives & deliverables	Jason Ramchurn																							
1.1.4	Process Mapping	Jason Ramchurn																							
1.1.5	Design of Forms	Jason Ramchurn																							
1.1.6	Configuration	Jason Ramchurn / Nathan																							
1.1.7	Training Documentation / Tool Kit	Jason Ramchurn / Nathan																							
1.1.8	Training (22) new process and new WOWs	Nathan Coleman																							
1.1.9	E-learning (Incidents) Reporting	Jason Ramchurn																							
1.1.10	E-learning (Incidents) Manager	Jason Ramchurn																							
Summary																									
ID	Project Name	Assigned To	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
2	LAS Complaints (Patient Experience)	Jason Ramchurn	146	4-Sep	26-Mar	Scoping																			
3	NHS 111	Jason Ramchurn	146	4-Sep	26-Mar																				
Summary																									
ID	Deliverable Name/Task Name	Assigned To	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
2	LAS Complaints System Configuration		176	4-Sep	7-May																				
ID	Deliverable Name/Task Name	Assigned To	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
4	Risk Register		176	4-Sep	7-May	Review																			
Summary																									
ID	Deliverable Name/Task Name	Assigned To	Duration	Start	End	4-Sep	11-Sep	18-Sep	25-Sep	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb	19-Feb	26-Feb	5-Mar	12-Mar	19-Mar	26-Mar	2-Apr	9-Apr	16-Apr
4	Risk Register		161	4-Dec	16-Jul																				
4.4.1	Define all coding and Mapping	Jason Ramchurn																							
4.4.2	Review Form	Jason Ramchurn																							
4.4.3	Configure Form	Jason Ramchurn																							
4.4.4	Test Forms	Jason Ramchurn																							
4.4.5	Risk Awareness	Jason Ramchurn																							
4.4.6	Datix Training new process & new WOWs	System Administrators																							
4.4.7	Templates	Jason Ramchurn																							
4.4.8	Reports	Jason Ramchurn																							
4.4.9	User Security Groups	Nathan Coleman																							
4.4.8	Module Access to all staff	Jason Ramchurn																							
4.4.9	Training Documentation / Tool Kit	Jason Ramchurn/Christine																							
4.4.9	BAF linkages and configuration	Jason Ramchurn/Frances Field																							

Risk Management Strategy Monitoring Dashboard (KPI's)

The number of overdue risks open on the Trust's risk register / DATIX to be 0
The number of overdue Si Reports on DATIX to be 0
≥ 90% of all risks reviewed within the last 3 months
≥ 90% of all reported incidents (other than SIs) are investigated and closed within 25 working days
≥ 90% of all operational (Sector, Directorate, Corporate) governance forums, corporate equivalents and Board sub-committees will review risk registers in line with the Risk Management Policy
≥ 90% of all staff will be compliant with risk management training. In line with the TNA within the Trust's Risk Management Strategy
The Trust is ≥90% compliant with the Risk Management audit as defined within the Trust's Risk Management Strategy.



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Data Quality Update			
Agenda item:	11			
Report Author(s):	Jill McGregor, Director of Performance / Matthew Bishop (Contractor)			
Presented by:	Jill McGregor, Director of Performance			
History:	ELT (18/05/2017, 18/07/2017, 03/01/2018), Audit Committee (March 2017, July 2017, February 2018)			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The purpose of this report is to provide an update on the delivery, progress made, and strategic direction of data quality in preparation for the next Well-led CQC inspection.				
Recommendation(s):				
The Board is asked to note the report and the next steps.				
Links to Board Assurance Framework (BAF) and key risks:				
There is no BAF risk relating specifically to data quality and this report does not identify any.				

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	☒

LAS Data Quality Strategy - Update

Introduction

1. This informational paper is to apprise the Board with progress of the data quality agenda at LAS. There have been a number of different perspectives on the issues and the correct approach to data quality for the Trust, but there is agreement amongst the stakeholders that this is a topic of significant importance.
2. This paper aims to summarise the contextual history, actions to date and describe the next steps to bring the various viewpoints to a consolidated strategy for the organisation.

CQC Inspection

3. In late June 2017, the CQC published the findings of their most recent inspection. The view of the inspectors was that the Trust required improvement and they highlighted areas where the Trust either must or should improve. There was only one area where the inspection team felt the Trust must improve - staff uptake of mandatory training subjects, and the "must do" action detailed a requirement to improve data quality:

"Importantly, the trust must [ensure]...the recording of [mandatory training subjects, including safeguarding vulnerable people and infection prevention & control]... to be more efficient and subject to scrutiny" CQC Inspection Report 29/06/2017 pg 5

4. The Trust is expected by the regulator to have acted on the challenges raised around the recording and reporting of mandatory training, demonstrate that data inconsistencies are understood and have a credible resolution plan.

Initial papers to ELT and the Audit Committee

5. Following initial feedback from the CQC, a research and best practice review was undertaken. In mid-May and mid-July 2017, papers were presented at ELT & the Audit Committee proposing a data quality assurance framework. Following feedback, a further review was conducted to:
 - prioritise assurance for organisational areas and their associated data assets (see table 1)
 - clarify and propose a governance structure
 - determine immediate next steps
 - recommend additional resource and costing for a data quality assurance team
 - clarify the roles and responsibilities of the data quality assurance team.

Immediate work from initial papers

6. The executive lead for data quality (the Director of Performance) took forward the steps to secure the finance for the data quality assurance team and formalise the full job descriptions.
7. A consultant was appointed to lead the work on the draft data quality strategy, engage with system owners and key stakeholders for priority areas, and undertake a root cause analysis on quality issues within the data for mandatory training.
8. In order to address the issues identified by the CQC with the mandatory training data, engagement has been secured and ownership agreed from finance, workforce,

resourcing, and education & training. This diagnostic work is current and ongoing - formal highlight reports are to be presented to the Audit Committee.

Strategy development

Initial development and presentation at ELT

9. A draft data quality strategy was written for the forthcoming financial year to allow the vision for the Trust to be tested against the competing perspectives and a more long-term strategy to be presented in the following year. This detailed how accountability, policies and procedures, systems and processes, and people and skills would be managed in the initial phase of the Trust's growth in data quality maturity.
10. This was brought to ELT in mid-January to determine the approach for governance and it was agreed that the executive lead for data quality would report progress highlights into the Audit Committee for the short-term period. The longer-term governance structural intentions were for data quality and IM&T to identify a combined and potentially additional group for all Health Informatics related programmes.

Feedback from Audit Committee

11. The draft data quality strategy was discussed at the Audit Committee in early February and prompted a great deal of discussion. Although supported it was felt that, before the Audit Committee could fully endorse the strategy, the following areas warranted further consideration and review:
 - the clarity and structure of the document with regards to the governance framework for data quality, including the roles of key players such as IM&T
 - how the strategy will prioritise the data areas most in need of attention
 - possible alternative approaches to data quality monitoring.

Next steps

12. Whilst the feedback from the Audit Committee is being progressed towards Board approval of the final strategy, the following areas of work are proposed to maintain continuity and momentum:
 - facilitate a two-fold diagnostic exercise
 - an initial report from the CQC mandatory training diagnostic work will be presented at the next Audit Committee, whilst the ongoing work continues
 - a report from our internal auditors to review, assess and document the current Trust position in relation to data quality best practice
 - continue to advertise and recruit to the data quality assurance team
 - identify a combined and potentially additional group for all Health Informatics related programmes.

Table 1 – Assurance priorities for organisational areas at presentation to ELT / Audit Committee July 2017

Organisational Area	Example of Data Collected	Priority Rating for Data Quality Assurance
Performance and Operations	All historic operational data (calls, incidents, activations)	Low – existing data quality processes and auditing focus on this area.
Clinical Audit and Research Unit (CARU)	Clinical Indicators and patient outcome information.	Low – existing data quality processes and auditing.
Quality	Risks; Complaints; Safeguarding; Serious Incident reporting.	Low – existing input and data quality processes; central system.
111	Historic operational data.	Medium – integration with 999 data storage and standardised with BI.
Finance	Budget; Costs; Activity forecasts.	Medium – requires two-way data linkage with all other departments.
Workforce	Recruitment profiles; joiners; leavers; establishment; sickness.	High – focus for CQC and Audit Committee.
Resourcing	Rosters; Abstractions; Overtime.	High – critical element as helps inform tactical/operational planning.
Fleet & Logistics	Vehicle numbers; make-ready processes; equipment replenishment.	Medium – various elements already reported on internally for assurance.
EOC	Real-time and historic data captured in control.	Low – existing data quality and operational change log processes.
Education & Training	To be scoped	Low
Communications	To be scoped	Low
Legal	To be scoped	Low



Assurance report:

Logistics & Infrastructure Committee

Date:

06/02/2018

Summary
report to:

Trust Board

Date of
meeting:

27/02/2018

Presented
by:

Theo de Pencier, Non-
Executive Director, Logistics &
Infrastructure Committee Chair

Prepared
by:

Theo de Pencier, Non-Executive
Director, Logistics &
Infrastructure Committee Chair

Matters for escalation:

The Committee was provided with and considered information about the key projects being undertaken by the fleet and logistics, estates and IM&T teams. Work is being progressed to improve the quality of this information in order to ensure that the Trust has appropriate benchmarks and dashboards to provide assurance about its performance in these areas.

The Committee discussed risks in the following areas, which it considered to be sufficient for inclusion on the Board Assurance Framework (BAF):

- Bow uninterruptible power supply (UPS) upgrade
- Service providers across the sector.

Further information is provided below and in the BAF.

A structure and programme board has been created – known as the Spatial Development Programme (SDP), the objective of which is to focus on the substantial changes required across the Trust's future estate to meet the needs of its future operation. The SDP will achieve this by providing a robust platform for operations across the Trust's activities ensuring capacity to respond appropriately, high quality assets that effectively support all activities enhancing quality, efficiency and governance. The Committee will receive regular updates on the work of this programme in order to provide appropriate assurance to the Board.

Other matters considered:

- The Committee also received updates on the progress being made on the work being carried out in relation to the Trust's procurement maturity action plan, its security action plan and its health and safety action plan. All of these activities are progressing appropriately. The Committee will focus on health and safety issues, alongside the Quality Assurance Committee, on behalf of the Board.
- The Trust's approach to productivity and efficiency, particularly in relation to estates, fleet and logistics and IM&T, was discussed by the Committee. This was a valuable discussion and is clearly linked to the Finance and

	Investment Committee's consideration of the Trust's approach to its Business Plan and the 2018/19 Annual Financial Plan. The Committee considered its effectiveness in 2017/18 and its forward plan through to the end of 2018/19. A number of minor recommendations will be presented to the Board as part of the Corporate Governance Review due to be undertaken in March.
Key decisions made / actions identified:	- The Committee identified the need for improved performance reporting and benchmarking in relation to the areas of the Trust's activities covered by its remit. - The Committee agreed that it should have sight of potential future business cases anticipated in the areas of the Trust's activities covered by its remit. - The Committee identified work that needed to be carried out in relation to the procurement maturity plan and ensuring that quality impact assessments were carried out and appropriate stakeholder engagement carried out across the Trust.
Risks:	- The Committee had previously identified a business continuity risk associated with replacement of the UPS at the Trust's Bow site. This particular risk had been mitigated by a changed approach to the replacement of the UPS; however a significant risk remains in relation to the need to ensure the stability of the UPS. The Committee proposes that this should be added to the BAF. - The Committee noted the impact that the unexpected withdrawal of service provision could have in relation to outsourced services and suggested that this should be considered for inclusion on the BAF. - The Committee will continue to oversee risks associated with the installation of Mobile Data Terminals (MDTs) and the implications of this for fleet deployment. This was not considered to be a BAF-level risk at this time.
Assurance:	The Committee is able to provide reasonable assurance about the performance management of key projects being undertaken by the fleet and logistics, estates and IM&T teams; however information about these requires continued improvement to provide increased assurance.



Assurance report:

People & Organisational Development Committee

Date: 08/02/2018

Summary report to:

Trust Board

Date of meeting:

27/02/2018

Presented by:

Jayne Mee, Non-Executive
Director, People &
Organisational Development
Committee Chair,
Patricia Grealish, Director of
People & Organisational
Development

Prepared by:

Jayne Mee, Non-Executive
Director, People &
Organisational Development
Committee Chair

Matters for escalation:

- The Committee spent a significant amount of time considering the actions that are being taken to improve the rate of recruitment of frontline staff, particularly within the Emergency Operations Centre (EOC). This has been an issue of Board concern for some time and has been identified as one of the top risks faced by the organisation. The Committee has been assured that short term actions, such as a refresh of job advertisements, together with activity to address longer term issues, such as the development of a pilot for a new approach to assessment centres, based upon the experience of other Ambulance Trusts, will ensure sustainable change in this area.

Other matters considered:

- Operations directorate restructure – this has been delayed slightly, but is moving ahead now. A four week consultation will have been launched by the end of February. Staff and the Trades Unions have been well engaged in the review of roles and subsequent role level evaluations.
- Apprenticeships – the Committee considered the importance of expanding the Trust's use of apprenticeships and the opportunity for strategic workforce planning that this could facilitate. Committee members acknowledged the impact that a well-run apprentice programme could have on the retention of staff in particular.
- Healthy workplace - a detailed update was provided on the work that had been done to manage the Trust's occupational health contract. The Committee emphasised the importance of ensuring that such contracts are appropriately scoped and managed. Information was also provided about the work being done to make sure that the Trust's vaccination programme

	is appropriate and that the Trust has appropriate support in place for those members of staff requiring support in relation to mental health issues. • Bullying and Harassment – Committee members were briefed on the work that had been taken forward in order to ensure that appropriate support was in place for those raising bullying and harassment concerns. The Trust's focus is moving away from management of such issues through grievance procedures to a resolution approach, which is much more positive and likely to result in outcomes that all involved can feel supported by.
Key decisions made / actions identified:	• Recruitment report – the Committee has requested a five year forecast model for consideration in draft at the Committee's next meeting. • Further progress is being made on rest-breaks and rostering and the Committee asked for information about this to be brought to its next meeting, together with progress on Annual Leave • The Committee asked for a report to be provided to give assurance on the status of the Band 6 Paramedic implementation programme. • People and OD Dashboard to be further revised with additional analysis for consideration at the Committee's next meeting • Independent Training Review – scope and then outcomes of this to be considered by both the Quality Assurance Committee and the People and OD Committee. • Agency – a plan setting out the actions required in order to achieve a 10% reduction in agency staff to be presented to the next meeting of the Committee.
Risks:	• The Committee considered the People and Organisational Development-related issues set out in the Board Assurance Framework. There are no proposed amendments.
Assurance:	• The level of management information available with regard to recruitment and retention issues continues to improve and provide assurance to the Committee. • The Committee received information about a number of planned activities, which it has asked for further information about at its next meeting. This should enable the Committee to provide the necessary assurance to the Board that the planned activities will achieve the anticipated outputs.



Assurance Audit Committee report:

Date: 12/02/2018

Summary report to: Trust Board

Date of meeting: 27/02/2018

Presented by: Theo de Pencier, Non-Executive Director, Audit Committee member

Prepared by: John Jones, Non-Executive Director, Audit Committee Chair

Matters for escalation:

Risk Management Strategy and Policy

A new Risk Management Strategy and Policy (this replaces the Risk Management Framework) was discussed and agreed by the Committee. The Policy is on the February Board agenda for agreement by the full Board following which action will be taken towards full implementation.

Risk Appetite Statement

A review of the Trust Risk Appetite Statement was undertaken. Each Board Assurance Committee has considered this and the full Board now need to confirm their approach. Discussion pointed to a similar statement to the current one except that further consideration should be taken on the risk appetite level for innovation.

Data Quality Strategy

A new Data Quality Strategy for the Trust was considered and prompted a great deal of discussion. Whilst the issue of data quality needs to be progressed the Committee was unsure whether there were other steps/studies that could be taken before a new model process was introduced. This issue will be further addressed by the Executive Team before being presented to the Trust Board.

Other matters considered:

- The updated Board Assurance Framework (BAF), which shows four red risks, was reviewed. These are also subject to monitoring by respective Board Assurance Committees.
- A proposed framework for the annual review of the Trust's corporate governance structure, including the production of the Annual Governance Statement, was reviewed and agreed. A report will come to the March Board meeting on the outcome of the review.
- The Committee considered Internal Audit reports on: core financial systems; fit and proper persons compliance; and serious incident reporting. An update report from the Local Counter Fraud Specialist (LCFS) was reviewed.

	• Nineteen audit recommendations are now overdue (last month 15) and the Committee agreed to a tightening of the review process (including review by Board Assurance Committees). The target is to achieve no overdue recommendations. • The outcome of the tendering exercise for the Internal Audit and Local Counter Fraud Service was considered and it was agreed a new contract be awarded to Grant Thornton for an initial three year term from 01 April 2018. • The external audit plan for 2017/18 was presented by Ernst and Young and agreed by the Committee. • The annual review of the Committee's effectiveness was carried out and minor amendments to the Committee's terms of reference were proposed. This will come to the Board in March for endorsement. • Use of single tender waivers to January 2018 were reviewed. • The Committee's forward plan was reviewed.
Key decisions made / actions identified:	• Adoption of the new Risk Management Strategy and Policy • Agreed to new Internal Audit and Local Counter Fraud contract from 1st April 2018. • Agreed External Audit Plan for 2017/18 • Agreed tightening of process for timely implementation of audit recommendations.
Risks:	• The General Data Protection Regulation (GDPR) becomes enforceable from 25 May 2018 and an internal audit study on our progress will not be available until April 2018. It was agreed that a report be circulated by the Executive Team before the March Board to ensure the Board is aware of our plans including a gap analysis.
Assurance:	• An assurance report was received on the progress made against the CQC findings in relation to risk management. • Assurance to the Committee was provided by the reports of the internal auditor and the LCFS. The above reviews produced the following assurance: • Core Financial Systems- Significant Assurance with minor improvement opportunities. • Fit and Proper Person Policy Compliance – Significant Assurance • Serious Incident Reporting – Significant Assurance • Additionally both representatives of the internal and external auditors were present at the meeting. • A private meeting was held with both internal and external auditors after the formal agenda and no significant issues were raised.



Assurance report:

Finance and Investment Committee

Date: 22/02/2018

Summary Report to:

Trust Board

Date of meeting:

27/02/2018

Presented by: **Fergus Cass**
Non-Executive Director and Chair,
Finance and Investment Committee
Lorraine Bewes
Director of Finance and
Performance

Prepared by: **Fergus Cass**
Non-Executive Director and Chair,
Finance and Investment
Committee

1,564k.

Matters for escalation:

In an extraordinary meeting, the Committee reviewed the draft Annual Financial Plan for 2018/19. The Trust's draft plan has to be submitted to NHS Improvement (NHSI) on 8th March. The Committee:

- noted the letter dated 6th February 2018 from NHSI communicating the revised 2018/19 control total, which is a deficit of £1,564k
- reviewed the activity level on which the 2018/19 plan is based; this entails growth of 1.68% on the expected out-turn in 2017/18 and reflects an extrapolation of recent trends, supported by a detailed analysis
- was updated on the contract negotiation with London CCGs, and on the gap between the income assumed in the draft plan and the amount currently being offered by the CCGs; the difference relates mainly to activity levels
- stressed that the final agreed position should include a realistic baseline activity level, with a mechanism for compensation if demand exceeds baseline
- noted the NHS Planning Guidance and the assumptions supporting the plan
- discussed how assurance will be obtained that the resources in the plan can deliver the Ambulance Response Programme (ARP) targets; the extent of any shortfall in resources will become clearer by the end of March, with the completion of modeling by Operations Directorate and ORH consultants
- noted that achievement of the 2018/19 control total will require delivery of CIP savings of £18.6m and was briefed all that is being done to develop and deliver the programme, including workshops, project prioritisation, benchmarking, and the creation of a Programme Management Office (PMO)
- noted that savings of £8.6m have been assessed as having a low to medium delivery risk, leaving £10m as high risk or still requiring identification; it is understood that a clearer picture will be available by the end of March
- noted that the capital expenditure plan for 2018/19 is being developed.

The Board will need to agree the process for finalisation of the March submission to NHSI.

Other matters considered / decisions made / actions identified:

The Committee briefly discussed the draft 2018/19 Business Plan, which it recognised was at an early stage. Suggestions were made, covering aspects such as overall length, patient focus, and internal consistency.

On a separate matter, the Committee:

- was briefed on the tender for provision of Integrated Urgent Care (IUC) services to South East London; the submission deadline is 13th March and intensive preparation is in hand
- proposed a process for review and decision-making in relation to finalisation of the tender
- was updated on governance arrangements for IUC activities, including the formation of a Programme Board that will oversee the North East London and South East London projects.

Risks:

At the current stage of development of the Annual Financial Plan, the main risks are believed to be the following :

- that a satisfactory agreement cannot be reached between the Trust and the CCGs regarding activity levels and the value of the 2018/19 contract
- that the evaluation of the resources required to deliver the ARP standards in 2018/19 will indicate a need for staff and /or equipment in excess of that funded by the draft plan
- that CIP activities will be unable to deliver in 2018/19 the £18.6m required to achieve the control total; this area is already a BAF risk.

Work is continuing to address these issues.

Assurance:

The Committee received assurance regarding:

- the basis of the projection of activity levels in 2018/19
- the arrangements for establishing departmental budgets and CIP projects, and for managing delivery of financial and savings targets

The Committee was informed that the programme of work supporting the CIP project about apprenticeships was recently reviewed by the People and OD Committee.

Assurance is still required regarding the risk areas noted above:

- agreement of the contract with CCGs
- adequacy of budgeted resources to deliver ARP performance targets
- ability to delivering the required total of CIP savings within the financial year.



Report to:	TRUST BOARD			
Date of meeting:	27 February 2018			
Report Title:	Integrated Quality and Performance Report			
Agenda Item:	16			
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 – TRUSTBOARD EXECUTIVE SUMMARY

February 2018

- * All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout January 2018 unless otherwise stated.



Delivery of care continues to be safe, but the ongoing demand pressures on the system remains challenging.
Cat 1 Mean for January was 7 minutes 9 seconds. LAS ranked 3rd in the Cat 1 90th centile compared to the other Trusts.

Trust vacancy rates have decreased from 8% to 7.2%. Appraisal rates have improved from 54% to 57%.

Year to date the position is £3.4m ahead of plan and £3.1m ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.

OUR PATIENTS

- ↔ A safety review of Winter has demonstrated we continued to provide a safe service over the busiest period supported by safety huddles.
- ↔ An external audit was conducted by KPMG which concluded that the new serious incident process provided significant assurance that the Trust was meeting the external CCG deadline of 60 working days. The policies were in line with best practice, the process for identifying and investigating serious incidents was well designed and our patients and relatives were well supported.
- ↓ Complaints over 35 days have reduced significantly compared to the previous month. The revised process should speed up resolution of complaints.

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 £2m below budget.
- ↔ Year to date CIPs are £6.9m behind plan and are currently offset by non-recurrent underspends on pay budgets.
- ↔ Cash is £33.4m, £7.9m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £7.8m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.4m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £7.5m. These movements are being offset by under payments of £10.6m on capital, provision of £0.8m and £10.9m on pay.

OUR PERFORMANCE

- ↓ Cat 1 Mean for January was 7 minutes 9 seconds, this is 9 seconds above the national standard however this is lower than December's mean of 7 minutes 23 seconds.
- ↑ 97,339 Incidents were provided with a face-to-face response. This was 1% above the plan for January (96,789). (Plus taxi responses at 1,140).
- ↓ Cat 1 90th Centile was 11 minutes 43 seconds, LAS ranked 3rd in the Category 1 90th centile performance measure, compared to the other Trusts.
- ↑ There was a 1.9% increase in Hours Produced by Double Crewed Ambulances from December to January.

OUR PEOPLE

- ↓ Vacancy rates have decreased from 8% to 7.2%.
- ↑ Overall turnover has increased from 10.3% to 10.4%.
- ↔ The monthly sickness position for January remains at 5.2%.

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

111 service delivery remains safe with no Serious Incidents declared during January.

The Patient Transport Service has seen a sharp increase in activity with a total of 1,757 journeys in January compared to 1,169 journeys in December.

LAS 111 (SOUTH EAST LONDON)

- ↑ Call demand was 10.5% higher than predicted in January, by up to 22% on weekdays and 19% at weekends. This contributed to the challenge of achieving the target for calls answered in 60 seconds (95%).
- ↔ The 111 service achieved 92% of calls answered in 60 seconds in January. This is marginally below the target of 95%.
- ↔ Referrals to 999 remain successfully and consistently low month on month.

PATIENT TRANSPORT SERVICE

- ↑ 5,387 journeys were completed in March 2017, a 9% increase from the previous month's total of 4,913 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.

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
Inadequate	Good	Requires improvement	Requires improvement	Inadequate	Inadequate

OUR 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.

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

Key Performance Indicator Report Summary



	Key Performance Indicator	Jan-18	Dec-17	Nov-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	Jan-18	Dec-17	Nov-17	Chart
111	Calls answered within 60s	↑	↓	↓	
	Calls abandoned after 30s	↑	↔	↑	
	Percentage of calls referred to 999	↓	↔	↑	

	Key Performance Indicator	Jan-18	Dec-17	Nov-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)	↓	↓	↑	

*These KPIs are reported one month in arrears

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.

	Key Performance Indicator	Jan-18	Dec-17	Nov-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
	Financial Stability Risk Rating (FSRR)	↔	↔	↔	
	Capital Service Capacity	↔	↔	↔	
	Liquidity Days	↔	↔	↔	

	Key Performance Indicator	Jan-18	Dec-17	Nov-17
FINANCE	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	↑	↑	↑

Our Patients



Safety

- Compliance with 6 weekly deep clean compliance continues to meet 90%
- IPC Training compliance rates continues to increase for Level 2
- IPC practical session of hand hygiene re-introduced into the non-clinical
- Advanced Paramedics to assist with clinical opinions
- The lead investigator training continues to attract a high number of managers wanting to undertake the training and has received positive feedback. All courses are currently fully booked for the next three months.
- Health and safety re review of action plan by independent source underway
- No SI overdue action plans being monitored closely <15 for closure
- North East Intensive support programme showing positive responses in Sis and statutory and mandatory training compliance

Actions & Assurance

- Continue to monitor incident reports.
- The next training session currently has 20 managers attending.

Effectiveness

- An external audit was conducted by KPMG which concluded that the new serious incident process provided significant assurance that the Trust was meeting the external CCG deadline of 60 working days, the policies were in line with best practice, the process for identifying and investigating serious incidents was well designed and our patients and relatives were well supported.

Actions & Assurance

- Serious Incident Reporting - KMPG audit.

Caring

- In January 56 out of 58 Public Education events were attended by the Trust. This is a significant increase on previous reporting months.
- Complaints response rates have improved from 24 overdue to 14

Actions & Assurance

- 1,234 staff have registered an interest in supporting Public Education events in their own time. The Patient and Public Education team have set up a Facebook page for staff to join and share their experiences to further increase the support we provide to the public, not only in an emergency.

Our Patients



Safety

- Inconsistent adherence to basic principles of infection prevention and control - hand hygiene, including use of alcohol gel
- Increase in number of PGD breaches (no patient harm)
- Review of DBS re-check and status underway, identified a number of managerial staff whose DBS needs to be checked. On risk register until evidence of compliance.
- Attitude and behaviour is now the highest proportion of complaints analysis with SIs and other sources underway to confirm issues relating to staff stress and fatigue.
- RIDDOR reporting timescales higher this month, this is due to legacy incidents being reported into the system. New RIDDOR reports within timescales.

Actions & Assurance

- 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
- Monitor trends via incident reporting
- Continue to review PGD breaches through serious incident group
- The Quality Governance and Assurance Team has made significant progress on clearing the backlog of overdue actions. The current actions that remaining overdue have only recently breached the deadline

Effectiveness

- Whilst still above the YTD target of 66%, Stroke to HASU (<60 mins) has decreased by 10% since October 2017 to 50% with the largest variation being seen in the South East. Hospital handovers in this area have been particularly challenged and may be a contributory factor.
- CARU analysis reflects reduction of stroke and STEMI time to arrival

Actions & Assurance

- CARU have undertaken an analysis of the data to ascertain if ARP may have had an affect and whilst there has been a small variation it is not thought to be related. The Stroke lead of the Trust has been made aware and will work to understand how this can be improved.

Caring

- Impact of impending changes relating to the Data Protection Act – Data Protection Regulation 2018.
- EOC call handling pressures – action plan to support staff and executive oversight

Actions & Assurance

- Work is underway to understand the change in regulation and how this may impact the Trust.



Patient Safety

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

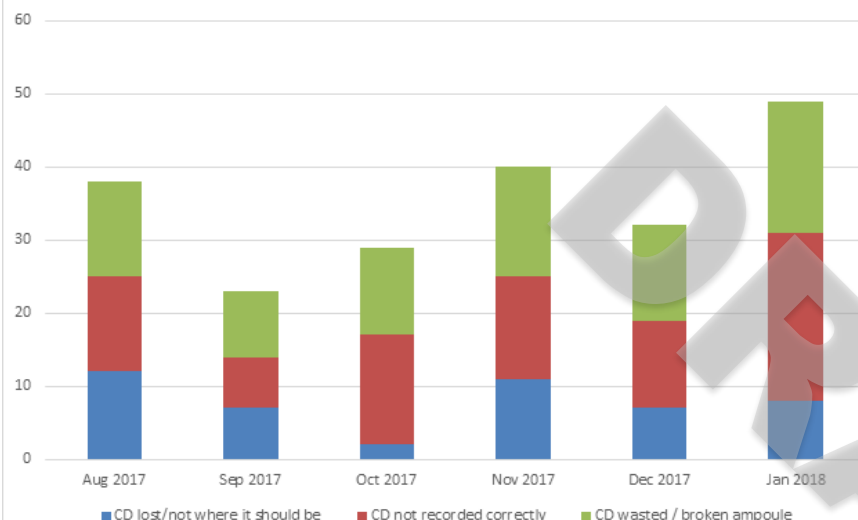
Measures	Target/Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule / LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	83%	98.0%	59.5%	85.0%	↑	↘		LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	2.7	2.9	2.2	↓	↘				
Patient related Adverse Events - NO HARM	1200	G	2136	187	186	171	↓	↘				
Patient related Adverse Events - LOW	30	G	244	23	36	24	↓	↘				
Patient related Adverse Events - MODERATE	25	G	156	21	29	8	↓	↘				
Patient related Adverse Events - SEVERE			68	10	12	2	↓	↘				
Patient related Adverse Events - DEATH			109	10	24	7	↓	↘				
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.4	3.9	2.9	3.2	↑	↘				
Staff related Adverse Events - NONE			1811	218	170	188	↑	↘				
Staff related Adverse Events - LOW			1297	137	105	122	↑	↘				
Staff related Adverse Events - MODERATE			66	12	9	4	↓	↘				
Staff related Adverse Events - SEVERE			2	0	0	1	↑	↘				
Controlled Drugs - Other Reportable Incidents			301	34	31	46	↑	↘				
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	3	1	0	0	↔	↘				
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	95%	93%	95%	↑	↘				
Percentage of Serious Incidents (SI) reported on STES within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔	↘		LQ20		
Potential Serious Incidents referred to SI Group			331	37	39	46	↑	↘				
Serious Incidents declared in-month			61	9	5	8	↑	↘				
Serious Incidents breaching 60 days	0	G	24	2	0	0	↔	↘				
Serious Incidents breaching 40 days	0	G	27	5	0	0	↔	↘				
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔	↘				
Medication Errors as % of Patient Adverse Events			5%	6.0%	5.6%	9.0%	↑	↘				
Needle Stick Injuries as % of Staff Adverse Events			2%	3.0%	2.5%	1.6%	↓	↘				
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%	79.9%	92.1%	93.5%	↑	↘				
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	R	79%	81.8%	83.8%	88.0%	↑	↘				
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	42.6%	42.0%	57.6%	↑	↘				
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	77%	76.9%	78.4%	76.9%	↓	↘				
Safeguarding Trust Board (3 Years)	90%	G	100%	100.0%	100.0%	100.0%	↔	↘				
Total Inquests where LAS asked to give evidence - In-Month			56	6	4	3	↓	↘				
Total Inquests where LAS asked to give evidence - Year to Date			324	49	53	56	↑	↘				
Missing Equipment Incidents as % of all reported incidents			3%	3%	4%	2%	↓	↘				
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			9%	8%	9%	1%	↓	↘				
Number of NRLS uploads In-Month	1	G	10	1	1	1	↔	↘		LQ21		



Medicines Management

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

Controlled Drugs Incidents by Month



Medicines Management Incidents

- One unaccounted for loss of syringe containing 5mg of morphine post administration
- Total of 40 other controlled drugs incidents
 - 40 recording or documentation errors or omissions
 - Two cases where morphine retained off-duty
 - Two cases of morphine ampoule breakages
- Non controlled drugs incidents
 - Drugs: Cabinets left unsecured (n=3) or in wrong location (n=1)
 - Management of cardiac arrest (n=1)
 - Return Of Spontaneous Circulation (ROSC) (n=1)
 - Patient Group Direction (PGD) breaches involving calcium (n=1) and tranexamic acid (n=1)
 - Administration of oxygen (n=1), morphine (n=1), GTN (n=1), ipratropium (n=1)
 - Drug pack driven over destroying contents
 - Glucose 10% given instead of normal saline IV infusion (n=1)

Actions

- Medication safety Bulletin on January 10th including a reminder to staff of the indications for use of tranexamic acid under patient group direction (PGD).
- Introduction of tamper evident device (TED) bags for movement of controlled drugs at group station level.
- Ongoing roll-out of secure drugs on stations project to strengthen security and monitoring of all drugs within LAS
- Pain management session incorporating pharmacology delivered as part of current core skills refresher programme.

Assurance

- No unaccounted for loss of controlled drugs from controlled drugs safes – single unaccounted for loss was post administration at a scene.
- No incidents of inappropriate administration of IM adrenaline by LAS staff



Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	31%	36%	32%		↓	↘		LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	42%	62%	57%		↓	↘		LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%		93%					↑	↗		LQ2b		
STEMI care bundle (AQI)	74%	R	70%	74%	73%	72%		↓	↘		LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	60%	59%	50%		↓	↘		LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	97%	96%		↓	↘		LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:35	00:31	00:31		↔	↗				
Survival to Discharge (AQI)			10%					↑	↗				
Survival to Discharge UTSTEIN (AQI)			38%					↑	↗				
STEMI- On scene duration (CARU continual audit)				00:40	00:36	00:40		↓	↘				
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	92%	94%	92%		↓	↘	✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	9.9%	14.4%	16.8%		↑	↗		LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.3%	97.0%	98.0%		↑	↗	✓	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%	92.0%	92.0%	93.0%		↑	↗	✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	96.0%	97.0%	97.0%		↔	↗	✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96%		↔	↗	✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%			↔	↗		LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	89%	87%	92%	86%	↓	↘		LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						30%	49%	↑	↗		LQ11	✓	

Actions

- In order to maintain current high levels of CPI Completion, in December CARU trained a further seven members of staff on how to undertake CPI audits. In addition, six student paramedics from the LAS Academy received CPI training as part of their student paramedic training course.
- In December, 185 members of staff received face-to-face CPI feedback, meaning between April and December 2017, 17% of LAS staff received two face-to-face CPI feedback sessions.

Assurance

- The proportion of CPI audits completed by Team Leaders increased for the second month in a row; at 53%, this is the highest proportion of CPI audits completed by Team Leaders this year.
- Care delivered to patients discharged at scene, experiencing difficulty in breathing or with severe sepsis remained of a high standard.
- Care provided to patients in cardiac arrest was of the highest standard since August 2017 and to patients with a diagnosed psychiatric problem since September 2016.

Caring

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



Measures	Target / Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	67%	100%	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	130	15	24	14	↓			LQ29b	
Rate of Complaints per 1,000 Incidents			0.8	0.9	0.9	0.8	↓			LQ29c	
Positive Feedback Compliments			912	90	80	74	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	7.6%	6.6%	7.2%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.0%	1.7%	1.9%	↑				
Mental Health related Incidents as percentage of all calls			5%	4.9%	3.7%	4.4%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.2%	0.3%	↑				
Rate of Frequent Callers per 1,000 Calls			3.16	3.6	3.2	3.6	↑				
CMC records viewed			3319	778	1458	307	↓			LQ30	

Assurance

Since CMC app was included on iPads, the number of CMC records reviewed have continued to increase month on month but dropped from a record 1,458 in December 2018 to 307 in January due to a more stringent data validation process. The Trust is working closely with CMC to simplify this process in order to return to, and improve upon the figures seen in December.

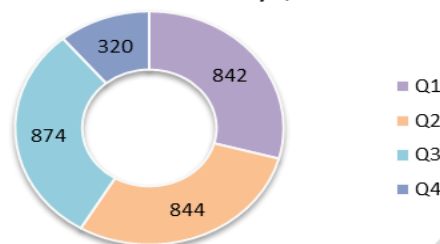
With aspirations for CMC to be in use by all NHS care providers across London, as mutually agreed by all CCG's, it is envisaged that access to patient care records by both operational and Clinical Hub staff will improve significantly for specialist patient groups such as End of Life Care, Patients requiring specific treatment, Emergency Department Care Plans and welfare concerns for babies yet to be born.



Health & Safety Scorecard – Q4 (January 2018)

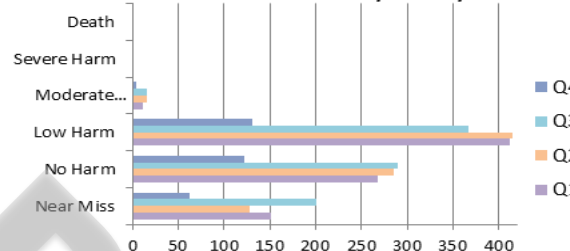
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Number of H&S incidents by Quarter



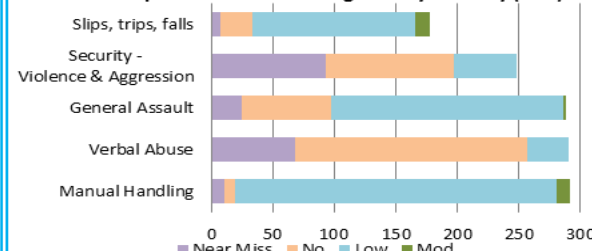
2880 health and safety related incidents have been reported during 2017/18. 16 additional incidents (covering Q1 & Q3) were reported in Jan'18. Total YTD H&S incidents account for 40% of all incidents reported Trust-wide during the year.

Accidents & Incidents by Severity



1373 (46%) of the H&S related incidents reported during 2017/18 resulted in low harm. 47 (1.6%) incidents resulted in Moderate Harm. 1507 (52%) of the incidents were reported as 'No Harm/Near Misses'.

Top 5 Incident Sub-Categories by Severity (YTD)

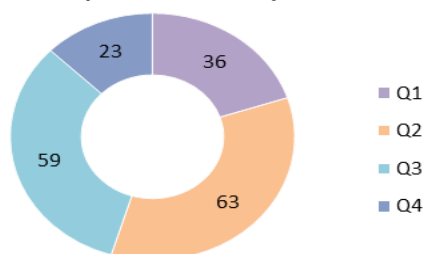


Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

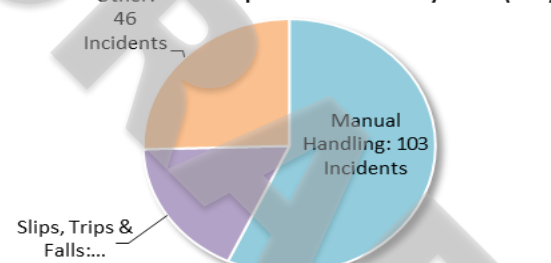
Key Updates:

1. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Practical MH refresher training will be provided for all frontline operational staff from CSR 1 – April 2018.
2. The Color tagging of Mangar Elks has commenced to minimize issues of compatibility reported Trust-wide. 12 weekly maintenance plan has been implemented for all equipment including tail lifts and track chairs supported by 6 weekly visual inspection checks to identify and rectify faults/defects.
3. No trends identified with increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
4. Prototypes of the proposed integrated Vehicle based ALS and first response bags are currently on trial across the Trust.
5. Fire risk assessment contract – under tender. Fire Marshal training being organised for nominated representatives between February/March 2018.
6. Audit of Trust-wide H&S arrangements to assess progress made since the June 2017 independent H&S review commenced on 29/01/2018.

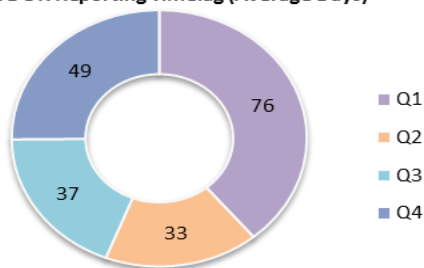
RIDDOR Reportable Incidents by Quarter



RIDDOR Reportable Incidents by Cause (YTD)

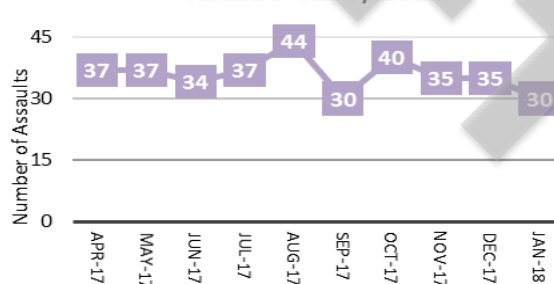


RIDDOR Reporting Timelag (Average Days)



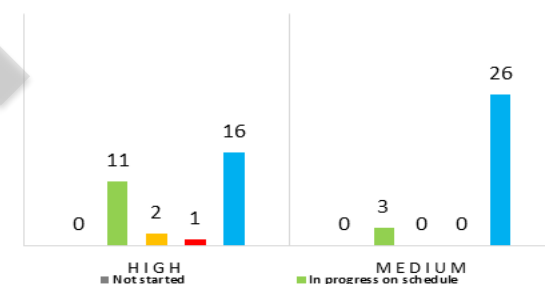
7. The average time lag for reporting RIDDOR incidents across the Trust in January was 49 days. This exceeds the statutory reporting timeline of 15 days for most RIDDOR incidents. In January 2018, 9 out of the 23 RIDDOR incidents were reported out of time.

Assaults on Staff by Patients



8. Assaults on staff by patients make up 31% of the violence, abuse and assault incidents reported in 2017/18. The most common underlying causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Status of H&S Review Action Plan



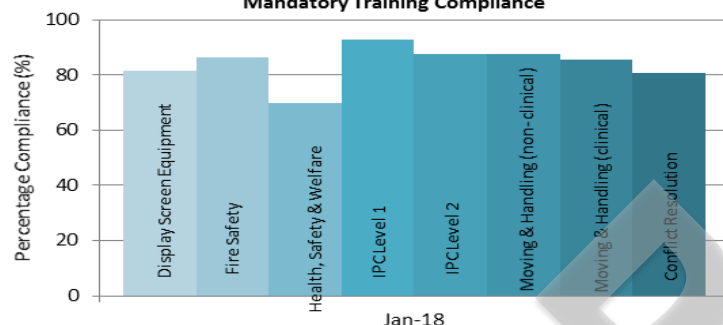
9. 42 of the 59 actions recommended have been completed.
16 actions are currently in progress with 4 actions due to be completed by 28/02/2018.
1 action is overdue.



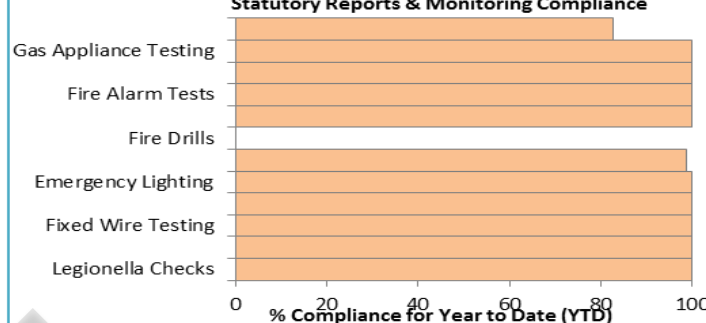
Health & Safety Scorecard – Q4 (January 2018)

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

Mandatory Training Compliance



Statutory Reports & Monitoring Compliance



Trust-wide compliance in January 2018 for 3 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					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Q3			Q4		
					Oct	Nov	Dec	Jan			
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	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Audit of Trust-wide H&S arrangements to assess progress made since the independent H&S review conducted in June 2017 commenced on 29 th January 2018.
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	9	Key training in practical manual handling has been delivered to Clinical Tutors in the Clinical Education Department. Practical manual handling refresher training to be provided from CSR 1 – April 2018. Business Case to replace all version 1 Mangar Elk approved. 12 – weekly maintenance programme implemented for all track chairs and tail lifts.
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	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 approved 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	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	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	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. LSMS in regular liaison with staff and sites where security related incidents have been reported. Where required, incidents are reported to the Metropolitan Police for investigation.
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	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. Recruitment ongoing however with difficulty finding interim staff (at the right level) to match the roles available within the team.



Learning from Complaints

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

Top 5 key complaints themes : January 2017 to January 2018

Complaints by subject 2015/17	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Total
Delay	36	16	27	21	17	16	14	26	9	22	33	19	17	273
Conduct	26	27	36	16	19	24	19	19	16	17	25	20	22	286
Road handling	7	9	16	12	11	13	14	10	7	14	9	7	6	135
Treatment	3	3	5	1	2	5	1	7	5	16	8	9	8	73
Non-conveyance	1	3	4	3	0	4	12	0	1	6	1	7	6	48
Total these subjects	73	58	88	53	49	62	60	62	38	75	76	62	59	815
Overall Totals	90	74	105	66	70	76	73	86	51	94	85	84	74	1028

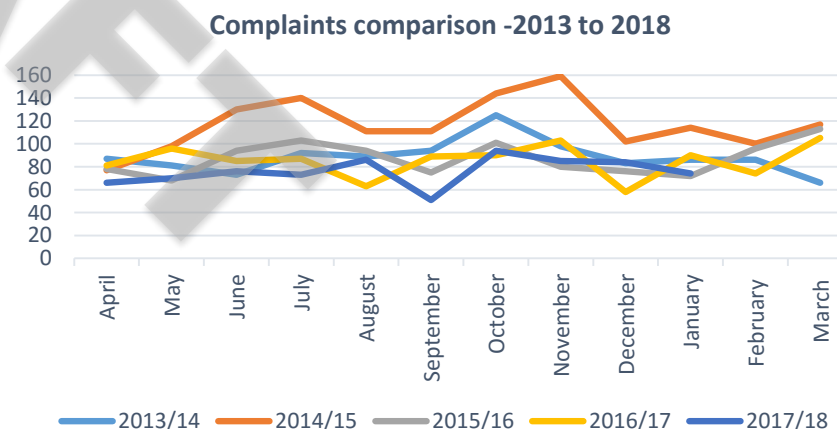
Review of January 2018

- The number of complaints relating to 'delay' has decreased over the annual average of 19 per month. Complaints where the main head of complaint relates to conduct and behaviour are now higher than delays
- Complaint numbers are currently 0.08% of calls attended by the Trust
- We have added 'Quality Alert' as a sub category in Datix with measured time frames to ensure a timely response
- We will be adding timeframes for internal stakeholders into Datix so that we can share our targets and to improve throughput
- The new Data Protection regulations (which are still being developed) will impact on subject access requests. We recommend that the Trust undertakes some training as the impact of the revised regulations is that document requests will no longer be chargeable and may impact on the numbers of those.

Assurance and learning

- During January we received 74 complaints. Of these, 8 were classed as HCP issues on behalf of the patient and 15 were from LAS111.
- A number of the 111 complaints related to the unavailability of a doctor to call back in a timely manner. These have been shared with the relevant Commissioning group.
- Of the 98 complaints which were closed, 7 were upheld and 18 partially upheld – examples in next slide.
- There were 7 Quality Alerts in January. This is expected to rise when we update the website for HCP's – estimated launch is April.
- During this month 22 complaints related to Category 2 in ARP, 14 were related to Category 3, 6 to Cat 4 and 1 to Cat 1. The other complaints were either before ARP or not CAD related. We will be preparing a quarterly summary with G&A

Complaint summary 2013/14 to 2017/18



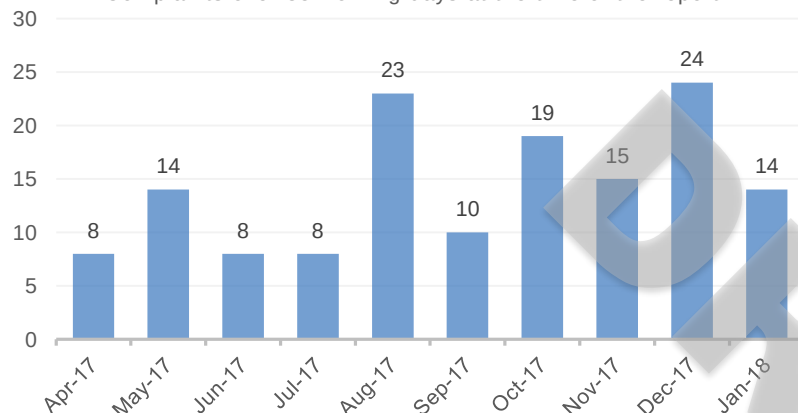


Learning from Complaints

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

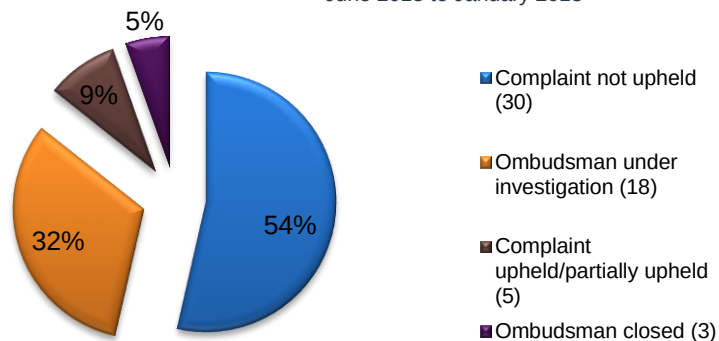
Performance against 35 day response target (January)

Complaints over 35 working days at the time of the report



Overview of Ombudsman cases 2015-2017

Complaint files requested by the Ombudsman
June 2015 to January 2018



Assurance and learning – case examples

Case example one:

Complaint from patient that the attending ambulance staff took her home but did not help her into her property despite being hardly able to walk.

We explained that it would have been more compassionate and safer practice to have ensured the patient was able to make it into her home. In addition, the assessment record does not make any reference to any assessment of the patient's hip, which should have been completed.

Case example two:

Complaint from patient's sister who is concerned at the aggressive attitude of the call handler.

The call handler did not adhere to protocols which may have prevented the conflicting answers you gave and the triage assessment to be conducted more quickly. She deviated from the prescribed questioning, omitted to use the breathing detector tool and failed to verify the location. She did not display appropriate customer service skills and should not have given precise details of the responding ambulance resource, as it is possible they could have been re-directed to another 999 call so this was misleading. An apology was offered and reflective practice arranged.

Case example three:

Complaint from patient who is upset that the attending medic did not administer a nebuliser after she suffered an asthma attack.

Extensive feedback will be given to the Paramedic by the local management team, with an emphasis on the importance of recording the assessment record to an optimum level. They will also jointly review the treatment protocols in relation to patients with symptoms similar to the patient's presenting symptoms.

Case example four:

Complaint from patient's husband who is concerned at the delay in providing a critical transfer ambulance for his wife who was experiencing a placental abruption.

The Quality Assurance evaluation confirms that from the information provided all 999 calls were largely managed in accordance with our protocols, although some shortcomings have been identified and the Clinical Hub should have applied an upgrade after 60 minutes as they misunderstood their responsibilities within the new guidance in line the ARP. This does not mean that an ambulance would have arrived sooner, however it does increase the likelihood of that.

An exceptional bulletin has been issued at all staff.



Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Events on database	Events attended	Interested staff
58	56	1234

Temple Mill Primary School – 11th January – CA

"A fantastic visit by CA, the children enjoyed trying on the jackets and helmets and asked a lot of questions. CH was informative but very friendly. All the children were engaged, thank you."

Coombe Hill Junior School – 24th January – WH

"I just wanted to say thank you so much to WH for coming to our school yesterday. He gave a really engaging assembly to 420 pupils and they responded really well. Not only has he educated our pupils on how and when to use the ambulance service but he has also inspired some of our young people to want to follow in this career path themselves. Please pass on our thanks and appreciation."

Key Updates

- Two of our Public Education Officers have been working on multi-agency knife crime projects. "No Knives, Better Lives" is aimed at young people who have either already committed an offence or are at risk of offending. Sessions are held in the Old Bailey and are hosted by a senior judge. Sessions are still being held in Pupil Referral Units, targeting challenged children who have been excluded from school, to teach them about CPR, blood loss and the risks of carrying knives.
- The Trust Dementia Project developed by a Public Education Officer is being rolled out in the north-central area and to NETS staff. An information pack has been produced for staff about dementia, and is encouraging them to find out key information about patients with dementia from their carers and relatives, which they can then use in communication with the patient.

Staff Awards

The Trust has been selected as a finalist in 3 out of 8 categories for the 2018 Control Room Awards;

Lifetime Achievement Award – Jules Lockett
Leader of the Year – Jules Lockett
Team of the Year – EOC

The winners will be announced at the APD Communications Control Room Awards ceremony on Thursday, March 8, at the De Vere Orchard Hotel in Nottingham

Staff Recognition

A group of over 20 staff from across the Service came together at CrossFit Central London for a fitness session run by professional coaches.

The idea to begin the group started on LiA Facebook with Paramedic Ross Aitchison gauging interest from colleagues. He then got into discussions with local gyms and found CrossFit Central London who volunteered to run two free sessions a month for the Service.

Two staff recently met with the Chief Executive Officer to celebrate their 35 year anniversary of service. Paramedic Susan Patey has spent her 35 years providing frontline patient care and Carole Bascoe, who initially started her career as a nurse, before moving to NHS Direct joined the LAS 111 team as a work based learning facilitator.

Our Performance



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.



Ambulance Response Programme – Performance Summary

	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
Previous month (Dec 17)	00:07:23	00:12:04	00:24:07	00:51:08	02:58:23	02:51:44
Last month (Jan 18)	00:07:09	00:11:43	00:20:23	00:42:05	02:25:11	02:19:04
Current YTD (2017/18)	00:07:13	00:11:46	00:21:14	00:44:13	02:32:34	02:31:55



Demand

- **97,339** Incidents were provided with a face-to-face response. This was 1% above the plan for January (96,789). (Taxis provided an additional 1,140 responses.)
- The **year to date** position for demand is **944,493**. This is **2% above** the year to date **plan** position (**926,237**) (including taxis).
- **8,471** incidents were categorised as **Category 1** and provided with a face-to-face response.



Performance

- The Mean response time for C1 was **7 minutes 9 seconds**. This is an improvement compared to the previous month, with *all* response time performance metrics showing an improvement in January compared to December.
- The C1 90th Centile was **11 minutes 43 seconds**. This has remained **within the 15 minute** national standard each **week** since the implementation of ARP.
- The Mean response time for C2 was **20 minutes 23 seconds**, this is above the 18 minute national standard.



Daily Response Times by Category

Daily - Category 1 Response Times

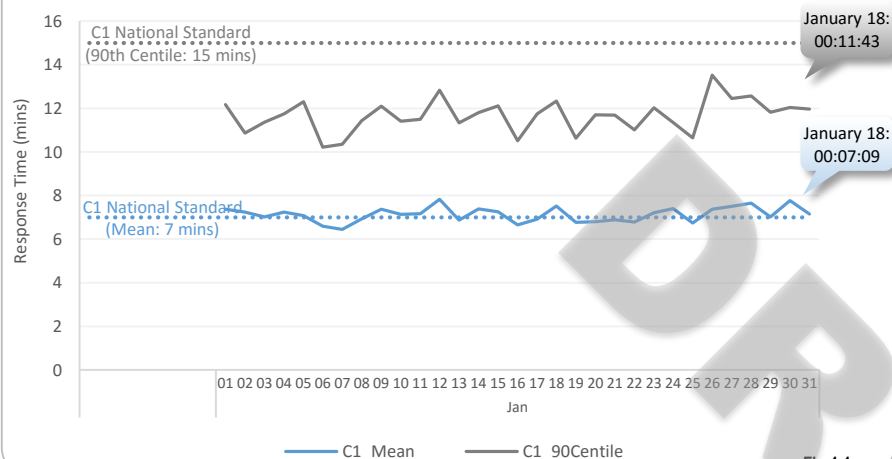


Fig 1.1

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.

C1 performance was fairly consistent over the month, with the mean close to the national standard, and the 90th centile performing well within the target.

Daily - Category 2 Response Times

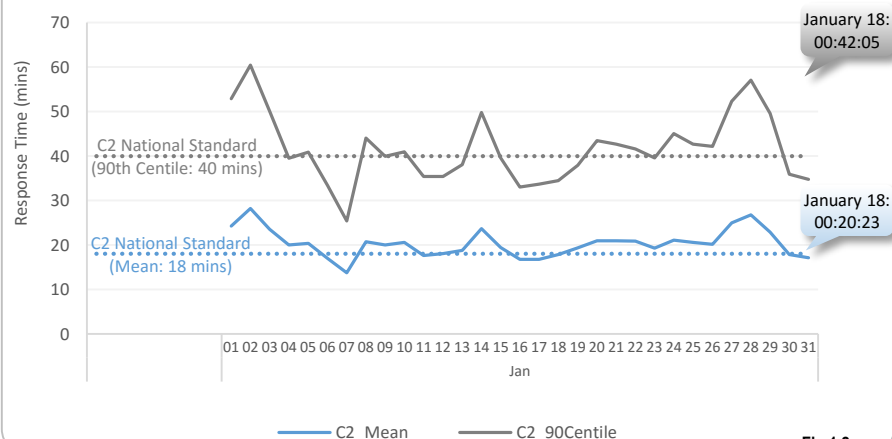


Fig 1.2

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.

Daily C2 mean and 90th centile performance were both close to the target for the majority of the month of January, with pressure points seen at the beginning of the month (as expected following New Year's Eve) and towards the end (when high C1 demand was experienced).



Daily Response Times by Category

Daily - Category 3 Response Times

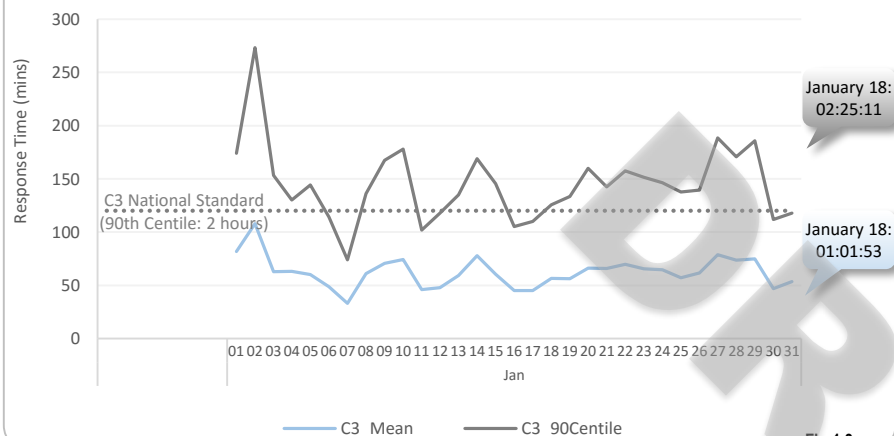


Fig 1.3

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.

Daily - Category 4 Response Times

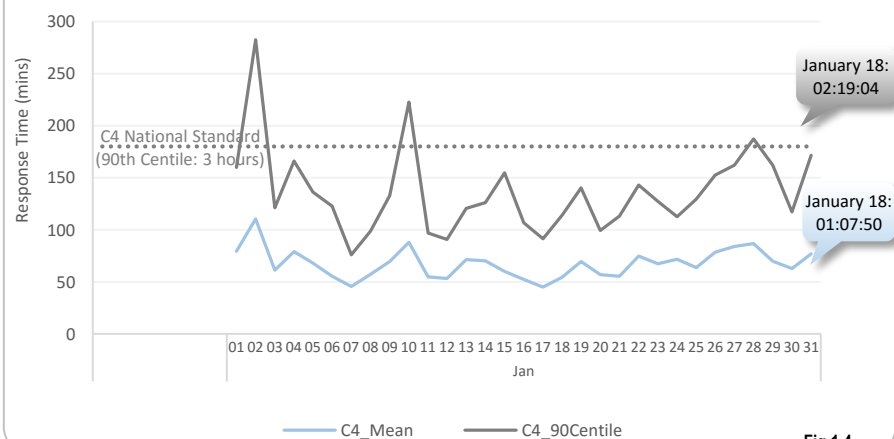


Fig 1.4

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.



Demand by Category

Category 1 Percentage of all Demand

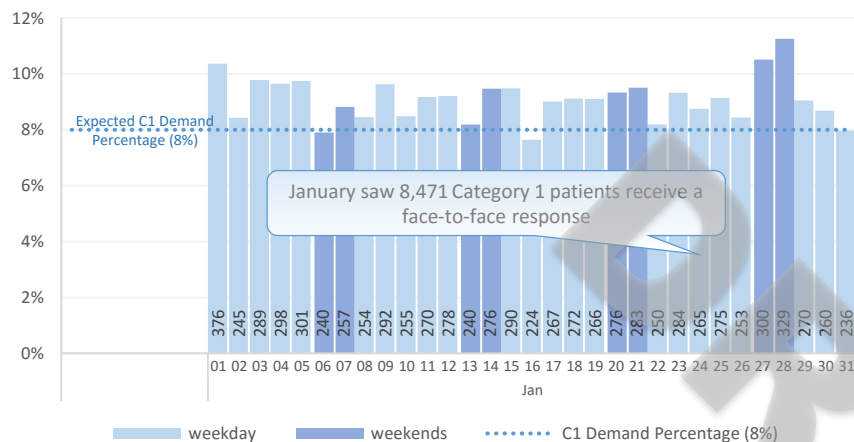


Fig 2.1

Category 2 Percentage of all Demand

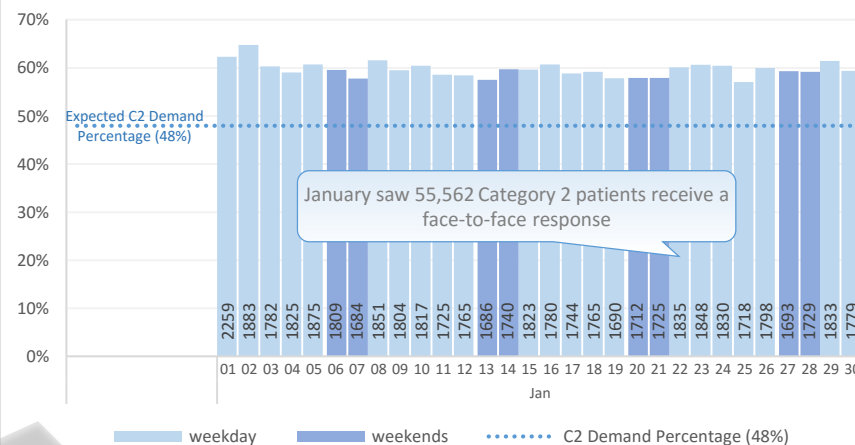


Fig 2.3

Category 3 Percentage of all Demand

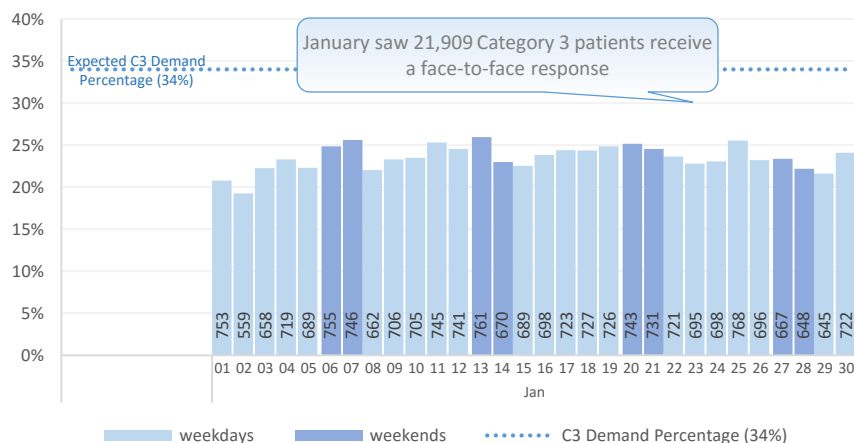


Fig 2.2

Category 4 Percentage of all Demand

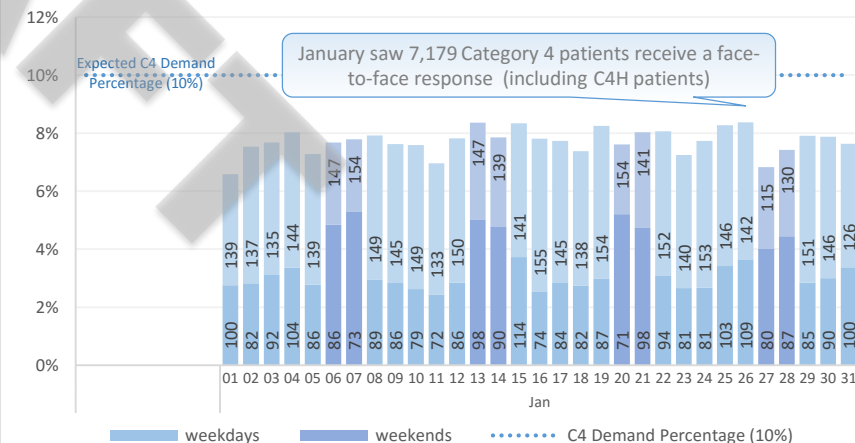


Fig 2.4



90th Centile Performance

Category 1 Response Performance

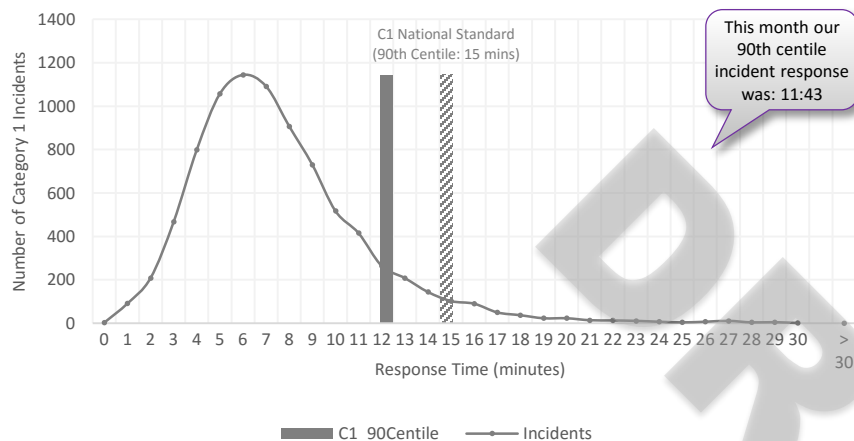


Fig 3.1

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

The 90th centile response time in **January** was **00:11:43** minutes, **within** the 15 minutes National Standard as set out in the guidelines by NHSI.

This is an **improvement** compared to December (**00:12:04**)

Of the 8,471 incidents requiring a Category 1 response, 7,623 incidents received a face to face response within 00:11:43 minutes.

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

Category 2 Response Performance

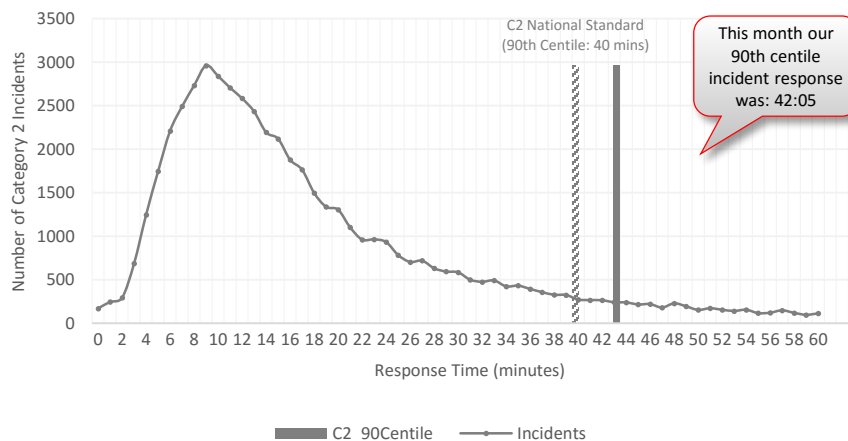


Fig 3.2

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

The 90th centile response time in **January** was **00:42:05** minutes, **above** the 40 minutes National Standard as set out in the guidelines by NHSI.

This is an **improvement** of over **9 minutes** compared to December (**00:51:08**)

Of the 55,562 incidents requiring a Category 2 response, 49,997 incidents received a face to face response within 00:42:05 minutes.



90th Centile Performance

Category 3 Response Performance

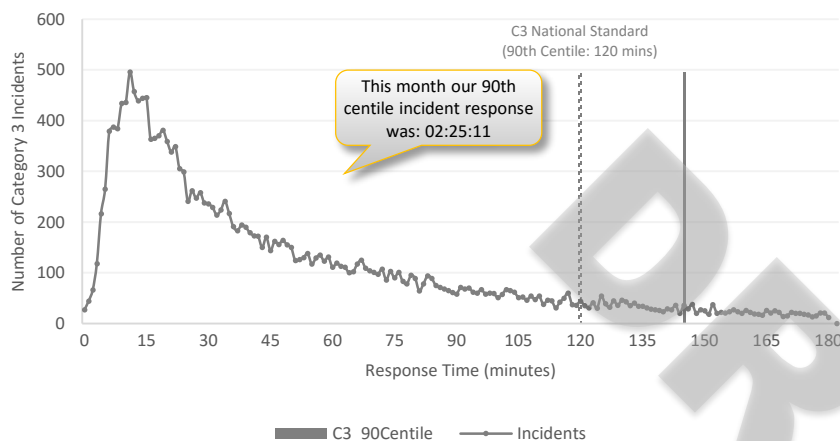


Fig 3.3

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

The LAS 90th centile response time in **January** was **02:25:11**. This is above the 120 minutes (2 hours) National Standard as set out in the guidelines by NHSI.

This is an **improvement** of over **30 minutes** compared to December (**02:58:23**).

Of the 21,909 incidents requiring a Category 3 response, 19,799 incidents received a face to face response within 02:25:11 minutes.

Category 4 Response Performance

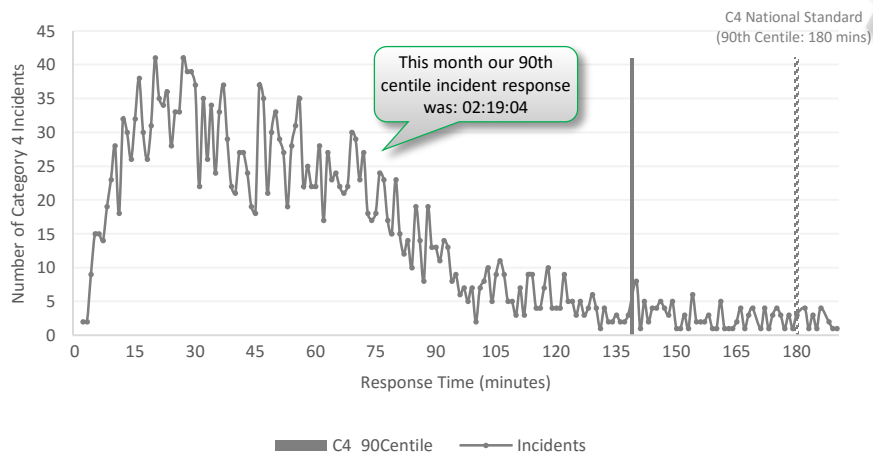


Fig 3.4

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

The 90th centile response time in **January** was **02:19:04** minutes, **within** the 3 hours National Standard as set out in the guidelines by NHSI.

This is an **improvement** of over **30 minutes** compared to December (**02:51:44**).

Of the 2,743 incidents requiring a Category 4 response, 2,468 incidents received a face to face response within 02:19:04 minutes.

The LAS 90th centile has been **within** the 3 hours standard for **14 weeks** out of 15 since ARP was implemented.



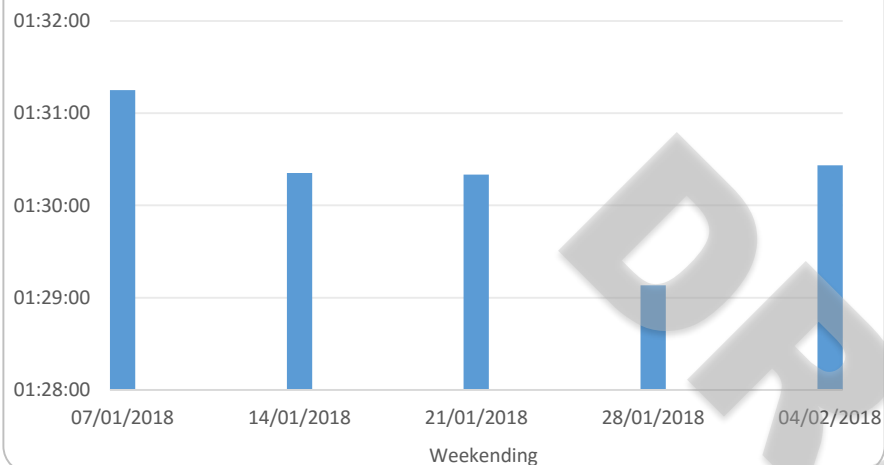
Key Metrics Variance

Category	Measure	LAS Monthly Performance	National Standard	Variance
Category 1	Mean Response Time	00:07:09	7 minutes	00:00:09
	90 th centile	00:11:43	15 minutes	00:03:17
Category 2	Mean Response Time	00:20:23	18 minutes	00:02:23
	90 th centile	00:42:05	40 minutes	00:02:05
Category 3	90 th centile	02:25:11	120 minutes	00:25:11
Category 4	90 th centile	02:19:04	180 minutes	00:40:56

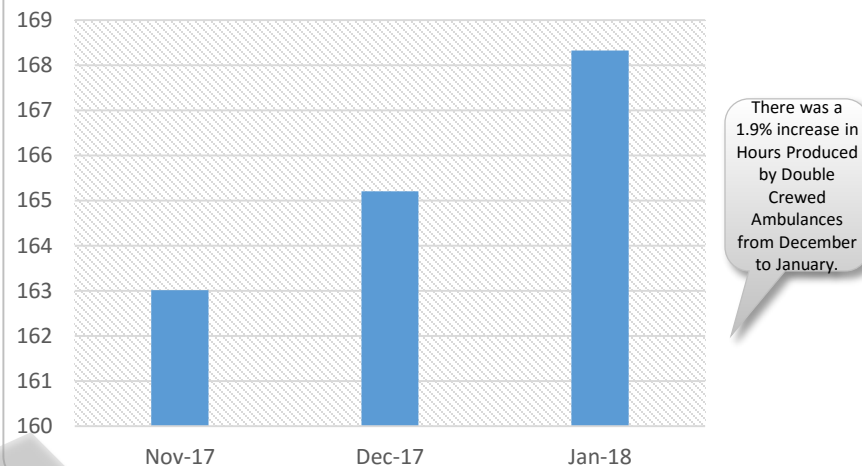


Job Cycle & Capacity

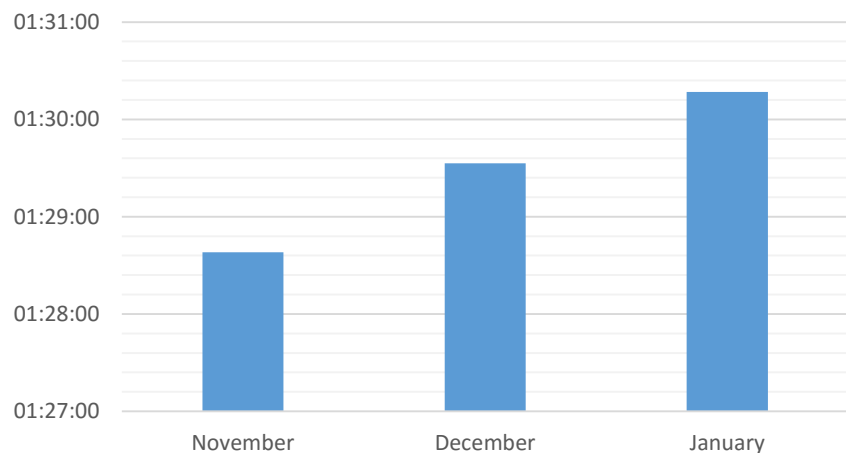
Average Weekly Job Cycle



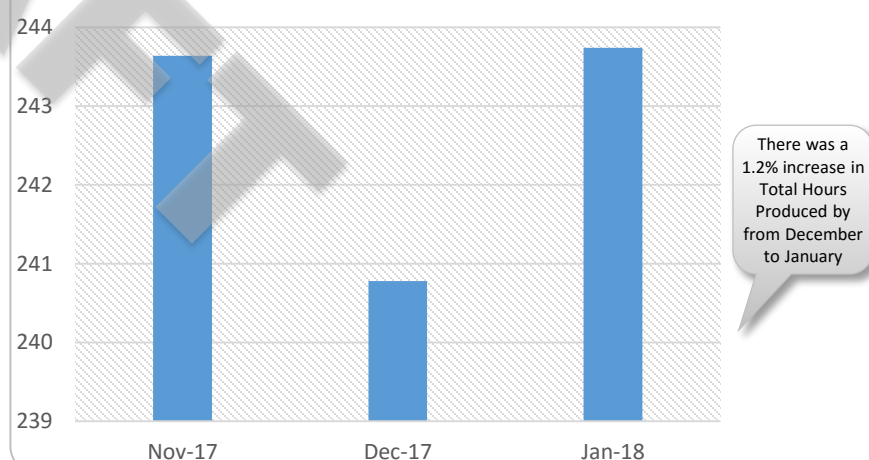
Double Crewed Ambulance Hours Produced



Average Monthly Job Cycle



Total Hours Produced





National Picture

January 2018

Category 1 Mean Performance across England in : January 2018

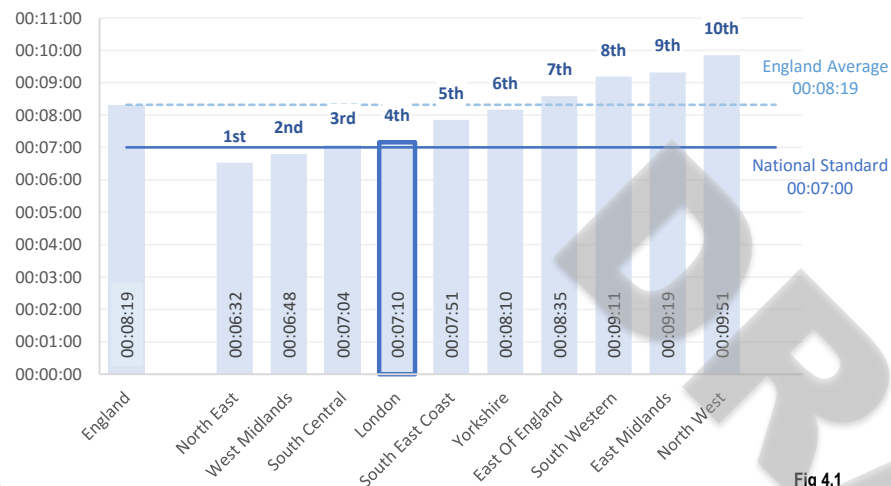


Fig 4.1

■ Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England during January 2018.

Additional information also displayed :

The National Standard (00:07:00)
The average for England (00:08:19).
The ranking position for each Trust *

- LAS achieved **7 minutes and 10 seconds** for the **mean** response time for **Category 1** patients. This is only marginally above the 7 minute national standard.
- LAS ranked **fourth** when compared to 10 Ambulance Trusts across England. *
- LAS also performed **within** the England average by **1 minute and 9 seconds**.
- Two Trusts performed within the National Standard.

* Isle of Wight not ARP compliant until Spring 2018

Fig. 4.2 Displays the six key ARP performance measures for each Ambulance Trust across England during January 2018.

- **LAS ranked 3rd** in the **Category 1 90th centile** performance measure, compared to the other Trusts.
- For **Category 4 90th centile**, **LAS ranked 1st** compared to the other Trusts.
- We ranked 4th for all other metrics.

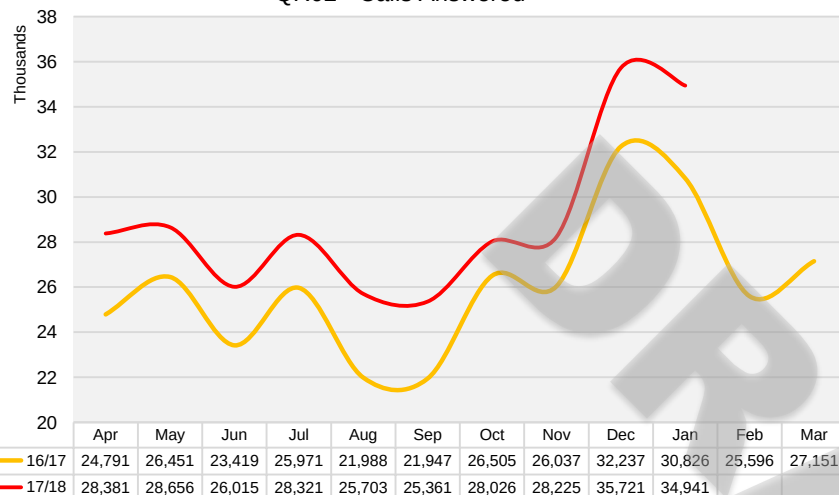
January 2018	Category 1	Category 1	Category 2	Category 2	Category 3	Category 4
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00
England	00:08:19	00:14:29	00:26:05	00:55:36	02:28:26	03:15:32
East Midlands	00:09:19	00:16:44	00:37:11	01:22:15	03:22:40	02:48:57
East of England	00:08:35	00:15:25	00:29:11	01:00:49	03:22:54	03:52:10
London	00:07:10	00:11:45	00:20:25	00:42:08	02:25:38	02:19:04
North East	00:06:32	00:11:22	00:23:23	00:48:58	03:28:22	03:09:57
North West	00:09:51	00:16:44	00:39:59	01:31:33	03:14:16	03:16:31
South Central	00:07:04	00:12:39	00:16:30	00:33:04	02:15:14	03:05:58
South East Coast	00:07:51	00:14:07	00:16:13	00:30:12	02:23:34	04:03:04
South Western	00:09:11	00:16:50	00:29:45	01:02:29	02:28:32	03:32:37
West Midlands	00:06:48	00:11:44	00:12:22	00:22:26	01:22:49	02:25:57
Yorkshire	00:08:10	00:13:56	00:26:57	00:59:30	02:31:51	03:45:02
Isle of Wight	-	-	-	-	-	-

Fig 4.2



LAS 111 (South East London): Demand and Capacity

QR02 - Calls Answered



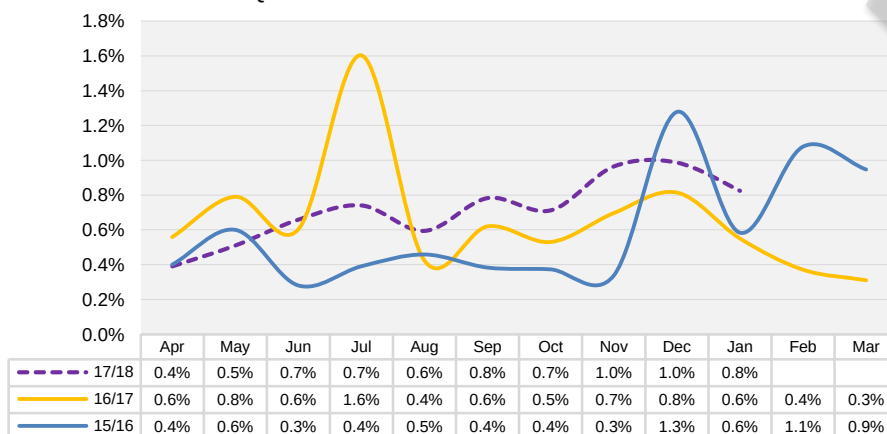
Demand: Call volume was slightly lower than December 2017 and 11.4% higher than in January 2017.

Capacity: Induction commenced in early January for Clinical Advisors and further increase to forecast have been agreed with commissioners to address ongoing increases in demand.

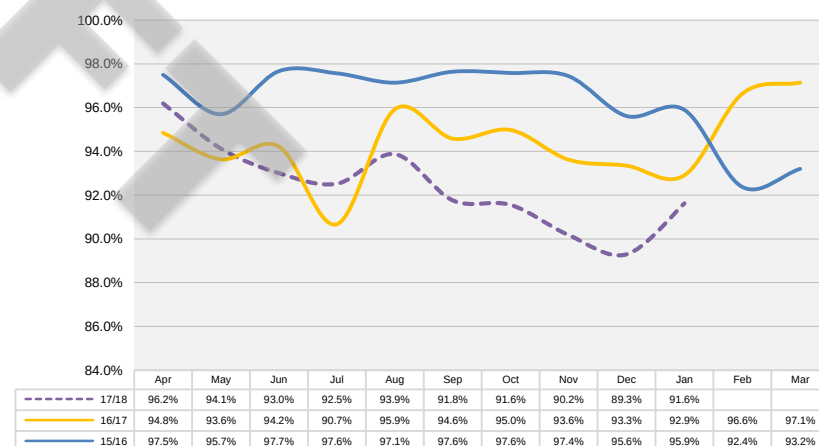
Efficiency: The percentage of calls answered in 60 seconds was 91.6% in January, with the target achieved on only 7 days. The operational focus has been on balancing access to the service and minimizing time to clinical call back and saw an increase in call backs achieved within 10 minutes.

Service Projects: The service's focus throughout January has been on increasing uptake of Direct booking of appointments into GP hubs to enhance the patient journey.

QR04 - Calls Abandoned after 30 Seconds



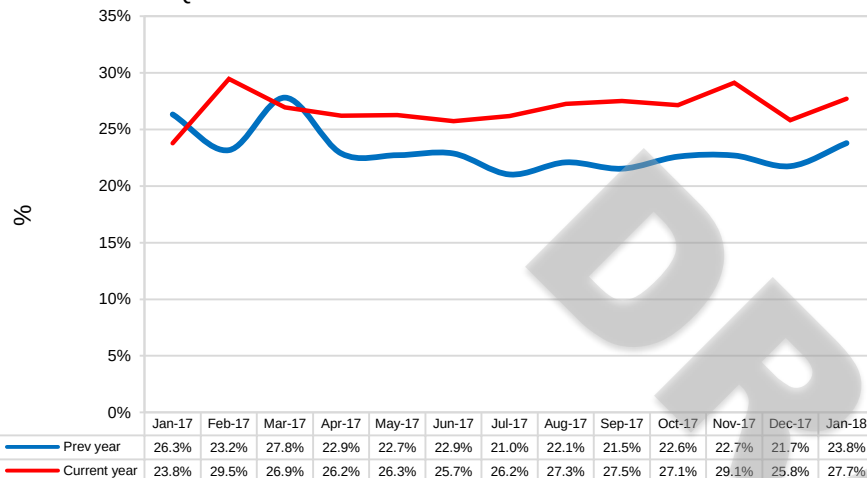
QR05 - Calls Answered within 60 Seconds





LAS 111 (South East London): Call Destinations

QR12a: % of calls referred to a clinical advisor

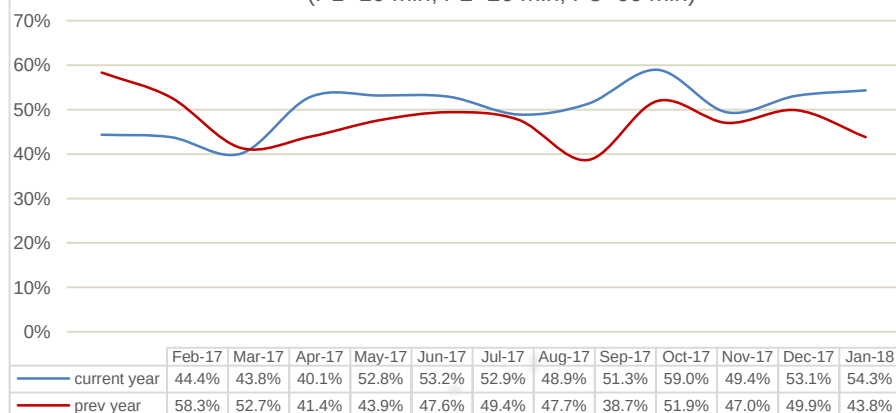


Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for low acuity ambulance outcomes and availability of Clinical Advisors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

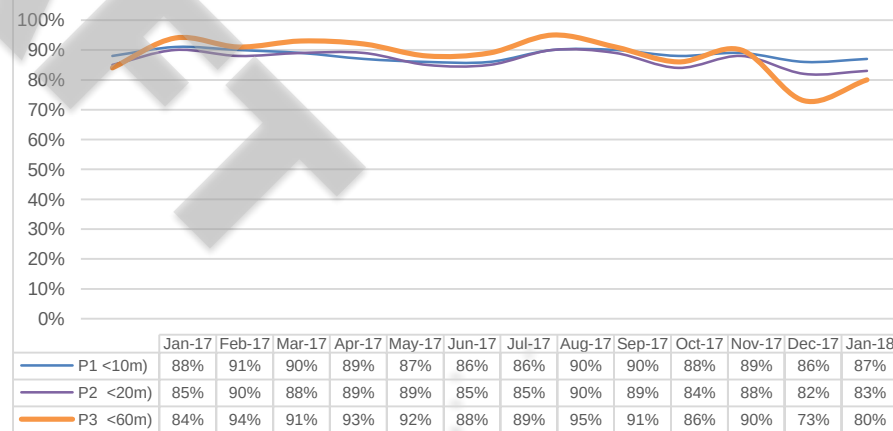
Safety: There were 117 Incidents in Datix with completed investigations in March. Of these 6.8% (n=8) related to authorized breaches in confidentiality including safeguarding referrals made with our patient consent, 31.6% (n=37) to failure to follow procedure, 56.4% (n=66) to delay in care and the remaining 5.1% (n=6) to other issues. Incidents are under investigation and feedback given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received eight complaints, four compliments and feedback from two HCPs.

QR12
calls % warm transferred
(P1=10 min, P2=20 min, P3=60 min)



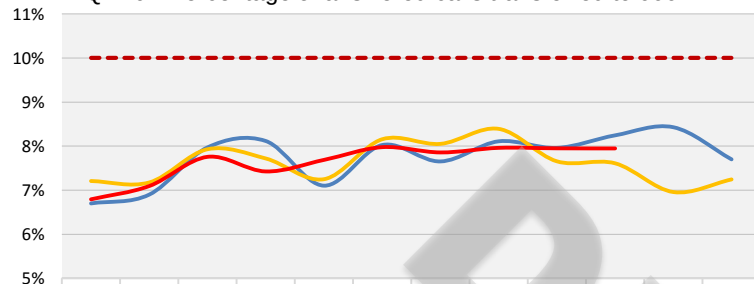
QR14 Call Backs and warm transfers
(P1=10 min, P2=20 min, P3=60 min)





LAS 111 (South East London): Triage destinations

QR10 - Percentage of answered calls transferred to 999

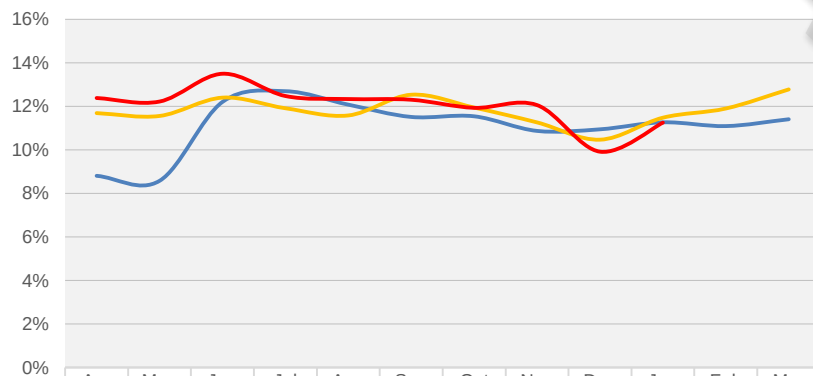


LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for low acuity ambulance outcomes.

Referrals to Emergency Departments are higher than for other providers, 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.

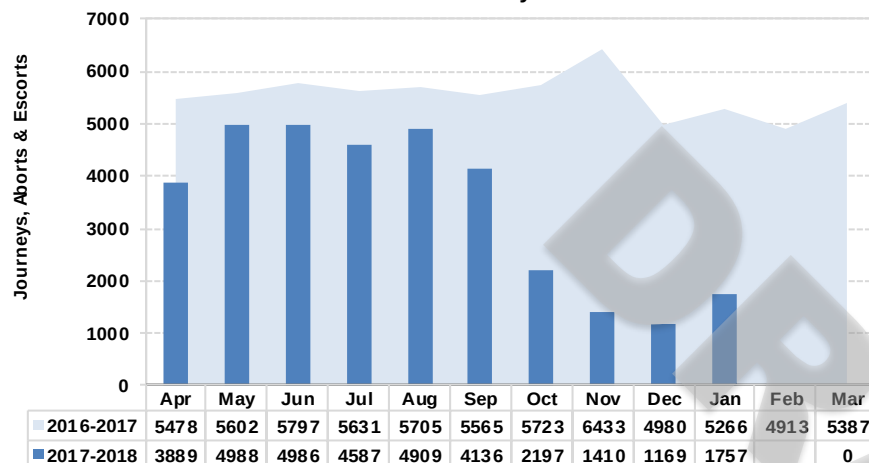
QR11 - Percentage of patients advised to attend Emergency Treatment Centre





Patient Transport Service – Activity Update and Profitability Update

PTS Total Activity - Contracted, A&EReferrals and Extra Contractual Journeys



January saw a sharp rise in the number of journeys with a total of 1,757 journeys being delivered as compared to the December total of 1,169 journeys.

The increase in journeys was the normal result seen of the impact of the Christmas break with outpatient services making up for the loss of working days along with impact of winter pressures.

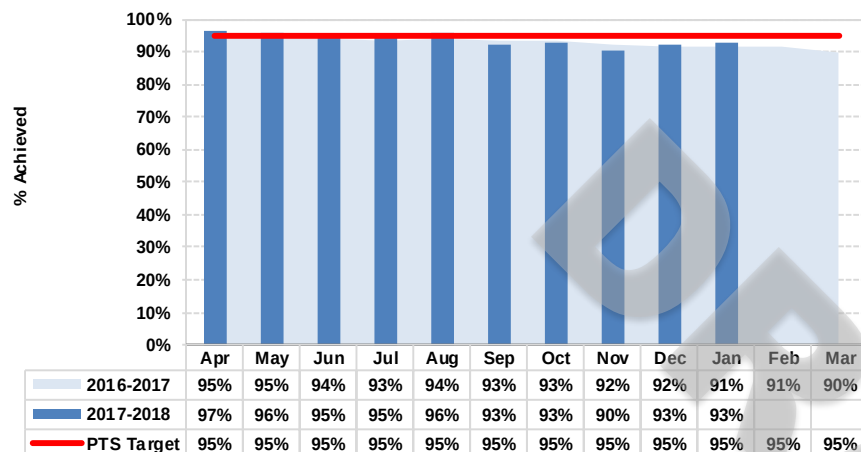
PTS now have only two contracts operating; St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March 2018.

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	1757
Feb	15232	9787	5306	4913	
Mar	13978	10520	5264	5387	
Total	184092	125988	78328	66480	34028



Patient Transport Service – KPI Update

Arrival at Hospital Against Appointment Time

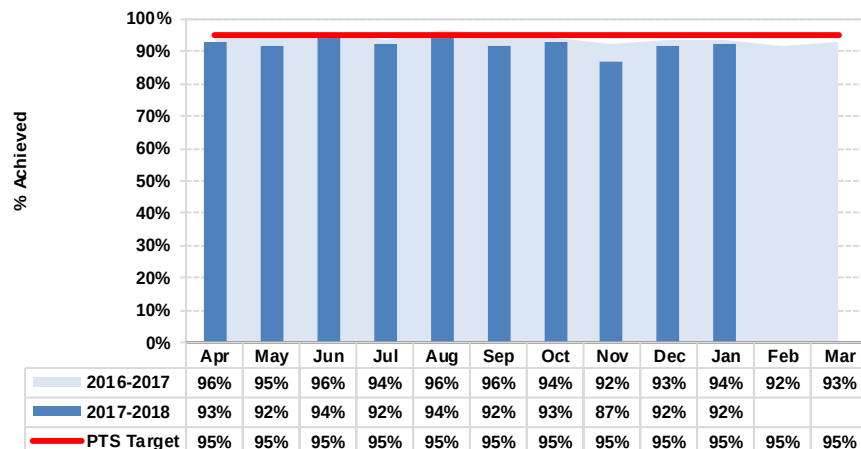


The arrival at hospital against the appointment time was maintained at 93% in January even with the increase in overall activity for the month but was well below the 95% target.

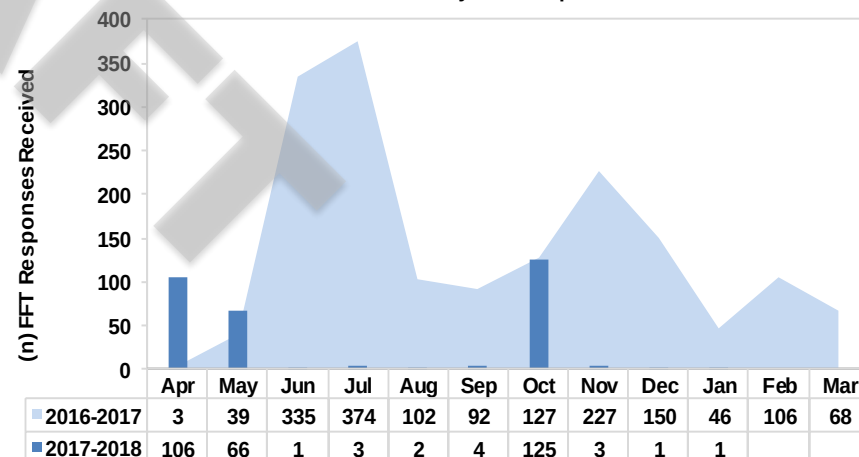
Our activity profile is linked to one of the remaining two contracts where we are providing transport in the community settings with longer distances and spread of care centres where patients are being taken to.

Departure against patient ready time also was maintained at 92% for January against the background of activity as given above. This was below the target of 95%.

Departure Against Patient Ready Time

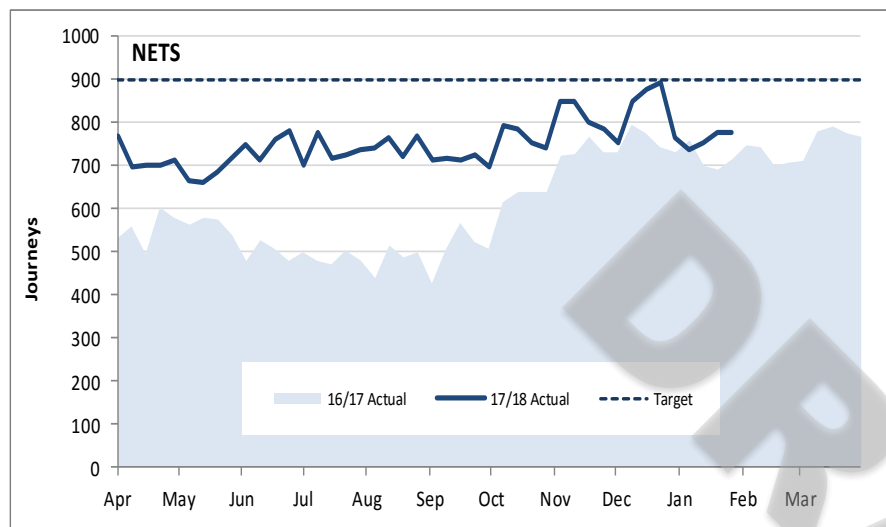


PTS Friends & Family Test Responses Received





Non-Emergency Transport Service



Non-Emergency Transport Update

NETs saw a decrease in the month and delivered an average of 765 journeys per week for the month, down from the previous month average of 844.

During January we saw the NETs overall weekly performance being maintained at a level 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 decreased from last months 1,179 per week to 1,036 calls per week for the month.

NETS staffing/resourcing was also impacted by high rates of short term sickness in the first two weeks of the month peaking at 8.9%.

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
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
01/01/2018	1136	7	394	735
08/01/2018	934	7	173	754
15/01/2018	1032	8	244	780
22/01/2018	1042	12	251	779
29/01/2018	1037	4	260	773

Our Money



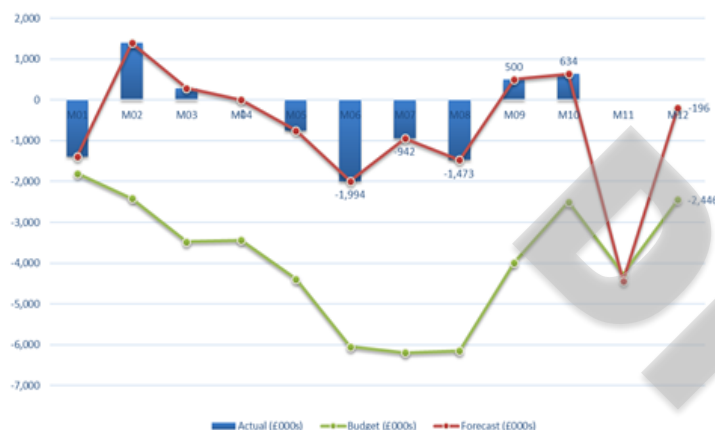
Financial Indicator	Summary Performance	Forecast Outturn	Current Month	Previous month
Surplus / Deficit (Year to date and Forecast)	Year to date the position is £3.4m ahead of plan and £3.1m ahead of re-phased budget. The Trust is forecasting a deficit of £1m at the end of 2017/18.	GREEN	GREEN	GREEN
	Key issues in the position are: - Income is £1.9m 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 £0.5m adverse in month, and £1.9m 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 M10 YTD is 2% higher than the contract baseline, and the variable income in relation to this (£3.9m) 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 confirmation that LAS meets all the requirements in 2017/18.	AMBER	GREEN	GREEN
Expenditure (Incl. Financial Charges)	In month expenditure is £0.9m adverse to re-phased budget in month, and £5m favourable YTD. The key drivers for this are: - On-going vacancies in operational pay (incl. EOC) (£2m favourable in month, £20m favourable YTD) - PAS overspends to compensate for vacancies (£0.6m unfavourable in month, £4.7m unfavourable YTD) are offset by various underspends in budgeted services spend	GREEN	GREEN	GREEN
CIPs	Year to date CIPs are £6.9m 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 has improved governance for recurrent efficiency programme implementation and tracking in 2018/19.	RED	RED	AMBER
Balance Sheet	Capital spend is £12.2m against the initial Capital plan of £20.7m, £8.5m behind plan. The forecast is to spend £20.3m vs the plan of £24.9m. In month 7 the Trust revised its Capital plan and this spend is £6m behind this plan. In addition to the previously reported confirmation of the carry forward and Digital Maturity funding, the Trust has received a further £0.64m to fund improvements to Cyber Security.	GREEN	GREEN	AMBER
Cashflow	Cash is £33.4m, £7.9m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £7.8m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.4m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £7.5m. These movements are being offset by under payments of £10.6m on capital, provision of £0.8m and £10.9m on pay.	GREEN	GREEN	GREEN
BPPC	Non-NHS 72%, NHS 88% performance (volume) for this month, performance is still below 95% target. The financial computer system upgrade in December has contributed to the fall in performance.	AMBER	AMBER	AMBER



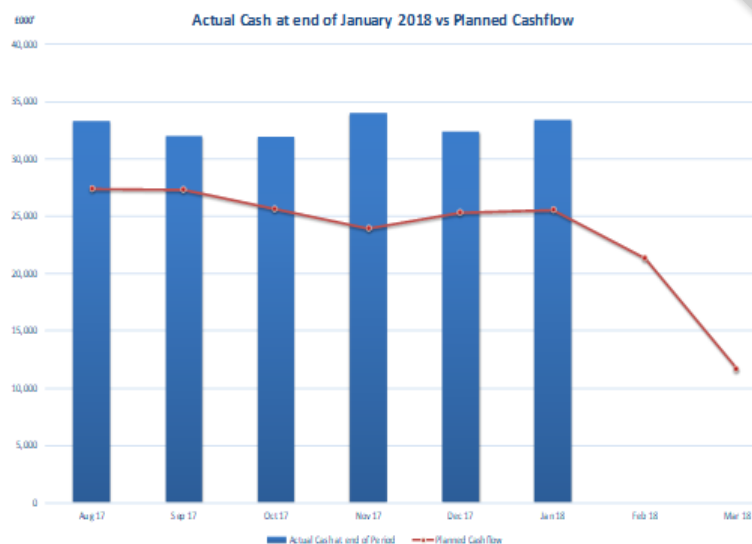
Executive Summary – Key Financial Metrics

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Cumulative Net Position - Budget vs Actual



Actual Cash at end of January 2018 vs Planned Cashflow



	Month 10 2017-18			YTD Month 10 2017-18			Full Year 2017-18
	Re-phased Budget	£000 Actual	Variance fav / (adv)	Re-phased Budget	£000 Actual	Variance fav / (adv)	Plan
Surplus / (Deficits)	1,488	135	(1,353)	(2,499)	634	3,134	(2,438)
EFL				(1,290)	(14,674)	13,384	12,538
CRL				20,695	12,123	8,572	28,806
Suppliers paid within 30 days - NHS	95%	88%	(7.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	72%	(23.0%)	95%	86%	(9.0%)	95%
EBITDA %	9.7%	4.7%	(5.0%)	4.3%	5.0%	0.6%	5.0%
EBITDA	3,116	1,498	(1,618)	12,977	14,825	1,848	18,185
NRAF (net return after financing)				0.41%	2.95%	2.5%	1.2%
Liquidity Days				(2.65)	4.07	6.72	(9.90)
Use of Resources Rating				2.0	1.0	1.0	2.0

- Year to date the position is £3.4m ahead of plan and £3.1 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. The month 10 forecast outturn is £0.2m deficit, £1.8m better than plan.
- Income is £0.5m 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 £8.5m behind target.
- Cash is £33.4m, £7.9m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £7.8m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.4m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £7.5m. These movements are being offset by under payments of £10.6m on capital, provision of £0.8m and £10.9m on pay.
- Non-NHS 72%, NHS 88% performance (volume) for this month, performance is still below 95% target. The financial computer system upgrade in December has contributed to the fall in performance.



Forecast and CIP Outturn (I&E)

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Divisional Budget Summary 2017/18

Division	Income and Expenditure					
	YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Central Corporate	20,473	15,782	4,691	25,634	18,675	6,959
Central Income	(288,064)	(284,139)	(3,925)	(346,668)	(346,661)	(7)
Chairman & Non-Executives	92	89	3	111	106	5
Chief Executive	2,652	2,364	288	3,112	2,874	237
Corporate Services	3,918	3,616	302	4,702	4,401	301
Estates	8,719	8,389	331	10,400	10,394	5
Finance	2,851	2,151	699	3,435	2,767	668
Fleet & Logistics	22,760	26,796	(4,036)	27,188	32,689	(5,500)
IM&T	11,607	10,493	1,114	14,478	14,229	249
Clinical Education & Standards	11,353	7,919	3,434	13,336	10,438	2,898
Medical	4,152	3,377	775	4,975	4,432	543
111 Service	(43)	(227)	184	(94)	(96)	1
Central Operations	18,801	17,964	837	22,533	21,681	852
Control Services	19,403	20,358	(955)	23,403	24,291	(888)
Core Frontline Central	18,488	36,366	(17,879)	21,109	43,834	(22,725)
South East Sector	29,223	26,420	2,803	35,064	31,955	3,109
South West Sector	18,828	17,896	932	22,591	21,500	1,090
North West Sector	31,495	27,697	3,797	37,791	33,467	4,323
North Central Sector	21,233	18,220	3,013	25,477	22,086	3,390
North East Sector	28,108	23,763	4,345	33,723	28,813	4,911
Non Emergency Transport	5,789	5,295	495	6,937	6,483	454
Patient Transport Service	(331)	(454)	123	(331)	(424)	93
Performance	1,001	882	119	1,201	1,021	180
Quality & Assurance	2,746	2,229	518	3,348	2,928	420
Special Measures	0	0	0	0	0	0
Strategic Communications	860	804	56	1,032	1,016	16
Support Services Senior Mngmnt	0	(0)	0	0	(0)	0
Transformation & Strategy	1,231	551	680	1,643	891	752
People & Organisational Development	5,154	4,765	388	6,317	6,405	(88)
Total	2,499	(634)	3,134	2,446	196	2,250

	Cost Improvement Plan					
	YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
	(2,310)	(2,106)	(204)	(2,899)	(2,741)	(158)
	(1,675)	(100)	(1,575)	(2,225)	(250)	(1,975)
	0	0	0	0	0	0
	(210)	(570)	360	(250)	(610)	360
	0	0	0	0	0	0
	(210)	(215)	5	(250)	(255)	5
	0	0	0	0	0	0
	(1,013)	(522)	(491)	(1,257)	(582)	(675)
	0	0	0	0	0	0
	(80)	0	(80)	(250)	0	(250)
	0	0	0	0	0	0
	0	0	0	0	0	0
	(400)	(1,223)	823	(500)	(1,352)	852
	(1,767)	(839)	(928)	(2,000)	(1,126)	(874)
	(5,027)	0	(5,027)	(6,550)	0	(6,550)
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	(778)	(1,272)	494	(1,000)	(1,454)	454
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	(494)	(247)	(247)	(600)	(380)	(220)
	(13,964)	(7,094)	(6,870)	(17,781)	(8,750)	(9,031)

Year to date CIPs are £6.9m 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 10 performance review updates



Statement of Comprehensive Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Month 10 2017-18 £000				YTD Month 10 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	30,341	31,915	31,375	(540)	299,179	297,917	295,046	(4,133)	(2,871)	358,182	355,300	(2,882)
Other Operating Income	287	287	336	48	2,097	2,098	3,077	980	979	2,673	4,749	2,076
Total Income	30,628	32,202	31,711	(492)	301,276	300,015	298,123	(3,153)	(1,892)	360,855	360,049	(806)
Operating Expense												
Pay	(22,216)	(22,824)	(22,263)	561	(225,768)	(224,457)	(214,657)	11,111	9,800	(269,210)	(260,563)	8,647
Non Pay	(5,977)	(6,262)	(7,950)	(1,688)	(61,362)	(62,581)	(68,642)	(7,280)	(6,060)	(74,968)	(82,504)	(7,536)
Total Operating Expenditure	(28,193)	(29,086)	(30,213)	(1,127)	(287,130)	(287,038)	(283,299)	3,831	3,740	(344,178)	(343,067)	1,111
EBITDA	2,435	3,116	1,498	(1,618)	14,146	12,977	14,825	679	1,848	16,677	16,982	304
EBITDA margin	8.0%	9.7%	4.7%	(5.0%)	4.7%	4.3%	5.0%	0.3%	0.6%	4.6%	4.7%	(0.3%)
Depreciation & Financing												
Depreciation & Amortisation	(1,497)	(1,275)	(1,097)	178	(13,393)	(11,938)	(10,833)	2,560	1,105	(14,487)	(13,123)	1,365
PDC Dividend	(350)	(350)	(350)	0	(3,500)	(3,503)	(3,500)	0	3	(4,204)	(4,200)	4
Finance Income	8	8	13	5	80	79	75	(5)	(4)	95	82	(13)
Finance Costs	(11)	(11)	(2)	9	(110)	(114)	(23)	87	91	(137)	(27)	110
Gains & Losses on Disposals	0	0	73	73	0	0	90	90	90	0	91	91
Total Depreciation & Finance Costs	(1,850)	(1,629)	(1,363)	265	(16,923)	(15,476)	(14,191)	2,732	1,285	(18,733)	(17,177)	1,556
Net Surplus/(Deficit)	585	1,488	135	(1,353)	(2,777)	(2,499)	634	3,411	3,134	(2,056)	(196)	1,860
NHSI Adjustments to Fin Perf												
Remove Depr on Donated assets	3	3	0	(3)	30	32	29	(1)	(3)	38	36	(3)
Remove STP funding 2016/17	0	0	0	0	0	0	(419)	(419)	(419)	(420)	(419)	1
Adjusted Financial Performance	588	1,491	135	(1,356)	(2,747)	(2,468)	244	2,991	2,712	(2,438)	(579)	1,859
Net margin	1.9%	4.6%	0.4%	(4.2%)	(0.9%)	(0.8%)	0.2%	1.1%	1.0%	(0.6%)	(0.1%)	0.6%

Income

- YTD the Trust has achieved £4.1m of its annual Cquin of £7.8m. The month 10 forecast has provided £636k against the annual total.
- Main contract activity for M10 YTD is 2% higher than the contract baseline, and the income relating to this (£3.8m) has been recognised in the Trust accounts.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £9.8m under re-phased budget, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure (£4.7m YTD) in non-pay. This underspend is expected to reduce with targeted recruitment.
- Private Ambulance expenditure is overspent by £4.7m (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 £1.5m in January which represents 4.7%. This was due to increased income in January through over performance.

Depreciation and Financing

- Overall Financial Charges are £1.3m favourable YTD to re-phased budget due to lower than budgeted depreciation and slippage in the capital programme.

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.

Actual and Forecast Expenditure by Month





Main Contract Variable Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Month:	Jan-18	2017-18 Monthly Contract Base (2016-17 Plan plus 6%)			2017-18 Actual Activity			2017-18 Actual Activity Increase / (Decrease) vs Contract Base			Total Incidents Difference to Contract Base (%)	CCG Split Based on Incident Difference
Area	CCG Names	Cat A	Cat C (incl Othe	Total Incidents	Cat A	Cat C (incl Othe	Total Incidents	Cat A	Cat C (incl Othe	Total Incidents		
NEL	NHS City and Hackney CCG	15,254	15,837	31,091			31,461			370	1.19%	£ 78,070.00
NEL	NHS Newham CCG	18,175	17,791	35,966			34,873			-1,093	-3.04%	£ 230,623.00
NEL	NHS Tower Hamlets CCG	15,307	14,048	29,355			29,184			-171	-0.58%	£ 36,081.00
NEL	NHS Waltham Forest CCG	14,038	13,498	27,536			26,401			-1,135	-4.12%	£ 239,485.00
NEL	NHS Barking and Dagenham CCG	12,282	12,926	25,208			24,574			-634	-2.52%	£ 133,774.00
NEL	NHS Havering CCG	13,890	15,329	29,219			29,500			281	0.96%	£ 59,291.00
NEL	NHS Redbridge CCG	14,875	14,520	29,395			29,412			17	0.06%	£ 3,587.00
NEL	NEL Total	103,821	103,949	207,770	0	0	205,405	0	0	-2,365	-1.14%	£ 499,015.00
NCL	NHS Barnet CCG	18,285	18,867	37,152			37,498			346	0.93%	£ 73,006.00
NCL	NHS Camden CCG	15,250	14,930	30,180			30,765			585	1.94%	£ 123,435.00
NCL	NHS Enfield CCG	18,113	15,793	33,906			33,768			-138	-0.41%	£ 29,118.00
NCL	NHS Haringey CCG	14,026	13,597	27,623			27,976			353	1.28%	£ 74,483.00
NCL	NHS Islington CCG	12,826	13,767	26,593			26,650			57	0.21%	£ 12,027.00
NCL	NCL Total	78,500	76,954	155,454	0	0	156,657	0	0	1,203	0.77%	£ 253,833.00
NWL	NHS Brent CCG	17,990	17,091	35,081			36,353			1,272	3.63%	£ 268,392.00
NWL	NHS Harrow CCG	10,426	10,753	21,179			22,647			1,468	6.93%	£ 309,748.00
NWL	NHS Hillingdon CCG	17,147	20,225	37,372			38,825			1,453	3.89%	£ 306,583.00
NWL	NHS Central London (Westminster) CCG	15,837	14,700	30,537			32,984			2,447	8.01%	£ 516,317.00
NWL	NHS Ealing CCG	17,606	17,279	34,885			37,702			2,817	8.08%	£ 594,387.00
NWL	NHS Hammersmith and Fulham CCG	9,816	9,465	19,281			21,396			2,115	10.97%	£ 446,265.00
NWL	NHS Hounslow CCG	14,469	14,430	28,899			28,518			-381	-1.32%	£ 80,391.00
NWL	NHS West London CCG	11,997	12,073	24,070			25,909			1,839	7.64%	£ 388,029.00
NWL	NWL Total	115,288	116,016	231,304	0	0	244,334	0	0	13,030	5.63%	£ 2,749,330.00
SEL	NHS Bexley CCG	11,696	13,393	25,089			26,034			945	3.77%	£ 199,395.00
SEL	NHS Bromley CCG	14,594	17,319	31,913			32,308			395	1.24%	£ 83,345.00
SEL	NHS Greenwich CCG	14,068	14,984	29,052			29,236			184	0.63%	£ 38,824.00
SEL	NHS Lambeth CCG	17,449	20,223	37,672			36,714			-958	-2.54%	£ 202,138.00
SEL	NHS Lewisham CCG	14,280	15,383	29,663			30,881			1,218	4.11%	£ 256,998.00
SEL	NHS Southwark CCG	16,855	19,825	36,680			36,792			112	0.31%	£ 23,632.00
SEL	SEL Total	88,942	101,127	190,069	0	0	191,965	0	0	1,896	1.00%	£ 400,056.00
SWL	NHS Croydon CCG	19,601	22,060	41,661			43,679			2,018	4.84%	£ 425,713.60
SWL	NHS Kingston CCG	7,038	8,895	15,933			16,559			626	3.93%	£ 132,086.00
SWL	NHS Merton CCG	8,386	10,857	19,243			19,766			523	2.72%	£ 110,353.00
SWL	NHS Richmond CCG	7,065	9,222	16,287			16,374			87	0.53%	£ 18,357.00
SWL	NHS Sutton CCG	8,834	11,482	20,316			21,194			878	4.32%	£ 185,258.00
SWL	NHS Wandsworth CCG	13,072	15,128	28,200			28,617			417	1.48%	£ 87,987.00
SWL	SWL Total	63,996	77,644	141,640	0	0	146,189	0	0	4,549	3.21%	£ 959,754.60
London Total		450,547	475,690	926,237	0	0	944,550	0	0	18,313	1.98%	£ 3,863,958.60

Initial reported activity ay M10 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 £3.8m of additional variable income. This has been recognised in the accounts at month 10.

The YTD activity is based on April, May, Jun, Jul, Aug, Sep, Oct & Nov freeze and Dec and Jan flex figures.



Cash flow Statement YTD

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Jan-18	Jan-18	
	Actual	Actual	Actual	Actual	Actual	Actual	YTD	YTD	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	34,142	33,342	31,985	31,916	33,997	32,414	18,637	18,700	(63)
Operating Surplus	669	181	2,454	875	3,395	1,498	14,818	14,147	671
(Increase)/decrease in current assets	965	5,815	(1,826)	1,999	(1,761)	730	15,814	16,627	(813)
Increase/(decrease) in current liabilities	(1,850)	(3,355)	229	407	(1,899)	1,717	1,743	(1,317)	3,060
Increase/(decrease) in provisions	87	(630)	(120)	15	83	(2)	(466)	(270)	(196)
Net cash inflow/(outflow) from operating activities	(129)	2,011	737	3,296	(182)	3,943	31,909	29,187	2,722
Cashflow inflow/outflow from operating activities	(129)	2,011	737	3,296	(182)	3,943	31,909	29,187	2,722
Returns on investments and servicing finance	6	5	18	6	9	13	75	80	(5)
Capital Expenditure	(677)	(1,324)	(824)	(1,221)	(1,410)	(2,996)	(15,198)	(25,877)	10,679
Dividend paid	0	(2,049)	0	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	(671)	(3,368)	(806)	(1,215)	(1,401)	(2,983)	(17,172)	(22,377)	5,205
Movement	(800)	(1,357)	(69)	2,081	(1,583)	960	14,737	6,810	7,927
Closing Cash Balance	33,342	31,985	31,916	33,997	32,414	33,374	33,374	25,510	7,864

There has been a net inflow of cash to the Trust of £14.7m.

Cash funds at 31 January stand at £33.4m.

Operating Surplus

- The operating surplus at £14.7m is higher than planned.

Current Assets

- The YTD movement on current assets is £15.8m, £0.8m lower than planned movement.
- Current assets movement was higher than planned due to receivables (£2.3m), accrued income £2.1m and prepayments (£0.6m).

Current Liabilities

- The YTD movement on current liabilities is £1.7m, a £3.1m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£2.5m), accruals £3.9m and deferred income £1.7m.

Provisions

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

Capital Expenditure

- Capital cash outflow is £10.7m 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 £1.3m of the £5.5m central capital funding requested by the Trust. The £1.3m funding is expected later in the year.



CQUINs

Owner: James Corrigan | Executive Lead: Lorraine Bewes

FIC - LAS 2017/18 ES & UC Contract – Commissioning for Quality & Innovation (CQUIN) SCHEDULE & UPDATE – as at 3rd November 2017

#	CQUIN Indicator title	ELT lead	Local lead	Final indicator period	Annual value	Qtr 1	Qtr 2	% Achieved Q2	Qtr 3	% Achieved Q3 TBC 27.02.2018	Qtr 4	% Achieved Q4 TBC 29.05.2018	Total Estimated Achievement for 2017/18	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	£260,562	Q1 = 0% £0	Q2 = 0% £0		Q3 = 0% £0		Q4 = 100% £260,562.00	25% £65,140.50	25% £65,140.50	Preliminary view that we have failed on two of the three indicators and improvement on the third only attracts partial payment of 25% - clarified with NHSE.
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% £260,562.00	100% £260,562.00	100% £260,562.00	Q3 view is that we are on target
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	£263,701	Q1 = 0% £0	Q2 = 0% £0		Q3 = 0% £0		Q4 = 100% £263,701.00	25% £65,925.25	25% £65,925.25	Current achievement (with 4 weeks left) suggests expected achievement of 25% payment. Minor progress made following previous forecast update.
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% £235,447.50	30% £235,447.50	Q4 = 70% £549,377.50	70% £549,377.50	100% £784,825.00	Q3 report submitted 22.01.2018 - expect full achievement for Q3 - confirmation following CQRG 27th Feb. Split over Q3/Q4 agreed at CQRG 30.01.2018
STP 1	National CQUIN: STP Engagement	Jamie O'Hara	Fiona Claridge	Final Period – Q4 17-18	£1,569,650	Q1 = 0% £0	Q2 = 0% £0		Q3 = 50% £784,825.00	46% £722,039.00	Q4 = 50% £784,825.00	46% £722,039.00	92% £1,444,078.00	Q3 report submitted 22.01.2018. Expected achievement for Q3 = 45%, based on initial feedback from commissioners & potential clawback. Expectation that commissioners will become stricter on
STP 2	National CQUIN: STF Delivery (Control Total)	Lorraine Bewes	James Corrigan	Final Period – Q4 17-18	£1,569,650	Q1 = 0% £0	Q2 = 100% £1,569,650	100% £1,569,650.00	Q3 = 0% £0		Q4 = 0% £0		100% £1,569,650.00	Achieved, based on 16/17 control total. LAS provided written confirmation to commissioners that the funding will be held in reserve until further notice.
L1	Mobile Devices	Ross Fullerton	Ian Golding	Final Period – Q4 17-18	£3,139,299	N/A	N/A		Q3 – 50%* £1,569,649.50	50% £1,569,649.50	Q4 – 50%* £1,569,649.50	47% £1,451,925.79	97% £3,021,575.29	Q3 report submitted 22.01.2018. Expect challenge regarding data capture and provision of initial reports. Potential challenge in Q4 re Data and Intervention, if current issues are not resolved shortly.
Total Value (2.5% of contract value)					£7,848,249.00	£0	£1,569,650		£2,589,922		£3,688,677		£7,211,756	
Total Value Achieved					-	-		£1,569,650.00	-	£2,527,136.00		£3,114,970		

Key - RAG status	
INTERNAL RAG (for ELT / monitoring)	
Red	denotes: CQUIN not achieved
Amber	denotes: partial achievement
Green	denotes: CQUIN confirmed as achieved in full

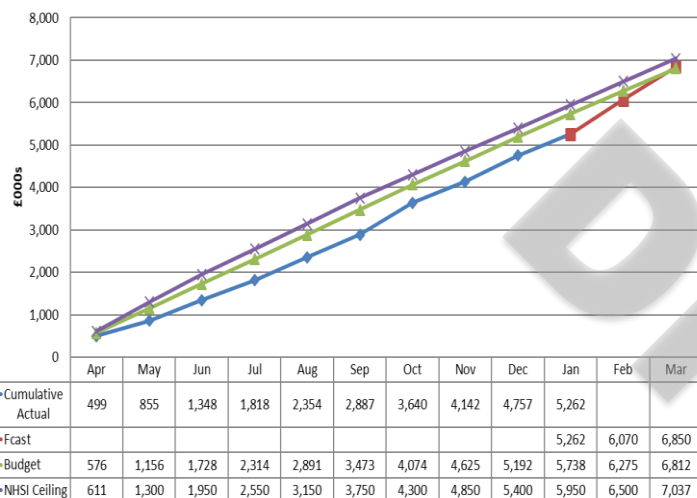
£636,492.96



Agency Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Cumulative Agency Trend

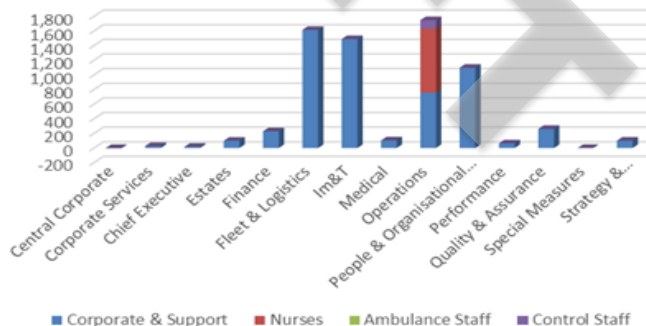


Agency Compliance					
Rule	Measurement	Description	Target	Achieved	Variance
Agency Ceiling	Forecast agency spend (£000s) vs agency ceiling	Is the Trust on Track to deliver on or below its agreed agency ceiling?	7,037	6,838	199
Framework	% Agencies used on Framework	Are all agencies used on an approved framework?	100%	91.20%	(8.8%)

Agency Summary by Type	Month 10 2017-18				YTD Month 10 2017-18				Full Year 2017-18			
	Budget £000s	Actual £000s	Variance £000s	WTE	Budget £000s	Actual £000s	Variance £000s	Average WTE	Budget £000s	Forecast £000s	Variance £000s	Forecast WTE
Operational												
Nurses	101	45	56	7	921	784	138	12	1,123	875	247	11
Ambulance Staff	0	0	0	0	0	0	0	0	0	0	0	0
Control Staff	0	21	-21	3	0	85	-85	2	0	117	-117	2
Subtotal	101	66	35	10	921	868	53	14	1,123	992	131	13
Non Clinical												
Managers & Professionals	252	272	-20	37	2,510	2,428	82	22	2,995	3,429	-433	23
Admin & Clerical	171	141	29	52	2,079	1,504	575	49	2,421	1,887	533	51
Maintenance & Works	23	26	-3	11	228	462	-234	14	274	542	-268	14
Other	0	0	0	0	0	-1	1	0	0	-1	1	0
Subtotal	445	439	6	100	4,817	4,393	424	86	5,690	5,857	-168	88
Total	547	505	41	110	5,738	5,262	477	100	6,812	6,849	-37	102

Agency Summary by Division & Type	Full Year Forecast (£000s)			
	Corporate & Support	Nurses	Ambulance Staff	Control Staff
Central Corporate	-2	0	0	0
Corporate Services	26	0	0	0
Chief Executive	18	0	0	0
Estates	100	0	0	0
Finance	229	0	0	0
Fleet & Logistics	1,614	0	0	0
Im&T	1,489	0	0	0
Medical	104	0	0	0
Operations	757	875	0	117
People & Organisational Dev	1,098	0	0	0
Performance	64	0	0	0
Quality & Assurance	261	0	0	0
Special Measures	0	0	0	0
Strategy & Communications	101	0	0	0
Total	5,857	875	0	117

Full Year Forecast Agency Spend by Type (£000s)



The Trust's NHSI agency spend ceiling is £7.037m. Agency spend in excess of this level would result in the loss of planned STF income, and ineligibility for further STF funding announced.

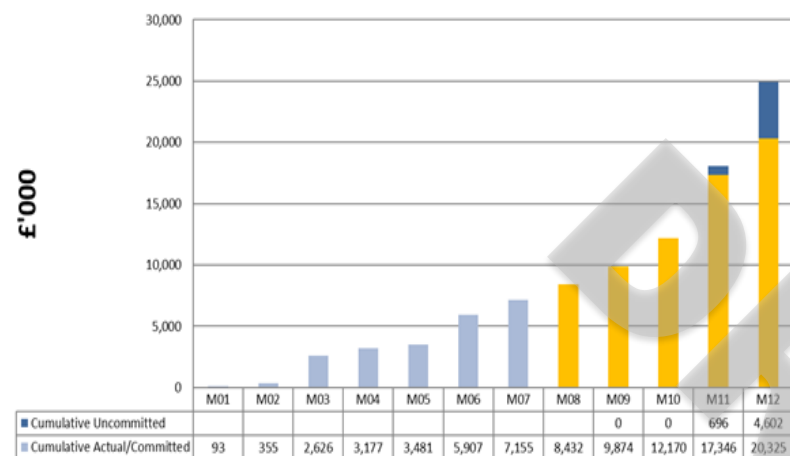
At present the Trust is forecast to stay within its NHSI agency ceiling for 2017-18.



2017/18 Capital Plan/Spend YTD – Month 9 Summary

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Capital Programme Forecast 2017/18



Forecast Full Year Capital Spend



Capital Programme	Exec Lead	Operational Lead	Month 10			Forecast Outturn
			Revised Plan	Actual	Variance	
			£'000	£'000	£'000	
Expenditure Plan:						
Estates - Maintenance	L Bewes	M Nelhams	1,338	960	378	1,605
Secure Drugs	L Bewes	M Nelhams	291	285	5	880
General Capital *	L Bewes	L Bewes	918	84	834	1,476
Fleet & Logistics Programme	L Bewes	J Wand	8,426	5,768	2,658	11,889
Other Fleet (Stretchers)	L Bewes	J Wand	807	743	64	807
Fleet Replacement	L Bewes	J Wand	1,229	653	575	1,229
IM&T General	R Fullerton	J Downard	3,287	1,728	1,558	4,661
IM&T Digital Maturity **	R Fullerton	R Fullerton	1,950	1,947	3	2,378
Capital Expenditure Plan			18,244	12,169	6,075	24,925

- The latest capital plan shows £24.9m of Capex. The plan has been profiled in month 10 to reflect forecast profile spend as agreed with operational leads.
- £24.9m 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 £641k 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

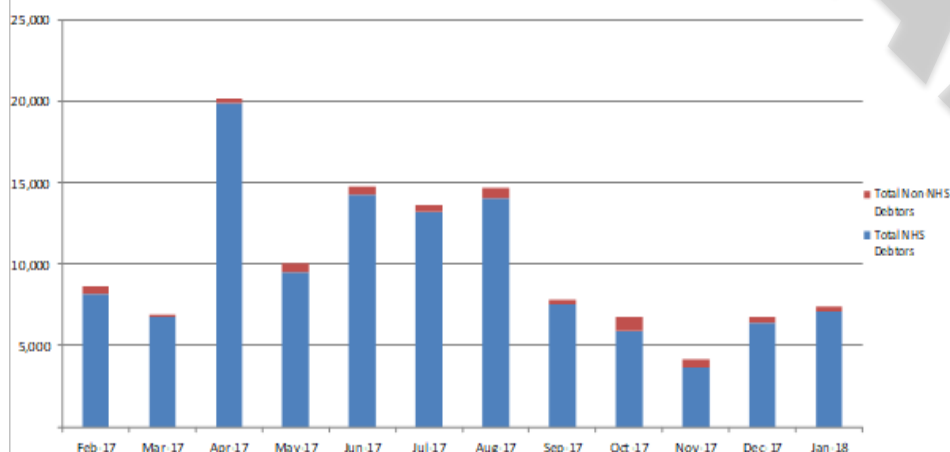
Owner: James Corrigan | Executive Lead: Lorraine Bewes

Aged debtors Summary 31st January 2018

		Days Overdue							
	Note	Total £'000	Current £'000	1 - 30 £'000	31 - 60 £'000	61 - 90 £'000	91 - 180 £'000	181 - 365 £'000	> 365 £'000
NHS Debtors									
NHS Brent CCG	1	3,485	-	3,408	76	-	2	-	-
NHS Bromley CCG	1	640	-	552	88	-	-	-	-
NHS Central London (Westminster) CCG	1	319	-	-	318	1	-	-	-
St Georges University Hospitals NHS FT	2	310	140	45	109	2	-	13	-
NHS Wandsworth CCG	1	270	-	-	-	270	-	-	-
NHS Camden CCG	1	238	-	18	171	45	2	1	-
<£238,000	1	2,909	398	402	1,273	303	147	229	157
Total NHS Debtors		8,172	538	4,425	2,035	621	151	243	157
Income Received in Advance (February SLA)									
NHS Southwark CCG	3	-1,052	-	-1,052	-	-	-	-	-
Total NHS Ledger Balance		7,120	538	3,374	2,035	621	151	243	157
Non-NHS Debtors									
Chelsea Football Club	4	40	12	28	-	-	-	-	-
Paramedic2 University Of Warwick	5	26	25	-	1	-	-	-	-
Arsenal Football Club	6	25	25	-	-	-	-	-	-
London Stadium 185	7	18	18	-	-	-	-	-	-
Unison	8	16	-	5	5	5	-	-	-
<£16,000	9	172	24	15	1	4	16	38	74
Total Non NHS Debtors		297	105	49	7	9	16	38	74
TOTAL DEBTORS 31st January 2018									
		7,417	643	3,423	2,042	630	167	281	232

Source: Debtors Ledger 31st January 2018

Debtors Analysis



Debtors Position: 31st January 2018

Total outstanding NHS and Non-NHS debtors as at 31st January 2018 amounted to £7.4 million. The NHS over 60 day's figure of £1.1m includes amounts due from both CCGs £0.9m and NHS Trusts £0.2m.

1. NHS Debtors over 60 days.

- Q1 Over Activity Billing 2017-2018 April to June - £582k. We received £537k from CCGs on the 1st February 2018. The remaining £45k (3 CCGs) are currently in credit due for Q2 Activity being below plan.
- PTS Non-Contract Activity - £80k - The PTS ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues.
- Out of London (A&E ECJ) Journeys - £89k - The A&E ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts and EOC team are liaising with the CCG's to resolve the issues.
- Sector Services (Falls Specialist Response - K466) - £21k (Barking & Dagenham CCG) - invoice has been approved for payment on the 15th February 2018.
- PTS Non-Contract Activity - £82k - 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 - £125k - The NTS invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues.

The Trust is actively pursuing the outstanding debts.

- St Georges University Hospitals NHS FT - £170k overdue (7 Invoices) and £140k (9 Invoices) due on the 26th February 2018. We received £61k from the trust on the 8th February 2018. We are liaising with the trust to clear the remaining outstanding invoices.
- Southwark CCG - £1.1m - February SLA and CQUIN paid in advance.
- Chelsea Football Club - £28k was paid on the 6th of February. The remaining £12k is awaiting approval and will be paid by the 28th of February 2018.
- University of Warwick - £26k (3 Invoices). £0.6k has been paid on 5th February. The invoices (£25.4k) have been approved and the expected payment date is the 15th February 2018.
- Arsenal Football Club - £25k - (1 invoice) A copy of the invoice was sent electronically on the 2nd of February. The invoice is due for payment on 24th of February 2018, we are liaising with Arsenal to ensure invoices are approved and paid in a timely manner.
- London Stadium 185 - £18k (3 invoices), confirmation received that the invoices have been approved and will be paid by the 21st of February 2018.
- Unison £16k (3 invoices) - these invoices have been under query, we issued credit notes on the 5th of February due to Unison being overcharged and have raised revised invoices.
- Non-NHS Debtors - £172k consists of; £112k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £12k of stadia events, the stadiums have been chased for payment on a regular basis. The remaining £48k 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

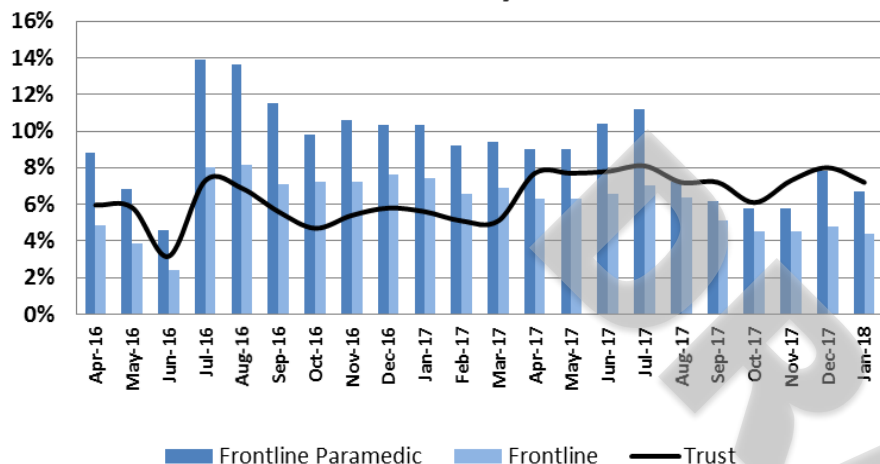


Section	Key Headlines	Jan	Dec	Nov
Vacancy and Recruitment	- The overall vacancy rate has decreased from 8% to 7.2% against a 5% target. - We have identified additional core front line posts to deliver the 17/18 increased demand. Work is in progress with colleagues in Operations to determine how these 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.	7.2%	8.0%	7.3%
Turnover	- Total Trust turnover has increased to 10.4% against a threshold of 10%. - Frontline turnover has increased from 8.5% to 8.9% Please note this does not include Control Room or NHS 111 leavers. - Frontline paramedic turnover has remained at 9.9%.	10.4%	10.3%	10.3%
Sickness	- Sickness for January remains at 5.2% against a target of 5%. - Sector Ops sickness has decreased from 5.7% to 5.4%.	5.2%	5.2%	5.4%



Vacancy – Trust wide

Trust Vacancy Rate



EOC Recruitment (Emergency Medical Dispatchers)

- Against our recruitment plan of 186 for 17/18 we have to date recruited 134 EMDs. Whilst applicant numbers remain high, conversion rates from shortlisting to appointment still remain a challenge.
- We are in discussions with other Trusts regarding their on-line assessment tools to determine the impact on their conversion rates and retention.
- EOC are in discussion with LAS partner universities to explore options for UK Grad paras to be trained and work in EOC during summer.
- We have advertised roles via Reed.co.uk to attract candidates.
- We have overfilled training places to allow for drop out.
- A new part-time rota has been designed and this should help recruitment and retention.
- For January, we assessed 106 candidates, interviewed 77 and appointed 27.

The establishment figures represent current budgeted position and may be subject to change following completion of current forecasting activities

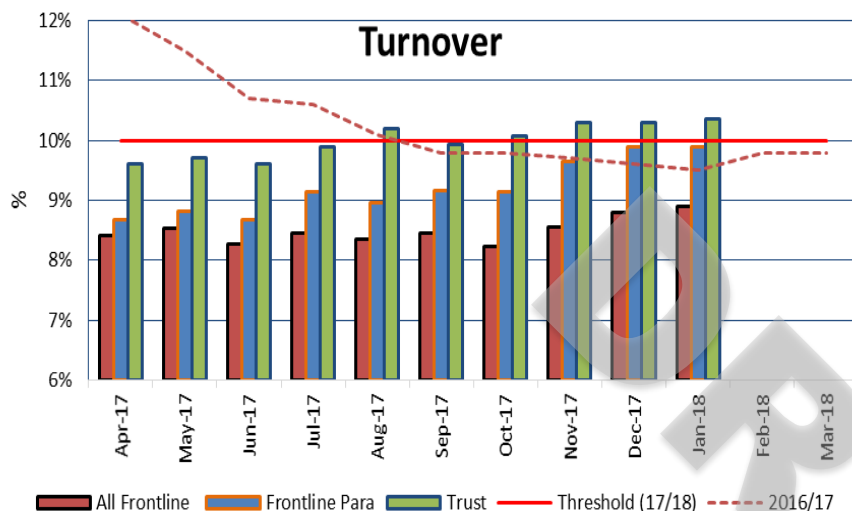
	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	5,414.09	5,023.84	390.25	7.2%
Total Frontline (Sector)	3,103.00	2,967.47	135.53	4.4%
Frontline (Sector) Paramedics	1,821.24	1,698.48	122.76	6.7%
Frontline (Sector) Non-Paras	1,281.76	1,268.99	12.77	1.0%
EOC (includes 73FTE 'new' posts)	502.00	424.55	77.45	15.4%
Other staff (including Corporate)	1,809.09	1,631.81	177.28	9.8%

Trainee Emergency Ambulance Crew recruitment – against our 17/18 plan of 375, we have filled 300 TEAC training places to date and we have 81 candidates in the pipeline. In order to unblock our pipeline, we have agreed to fund C1 licence costs for our TEAC recruits (approximately £1,200 per person). We have contacted 43 eligible candidates and offered them this incentive of which 23 have indicated that they are interested. There are two assessments and two Super Saturdays scheduled to take place in February 2018.

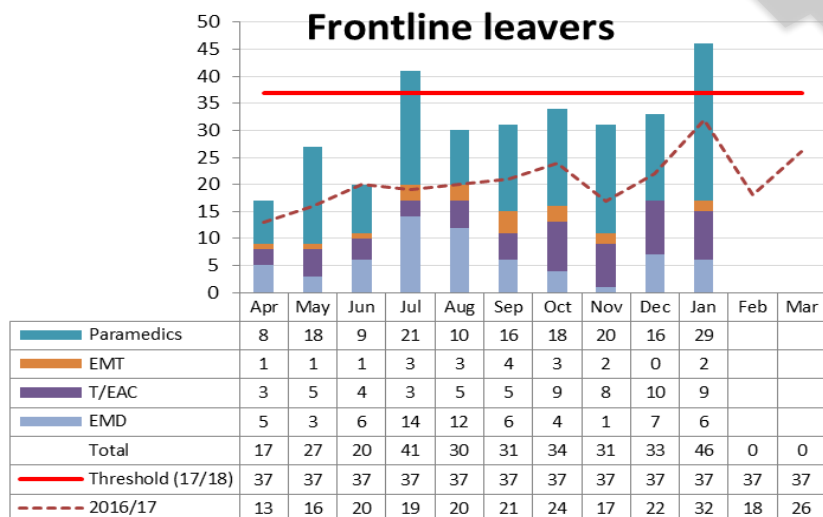
Paramedic Recruitment – iParas - we are currently working with candidates and Education to co-ordinate visas and start dates to maximise use of training places. We have a 100% confidence level for iPara starters in February and 93% for March. We currently have confirmed training places for Q1 only at this stage (and have filled all but one place) and whilst we have an interested pool of candidates awaiting start dates in Q2, the likelihood of withdrawals is increasing until we can confirm start dates. We will have a definitive position on interested candidates by Wednesday 21st February.



Turnover/Leavers – Trust wide



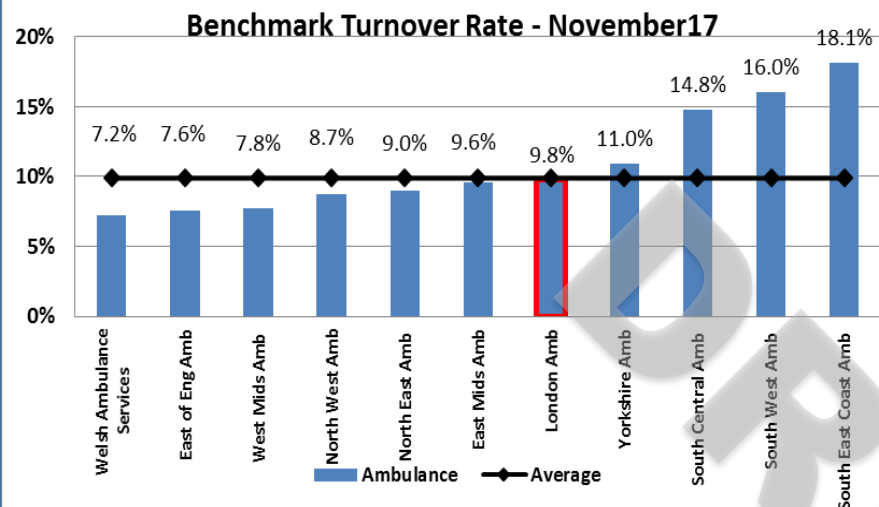
- The total Trust turnover has increased from 10.3% to 10.4% (12 month rolling figure).
- Frontline turnover (Sector Ops) has increased from 8.5% to 8.9%.
- Frontline paramedic turnover has remained at 9.9%.
- EOC turnover is 17.7%.
- NHS 111 turnover is 16.8.
- Corporate Directorates turnover is 11.5%.



- There were 46 frontline leavers in January (see table opposite).
- 86% of the frontline leavers (37 staff) were resignations i.e. unplanned.
- 71% (20) of paramedics left for reasons of relocation.
- 38% of paramedics had two year's or less service.
- Year to date there have been 163 paramedic and 65 EAC leavers (228 total). This is below the total of 270 FTE (year to date) that we had built into the planning model for 17/18.

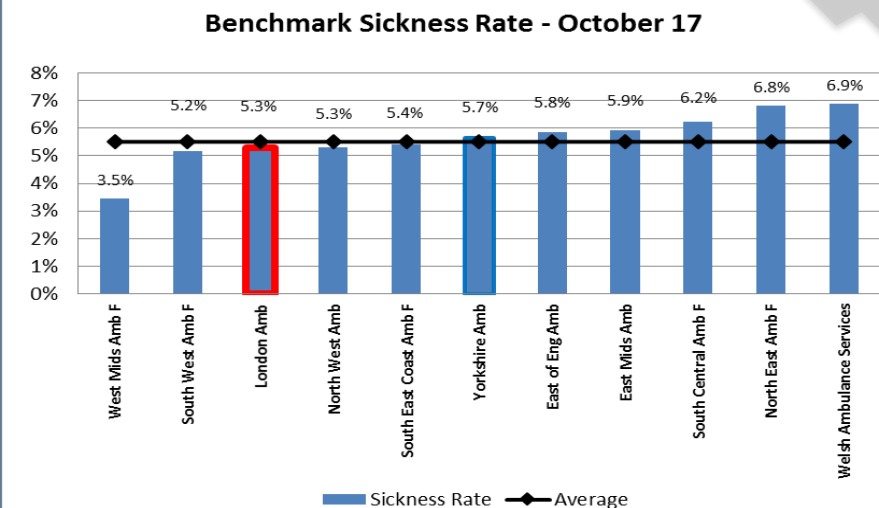


Benchmarking Turnover/Sickness – Trust wide



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has moved from 6th to 7th place.
- The LAS is below the national average of 9.9%.

Source of data: NHS Health and Social Care Information Centre – data as at 30th November 2017. Data is available two months in arrears.

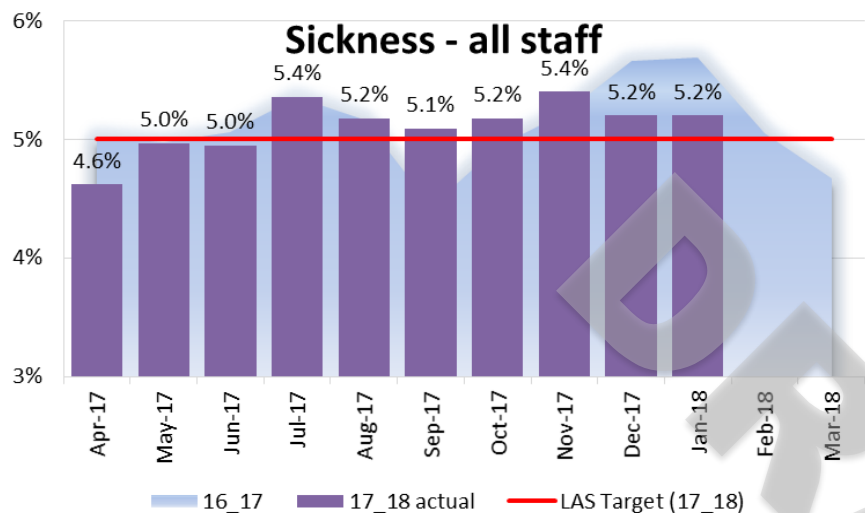


- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has moved from 4th to 3rd.
- The LAS is below the national average of 5.5%.

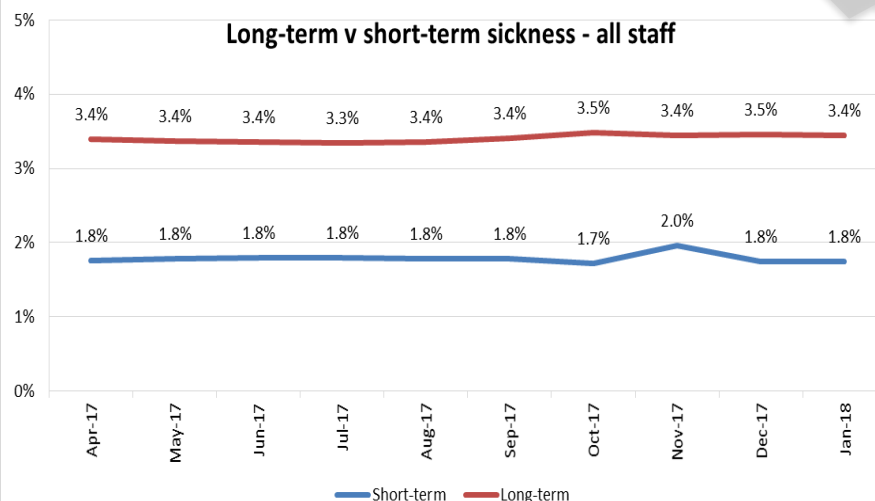
Source of data: NHS Health and Social Care Information Centre – data as at 31st October. Data is available three months in arrears.



Sickness Absence – Trust/Sector level



- Trust wide sickness for January remains at 5.2%.
- Frontline sickness (non-corporate) has decreased from 5.7% to 5.4%.
- Corporate sickness is at 3%.

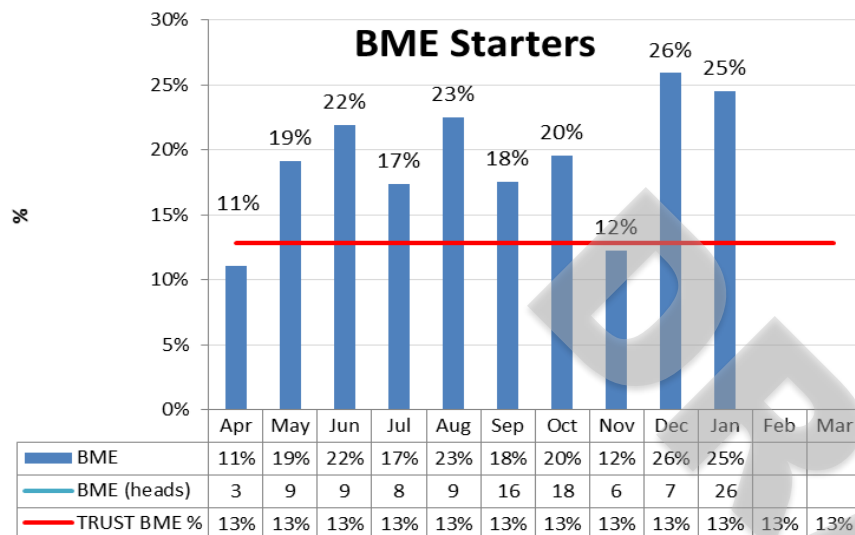


- This graph shows the sickness rate for all staff split by short-term and long-term sickness.
- The LAS 17/18 target for sickness is 5% (2% short-term, 3% long-term), a reduction of 0.5% from 16/17.
- In January, the short-term sickness remained at 1.75% and the long-term sickness decreased from 3.46%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

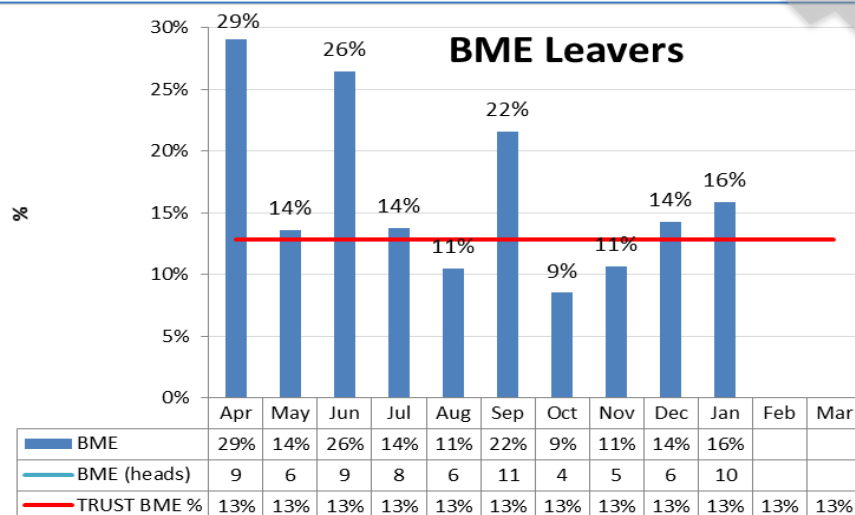
NB. Long-term sickness is any continuous episode of sickness lasting for 28 days or longer.



Workforce Race Equality Standard (WRES)



- 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. These show the numbers of BME starters and leavers from April 2017 to January 2018 compared to the current Trust BME profile.
- In January we had 26 BME starters in 111 (12%), Corporate (35%), EOC (19%) and Operations (35%).
- In January we had 10 BME leavers, 9 of whom were in frontline roles covering 111, EOC and Ops.
- Year to date we have had 110 BME starters (20% of all starters). 67% of this group are in frontline roles (Ops, 111, EOC, NETS).
- Year to date we have had 74 BME leavers (16% of all leavers).



Equality Committee - The Equality committee meet on the 9th February and discussed Gender Pay Reporting, the Sickle Cell project run with Insight, the Workforce Disability Equality scheme and the Outreach charity project for homeless people in London.

National LGBT meeting - The LAS LGBT Network hosted the National LGBT meeting on the 8th February at Bow. Our CEO opened the day and there was representation from all Ambulance Trusts.

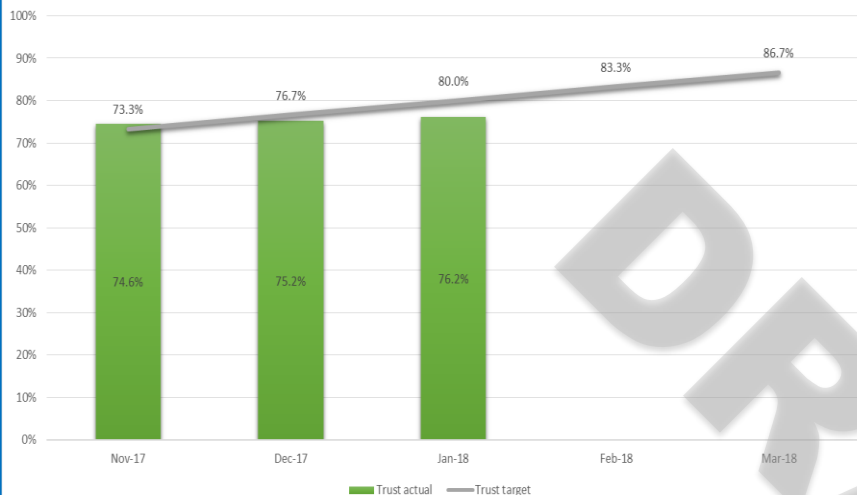
National BME meeting - this was held on the 1st February with representation from the LAS.

Community Engagement Events - on the 8th January we started our road show of community engagement events at Westfield (East) and the Stratford Centre. The LAS attended for 7 days and we had 208 expressions of interest. We have also attended events at Barking and Brent Cross Shopping Centre.



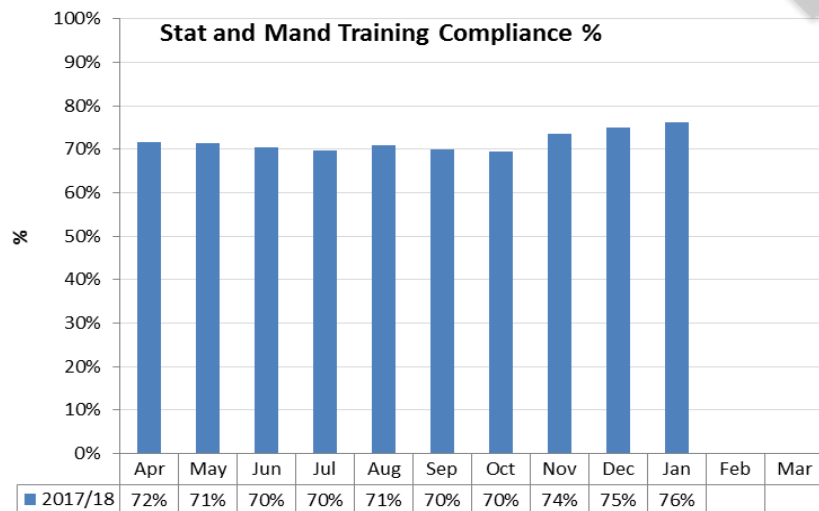
Statutory and Mandatory Training

Stat and mand training - Trust level (as at 31st January 2018)



- The launch of My ESR has been a success with over 85% of Trust staff (4,857) accessing the new version of the system which became available to Trusts nationally in May 2017. We have the highest % of users using the new ESR Portal in London (71 Trusts) and we are the 11th highest % of users nationally.
- During this time over 36,000 e-learning modules have been completed by LAS staff covering 131 different courses and this includes 800 non-Stat and Mand course completions for CPD courses. The first ever online e-learning CSR 2017.2 was launched in October 2017 and over 2,100 staff have successfully completed this to date.
- Current Trust stat and mand compliance is 76% as at the end of January 2018.
- Corporate compliance is currently 94% as at 5th February 2018 (Target 100%).
- Current Operations compliance is 75% as at the end of January 2018.
- CSR.2017.2 compliance is being monitored weekly with reports sent to DDOs which is followed up by ADOs in their sectors with compliance leads chasing completions.

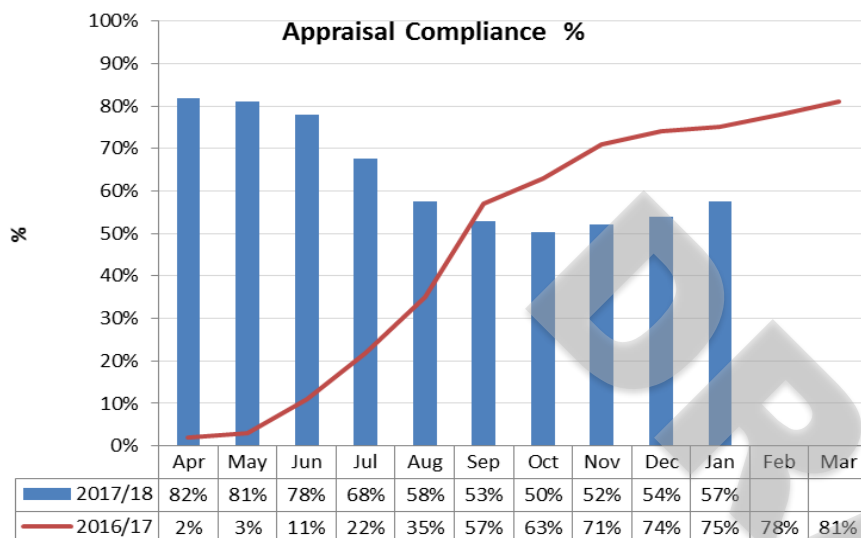
Stat and Mand Training Compliance %



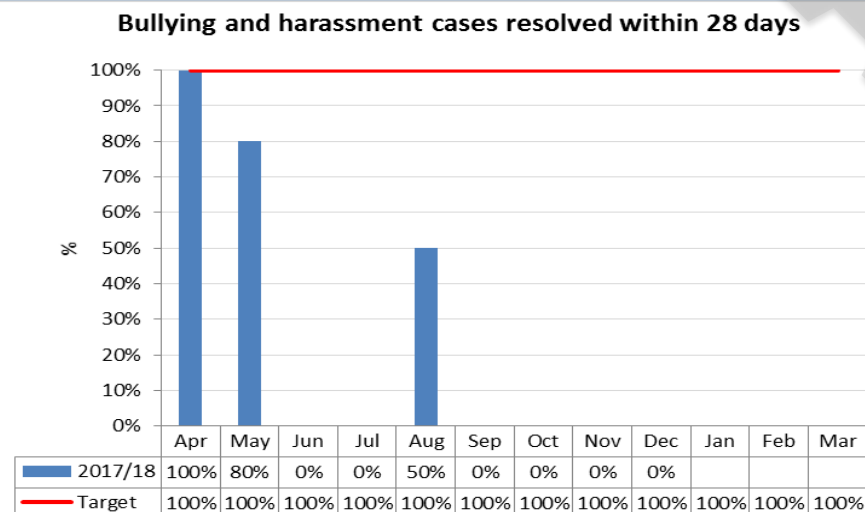
- The ESR Project Team met with Emergency Planning to review EPRR Operational & Tactical Commander records held. The team completed an upload of all courses/attendance into ESR which has resulted in the following improvements:-
- Operational Commander improved from 31% reported at end Dec 2017 to 77% to date.
- Tactical Commander improved from 46% reported at end Dec 2017 to 70% to date.
- There is a meeting in February with Tina Ivanov to discuss the following:
 - Statutory and Mandatory Training delivery/methods.
 - Establishment of a joint Learning and Education Group whose remit will include approval and forecasting of Stat Mand training requirements.
 - Where CSR.2017.2 completions are not met.



Appraisal/Bullying & Harassment



- The appraisal rate has improved from 54% in December to 57% in January.
- From 1st February 2017 to 31st January 2018 there have been 2,686 appraisals completed out of 4,674 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).
- A series of communications have been sent to all employees during January and February 2018. The communication emphasised the importance of quality of appraisal. In order to support quality, an appraisal audit will take place in March 2018. This will include semi-structured interviews which will take place across selected areas. The interviews will be supported by a questionnaire to all staff. The results of both will be analysed and recommendations made in April 2018.
- Appraisal training for both managers and staff is being delivered throughout February and March 2018.



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.
- To continue Cathe Gaskill's work, new Bullying and Harassment Workshops are being scheduled during February and March as well as design of an element to be included on Induction which will incorporate Freedom To Speak Up input from our FTSU Guardian, Conal Percy.
- In January, there was one open formal bullying and harassment case and this has breached the 28 day target.

OUR RISKS



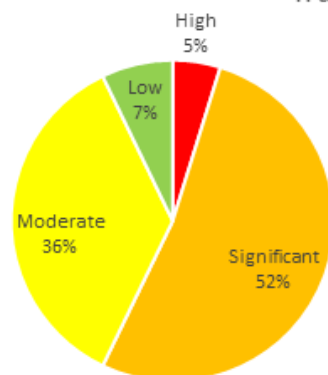
There are 12 risks with a risk level of High, these sit in Operations (4), Finance and Performance (2), Quality Directorate (2) People and Organisational Development (2) IM&T (2) . The highest risk scores at 20, with the others at 15 or 16. These risks are:

Section	Risks
Operations	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. 706 - Lack of capacity to deliver training through reliability, space and insufficient facilities This has been through age, fair wear and tear.
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.
IM&T	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.



Our Risks

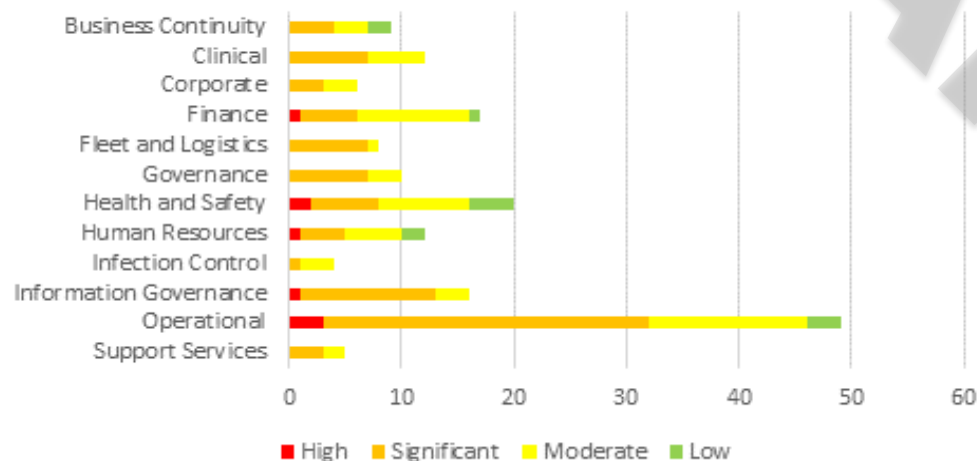
Trust Risks by Risk Level



The register of risks approved showed the following at 15th February 2018:

- 57% 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 Health and Safety risks accounting for 12%, Information Governance risks accounting for 10%, Finance risks accounting for 10%, Clinical risks accounting for 7% and Human Resources risks accounting for 7%.

Risks by Subtype



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	Acronym	Meaning / Description
ADO	Assistant Directors of Operations	HAC	Heart Attack Centres
ARP	Ambulance Response Program	HART	Hazardous Area Response Teams
APP	Advanced Paramedic Practitioners	HASU	Hyper Acute Stroke Unit
AQI	Ambulance Quality Indicator	HCP	Health Care Professional
BME	Black and Minority Ethnic	iPara	International Paramedic
CARU	Clinical Audit and Research Unit	JCT	Job Cycle Time
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System	KPI	Key Performance Indicator
CCG	Clinical Commissioning Group	LIN	Local Intelligence Network
CD	Controlled Drugs	LINC	Listening Informal Non-Judgemental Confidential
CDLO	Controlled Drugs Liaison Officers	MAR	Multiple Attendance Ratio
CISO	Clinical Information & Support Overview	MRU	Motorcycle Response Unit
CPI	Clinical Performance Indicator	MTC	Major Trauma Centre
CPD	Continuing Professional Development	NETs	Non-Emergency Transport
CQUIN	Commissioning for Quality and Innovation	NRLS	National Reporting and Learning System
CRL	Capital Resource Limit	OOH	Out Of Hours
CRU	Cycle Response Unit	OWR	Operation Workplace Review
CSR	Core Skills Refresher (Training)	PAS / VAS	Private / Voluntary Ambulance Services
DBS	Disclosure & Barring Scheme	PED	Patient Experiences Department
DOC	Duty of Candour	PGD	Patient Group Directions
EAC	Emergency Ambulance Crew	PFVH	Patient Facing Vehicle Hours
ED	Emergency Department	PRF	Patient Record Form
ELT	Executive Leadership Team	PSP	Patient Specific Protocol
EMD	Emergency Medical Dispatcher	PTS	Patient Transport Service
EMT	Emergency Medical Technician	QGAM	Quality, Governance and Assurance Manager
EOC	Emergency Operations Centre	QR	Quality Requirement
ESR	Employee Service Record	RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)	ROSC	Return of Spontaneous Circulation
FFT	Friends and Family Test	SI	Serious Incident
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale	SIG	Serious Incident Group
FRU	Fast Response Unit	STEMI	ST-Segment Elevation Myocardial Infarction
GCS	Glasgow Coma Scale	TEAC	Trainee Emergency Ambulance Crew
GTN	Glyceryl Trinitrate	TRU	Tactical Response Unit
		YTD	Year to Date
		WTE	Whole Time Equivalent



Integrated Performance Report – Glossary

Other Terminology	Meaning
Green ambulance outcomes	Lower acuity ambulance outcomes

LAS 111 (South East London)			
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 referred to 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?

Other London 111 service provider	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. 2. Outer North East London
London Central & West (LCW)	1. Inner North West London, 2. North Central London
Vocare	1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Board Assurance Framework, Corporate Risk Register and Risk Appetite Statement			
Agenda item:	17			
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 the Board Assurance Framework (BAF), Corporate Risk Register (CRR) and a proposed risk appetite statement.				
Recommendation:				
The Board is asked to comment on this report.				
Links to Board Assurance Framework (BAF) and key risks:				
This paper sets out the content of the BAF and the CRR.				

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 four risks on the BAF which have a net rating of 15 or above, one which has a net rating of 12 and one with a net rating of 10, they are set out below in descending order of severity.

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	Quality Assurance Committee Logistics and Infrastructure Committee	
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	Quality Assurance Committee 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	
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	
5	BAF Risk 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving	Benita Mehra Director of Assets and Property	Logistics and Infrastructure Committee	Proposed addition to the BAF following Logistics and Infrastructure Committee discussion

	the Trust without a service provider at short notice			
6	BAF Risk 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	Benita Mehra Director of Assets and Property	Logistics and Infrastructure Committee	Proposed addition to the BAF following Logistics and Infrastructure Committee discussion

Risk discussions in February

Board Assurance Committees

2. At its meeting on 06 February 2018, the Logistics and Infrastructure Committee discussed the potential risk identified by the Executive Leadership team at its meeting on 31 January 2018 relating to not being able to deploy ambulances as a result of technical equipment requirements. Following this discussion the Committee considered that this did not constitute a BAF-level risk at this time.
3. The Logistics and Infrastructure Committee also discussed two further risks that its considered should be recommended to the Board as BAF-level risks:
 - a. Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice
 - b. The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room
4. At its meeting on 08 February 2018, the People and Organisational Development Committee discussed the potential risk identified by ELT at its meeting on 31 January 2018 relating whether the Trust's training capacity was sufficient. Following this discussion it was considered that this was not a BAF-level risk, although the review of this capacity is due to be scrutinised by both the Quality Assurance Committee and the People and Organisational Development Committee at future meetings.
5. It was noted at the Risk Compliance and Assurance Group on 01 February 2018 that a significant improvement had been made in the review of current risks and escalation of new risks to the CRR.

Corporate Risk Register

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

Risk Appetite Statement

7. In 2016, the Trust Board agreed the following general risk appetite statement:

'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationship with its patients, the public and strategic partners.

As such, the Trust will not accept risks that materially impact on quality of services as defined above (safety, patient experience, and effectiveness), and similarly reputational and regulatory risks. However the Trust has a greater appetite to take considered risks in terms of finance and innovation where there may be options for limited potential gains.' This statement is depicted in the chart below:

Risk appetite by category					
Significant					
High					
Moderate					
Low					
	Risks to quality of service	Risks to the Trust's reputation	Risk to Innovation	Financial Risk	Regulatory Risk

8. At its development session on Tuesday 12 December 2017 the Trust Board considered the organisation's risk appetite and determined that it should be reviewed through Board Assurance Committees wherever possible, ahead of agreement by the Board.
9. Guidance on risk and risk appetite for Board members from the Good Governance Institute has been circulated to all Board members, through their membership of the Board Assurance Committees to help inform their views on what the Trust's risk appetite should be in relation to the risks it faces. (See Annex A to this report for Bullivant J & Corbett-Nolan A (2012) *Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking*).
10. A proposed risk appetite statement is set out below:
 - 10.1 The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The statements below are a reflection of the Trust's current position in relation to the primary risk groupings as set by the Good Governance Institute (2012). This reflects the position of the Trust's risk appetite, relating to its strategy and associated quality plans. This statement will be reviewed no later than April 2019 by the Audit Committee and Trust Board, or following the next regulatory review of the Trust (Care Quality Commission or NHS Improvement).

Quality

- 10.2 The Board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the potential for consequent effects on patient safety, experience or outcomes are low and the potential for mitigating actions are strong.

Reputation

- 10.3 The Board has a cautious approach to the management of the Trust's reputation and is prepared to only accept minimal risk in relation to this. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions.

Innovation

- 10.4 The Board's risk appetite for innovation, strategic transformation and developing effective external relationships and alliances is broad, depending on the nature of the innovation being proposed. It has a flexible view of innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other innovations will be limited to only essential developments and with decision making held by senior management.

Financial

- 10.5 The Board will adopt a flexible approach to financial risk and is prepared to invest in resources that deliver improvements in quality and patient safety. Financial decisions impacting on quality and patient safety will be subject to rigorous quality impact assessments. The Trust has a more cautious approach to commitments other than those related to quality, patient safety and improve the patient experience.

Compliance/Regulatory

- 10.6 The Board will take minimal risks when it comes to compliance and regulatory issues. It will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them. The Board is willing to take opportunities where positive gains can be anticipated and within the regulatory environment.

11. Is the Board content with the proposed risk appetite statement?

Frances Field
Risk and Audit Manager

Risk Appetite for NHS Organisations

A matrix to support better risk sensitivity in decision taking



Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels ▶	0	1	2	3	4	5
Key elements ▼	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM)	Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VFM is the primary concern.	Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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Board Assurance Framework – February 2018

IMPACT	Catastrophic		50	45 49			In order of severity:
	Major			51	47	46	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 preferred LAS strategy is not deliverable within the Trust's identified strategic timeframe due to the scale of investment required.
	Moderate						BAF Risk 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. BAF Risk 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room
	Minor						BAF Risk 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice
	Negligible						
		Rare	Unlikely	Possible	Likely	Almost Certain	

Risk Severity

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

LIKELIHOOD

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
1, 2, 3	50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	• A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.
1, 2, 3	51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	• We are developing a tender for services which we will be taking to market in the next four months.

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

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
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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
4	50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	• A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.
4	51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	• We are developing a tender for services which we will be taking to market in the next four months.

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
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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	20	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 separately) . 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 None identified.		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. Meet relevant people at Met Police to share and establish best practice and mutual ways of working. 3. Review feasibility of online assessment for EOC recruitment and run pilot. 4. EOC Recruitment Project Meetings to take place. 5. Allocate appropriate resource to interview and assessment activities.		31/03/2018 31/03/2018 30/04/2018 31/10/2018 31/10/2018

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:		Gross Rating	Current/Net Rating	Target Rating
1. Unknown Target Operating Model.				
2. 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.		25	15	10
3. Need for appropriate programme approach/resource to deliver efficiency projects.				
4. 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. 5. 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. 6. The Trust has delivered only £6m of the £17.8m CIP recurrently in 17/18 due to insufficiently robust governance and project management capability.				

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.	31/07/18
		2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency).	31/03/18
		3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme.	1st cut completed Dec 17. 2nd cut to be completed after publication of Carter report in April 18
		4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impact assessment on Quality and Performance as part of Business Planning	28/02/18
		5. Design and confirm programme resource budget to deliver strategic intent Yr 1 enablement, service development, business process improvement and efficiency programme.	31/03/18
		6. Establish programme management office	31/03/18

		7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy.	31/03/18 31/03/18
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	10
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.	1. Initial Bid to NHSD for Cyber funding Capital (Bid 1) 2. NHS Digital led review of LAS cyber security (November 2017). 3. Implementation of HMG good practice in cyber controls (Cyber Essentials) 4. Potential second bid to NHSD for Cyber funding Capital (Bid 2) 5. Implementation of a Cyber programme of works (to include the recommendations from the PA consulting report) 6. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS	30 Nov 2017 Successfully Completed 01/03/18 01/03/18 01/04/18 31/05/18 31/05/18	
Signed: Ross Fullerton				

BAF Risk no. 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room

Risk Classification: Estates		Risk Owner: Benita Mehra		Scrutinising Committee: Logistics & Infrastructure Committee	
Date risk opened: 20/02/2018		Date risk expected to be removed from the BAF: June 2018			
Underlying Cause/Source of Risk: Existing UPS is undersized for the demand requirement in the building			Gross Rating	Current/Net Rating	Target Rating
			15	10	5
Existing Controls		Positive Assurance of Controls		Further Actions	
1. The current UPS has until this point been effective when a power failure occurred. This was tested recently when the UK Power main supply failed.		1. No degradation of service materialised during the power failure.		1. A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.	
Signed: Benita Mehra					

BAF Risk no. 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice

Risk Classification: Estates and Fleet and Logistics	Risk Owner: Benita Mehra	Scrutinising Committee: Logistics & Infrastructure Committee
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Date risk opened: 20/02/2018	Date risk expected to be removed from the BAF: June 2018
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Underlying Cause/Source of Risk:	Gross Rating	Current/Net Rating	Target Rating
1. External influences to the market volatility affective service provider's ability to function.	16	12	4

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Business continuity plan is in place which includes Legal and People and OD feedback.	1. The business approach is being discussed with NHSI and the Cabinet Office bi weekly.	1. We are developing a tender for services which we will be taking to market in the next four months.	4 months subject to OEJU requirements.

Signed: Benita Mehra

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. 3. Lack of arrangements to effectively manage human factors associated with alcohol, drugs, fatigue or night work and their impact on HS&S performance. 4. Lack of clearly defined management systems. 5. Limited verification that controls or training are effective. 6. Limited performance reporting, monitoring or clear governance arrangements.	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 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.	Bain, Trisha	08/02/2018	20	High	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).	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 and monthly CEO Performance Meetings. 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		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 25 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.	Woodrow, Paul	19/01/2018	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. An end of shift working group which includes trade union representatives commenced in early January and will publish its plan by 1 February 2018 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 2015. Increase rest break window to allow more time for the allocation of breaks. 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 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. Launch a robust communications strategy for internal and external parties which will explain the rationale for changes being implemented from 1 February 2018 Development of a clear clinical safety process to support dispatch staff at times of reduced DCA availability. Formal review of the number of rest breaks/flexible breaks taken three months after implementation. Commence operational roster review. Implement new rest break policy. On-going rigorous management of out of service.	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.	8	Significant
706	Lack of capacity to deliver training through reliability, space and insufficient facilities This has been through age, fair wear and tear.	27/10/2017		20	High	Martin Nelhams looked at viable space - nothing suitable for use across LAS or collaboration premises. Replacement of faulty equipment ongoing. Work carried out by estates to rectify surface issues. Viewing of 8 local venues with the capacity to be able to develop an appropriate training centre - but not able to be sponsored by LAS estates team. Utilisation of alternative desk space at different locations.	Bewes, Lorraine	29/12/2018	16	High		DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downard aware and supportive of the urgent review of premises and continued co-located situation.	4	Moderate
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		16	High	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	Grealish, Patricia	19/01/2018	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 Director of Operations to review recruitment activities, education capacity and outcomes and numbers released to operations (Operational Resourcing Group) 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 cohorts to confirm starting arrangements 9. Improved UK Graduate numbers for 2018/19 – estimated to recruit 244 FTE 10. Healthy TEAC recruitment pipeline – we have recruited 244 this year with over 80 in the pipeline 11. Working with partner universities to encourage graduates to London 12. Working with non-partner universities to increase graduate numbers to London 13. Implementation of Band 6 - will reduce migration to other Trusts 14. Development of an improved workforce planning report 15. Closer working relationships with HEE 16. Potential conversion of other HCPS 17. Encourage UK graduates to see LAS as 'employer of choice' through direct engage at universities	8	Significant

704	The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre	17/11/2017	47	16	High	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 (NWS currently use this approach) and will look to pilot a scheme should it prove affordable and of value	Grealish, Patricia	17/01/2018	16	High	Include role in planned recruitment campaign EOC Recruitment Project Meetings take place Allocate appropriate resource to interview and assessment activities Review feasibility of online assessment for EOC recruitment and run pilot Meet relevant people at Met Police to share and establish best practice and mutual ways of working	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	8	Significant
713	There is a risk that 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.	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	18/01/2018	15	High	8. Develop budget and business case training programme to support financial strategy. 5. Revenue and Capital financing options to be identified. 6. Confirm programme resource budget to deliver strategy. 7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 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. 1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impact assessment on Quality and Performance as part of Business Planning	Trust Board and FIC finance reports Capital Programme action plans	10	Significant
734	There is a risk that a cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period.	14/12/2017	45	20	High	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	Fullerton, Ross	15/01/2018	15	High	Introduce scenario planning and rehearsals a cyber attack on LAS NHS Digital led review of LAS cyber security Implementation of HMG good practice in cyber controls (Cyber Essentials) Potential second bid to NHS for Cyber funding Capital (Bid 2) Implementation of a Cyber program of works (to include the recommendations from the PA Consulting report) Initial Bid to NHS for Cyber funding Capital (Bid 1)	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.	10	Significant
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. 4. Damage to organisational reputation. 5. Potential breach of statutory duty. 6. Wasting and increased financial costs from claims.	20/09/2017	47	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 handling activities. 10. TOR for Manual Handling Group has been finalised and agreed. The group does not currently report to any of the Trust's high level committees. 11. Manual Handling policy has been updated and agreed. 12. Business case to replace all version 1 Mangar Elk lifting equipment has been approved.	Bain, Trisha	08/02/2018	15	High	1. Review of Trust TNA and clinical education training plan to reflect practical MH training frequencies for all staff involved in undertaking MH tasks (including Estates, Fleet & Logistics). Deadline: 31/03/2018 2. Review use of small handling aids kit. Deadline: 31/03/2018 3. Review of current Datix incident categories to ensure these accurately capture/reflect incidents reported. Deadline: 01/04/2018. 4. Deliver practical manual handling refresher training to all frontline operational staff during CSR 1 of 2018/19. Deadline: 30/04/2018 5. Ensure arrangements are in place to deliver practical manual handling training to staff in support services such as IM&T, Fleet, Logistics e.t.c. Deadline: 28/02/2018. 6. Send Manual Handling policy to PMAG for approval. Deadline 28/02/2018. 7. Fleet & Logistics to commence the process for purchasing/replacing all version 1 Mangar Elk equipment. Deadline: 31/03/2018	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 individual patients. 8. Introduction of reflective practice (as part of Module J programme). 9. Dissemination of learning from clinical incidents and Serious Incidents. 9. Medical Directorate and CARU monitor trends and themes via audit and incident reporting. 10. Clinical team leader and clinical manager updates completed (2015). 11. Deputy Director of Education and Standards directly oversee delivery of CSR 2016/2017 and content of the CSR sessions.	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 6 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 9, DCA and FRU specification signed off 10, Revised fleet monitoring 11, DCA fleet increased to support VP roll out 12, 20 DCA vehicle held back for events/training 13, Vehicle allocations to complex being revisited to assess against areas with excessive out of service time. Re-allocation and consideration of holding spares at Sector level to be considered. 14, Business case for 140 new ambulances is finalised for submission to TDA by DoF 15, DCA & FRU specification agreed & signed off by Head of Fleet and Logistics 16, Delivery of 60 new FRUs in 2016 17, Development of a bid for 25 APP vehicles 18, Development of BC for additional 60 FRU to be planned in for 2017 19, BC for DCA approved by NHSI November 2016 impacting on delivery on 16/17 20, Review of requirement for IRO's and GSM's 21, Draft fleet strategy developed and distributed for comment Nov 2016	Benita Mehra	31/01/2018	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 Preparation Scheme Delivery of 140 new vehicles throughout 2017 Draft and implement action plan to ensure all potential capacity can be realised from the existng fleet	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 5, serial numbers on all re-usable equipment that can be accurately tracked.	Benita Mehra	18/01/2018	12	Significant	introduce improved asset tracking to improve location tracking of equipment Clarify the risk and totally review Roll out of vehicle preparation 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	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 checking and restocking/equipping vehicles 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role 8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 9, Current VP contract reviewed and any immediate changes are agreed 10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed 11, Pilot project in NE area to provide and resupply equipment store implemented. 12, Business case for the roll out of VP pan London has been agreed 13, Project board and working groups established. 14, Review of delivery standards completed 15, New KPIs reported through to QIP 16, Deep dive by QIP panel completed 17, Preparation of tender documents and standard commencing DEC2016 18, Contract variations being developed to increase scope of works to include FRU and NETS vehicles 19, Proposal developed for the implementation of a depot based make Ready managers and 2 Make Ready Operations Managers to oversee the delivery of the contractor, coordinate more effectively with Fleet Workshop managers and local operational management teams on a daily basis. 20, Additional equipment is being sourced to facilitate the roll out where needed.	Benita Mehra	18/01/2018	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		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. 11, BC for roll out of VP system pan London developed. 12, Board approval gained for BC 13, Project board and working group developed 14, Project plan defined and agreed 15, Additional equipment purchased to support roll out 16, project reclaiming, decontaminating and resupplying medical equipment established. 17, 'Managed stores' system established to support VP and daily supply of medical consumables 18, 'Blanket' trial and evaluation established and recommendations developed. 19, KPIs developed and monitored for the completion of wash and stocking of vehicles 20, Medicines management programme defined encapsulating all aspects of prep, supply and delivery, collection and disposal. 21, Development of Bag Review Group in April 2017 working schedule to review and replace modular bags as required and for personal issue equipment to be phased out	Benita Mehra	18/01/2018	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	09/02/2018	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 staff engagement. 14. findings from unannounced MPS visits shared with DDO's and ADO's. 15. Medicines management update for CSR2016.1 has been completed. 16. LAS pharmacist now in post, has conducted full estate review and has made recommendations on action to be taken. 17. Perfect Ward implemented pan-London and audits routinely conducted. 18. MedMan drugs usage monitoring portal - completion of form in drugs bag ensures drugs removed from drugs bags have been given to patients, enables drugs can be married up by MI. 19. OP079 - produced and signed off - go live 13th Nov policy on the transportation of control drugs (specifically schedule two medicines) 20. "Secure drugs on station" project continues	Woodrow, Paul	09/02/2018	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 identified 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	09/02/2018	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	26/01/2018	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	16/01/2018	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
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	24/01/2018	12	Significant	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
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 above making staff want to remain with the CHUB.	Cranmer, Pauline	30/01/2018	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		16	High	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 checks (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	Grealish, Patricia	21/01/2018	12	Significant	Stat + Mand training Recruit Bank Coordinator DBS check all 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')	4	Moderate

708	EMDs remaining on line for mental health callers or patients threatening suicide is impacting on call answering performance and the staff well-being	27/10/2017		15	High	While EMDs have attended mental health awareness session Mental Health Nurses work in EOC	Cranmer, Pauline	30/01/2018	12	Significant	Reviewing types of calls and frequency. To review what support can be given in EOC. QA to include in their audit/feedback of such calls how long EMDs stay on the line if unnecessarily.	Further discussion at the Quality and Business Group meeting	9	Significant
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	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
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 disproved with the benefit of accessing voice recordings.	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	01/02/2018	12	Significant	Provide update for Risk Register 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
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	30/01/2018	12	Significant	Loading of Tableau to Desktop and Laptops Introduce KPIs into dispatch Write Business plan for QAD, incorporating a plan for the introduction 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	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. (Previously held as ID NC13)	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.	Brincombe, Sean	17/01/2018	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	31/01/2018	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	16/01/2018	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
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) 8, Signage placed in Ambulances to indicate the type and correct operation of the tail lift in question. (from further actions) 9, Instructional video demonstrating the procedure to operate the tail-lift in an emergency – placed on the "Pulse" June 2015 plus notes in "RIB" (from further actions) 10, 104 new A&E Ambulances to replace 67 x 12yr old units.(from further actions) 11, new tail lift design being implemented as part of New DCA specification (140 vehicles) Contract management in place Contract let to specialist contractor supporting maintenance	Bewes, Lorraine	18/01/2018	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
448	Due to the expansion of functions in Control Services, there is a risk that in the event of a planned or unplanned CAD outage or need to move to single site working, there is insufficient space to adequately accommodate all EOC functions. As a result, a decision will be required as to what NON-CRITICAL functions will not be undertaken should the above occur.	11/06/2016		12	Significant	Current actions identified are: Priority list of NON Critical functions to be stopped is circulated. Watch Managers tasked to dynamically assess requirements	Cranmer, Pauline	30/01/2018	12	Significant	Review of CRITICAL and NON CRITICAL functions of EOC Review of the Trust/EOC Business Continuity Plan Review of EOC estate capacity issues Identify potential suitable sites for expansion, both internally and externally Review relevancy of current dispatch model Review numbers of staff required for each function	Plan for paper operations (OP66) is up to date and is available on The Pulse Dates are planned to test the Control Services plan for paper operations Control Services representation is included in the BC / DR steering group	6	Moderate

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		12	Significant	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	17/01/2018	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.	6	Moderate
475	There will be a detrimental impact on service delivery targets at times of high demand. Unexpected and unplanned increase in call volume which outstrips staffing capacity may have a detrimental effect on the service delivery.	23/09/2016		12	Significant	1. Demand management plan in place to manage acute changes in demand 2. Operational managers on duty 24/7 to monitor performance, changes in demand and escalation to relevant parties when required 3. On call access to LAS111 senior management, EOC Incident Delivery Managers, Gold on call Directors and NHSE representatives 4. Business continuity plan in place with escalation procedure documented	Daw, Nicholas	26/01/2018	12	Significant	1. Review of business continuity plan Review of staffing forecasting against predicted demand Ongoing recruit to fill vacancies Roster review Build break relief into rosters Review of business continuity plan Review of staffing forecasting against predicted demand Review Recruitment Plan for 111 Roster review	1. Current staffing matched against forecast planning 2. Continual use of agency staff to cover gaps 3. Roster review commenced to include training and relief addition to forecast.	8	Significant
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	17/01/2018	12	Significant	1. Continued monitoring at Sector Operations Group. 2. Pro-active deployment of IROs to ED as required. 3. Continued regular engagement by SEM to ED Senior Team.	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
675	There is a risk that the management of the student journey is reduced due to the reliance on local databases for recording activities, leading to decreased accuracy in, and restricted accessibility to, progress details.	19/09/2017		12	Significant	Recording of all activities on a student database, held centrally. Utilising other electronic systems where possible such as OLM, ESR, GRS and Moodle Scanning and electronic storing files and copies of documents in common drives	Ivanov, Tina	09/02/2018	12	Significant	Set up a meeting for a demonstration of the Intrepid database	Standardisation committee Credentialing committee	3	Low
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 Police support available for staff. 10. Operational monitoring of incidents at Sector Level through the QGAMs and GSMs. 11. Conflict resolution training is provided to all frontline staff at induction and refreshed every 3 years. 12. Obstructing Emergency Worker legislation in place. 13. Post Violence Support Procedure in place to support staff. 14. Stab vest and relevant PPE are provided to A&E and NETs staff	Bain, Trisha	08/02/2018	12	Significant	1. H,S&S Team to support Ops with implementing lone working arrangements across the Trust with the view of implementing robust risk assessments that addresses the risks associated with lone working. Deadline - 31/03/2018 2. H,S&S Team to incorporate security training into the Trust's H&S Induction Training Sessions. Deadline - 10/02/2018. 3. H,S&S Team to liaise with Wellbeing Team regarding the implementation of stress audits. Stress work group being formed. Deadline - 28/02/2018. 4. LSMS to work with Operations regarding the timely issue of stab vests to new starters. Deadline - End of Q4, 2017.	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	08/02/2018	12	Significant	1. H&S Team to reinforce the importance of reporting incidents to staff through training, bulletins e.t.c. ongoing - End of Q4 - 2017. 2. Corporate health & Safety Committee to monitor overdue/outstanding incident investigations and escalate to relevant managers to ensure closure. Deadline - 31/01/2018.	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
699	The Supplier of the Redbox recording system for 999 and 111 calls, does not proactively, manage O/S and security updates from Microsoft. Therefore if Microsoft release a security update for its servers or an O/S patch. Redbox do not test these patches or updates first to ensure that they will work with a customers configuration. Therefore the customer takes the risk of applying these patches/ OS upgrades and if they cause an issue only at that time will Redbox work with us to produce a solution. We do not have a test environment currently in place to test any new patches or O/S updates	11/10/2017		12	Significant	A test environment will need to be put in place to ensure that any updates from Microsoft for their servers can be tested before being released to the Redbox servers	Downard, John	30/01/2018	12	Significant	a test environment to be provided to test new patches.	A test environment will ensure that we can control and test and patches in a safe environment.	4	Moderate
714	There is a risk that the Trust will be subject to regulatory intervention as a result of not achieving its 2017/18 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&F, Capital, CQUIN & CIPs. CQUIN progress reported regularly to ELT	Bewes, Lorraine	01/02/2018	10	Significant	1. Budget management training and support based on best practice (Future Finance Focussed & HFMA programmes) to be introduced; 2. Review Finance structure and prepare case to Trust Board to enable business partnering support 3. Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme	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	Fullerton, Ross	30/01/2018	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	30/01/2018	10	Significant	Additional activities required to successfully complete the Quality Improvement Programme	On-going reporting to the Board and ELT CQC re-inspection in Q4 2017/18	10	Significant
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Report to:	Trust Board		
Date of meeting:	27 February 2018		
Document Title:	Serious Incident Update		
Agenda item	18		
Report Author(s):	Kirstie Smith, Clinical Adviser		
Presented by:	Dr Patricia Bain, Chief Quality Officer		
History:	Quality Oversight Group membership, Executive Leadership Team		
Status:	☒	Assurance	☐ Discussion
	☐	Decision	☐ Information
Background / Purpose:			
The purpose of this report is to summarise the findings from the quarter three thematic review of Serious Incidents (SIs) and compare these findings with those from the quarter two review. The thematic review analysed serious incident activity across the Trust and each STP/Sector. The document will provide an overview of the main contributory factors that influence serious incidents and the actions taken by the Trust to address recurring themes.			
Recommendation(s) to Trust Board:			
The Board is requested 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 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 Incidents Update

Quarterly Review: Q3

Introduction and Background

1. This paper includes a thematic review of serious incidents closed in Q3 specifically focusing on serious incidents (SI) by category and key contributory factors.

Context

2. During Q3 18 SI reports were closed by the CCG. The average time for commissioners to sign off and close a report is currently 23 days (range 13 to 31). This is a reduction of 5 days from the previous review. The CCG have a target of 20 working days to provide comments back to the Trust for clarification or amendment. Any comments referred to the Trust must be answered within 10 working days prior to the CCG agreeing closure of the investigation.
3. The Trust's current position on meeting the 60 working day target for submitting SI reports is 100%. A recent external audit conducted by KMPG detailed the Trusts compliance with the SI investigation process and evidenced significant assurance.

Thematic Review (comparison Q2 - Q3)

Serious Incidents by CCG and STP/Sector

4. The following graphs show the distribution of serious incidents across the STPs/Sectors.

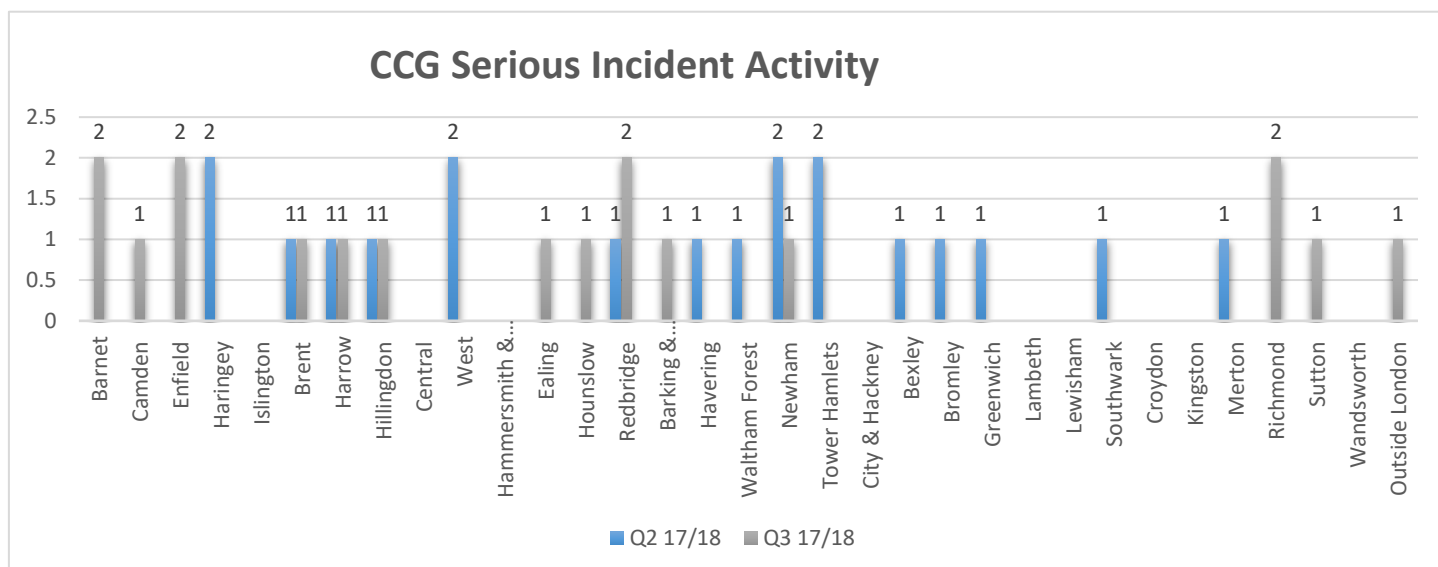
Fig. 1: Serious incidents by STP/Sector Q2 and Q3



Fig 1 shows a decrease in serious incidents closed across the North West, North East and South East sectors with an increase across the North Central and South West sectors. The reasons for this are currently being reviewed.

Fig. 2 demonstrates the distribution of serious incidents by CCG.

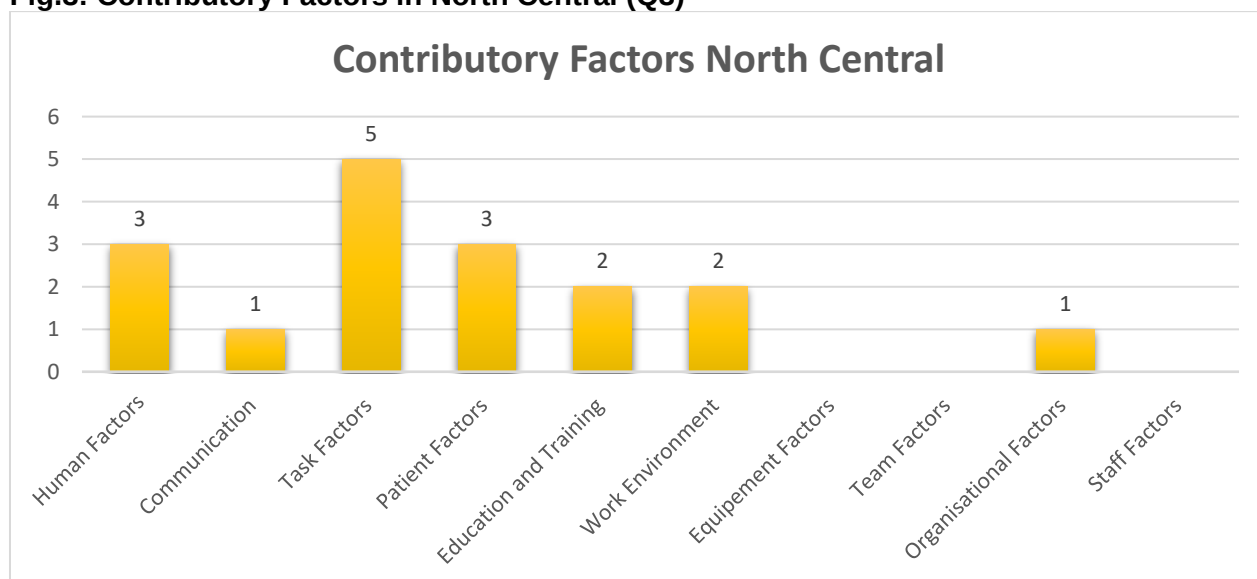
Fig.2: Serious Incidents by CCG Q2 and Q3



Contributory factors by STP/Sector

- The following graphs demonstrate the contributory factors from investigated SIs by STP/Sector. The South East sector did not have any serious incident investigations closed during Q3 and therefore will not be included.

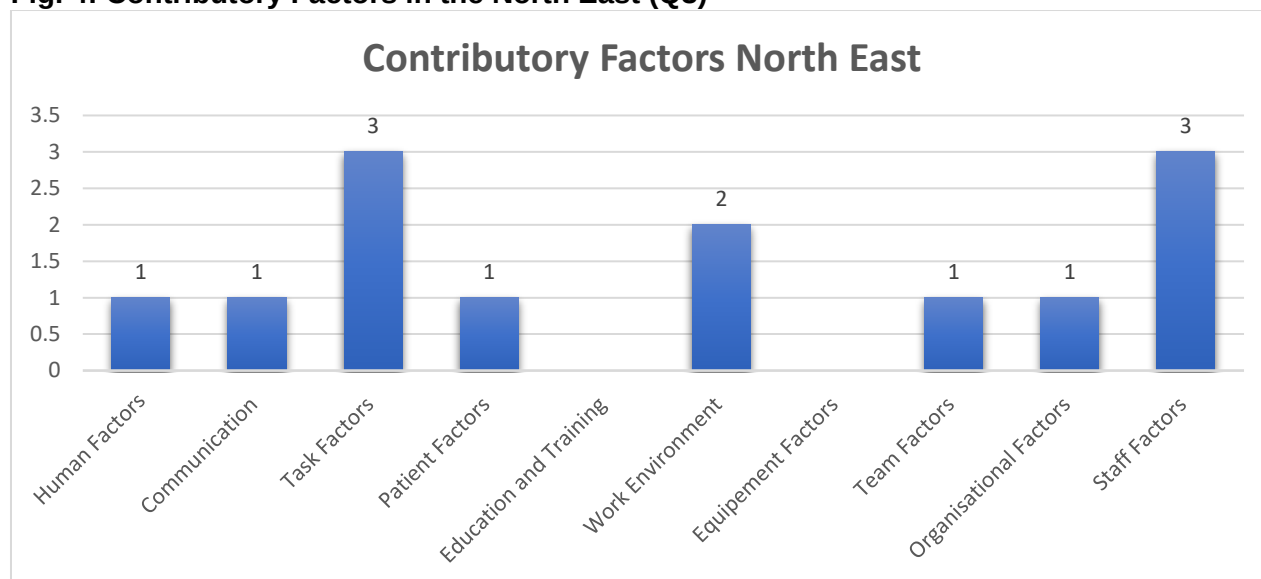
Fig.3: Contributory Factors in North Central (Q3)



- A total of six serious incident investigations were closed from the North Central sector during Q3. From the six investigations task factors were highlighted to be the main contributory factor followed by human and patient factors.
- Investigations found that a lack of adherence to clinical guidelines was the main task factors which resulted in inaccurate clinical decisions being made. Furthermore, the lack of adherence to guidance was evidenced to be a result of either patient or human factors.
- Complex medical presentations or the lack of a clear history of events led to emergency crews missing clinical red flags and/or not consulting guidance provided by the Trust.

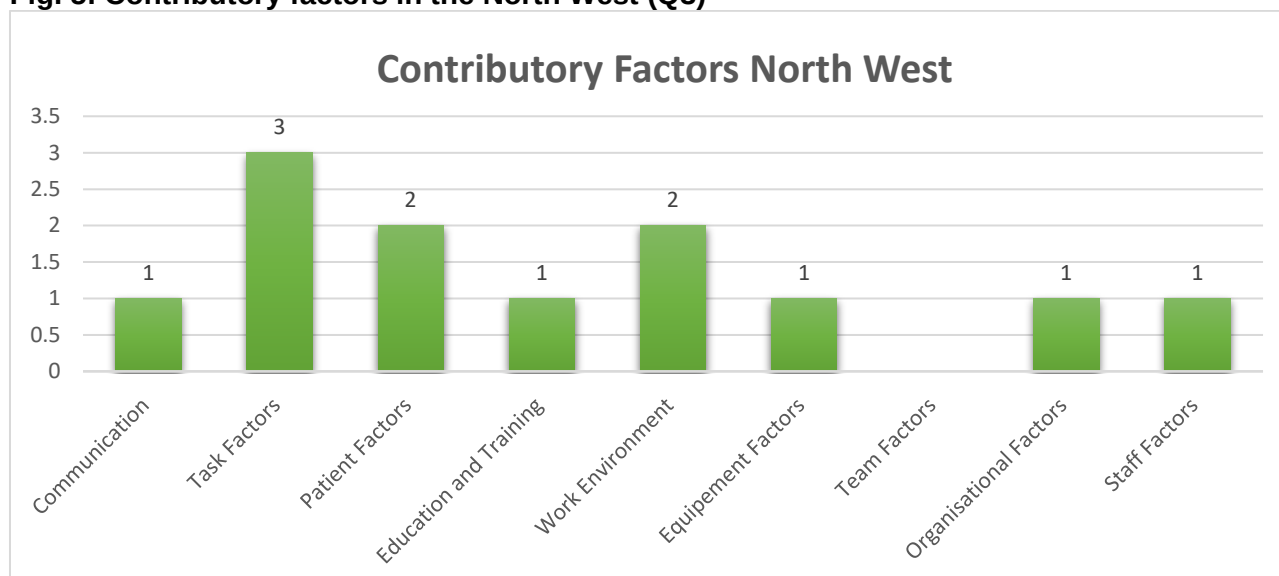
9. Additional human factors included crew fatigue, lack of quality experience in managing complex patient extrications and a lack of experience managing challenging 999 calls by Emergency Medical Dispatchers.
10. Patient factors predominantly concerned extensive pre-existing medical conditions masking acute injury. This resulted in acute injuries being missed and patients were taken to emergency departments that do not have the correct facilities to manage the patient's clinical condition. These patients underwent a secondary transfers to the correct facility which resulted in a delay in care.

Fig. 4: Contributory Factors in the North East (Q3)



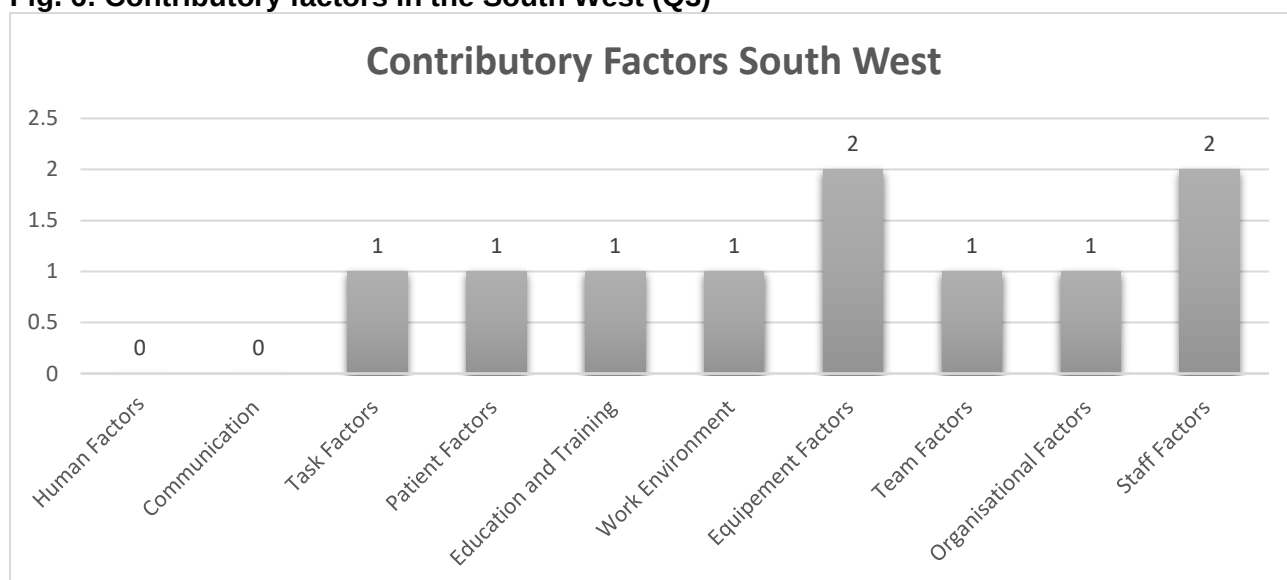
11. A total of four serious incidents were investigated and closed by the CCG from the North East sector during Q3. Of these investigations task and staff factors were considered to be the main contributory factors which influenced the root cause of an incident.
12. Task factors included a lack of adherence to operational policies for the Emergency Operations Centre (specifically OP/023 – Procedure for the Dispatch of Emergency Vehicles by EOC). Similarly to those investigations in North Central, a lack of adherence to Trust guidelines resulted in a delay in the appropriate level of care being provided after patients were taken to local emergency departments rather than Major Trauma Centres.
13. Staff factors included fatigue, a lack of clinical leadership on scene and stress/distraction due to personal circumstances.

Fig. 5: Contributory factors in the North West (Q3)



14. Of the three serious incident investigations that took place in the North West task factors were again highlighted to be the main influence to the root cause of an incident.
15. Task factors in the North West were predominantly focused around EOC and the management of 999 calls. This was complicated by work environment issues which included service demand within the control room(s), policies no longer being fit for purpose or lacking direction on the management of calls received from other ambulance Trusts.

Fig. 6: Contributory factors in the South West (Q3)



16. Of the two serious incidents that were investigated and closed in the South West the new contributory factor of equipment issues was highlighted.
17. Both investigations concerned the management of cardiac arrests. One related to a delay in shocking ventricular fibrillation, which is a known theme across the LAS currently. The second concerned the management of a patient who rapidly deteriorated in the presence of an inexperienced paramedic.

18. The equipment issues related to the LifePak 15 monitor and concerned the information the monitors were displaying at the time of the incident.
19. Staff factors concerned a lack of quality experience in managing a critically unwell patient, a lack of clinical leadership and a gap in the attending clinician's knowledge.

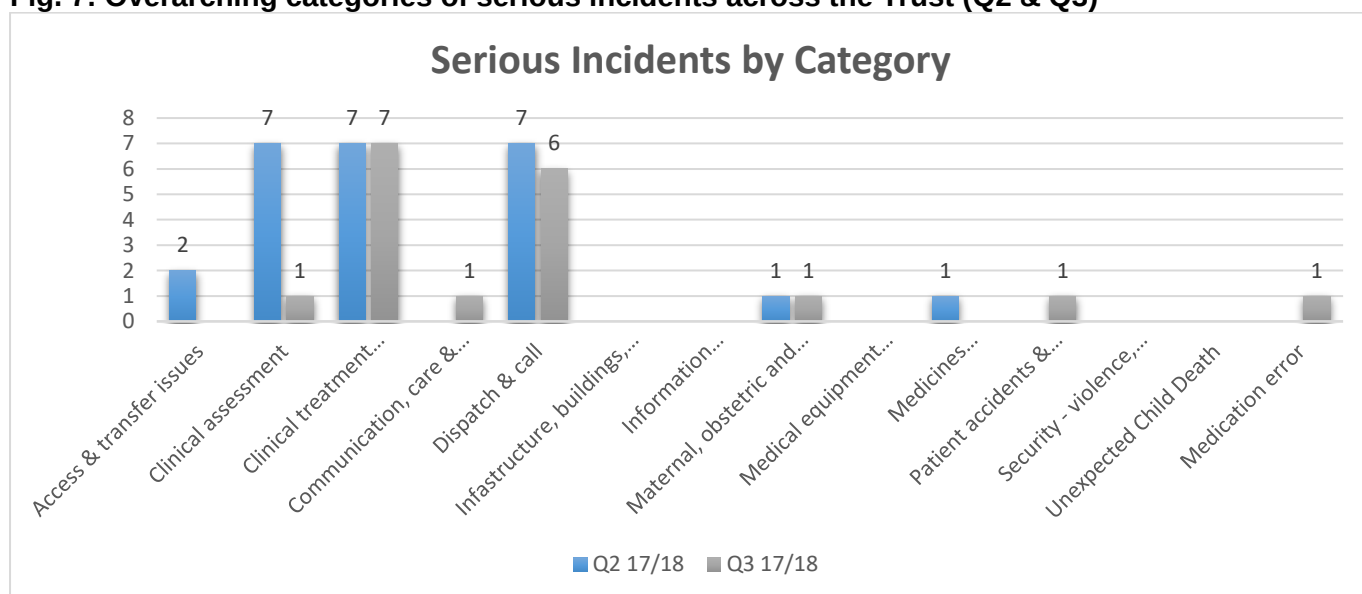
Overarching Serious Incident Themes Q3

20. Following on from the previous thematic review there has been a reduction in clinical assessment errors from Q2 (n=7) to Q3 (n=1). Additionally there has been a reduction in cases of delayed defibrillatory shocking of ventricular fibrillation from five to one when compared to the previous thematic review.

Management of cardiac arrest (delayed defibrillation) (n=2)

21. The two cases investigated during Q3 presented challenging situations for the attending crews which complicated the management of the cardiac arrest.
22. In one incident, the patient presented with an anterior-lateral myocardial infarction and suffered a cardiac arrest during transportation to hospital. The delay in providing treatment was a result of clinical inexperience and patient factors. The attending crew described the patient to suffer from seizure like activity after becoming unconscious which led them to believe the patient was alive. This description is typical of the abnormal 'posturing' seen in the early stages of a ventricular fibrillation cardiac arrest.
23. The second case of mismanagement was again complicated by patient factors in that the patient had a pacemaker in place however this information was not conveyed to the attending crew. The crew mistakenly identified the cardiac rhythm as pulseless electrical activity rather than ventricular fibrillation.

Fig. 7: Overarching categories of serious incidents across the Trust (Q2 & Q3)



24. The main categories identified during Q3 continued from the thematic review for Q2:

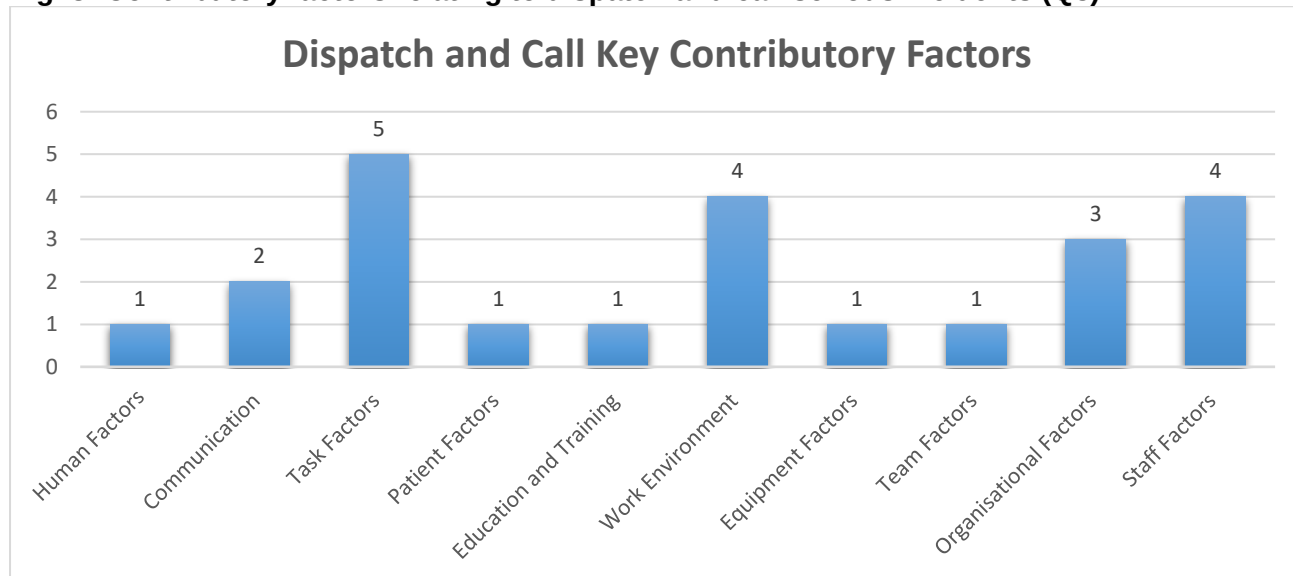
Category	Q2	Q3
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Dispatch and Call	7	6
Clinical Treatment	7	7

Dispatch and Call Issues (n=6) Q3

25. Many of the task and staff factors identified are largely similar to those reported during the last quarter. The previous report provided number of recommendations specifically relating to EOC policies that had been identified to be unfit for purpose and in need of review.

Fig. 8: Contributory factors relating to dispatch and call serious incidents (Q3)



EOC Action Plan

26. The thematic review in Q2, identified that the majority of task factors concerned three EOC policies that were identified to be unfit for purpose. The request to review and amend these policies was incorporated into an intensive EOC action plan. We would hope to see a reduction in these themes by Q4 2018/19.

27. OP/060 – Control Services Call Taking Procedure was updated and re-published towards the end of October 2017. OP/023 – Procedure for the Dispatch of Resources by EOC is currently awaiting executive approval before it is published. OP/066 – Operational Procedure for the Use of Paper Operations within Control is currently under review.

28. Additionally, learning from serious incident and recurrent themes is being included in the EOC core skills refresher training this quarter (Q4) with the first session being delivered February 2018 by the Quality Governance and Assurance Team supported by EOC Quality Assurance subject matter experts.

Work Environment

29. In addition to task and staff factors a new contributory factor was identified during the quarter 3 review. Issues relating to the work environment typically included:

- Lack of clinical oversight of None Emergency Transport Service (NETS) calls
- Stress, distraction and fatigue
- Service demand

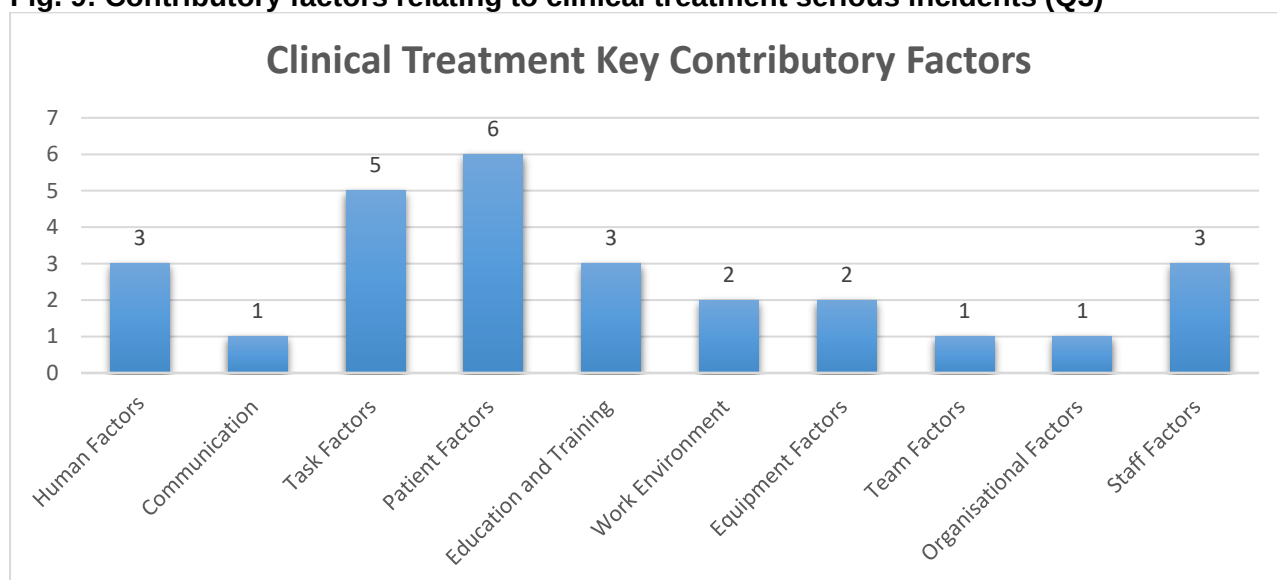
Actions Taken (Work Environment)

30. A clinical safety review of the NETS process is currently underway by the Interim Head of Quality, Governance and Assurance and is due for completion by 7th March 2018.
31. Two welfare rooms have been identified at both control room sites which will provide EMDs with a facility to seek welfare and emotional support from managers or LINC workers in a quiet and private space.
32. Based on an analysis of previous call handling recruitment data it has been highlighted that vacancy adverts generate high interest however this does not convert to high levels of applications leading to successful appointments. The Director of People and Organisational Development is researching alternative assessment processes in an attempt to increase the conversation rate from the application stage. Once recruited and trained the additional staff should assist in reducing the demand within the control rooms and assist in the workload associated with both call handling and dispatch. As a result this should reduce the number of errors made as a direct result of the stress and distraction of attempting to meet the key performance indicators, specifically call answering times.

Clinical Treatment Issues (n=7) Q3

33. Of the 7 SI investigations undertaken relating to clinical treatment errors, a review of the contributory factors showed that issues relating to patient and task factors were considered to have contributed to the root cause of the incidents. There has been a reduction in both the staff factors and education and training issues that were highlighted in the previously reported thematic review. Patient factors is a new theme which has been highlighted this quarter.

Fig. 9: Contributory factors relating to clinical treatment serious incidents (Q3)



Patient Factors

34. Issues relating to patient factors typically included:

- Complex medical presentations

Example: 68 year old female suffered a mechanical fall. Following the fall she had got back into bed before the LAS was called. The patient had a medical history of osteoarthritis and

osteoporosis for which she already had a neck brace. The crew were falsely reassured that the pain experienced by the patient was as a result of her pre-existing medical concerns and as a result missed clinical red flags to suggest that the patient had suffered a spinal injury.

- An unclear mechanism of injury; particularly with trauma patients

Example: 48 year old female had been found on the ground after falling 48 hours previously. The attending crew immobilised her due to concerns regarding a possible spinal injury however due to the lack of information regarding the mechanism of fall, a traumatic cause was not considered by the attending crew and the major trauma tool was not applied. The patient was conveyed to a local emergency department before a secondary transfer was requested to convey the patient to a major trauma unit with a fractured spine and cord injury at C5.

- Unclear or lack of information provided to the attending crew

Example: 28 year old male believed to have been assaulted and was intoxicated. Due to the intoxication the patient could not be clear about what had happened. Due to the lack of information concerning the mechanism of injury and the unclear history provided by the patient, the attending crew did not recognise the need to consult the major trauma tool and subsequently conveyed the patient to a local emergency department.

Tasks Factors

35. Issues relating to task factors typically included:

- Clinical guidance not being adhered to; specifically the major trauma assessment tool

Example: 11 year old female jumped from a first floor window. Following the incident she had walked back to her flat prior to the LAS being called. This contributed to a lack of situational awareness during the clinical assessment undertaken by the crew. As such the major trauma decision tool was not consulted during the assessment and led to the patient being conveyed to a local emergency department. The patient was later transferred to a major trauma centre.

- Difficult extrication of the patient

Example: 68 year old female immobilised due to a suspected spinal injury located on the 6th floor of a block of flats with no lift facility. The challenges in extricating the patient from the property led to a prolonged on scene time.

- One case involved the mismanagement of a patient in cardiac arrest. In this incident the patient deteriorated and suffered a cardiac arrest on conveyance to the hospital. The guidelines and protocols around the management of the cardiac arrest and conveyance of a confirmed STEMI patient were not followed.

Major trauma decision tool task factors

36. The Clinical Audit and Research Unit conduct bi-monthly audits of calls which have resulted in secondary transfers to major trauma units. These calls are clinically reviewed and any concerns regarding initial conveyance to a local emergency department are referred to the serious incident group. This accounts for the theme of major trauma units being highlighted this quarter.
37. There will be a delay between the incident occurring and the issue being referred to the serious incident group via this method. However it is good practice and picks up any incidents not reported via the Datix system.

38. A senior clinician applied the major trauma tool retrospectively and, based on the information provided on the patient report forms, each instance would have suggested conveyance to a major trauma centre. It is apparent from the investigations that the complexity of the scene, lack of significant history or an unclear mechanism of injury resulted in the attending crews not considering the application/requirement to apply the major trauma tool.
39. Four of the above examples included above related to cases of ambulance crews not consulting the major trauma decision tool designed to sign post patients to the most appropriate place of care.

Conclusion

40. We are maintaining our targets of 60 working days in relation to submitting completed SI investigations. SI action compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required.
41. A recent external audit of the serious incident investigation procedure conducted by KMPG has provided significant assurance that incidents are managed correctly, in accordance with Trust and NHSE policies and investigated to a high standard.
42. We have evidenced that interventions identified from themes from previous thematic reviews are having an impact with a reduction in specific types of incidents.
43. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the serious incident group and assurance processes.
44. The Call Handling action plan for EOC is expected to address recurrent policy concerns and the welfare of our staff. The Quality Governance and Assurance Team will continue to monitor for trends, particularly around the work environment which was a new theme this quarter.

Dr Patricia Bain

Chief Quality Officer



SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/25117

Datix reference: 11391

Date of Incident: 02.10.2017

Date report: 09.01.2018

**Incident
description:**

The LAS were called to a patient who was reportedly intoxicated and had been assaulted with a plank of wood. The call was assessed as a C1 priority and the Metropolitan Police Service (MPS) were called to scene by the Emergency Operations Centre (EOC).

Thirteen minutes after the original call a second call was received stating that the patient had become aggressive, had lost consciousness and had begun fitting. This call was re triaged and allocated a red 2 priority.

A Double Crewed Ambulance (DCA) was dispatched to scene 22 minutes after the original call (6 minutes after the upgraded second call) The DCA arrived on scene 35 minutes after the original call (13 minutes after the upgraded second call).

The attending crew assessed the patient and discharged the patient leaving the patient in the care of the MPS.

2 hours 40 minutes after the original call (45 minutes after the original crew left the scene) the LAS received a call from a nurse stating the patient that the patient was in Police custody with facial injuries, fluid in eye and vomiting. The call was assessed by the Clinical Hub (CHUB) and a two hour response was agreed.

A DCA was dispatched to this call and arrived on scene within 3hours 14 minutes. On arrival of the second crew assessed the patient and recorded a reduced Glasgow Coma Scale (GCS) with facial bruising and a boggy mass to the head prompting a blue call to a Major Trauma Centre (MTC).

The time taken from the original call to the patient arriving at a MTC was 6 hours 44 minutes.

The patient was treated as an in-patient in hospital and was subsequently discharged home.

**Immediate risk
mitigation:**

N/A

Findings of investigation:

The ambulance crew who attended the patient failed to fully appreciate the patient's presenting symptoms were consistent with the patient suffering a serious head injury. They attributed the patient's condition solely to ethanol intoxication relying on contradictory reports they were given by witnesses and the police about what had taken place before their arrival on the scene.

Recommendations:

- The crew to receive a locally facilitated learning session with reflective practice.
- The Trust to co-ordinate shared learning facilitated by an article concerning working in challenging environments with intoxicated patients and identifying red flags, to be published in the "Insight" magazine by the medical directorate.

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:

1. Provide Paramedic A and Emergency Ambulance Crew (EAC) EAC A with facilitated local learning with regards to managing intoxicated patient with potential head injuries. This should include viewing the MPS body worn CCTV footage.

Owner: Quality Governance and Assurance Manager

2. Shared learning facilitated via the Insight Magazine

Owner: Clinical Advisor to the Medical Directorate



SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/25123

Datix reference: 11983

Date of Incident: 05.10.2017

Date report: 23.01.2018

Incident description:

A call was received for an 87 year old reported to be in cardiac arrest. Two London Ambulance Service NHS Trust (LAS) vehicles and one Metropolitan Police Service (MPS) vehicle were activated to attend the scene.

The MPS arrived first and started cardiopulmonary resuscitation (CPR), delivering one shock to the patient with their automated external defibrillator (AED). The LAS then arrived and took clinical primacy for the cardiac arrest, initiating the advanced life support (ALS) protocol for a non-shockable rhythm. The patient was identified as being in asystole.

The full ALS protocol was followed and the patient's condition had not improved, with the cardiac rhythm remaining in asystole throughout.

The decision to terminate resuscitative measures was jointly made by the patient's wife and the crews on scene; however, when the diagnostic rhythm strip was printed for the Recognition of Life Extinct (ROLE) form it exhibited evidence of fine ventricular fibrillation (VF), which is a shockable rhythm that paramedics cannot declare as life extinct.

No staff on the scene correctly identified the rhythm as VF, and instead rationalised it as asystole with artefact. The clinicians on scene then proceeded to complete the patient report form and ROLE paperwork.

One of the crews felt uncertain about the interpretation of the rhythm strip on their return to their ambulance station and sought the advice of an off duty Advanced Paramedic Practitioner (APP) and Clinical Team Leader (CTL). They advised that the rhythm was VF and that it was to be escalated through the LAS serious incident procedures.

Immediate risk mitigation:

Paramedic B and Emergency Ambulance Crew (EAC) A were both spoken to by the CTL and APP and made aware of the error the same day of the incident. The following day, Paramedic A was approached by a CTL on station and advised of what had happened. The debriefing process took place in a prompt fashion and all clinicians involved were made aware of the incident.

Findings of investigation:

Advice was also given around the utilisation of AED mode if there is any uncertainty around whether the rhythm is shockable or non-shockable.

Once on scene the LAS crews assumed primacy of care from the MPS and attached a LP15 to the patient so that the cardiac rhythm was visible on the screen. It was agreed by all LAS staff on scene that the rhythm presenting on the screen was asystole. Unfortunately there is no way of confirming whether the patient had been in asystole throughout the resuscitation as the LP15 data could not be downloaded.

A clear and professional discussion took place between the wife and the paramedics regarding the decision to cease resuscitation, and it was unanimously agreed that resuscitation would be terminated. The wife also had mentioned to the crews that the patient had a pacemaker.

Upon stopping resuscitative efforts a diagnostic rhythm strip was printed for submission with the ROLE documentation. This strip presented with a fine VF morphology, not asystole. The crews were initially confused by the sudden rhythm change and rationalised that it wouldn't be possible for a patient to be in VF after having spent so much time in asystole, ultimately deciding that it was more likely asystole with artefact; this was incorrect.

In the event of uncertainty the correct course of action (as per LAS cardiac care circular 007) is to initiate the 'AED' mode on the LP15 and have it automatically analyse the rhythm to determine whether a shock is advised. In this case resuscitation should have resumed.

The EAC had initially started this process by activating 'AED' mode after resuscitation attempts had ceased, but cancelled the function before it could offer any advice relating to delivering a shock. Their reasoning was that a discussion between qualified clinicians was already taking place.

In accordance with ALS guidance, paramedics cannot autonomously terminate resuscitation of patients in VF; however, the interviews revealed that the crews did not purposefully terminate the resuscitation against guidelines and had instead misinterpreted the printed rhythm strip.

Paramedic B was uncertain of how to interpret the presenting printed rhythm strip and therefore deferred to Paramedic A for an explanation, who then incorrectly identified the rhythm as asystole.

It was also found that during the ongoing discussion throughout the resuscitation attempt both with the crew members and with the patient's wife,

that the crews exhibited signs that they chose evidence which confirmed their views of the patient's poor prognosis.

In subsequent contact by the Nominated Contact (NC), the patient's wife stated that she had forgotten to tell the crews that the patient had a Do Not Attempt Resuscitation (DNAR) order. This information was unknown to the crews during the incident.

Recommendations:

This report recommends that the three clinicians involved in this incident (Paramedic A, Paramedic B and EAC A) improve upon their awareness of:

- Common ECG presentations in cardiac arrest
- Cardiac arrest protocols (including cardiac care circular 007)
- The importance of AED mode on the LP15 in analysing rhythms that are not clear
- The pitfalls of confirmation bias

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:

One day training session for Paramedic A, Paramedic B and EAC A.

This session will comprehensively cover the recommended topics listed above and will take place no later than the 15 February 2018. The tutor will then provide feedback to the LI as to whether further training is required or if there are any significant issues identified.

Owner: Clinical Tutor



SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/26413

Datix reference: 12350

Date of Incident: 19.10.2017

Date report: 16.01.2018

**Incident
description:**

A male patient with a three-day history of leg pain started to experience difficulty in breathing (DIB) after their leg was massaged. A 999 call was received in the Emergency Operations Centre (EOC) stating the patient had trouble speaking between breaths. The call was triaged appropriately and staff arrived on the scene within the LAS's standard timescales.

Paramedic A arrived on scene and commenced Basic Life Support (BLS), noting that the patient's airway was difficult to manage and required regular suctioning.

The second resource to arrive (a Double Crewed Ambulance (DCA)) was staffed by two paramedics, one of whom, Paramedic B, placed an i-GEL (advanced airway), however, the airway continued to cause problems during resuscitation.

With the arrival of the third ambulance resource, Paramedic C attempted to intubate the patient with an Endotracheal Tube (ETT). The ETT is a more secure advanced airway. The intubation was not effective but this was not recognised and corrected until six minutes had elapsed when then the ETT was removed.

The delay to recognise oesophageal intubation was flagged by the Advanced Paramedic Practitioner (APP) and Paramedic C who reported this incident.

**Immediate risk
mitigation:**

Paramedic C had responsibility for the airway management and intubation attempt owing to the fact that they were the only intubation-trained paramedic at the time, despite being the second ambulance resource to arrive on the scene. As per standard LAS procedure, and without apportioning blame to the individual, a decision was taken to restrict paramedic C's practice of intubation until completion of the SI investigation and findings and appropriate retaining and assessment has been completed.

**Findings of
investigation:**

The investigation identified contributory factors including a difficult airway to manage in a small room and a deviation from the Airway Management Guidelines 2014.

There was also no documented assessment made with a stethoscope to check for breaths while ventilating the patient. Paramedic C did recognise a continued airway problem and began problem-solving almost immediately but did not act to extubate the patient and replace the airway. The six-minute

window before corrective action (extubation) occurred was in the main attributable to confirmation bias due to the visualisation of the cords and the initial box waveform on capnography that mislead Paramedic C. There was also a delay while the APP assessed the patient.

Recommendations:

Paramedic C is to receive local training with the Clinical Team Leader (CTL) on intubation, along with a review of the Airway Management Guideline.

The learning from this incident is to be shared with an anonymised case study for inclusion in the 'Clinical Update' magazine.

Local training with Station Groups to highlight the Airway Management Guideline 2014.

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk
5 (catastrophic)	2 (unlikely)	10

Action plan/owner:

Local training for Paramedic C on intubation with CTL. Review of the Airway Management guideline.

Owner: CTL lead

Anonymised case study in 'Clinical Update' magazine.

Owner: Consultant Paramedic

Revisit intubations on CSR courses

Owner: Deputy Director of Clinical Education Standards

Local training with Station Groups to highlight Airway Management Guideline 2014.

Owner: CTL Lead



SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO: 2017/28837

Datix reference: 13261

Date of Incident: 19.11.2017

Date report: 29.01.2018

**Incident
description:**

The LAS received a call from a patient with chest pain. They stated their breathing was heavy and their legs felt like lead.

The call was categorised as a Category 2. This category has a target of a mean ambulance response of 18 minutes.

Due to a lack of ambulance resources and increased demand, it took sixty-three minutes to dispatch an ambulance to this call.

An ambulance was dispatched to the patient and after assessing them, the crew contacted the Emergency Operations Centre (EOC) and said the patient was having a heart attack and asked if a paramedic could be dispatched as well. A Fast Response Unit (FRU) was dispatched.

The ambulance crew on the scene then provided a further update, reporting that the patient was now in cardiac arrest. As a result of this information, an additional FRU and also an Advanced Paramedic Practitioner (APP) was dispatched. A blue call was placed to transport the patient in cardiac arrest to the nearest Heart Attack Centre, where the patient died.

**Immediate risk
mitigation:**

Clinical hub (CHUB) staffing has been increased and a dedicated clinician is responsible for oversight of Category 2 calls that have not had a resource dispatched to them. Calls are rung back and assessed through the Manchester Triage system and where required the response category is amended following the assessment.

**Findings of
investigation:**

When the Trust moved to Ambulance Response Programme (ARP), the resource mix of Ambulances to FRUs was not changed. This is on-going now and there has been a reduction in FRUs, however there is a need to increase the number of ambulance hours to meet the ARP response model

As this call was triaged as a Category 2, the Trust determined that because this was under the ARP response criteria, an FRU response was not appropriate for this call. While this makes sense because Category 2 calls almost always need conveying to hospital, an FRU clinician in this instance could have provided immediate care and undertaken a face-to-face assessment, potentially upgrading the call

The Clinical hubs at the time were not reviewing Category 2 calls. This was due to both staffing issues and the need to ensure Category 3 and 4 calls were being managed appropriately to the response criteria under ARP

Recommendations:

Clinical hub to have oversight of all Category 2 calls that breach the 18-minute response time and recommend to dispatch that a FRU is sent where it could see, treat and provide interventions to support their clinical care.

Dispatchers to be more aware of Category 2 calls that have breached the 18-minute mean response time and where they have a FRU should be dispatched where one is available to the call to provide initial clinical intervention

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:

Plan Number	Action	Action Owner
1	The Head of Clinical Hub to produce staffing options to ensure that there are sufficient clinicians on duty in the Clinical hub to have oversight of Category 2 calls that have breached the mean response time and ensure that each of these are reviewed for if an FRU response was appropriate. Issue a bulletin to support the use of FRU's attendance where they would or could benefit a patient.	Head of Clinical Hub
2	General Managers to brief dispatch teams on clinical need to send a non 50 call sign FRU where a clinician has reviewed the call and determined a clinician would or could provide benefit to a patient.	General Manager
3	Reduce the number of FRU produced hours across the day to meet the modelled number. Increase the number of ambulances across the day to meet the modelled number	Director of Operations



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Quality Improvement Plan and CQC Preparation			
Agenda item:	19			
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:				
The purpose of this report is to provide an update on the current actions in the Quality Improvement Plan (QIP) and the Care Quality Commission (CQC) Preparation Plan for the next Well-Led CQC inspection.				
Recommendation(s):				
The Board is asked to review and comment on the report. 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. Additional information was requested by CQC and submitted. CQC have also attended a small number of Trust meetings, including the patient Forum.
2. Issues identified from the station quality assurance reviews and Mock Inspections are being managed to completion by the Assistant Directors of Operations (ADOs) and their GSMS .
3. Mock interviews for the Executive leadership Team (ELT) have completed with some further follow-up interviews planned including some of the Non-Executive Directors (NEDs).
4. Preparation and readiness activities have continued for the CQC Inspections.
5. Various communications activities have continued with products including the staff handbook issued.
6. An information hub has been established to support and manage the CQC inspection activities during the inspection period.

CQC Inspection Date

7. CQC have confirmed that they will carry out a provider level inspection of 'well led' on 21-22 March 2018, with an unannounced inspection of at least one core service and a short notice inspection of at least one core service. CQC have attended the following meetings:
 - Sector Quality Gov. Meeting 7 February 2018
 - Patient Forum 12 February 2018
 - Quality Oversight Group 15 February 2018

CQC additional Information Request

8. Additional information was requested and provided on temporary and bank staff usage. There have been no further requests with regards to the Routine Provider information Request (RPIR) submission. Any possible further requests for information are now expected to be direct from the CQC inspection team.

CQC Preparation and Readiness

9. In preparation for the Well led Inspection, Mock Interview have been held with the ELT and feedback provided. A further number of Mock Interviews have also been arranged with some of the NEDs. In addition, readiness sessions have also been with the ELT ensuring that they are well prepared and able to describe the Trust's journey and achievements since the last inspection (February 2017) as well be able to outline the activities over the next 12 months.
10. An information hub has been established to manage all inspection activities for both announced and unannounced visits ensuring that the Trust can react and rectify any issues that may be identified as well as collecting information to inform the ELT.
11. A number of supporting documents have been prepared including Directorate Portfolios which outline the key activities for each Directorate on a single page, as well as a storyboard which details the Trust's journey over the year.

Quality Assurance Visits

12. 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.
13. 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 ADO's were tasked to ensure that all the actions have been completed and ensure that the required standards are maintained.
14. The Quality Assurance visits will now continue as business as usual checks, with all stations/locations being visited on a quarterly basis.

Mock Inspections

15. 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. The problems identified have been managed by regular reviews with sector ADOs and on the ground by the GSMs.

Communications

16. Comprehensive staff communications have been developed, recognising, celebrating, and sharing achievements over the last 12 months in an engaging manner that enables all staff to feel valued and part of the bigger picture. Key documents developed include:

- Staff Handbook
- Board and Senior Managers Handbook
- CQC Inspector Handbook
- Building a 'Well-led' organisation card
- Posters detailing the Board members and other key senior leaders



Quality Improvement Plan (2017-18)

17. 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.
18. 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. Evidence was collected from each of the action owners which was verified prior to the action being closed. Two of the actions are ongoing and being managed as part of Business as usual whilst continuing to be monitored as part of the QIP deliverables.

- Statutory and Mandatory Training (see below)
- Management of Bank Staff

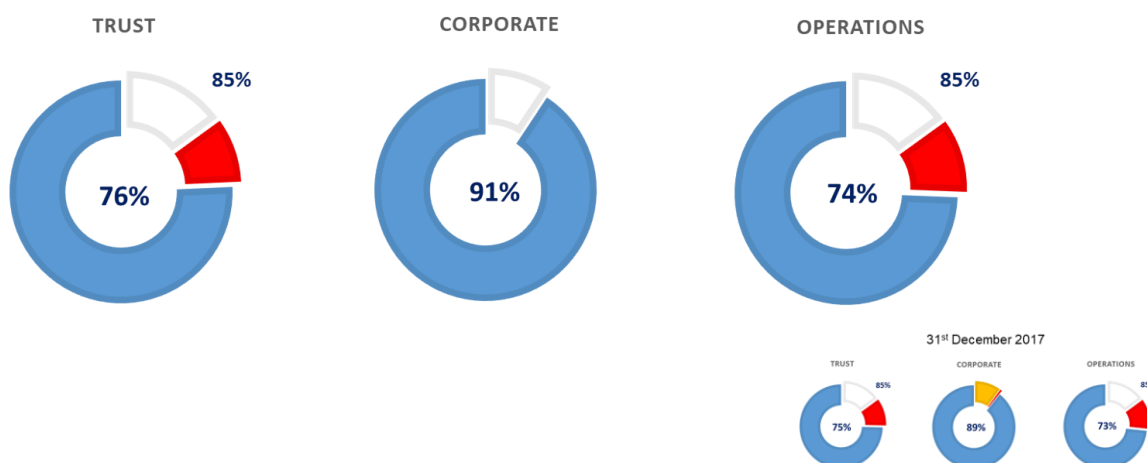
LAS Countdown Plan

19. 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

20. Improvement in the Statutory and Mandatory Training position has continued with Trust compliance now 76% as at the 31st January against the target of 85% by end of Mar-18.
21. Corporate compliance is 91% against a target of >90% compliance by end of Nov-17 and Operations compliance is 74% at the end of January targeting to achieve 85% by end of March following staff completing their CSR3 training.

Status as at 31st January



22. 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 were moved into a 'do not use' status.
23. 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)

24. The latest Impact KPIs against the various domains have been updated and are presented in the Appendix.
25. All of the actions are now complete or have an approved plan to complete.

Staff are Valued, Respected, and Engaged (Should Do)

26. Focus on Statutory and Mandatory training has continued to ensure that staff complete all required training. (see previous section for more information)
27. 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 4 th December)	27

Patients Receive Safe, Timely and Effective Care (Should Do)

28. 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.
29. 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.
30. LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays.

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 4 th December)	20

Efficiency and Sustainability Will Drive Us (Should Do)

31. The implementation of ARP was successfully achieved on the 1st November and response targets continue to be met.

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 4 th December)	5

Progress against Well Led domain (Should dos)

32. The new Director of Strategic Assets and Property has started.
33. Board and Executive development is an on-going and is continually reviewed.
34. Work on the revised strategy has continued and is on track to be presented to the board later this year.

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 4 th December)	50

Risks and Issues

35. The risks from last month have been updated.

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	
All	ELT have very busy schedules and may not have sufficient time to properly prepare for CQC inspections	Required to clear their diaries prioritise CQC preparation and delegate authority, meetings and actions to their teams as far as is possible	



Occurrence of risk is decreasingOccurrence of risk is unchangedOccurrence of risk is increasing

Dr Patricia Bain
Chief Quality Officer

Appendix: Impact KPI's Scorecard (Must Do/Should Do and Well-Led Domain)
December '17

Dec-17 Impact KPI's Scorecard - sorted by RAG / Monthly Trend			
Domain	Measure	RAG	Trend
	Sickness/Absence - Long-term	●	▲
	Infection, Prevention & Control: Hand Hygiene compliance	●	▼
	Infection, Prevention & Control: Monthly Premises Cleaning	●	◄►
	Ambulance Response Programme: Cat 1		▲
	Ambulance Response Programme: Cat 2		▲
	Ambulance Response Programme: Cat 3		▲
	Ambulance Response Programme: Cat 4		▲
	Rest Breaks - DCA		▼
	Rest Breaks - FRU		▼
	Job Cycle Time (mins)	●	▲
	Avg. Hospital arrived to Patient Handover (mins)	●	▲
	Avg. Patient Handover to Green (mins)	●	◄►
	Sickness/Absence - All Staff	●	▼
	Sickness/Absence - Frontline Staff	●	▼
	BME% Starters	●	▲
	No Harm / Low Harm % of Incidents <i>(Reported incidents to NRLS - 12 month rolling)</i>	●	▲
	Controlled Drugs: Non LIN reportable incidents	●	▼
	Missing equipment incidents as % of all reported incidents	●	▲
	Failure of device/equipment/vehicle as % of all missing incidents	●	▲
	Statutory & Mandatory Training: Trust compliance	●	▲
	Statutory & Mandatory Training: Corporate	●	▲
	Statutory & Mandatory Training: Operations	●	▲
	BME% Leavers	●	▲
	Sickness/Absence - Short-term	●	▼
	Bullying & Harrasment cases resolved within 28 days	●	◄►
	Serious Incidents breaching 60 days	●	▼
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean	●	◄►
	Controlled Drugs: LIN reportable	●	▼
	Staff survey response rate	●	▲
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		

Dec-17 Impact KPI's Scorecard

Domain	Measure	Baseline		Benchmark	Target	Actual / Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	RAG	Trend	Jan-18	Feb-18	Mar-18
		2015/16	2016/17																	
STAFF ARE VALUED, RESPECTED & ENGAGED	Statutory & Mandatory Training: Trust compliance				85%	Actual	67%	67%	66%	65%	66%	66%	70%	74%	75%	●	▲	76%	85%	87%
						Trajectory							67%	69%	75%					
	Statutory & Mandatory Training: Corporate				90%	Actual	58%	57%	58%	59%	66%	65%	76%	86%	89%	●	▲	91%		
	Statutory & Mandatory Training: Operations				85%	Actual	68%	68%	67%	66%	66%	66%	70%	73%	73%	●	▲	74%		
	Statutory & Mandatory Training: Bank				100%	Actual						tbc	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%	5.2%	●	▼			
	Sickness/Absence - Long-term		3.3%		3.0%	Actual	3.4%	3.4%	3.4%	3.3%	3.4%	3.4%	3.5%	3.4%	3.5%	●	▲			
	Sickness/Absence - Short-term		1.8%		2.0%	Actual	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%	2.0%	1.8%	●	▼			
	Sickness/Absence - Frontline Staff	5.6%			5.0%	Actual	5.1%	5.5%	5.5%	5.5%	5.6%	5.6%	5.5%	5.9%	5.7%	●	▼			
	KF17 Not felt unwell due to work related stress in last 12 months (Q9c)	45%	49%	52%	Improve	Actual											▶▶			
	KF19. Organisation & management interest in & action on health & wellbeing (Q7f, 9a)	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%	8%	●	▲			
	BME% Leavers		16%	-	14%	Actual	29%	14%	26%	14%	11%	22%	9%	11%	14%	●	▲			
	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 % Not experiencing discrimination at work in last 12 months (Q17a-b)	70%	79%	80%	26%	Actual											▶▶			
	KF21. % believing the org provides equal opportunities for career progression/promotion	60%	78%	70%	73%	Actual											▶▶			
PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE	Bullying & Harassment cases resolved within 28 days					Actual	100%	80%	-	-	50%	-	-	-	-	●	◀▶			
	KF26. % of staff not experiencing harassment, bullying or abuse from staff in last 12 months	62%	67%	72%	73%	Actual											▶▶			
	Serious incidents breaching 60 days			0		Actual	7	9	5	0	1	0	0	2	0	●	▼			
	Incident Reporting - No Harm (Reported incidents to NRLS - 12 month rolling)			1200		Actual						1,201	1,290	1,425	1,588	●	▲			
	Incident Reporting - Low Harm (Reported incidents to NRLS - 12 month rolling)			500		Actual						395	428	314	302	●	▼			
	No Harm / Low Harm % of Incidents (Reported incidents to NRLS - 12 month rolling)				90%	Actual							82%	84%	86%	●	▲			
	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%	60%	●	▼			
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean				90%	Actual	97%	97%	95%	94%	97%	96%	93%	95%	95%	●	◀▶			
	Infection, Prevention & Control: Monthly Premises Cleaning				90%	Actual	96%	96%	97%	98%	79%	92%	98%	88%	88%	●	◀▶			
	Controlled Drugs: Non LIN reportable incidents			<15	Actual	16	24	38	31	35	23	33	34	31	31	●	▲			
EFFICIENCY & SUSTAINABILITY WILL DRIVE US	Controlled Drugs: LIN reportable			0	Actual	0	0	0	0	0	0	0	1	1	0	●	▼			
	Missing equipment incidents as % of all reported incidents					Actual	3%	3%	3%	2%	2%	3%	4%	3%	4%	●	▲			
	Failure of device/equipment/vehicle as % of all missing incidents					Actual	10%	12%	16%	9%	9%	8%	11%	8%	9%	●	▲			
	Q4f "I have adequate materials, supplies and equipment to do my work"	32%	40%	52%	Improve	Actual											▶▶			
	Ambulance Response Programme: Cat 1		7 mins (mean) (15 mins 90 th centile response time)			Actual								00:07:03	00:07:24		▲	00:07:09		
	Ambulance Response Programme: Cat 2		18 mins (mean) (40 mins 90 th centile response time)			Actual								00:18:25	00:24:07		▲	00:20:22		
	Ambulance Response Programme: Cat 3		120 mins 90 th centile response time			Actual								133 mins	178 mins		▲	145 mins		
	Ambulance Response Programme: Cat 4		180 mins 90 th centile response time			Actual								149 mins	172 mins		▲	139 mins		
	Rest Breaks - DCA					Actual								4.40%	1.30%		▼	1.80%		
	Rest Breaks - FRU					Actual								83.50%	68.70%		▼	74.30%		
	Job Cycle Time (mins)	88			78	Actual	82	82	81	81	80	81	82	89	90	●	▲			
	Avg. Hospital arrived to Patient Handover (mins)		19		15	Actual	20	20	19	19	19	20	20	20	21	●	▲			
	% Arrive at Hospital To Patient Handover Over 15 Mins					Actual	60%	60%	57%	57%	57%	58%	59%	58%	63%					
	Arrive at Hospital to Patient Handover - Total Hours Lost > 15 Mins					Actual	5018	5422	4638	4757	4751	5172	5794	5752	7269					
WELL LED	Avg. Patient Handover to Green (mins)		17		14	Actual	18	18	18	18	18	18	18	18	18	●	◀▶			
	% Patient Handover To Green Over 14 Mins					Actual	58%	57%	57%	57%	57%	57%	57%	57%	58%					
	Patient Handover to Green - Total Hours Lost > 14 Mins					Actual	4878	4965	4851	4906	4805	4735	5061	5139	5476					
	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 survey 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) (Q2a-c)	3.33	3.52	3.67	Improve	Actual											▶▶			
	KF7. Staff ability to contribute towards improvements at work % (Q4a-b, 4d)	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											▶▶			

●

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

CQC Countdown Plan

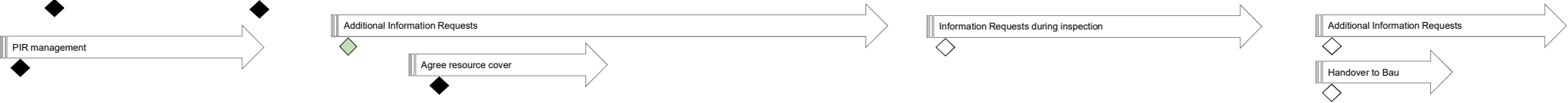
week ending

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



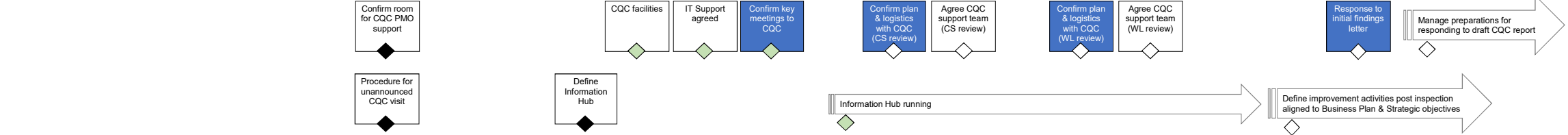
Quality Assurance



Maintaining Focus



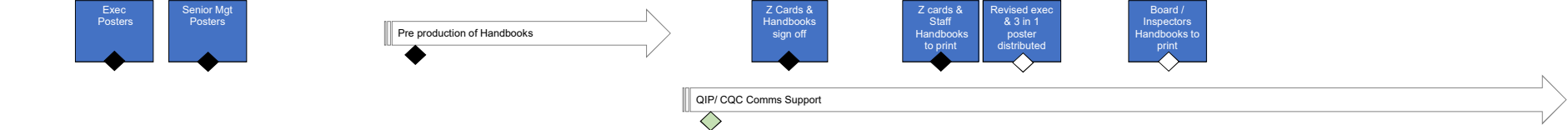
CQC logistics



Trust journey



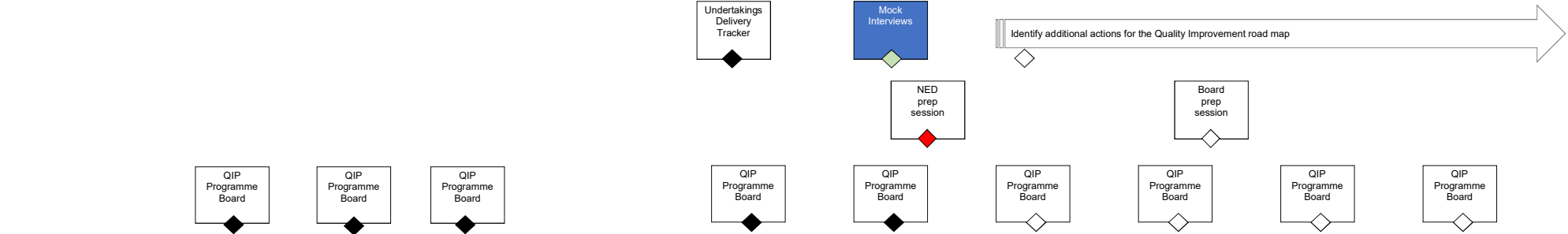
Communications



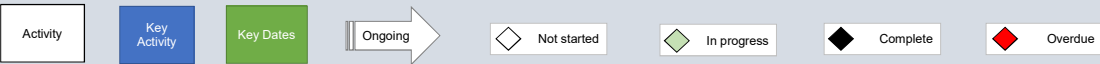
Stakeholder communications



Board preparation



Legend





Report to:	Trust Board			
Date of meeting:	27 February 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

		2017/2018
Area	Lead	March - Tuesday 27 March 2018
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO STP Engagement Update
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management Rest Break Policy implementation review Plan for Roster Review
Annual Reporting	LB, PH PH JJ TB	
Strategy & Planning	GE LB TB PG	Quarterly Strategy Update Business and Financial Plan Staff Survey Results and Actions
Governance	TB PH PH PH PH PH	Quality Improvement Plan Update Report from the Trust Secretary Trust Board forward planner Approval of Information Governance Toolkit Annual Corporate Governance Review
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting
Additional reports	TB TB RF PG	Quality Report

Trust Board forward planner: 2017/18 + 2018/19

		2018/2019		
Area	Lead	April	May - Thursday 24 May 2018	June
Standing items	HL All HL HL TB HL GE All		Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW		Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management	
Annual Reporting	LB, PH PH JJ TB		Annual Report and Accounts (incl AGS) Self Certification of Compliance with Provider Licence Audit Committee Annual Report Health & Safety Annual Report	
Strategy & Planning	GE LB TB PG		Business and Financial Plan	
Governance	TB PH PH PH PH PH		Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report	
Concluding matters	HL HL All		Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG		Quality Report Infection Prevention and Control Annual Report Safeguarding Annual Report Mental Health Annual Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	July - Tuesday 31 July 2018	August
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management Rest Break Policy implementation review	
Annual Reporting	LB, PH PH JJ TB		
Strategy & Planning	GE LB TB PG	Quarterly Strategy Update	
Governance	TB PH PH PH PH PH	Report from the Trust Secretary Trust Board forward planner	
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG	Quality Report Patient Experience Annual Report Patient and Public Involvement Annual Report Public Education Annual Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	September - Tuesday 25 September 2018	October
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management	
Annual Reporting	LB, PH PH JJ TB		
Strategy & Planning	GE LB TB PG	Quarterly Strategy Update	
Governance	TB PH PH PH PH PH	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report	
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG	Quality Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	November - Tuesday 27 November 2018	December
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report Logistics & Infrastructure Cttee Assurance Report BAF & Corporate Risk Register Serious Incident Management	
Annual Reporting	LB, PH PH JJ TB		
Strategy & Planning	GE LB TB PG	Business Plan progress review	
Governance	TB PH PH PH PH PH	Report from the Trust Secretary Trust Board forward planner	
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG	Quality Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	January - Tuesday 24 January 2019	February
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management	
Annual Reporting	LB, PH PH JJ TB		
Strategy & Planning	GE LB TB PG	Quarterly Strategy Update	
Governance	TB PH PH PH PH PH	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report	
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG	Quality Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	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	
	PW	
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	Quarterly Strategy Update
	LB	
	TB	
	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	



Report to:	Trust Board			
Date of meeting:	27 February 2018			
Report title:	Quality Report – February 2018			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer/Dr Fenella Wrigley, Medical Director			
Presented by:	Dr Patricia Bain, Chief Quality Officer/Dr Fenella Wrigley, Medical Director			
History:	Quality Oversight Group 15 February 2018			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This paper provides the Board with the details of the current status of the quality performance and programmes in January 2018..

Recommendation(s):

The Board is asked to receive the report for information.

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	☒



London Ambulance Service

NHS Trust



Quality Report

February 2018

All data pertains to January 2018 performance
unless otherwise stated

All data is correct as at 10th of the month

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● Above Target
 Legend ● Within 5% of Target
● Over 5% from Target

Executive Summary: Exception Report (Positive)



Safety

- Compliance with 6 weekly deep clean compliance continues to meet 90%
- IPC Training compliance rates continues to increase for Level 2
- IPC practical session of hand hygiene re-introduced into the non-clinical
- Advanced Paramedics to assist with clinical opinions
- The lead investigator training continues to attract a high number of managers wanting to undertake the training and has received positive feedback. All courses are currently fully booked for the next three months.
- Health and safety re review of action plan by independent source underway
- No SI overdue action plans being monitored closely <15 for closure
- North East Intensive support programme showing positive responses in Sis and statutory and mandatory training compliance

Actions & Assurance

- Continue to monitor incident reports
- The next training session currently has 20 managers attending

Effectiveness

- An external audit was conducted by KPMG which concluded that the new serious incident process provided significant assurance that the Trust was meeting the external CCG deadline of 60 working days, the policies were in line with best practice, the process for identifying and investigating serious incidents was well designed and our patients and relatives were well supported.

Actions & Assurance

- Serious Incident Reporting - KMPG audit

Caring

- In January 56 out of 58 Public Education events were attended by the Trust. This is a significant increase on previous reporting months
- Complaints response rates have improved from 24 overdue to 14

Actions & Assurance

- 1234 staff have registered an interest in supporting Public Education events in their own time. The Patient and Public Education team have set up a Facebook page for staff to join and share their experiences to further increase the support we provide to the public, not only in an emergency

Executive Summary: Exception Report (Improvement Required)



Safety

- Inconsistent adherence to basic principles of infection prevention and control - hand hygiene, including use of alcohol gel
- Increase in number of PGD breaches (no patient harm)
- Review of DBS re-check and status underway, identified number of managerial staff whos DBS need to be checked. On risk register until evidence of compliance.
- Attitude and behaviour is now the highest proportion of complaints analysis with SIs and other sources underway to confirm is issues relating to staff stress and fatigue.
- RIDDOR reporting timescales higher this month, this is due to legacy incidents being reported into the system. New RIDDOR reports within timescales.

Actions & Assurance

- 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
- Monitor trends via incident reporting
- Continue to review PGD breaches through serious incident group
- The Quality Governance and Assurance Team has made significant progress on clearing the backlog of overdue actions. The current actions that reaming overdue have only recently breached the deadline

Effectiveness

- Whilst still above the YTD target of 66%, Stroke to HASU (<60 mins) has decreased by 10% since October 2017 to 50% with the largest variation being seen in the South East. Hospital handovers in this area have been particularly challenged and may be a contributory factor.
- CARU analysis reflects reduction of stroke and STEMI time to arrival

Actions & Assurance

- CARU have undertaken an analysis of the data to ascertain if ARP may have had an affect and whilst there has been a small variation it is not thought to be related. The Stroke lead of the Trust has been made aware and will work to understand how this can be improved

Caring

- Impact of impending changes relating to the Data Protection Act – Data Protection Regulation 2018
- EOC call handling pressures – action plan to support staff and executive oversight

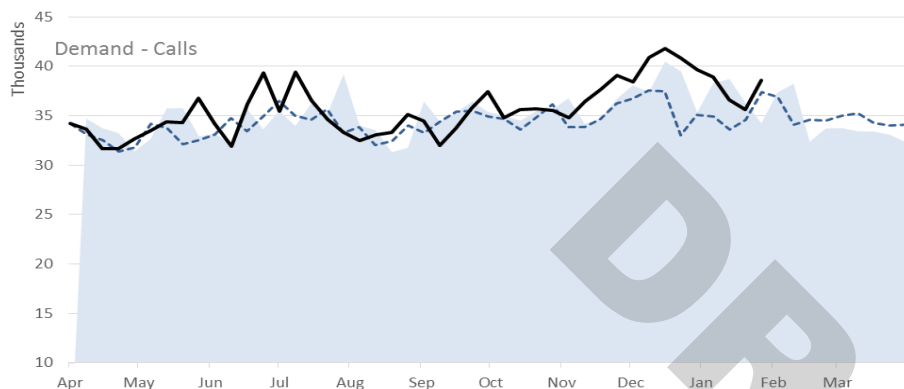
Actions & Assurance

- Work is underway to understand the change in regulation and how this may impact the Trust

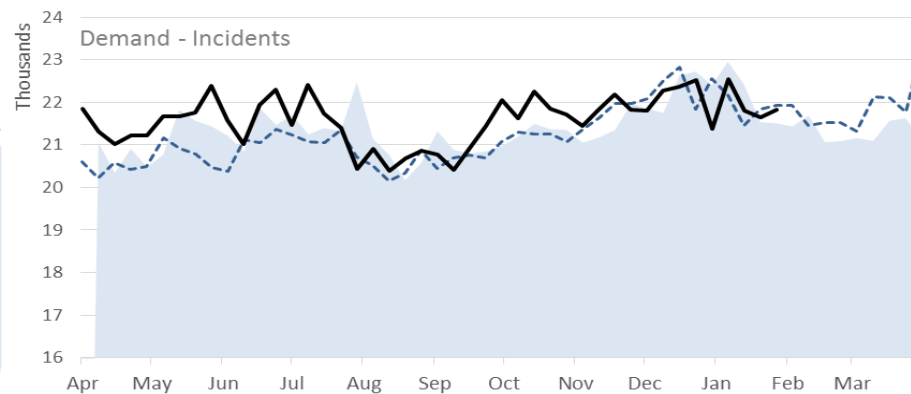
Performance Pressure



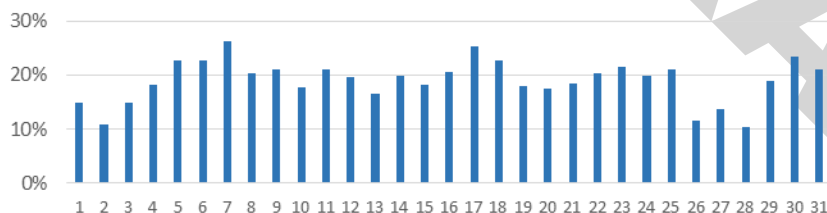
Pressures



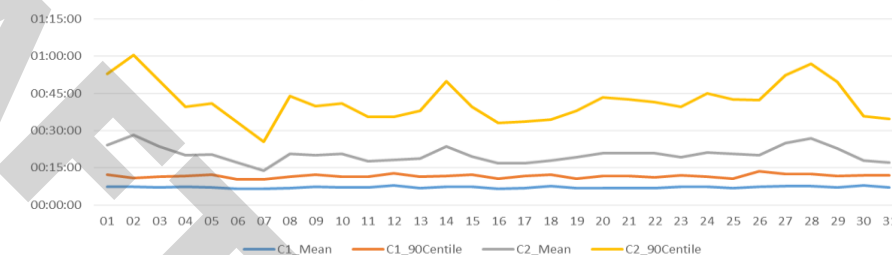
Performance



% of Rest Breaks Given



Daily Performance January 2018



- As part of the Trust response to winter, a number of initiatives were implemented to increase the level of oversight in activity in order to ensure the safety of our patients;
 - Daily Safety Huddle Calls
 - LAS Winter Briefing Document to Acute Trusts and external partners
 - Support to the NHSE/I Winter Resilience Room
- The combination of the above has enabled delivery of a safe service to patients over winter and as a result the Trust has been asked to provide a summary of these initiatives in the interest of sharing learning. A summary report for maintaining safety has been submitted to commissioners.

Patient Safety

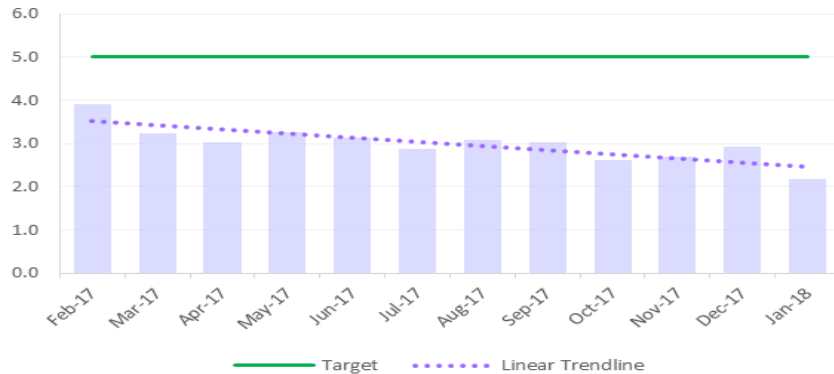
Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain



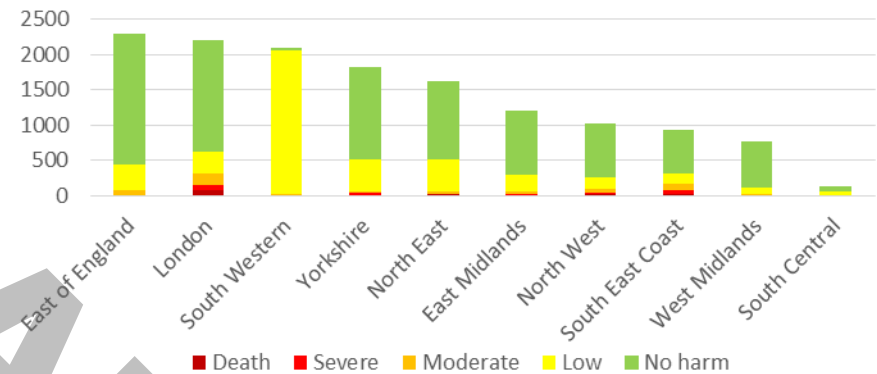
Measures	Target/Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule / LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	83%	98.0%	59.5%	85.0%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	2.7	2.9	2.2	↓					
Patient related Adverse Events - NO HARM	1200	G	2136	187	186	171	↓					
Patient related Adverse Events - LOW	30	G	244	23	36	24	↓					
Patient related Adverse Events - MODERATE	25	G	156	21	29	8	↓					
Patient related Adverse Events - SEVERE			68	10	12	2	↓					
Patient related Adverse Events - DEATH			109	10	24	7	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.4	3.9	2.9	3.2	↑					
Staff related Adverse Events - NONE			1811	218	170	188	↑					
Staff related Adverse Events - LOW			1297	137	105	122	↑					
Staff related Adverse Events - MODERATE			66	12	9	4	↓					
Staff related Adverse Events - SEVERE			2	0	0	1	↑					
Controlled Drugs - Other Reportable Incidents			301	34	31	46	↑					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	3	1	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	95%	93%	95%	↑					
Percentage of Serious Incidents (SI) reported on STES within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			331	37	39	46	↑					
Serious Incidents declared in-month			61	9	5	8	↑					
Serious Incidents breaching 60 days	0	G	24	2	0	0	↔					
Serious Incidents breaching 40 days	0	G	27	5	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			5%	6.0%	5.6%	9.0%	↑					
Needle Stick Injuries as % of Staff Adverse Events			2%	3.0%	2.5%	1.6%	↓					
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%	79.9%	92.1%	93.5%	↑					
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	R	79%	81.8%	83.8%	88.0%	↑					
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	42.6%	42.0%	57.6%	↑					
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	77%	76.9%	78.4%	76.9%	↓					
Safeguarding Trust Board (3 Years)	90%	G	100%	100.0%	100.0%	100.0%	↔					
Total Inquests where LAS asked to give evidence - In-Month			56	6	4	3	↓					
Total Inquests where LAS asked to give evidence - Year to Date			324	49	53	56	↑					
Missing Equipment Incidents as % of all reported incidents			3%	3%	4%	2%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			9%	8%	9%	1%	↓					
Number of NRLS uploads In-Month	1	G	10	1	1	1	↔			LQ21		



Rate of Patient related Adverse Events per 1,000 Incidents

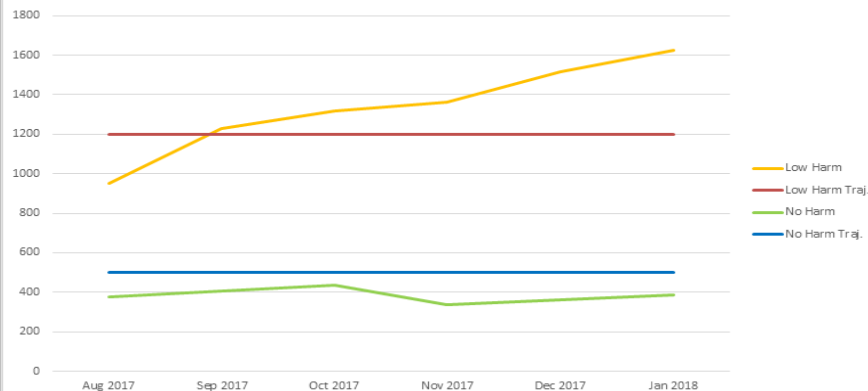


Incidents Reported to the NRLS Jan to Dec 2017



National Reporting and Benchmarking

Number of No Harm and Low Harm Incidents reported to the NRLS (rolling year, previous month)



- The number of Death incidents reported by the LAS for the rolling year is still the highest amongst the other Ambulance Trusts, however this number has reduced since October 2017, when the quality check of incidents was introduced.
- The LAS has remained second place in reporting of incidents to the NRLS, with East of England and South Western swapping places (now 1st and 3rd respectively)
- A mortality group has been set up in preparation for reporting by ambulance Trusts.

Safety (Infection Control)

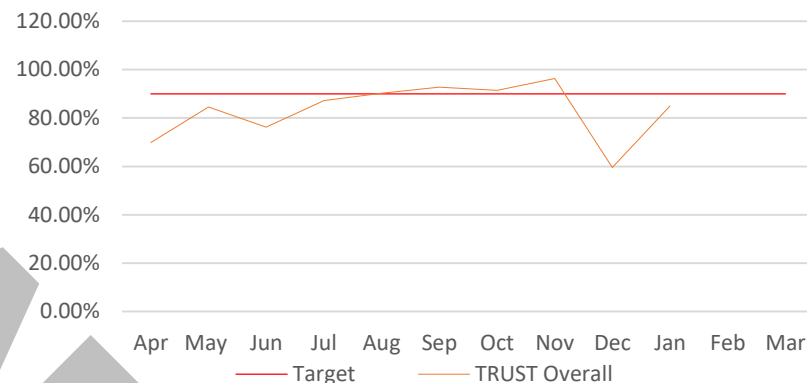
Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Monthly Hand Hygiene Compliance 2017 – 2018 (Trust Compliance target: 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Target	90.00%	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%	84.97%	83.31%
North East	97.40%	90.60%	60.90%	57.00%	95.30%	100.00%	67.00%	95.66%	66.66%	93.33%	82.39%
North Central	100.00%	100.00%	48.90%	89.00%	100.00%	100.00%	96.70%	95.60%	83.33%	66.66%	88.02%
North West	56.00%	73.80%	92.00%	95.00%	100.00%	76.40%	97.50%	93.40%	56.00%	68.20%	80.83%
South East	33.30%	95.80%	95.80%	95.00%	62.00%	100.00%	96.00%	100.00%	66.66%	96.66%	84.12%
South West	62.50%	62.50%	83.60%	100.00%	93.80%	87.50%	100.00%	97.00%	25.00%	100.00%	81.19%
Others	-	-	-	-	-	-	-	-	-	-	-
TPAPs	-	-	-	-	-	-	-	-	-	-	-

YTD Overall Hand Hygiene Compliance 2017-2018



Performance:

- 17/18 station groups submitted Operational Workplace Reviews this month which is a significant improvement on December data and is in line with the reduction of REAP level to 2 – Moderate Pressure
- 14/18 group stations met 90% target . Analysis of aggregated data however demonstrated 84.97% compliance, missed the target of 90% set for the second month

Assurance:

- QGAMs continue to focus on the quality of services; the OWR tool was amended and agreed January 2018
- 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
- 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
- North West and North Central QGAM's will work to improve the compliance scores in their sector.

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Monthly IPC Training Compliance 2017 -2018 (Trust Compliance target: 90%)

TRUST Overall	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Level 1 *	87.80%	88.18%	87.96%	88.50%	91.56%	91.88%	91.31%	92.53%	93.13%	92.80%
Level 2 *	87%	84.92%	82.30%	78.28%	78.15%	79.73%	77.41%	83.05%	84.90%	87.7%
Level 1 (No: trained)	4471/5093	4491/5093	4493/5108	4510/5096	4634/5061	4707/5123	4719/5168	4791/5178	4812/5167	4821/5192
Level 2 (No: trained)	3383/3887	3288/3872	3200/3888	3039/3882	3018/3862	3128/3923	3081/3980	3302/3976	3335/3928	3421/3898

Performance

IPC training figures for level 1 and level 2 continues to be monitored via ESR; the system allows easy access to robust data in a timely way.

- Level 1 training continues to show compliance since August 2018
- Level 2 training compliance continues to improve month on month, achieving 87.7%
- IPC and practical Hand Hygiene was re-introduced to the Corporate Induction day in January 2018.

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



Six weekly deep clean compliance 2017 – 2018 (Compliance Target 90%)

	Apr	May	Jun	Jul	Aug*	Sep	Oct	Nov	Dec	Jan	YTD
TRUST Overall	97%	97%	94.80%	94.30%	96.80%	95.72%	93%	95%	95%	93%	95%
North East	95%	95%	97.80%	96.20%	96%	97.00%	98%	98%	98%	98%	97%
North Central	99%	99%	82.50%	91.20%	97%	97%	97%	90%	97%	91%	94%
North West	99%	99%	98%	98%	98%	96.00%	96%	93%	96%	98%	97%
South East	99%	98%	98.30%	95.50%	97%	98.00%	98%	96%	97%	93%	97%
South West	97%	97%	94%	94%	96%	98.00%	99%	97%	95%	95%	96%
Others							95%	95%		100%	
HART							65%	81%	89%	80%	
NETS	93%	93%	98.30%	91%	-	88.33%	96%	95%	83%	87%	92%

Performance

- Vehicle 6 weekly deep clean compliance continues to exceed 90%.
- All 14 hubs are operational and Phase 2 continues
- ATP swabbing of equipment and environment to provide assurance of the quality of cleaning, continues.
- 4/5 sectors have been completed

Assurance

- Monthly and Quarterly data submission for monitoring by the IPC team, Sector Quality Meetings, ICDG, IPCC
- HART & NETS will see improved quality & governance oversight through the revised operational structure



Premises cleaning 2017 -2018 (Compliance Target 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
TRUST Overall	96%	96.58%	96.70%	98.20%	78.65%	84.25%	98.15%	87.67%	88.00%	77.88%	90.00%
North East	92%	93%	95%	96%	97.30%	64.30%	96.60%	63.66%	63%	59.66%	82.00%
North Central	99%	99%	96%	100%	66.70%	66.70%	100%	100%	100%	100.00%	93.00%
North West	96%	95.40%	97%	98%	98%	94%	98%	77.80%	77.40%	57.20%	89.00%
South East	97%	97%	97%	98%	33%	98%	97.66%	97.66%	98.85%	99.33%	91.00%
South West	96%	98.50%	98.50%	99%	98.25%	98.25%	98.50%	99.25%	98.50%	73.25%	96%

Performance

- 14/18 (77%) stations submitted their cleanliness audit data this month, which resulted in poor overall compliance, as station who do not submit are scored '0%'.
- Of those 14 stations who submitted, overall compliance was high at 96.8%
- No Estates or Contractor audit data was received this month, to enable triangulation.
- IPC team are undertaking validation station audits.

Assurance

- QGAMs and GSM to monitor and ensure submissions of audit data
- Increased IPC capacity enabled progress of validation audits and support to station management and staff, IPC Champions, Estates team 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



H&S Incidents by Sub-category	2017 Q1	2017 Q2	2017 Q3	2017 Q4 *to date	Total	CAT
Exposure to bodily fluids	44	45	33	9	131	IPC
Incident involving broken ampoule or vial	11	11	17	2	41	IPC
Needle stick injury - Cannula (contaminated)	11	10	14	1	36	IPC
Razor injury (clean)	7	4	5	2	18	IPC
Bit by a person	4	3	9	1	17	IPC/Sec
Needle stick injury - IM (contaminated)	3	1	6	1	11	IPC
Needle stick injury - IM (clean)	0	3	2	0	5	IPC
Needle stick injury - sub-cutaneous (contaminated)	2	0	1	2	5	IPC
Lancets injury (contaminated)	3	0	0	1	4	IPC
Needle stick injury - Cannula (clean)	0	1	2	0	3	IPC
Contact with sharps (includes needle stick)	0	1	2	0	3	IPC
Razor injury (contaminated)	1	0	0	1	2	IPC
Lancets injury (clean)	1	0	0	0	1	IPC
Needle stick injury - sub-cutaneous (clean)	0	0	0	0	0	IPC

Performance:

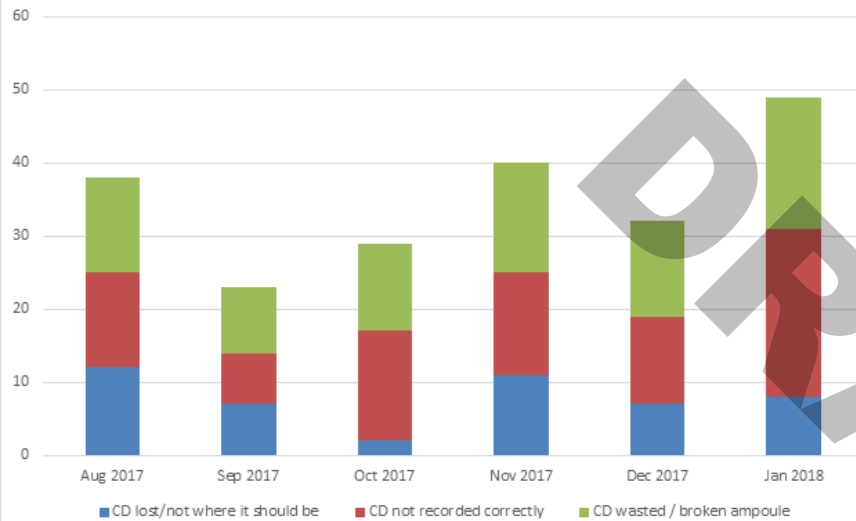
- YTD incidents to April 2017 - January 2018: 277 in total
 - In December, 30 reported incidents (include 2 near misses):
 - Needle Stick Injury clean : 2; Needle Stick Injury contaminated: 5
 - Bit by a person: 7 (4 broke the skin)
 - Broken ampoules: 5, these are managed by Medicine Management
 - Exposure to Bodily Fluids: 9
 - 6 relating procedures (3 airway care, 2 cannulation, 1 wound dressing), 3 vomitus/cough, 1 exposure to communicable disease
 - Razor incident: 2 (clean equipment)

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, Workforce and Occupational Health teams to ensure that all aspects are considered and acted upon
- LAS uses Safer needles
- Monitored monthly by IPC team, quarterly at Sector meetings, ICDG, IPCC



Controlled Drugs Incidents by Month



Medicines Management Incidents

- One unaccounted for loss of syringe containing 5mg of morphine post administration
- Total of 40 other controlled drugs incidents
 - 40 recording or documentation errors or omissions
 - Two cases where morphine retained off-duty
 - Two cases of morphine ampoule breakages
- Non controlled drugs incidents
 - Drugs: Cabinets left unsecured (n=3) or in wrong location (n=1)
 - Management of cardiac arrest (n=1)
 - Return Of Spontaneous Circulation (ROSC) (n=1)
 - Patient Group Direction (PGD) breaches involving calcium (n=1) and tranexamic acid (n=1)
 - Administration of oxygen (n=1), morphine (n=1), GTN (n=1), ipratropium (n=1)
 - Drug pack driven over destroying contents
 - Glucose 10% given instead of normal saline IV infusion (n=1)

Actions

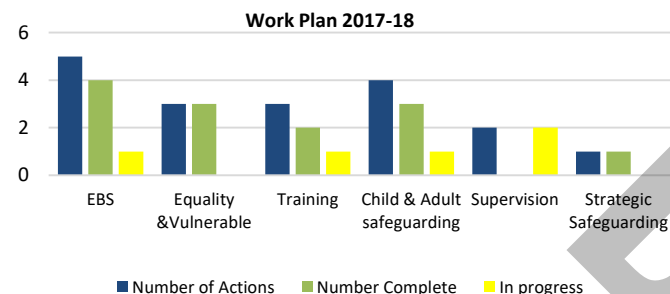
- Medication safety Bulletin on January 10th including a reminder to staff of the indications for use of tranexamic acid under patient group direction (PGD).
- Introduction of tamper evident device (TED) bags for movement of controlled drugs at group station level.
- Ongoing roll-out of secure drugs on stations project to strengthen security and monitoring of all drugs within LAS
- Pain management session incorporating pharmacology delivered as part of current core skills refresher programme.

Assurance

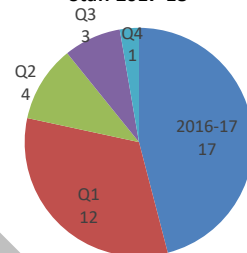
- No unaccounted for loss of controlled drugs from controlled drugs safes – single unaccounted for loss was post administration at a scene.
- No incidents of inappropriate administration of IM adrenaline by LAS staff

Safeguarding

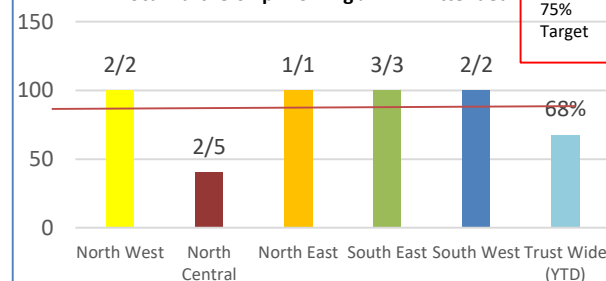
Owner: Alan Taylor | Exec Lead: Dr Trisha Bain



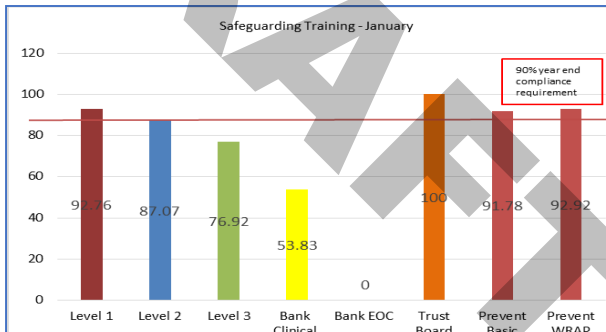
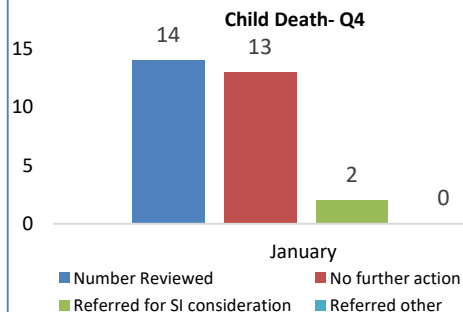
Safeguarding Allegations Against Staff 2017-18



Local Partnership Working % RRM Attended



Work Plan: All progressing well except EBS 24/7 telephone referrals and taped line. **Safeguarding Allegations Against Staff:** 1 new allegation in Feb, currently under police investigation. **Local Partnership Working % RTM Attended** North Central continues to be unable to meet the requirement to attend 75% of RRM's discussions ongoing with Area managers.



Trust safeguarding referrals and concerns raised					
Month	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%
Jan-18	397	743	672	1812	1.90%

Child Death: 100% were processed within 3 weeks of receiving. **Safeguarding Training December:** Level three courses are planned to ensure 90% compliance by EOY. Level 2 remains a concern, Executive lead has informed area managers of requirement. EOC remains the lowest compliance for both staff and bank with 0% for the 11 bank staff. **Trust Safeguarding Referrals & Concerns Raised:** Referrals remain within expected levels.

Health and Safety Risk Tracker				Initial Risk Rating	Current Risk Rating						Target Risk Rating	Key Changes/Updates since last review
Risk No.	Risk description	Risk Owner	Exec Lead		Q2			Q3				
					Jul	Aug	Sep	Oct	Nov	Dec		
69	Compliant with safeguarding training requirements for clinical and non-clinical staff.		Trisha Bain	12	12	12	12	8	8	8	4	The trust has now moved to ESR for recording all training, further enhancements need to be made.

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



Measures	Target / Range	RAG	YTD 17/18	Oct-17	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	31%	36%	32%		↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	42%	62%	57%		↓			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%		93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	74%	73%	72%		↓			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	60%	59%	50%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	97%	96%		↓			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:35	00:31	00:31		↔					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:40	00:36	00:40		↓					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	92%	94%	92%		↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	9.9%	14.4%	16.8%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.3%	97.0%	98.0%		↑		✓	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%	92.0%	92.0%	93.0%		↑		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	96.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96%		↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%			↔			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	89%	87%	92%	86%	↓			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						30%	49%	↑			LQ11	✓	

Actions

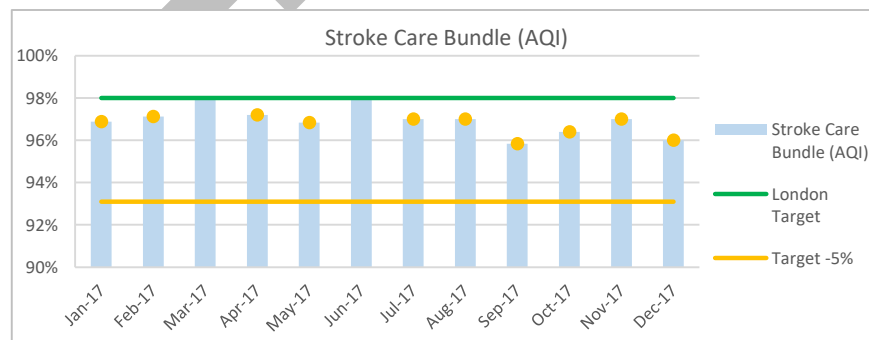
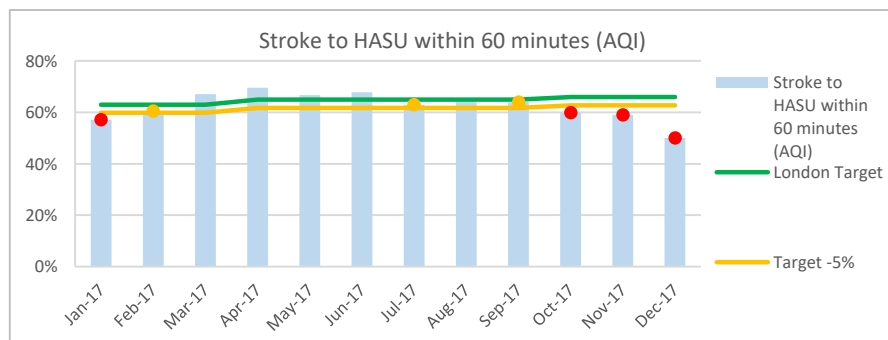
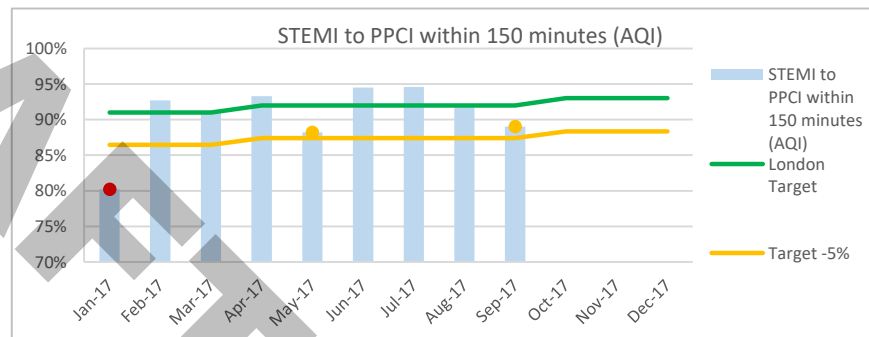
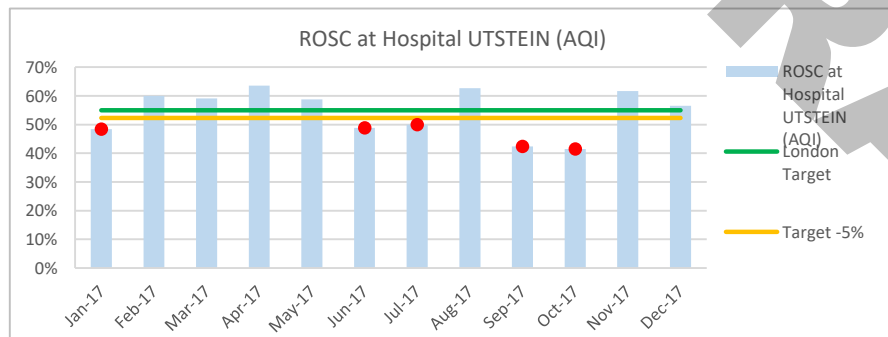
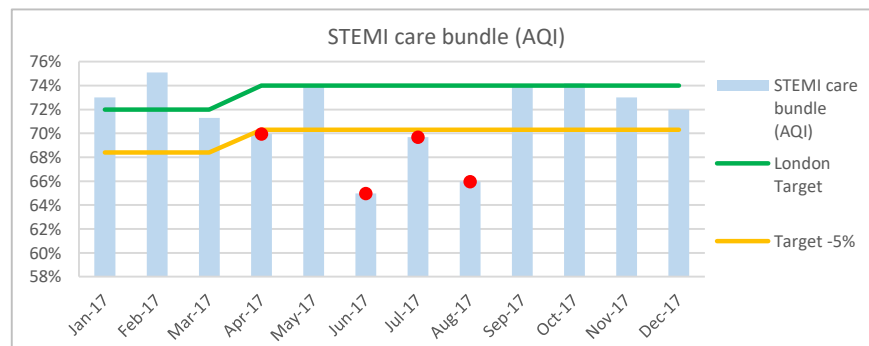
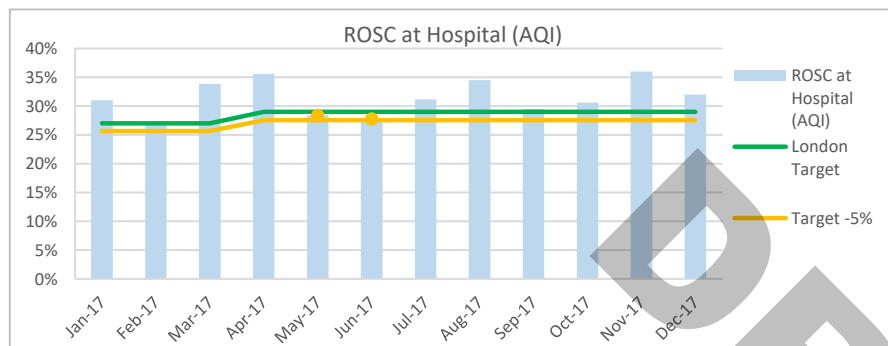
- In order to maintain current high levels of CPI Completion, in December CARU trained a further seven members of staff on how to undertake CPI audits. In addition, six student paramedics from the LAS Academy received CPI training as part of their student paramedic training course.
- In December, 185 members of staff received face-to-face CPI feedback, meaning between April and December 2017, 17% of LAS staff received two face-to-face CPI feedback sessions.

Assurance

- The proportion of CPI audits completed by Team Leaders increased for the second month in a row; at 53%, this is the highest proportion of CPI audits completed by Team Leaders this year.
- Care delivered to patients discharged at scene, experiencing difficulty in breathing or with severe sepsis remained of a high standard.
- Care provided to patients in cardiac arrest was of the highest standard since August 2017 and to patients with a diagnosed psychiatric problem since September 2016.

Effectiveness (Clinical AQIs)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



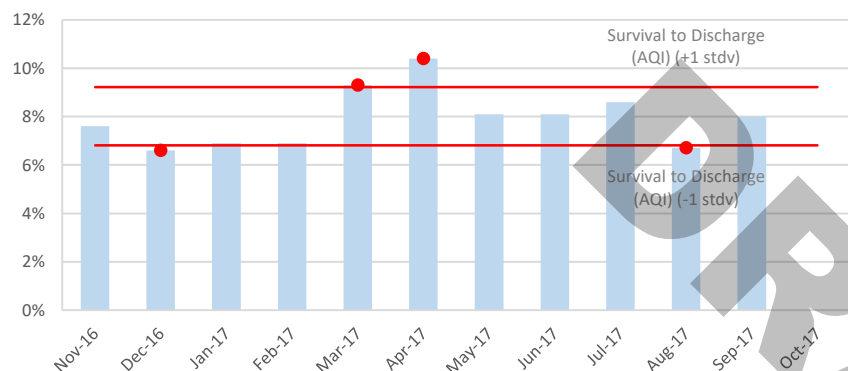
* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Effectiveness (Clinical AQLs)

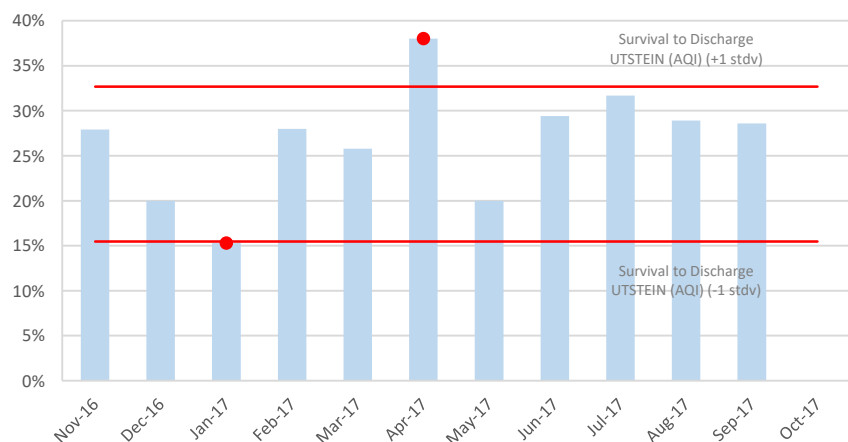
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



Survival to Discharge (AQL)



Survival to Discharge UTSTEIN (AQL)



AQL: Narrative

- AQLs for August 2017 show the LAS continues to have one of the highest proportions of STEMI patients with a call to balloon within 150 minutes (91.6%); however our care bundle rates for these patients remain below average (66.1%) and require improvement
- Overall ROSC reached 34.5%; 62.7% for the Utstein comparator group (above the national average)
- Survival to hospital discharge was the lowest it has been since April 2017 (6.7%); for the Utstein group it has also decreased but remains in line with the national average. As the number of patients each month is small any variation will result in an apparently disproportionate variation in percentage value
- The percentage of stroke patients who reach a HASU within 60 minutes declined to 50% despite lower on-scene times. However the proportion receiving the stroke care bundle remains consistently high

AQL: Actions

- Guidelines for conveyance of patients to Heart Attack Centres and Emergency Arrhythmia Centres (CCIC 021) was re-released in January
- A reminder regarding the importance of STEMI Care Bundle was included in a cardiac update (MDB 202); re-iterated at the Clinical Team Leader Conference and during ECG presentations at stations
- The Clinical Update magazine (issue 47) had a reminder about importance of not withholding GTN in inferior STEMI
- Feedback was given to staff after one FAST+ patient in December was incorrectly conveyed to the ED
- A Category 2 guidance bulletin has been issued to EMD's for the management of held calls

AQL: Assurance

Over the last couple of months CARU have worked efficiently to incorporate ARP guidelines into our data capture, processing and monthly reporting

* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

STEMI: ARP response times comparison

Fenella Wrigley

Owner: Dr. Rachael Fothergill | Exec Lead: Dr.



STEMI	Response times (in minutes)		
	November & December 2016	November & December 2017	+/-
Call Connect - Clock Stop	12	25	+13
Clock Start* - Clock Stop	10	23	+13
Call Connect - Arrive Hospital	73	80	+7
Clock Stop - Arrive Hospital	61	55	-6
Call Connect - 1st Ambulance On-scene	21	25	+4

*Clock Start: 2016 data is based on the ORCON definitions applied at the time; 2017 data is based on current ARP definitions

A comparison of data from November and December 2017 with the same months from 2016 shows that patients are arriving at definitive care 4 minutes later than in 2016. As a DCA, not FRU, is now despatched, there is, on average, a 13 minute longer response to STEMI patients compared with the previous year. Looking at arrival of first ambulance capable of conveying, the increase is less, at 4 minutes on average. The change to a DCA response means patients are waiting on average 13 minutes longer on-scene before a clinician arrives with them and starts assessing them. The AQI outcome data for cardiac arrest and STEMI patients available currently is calculated for patients attended by the LAS in August 2017 as a result of the time lag in receiving hospital outcomes. Therefore the impact of introducing the Ambulance Response Programme on patient outcome is still unknown.

A Category 2 guidance bulletin has been issued to EMD's for the management of held calls

The AQI outcome data for cardiac arrest and STEMI patients presented on the previous slides (STEMI to PPCI within 150 minutes & Survival to Discharge) is calculated for patients attended by the LAS in August 2017 as a result of the time lag in receiving hospital outcomes. Therefore the impact of introducing the Ambulance Response Programme on patient outcome is still unknown.

Stroke: ARP response times comparison

Fenella Wrigley

Owner: Dr. Rachael Fothergill | Exec Lead: Dr.



Stroke (potentially eligible for thrombolysis)	Response times (in minutes)		
	November & December 2016	November & December 2017	+/-
Call Connect - Clock Stop	14	24	+12
Clock Start* - Clock Stop	12	21	+9
Call Connect - Arrive Hospital	64	67	+3
Clock Stop - Arrive Hospital	49	44	-5
Call Connect - 1st Ambulance On-scene	23	25	+2

*Clock Start: 2016 data is based on the ORCON definitions applied at the time; 2017 data is based on current ARP definitions

• On average, the response to Stroke patients (from call connect) by an ambulance is on average 2 minutes longer than pre-ARP implementation. When an FRU was sent the initial non conveying response arrived 12 minutes earlier. The combined on-scene and journey times are shorter, but the extended response time means that overall the time from the call to arrival at hospital is on average 3 minutes longer. The time stroke patients who are potentially eligible for thrombolysis are arriving at hospital is comparable with the last year.

• As a result of our Continuous Re-contact Clinical Audit, 64 cases of patient care were recommended for feedback (32 positive & 32 constructive) and 11 Clinical Advisors from the Clinical Hub received feedback (2 positive & 9 constructive). One EMD was received for constructive feedback. In addition, one incident was raised on Datix but following review by SIG, it was deemed that LAS decision making was appropriate. Looking at arrival of first ambulance capable of conveying, the increase is less, at 2 minutes on average. This suggests that the time stroke patients who are potentially eligible for thrombolysis are arriving at hospital is comparable with the last year.

Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



Clinical Audit: Latest project summary

In January CARU published their clinical audit report on the use of ondansetron in the LAS. The results showed:

- 99% of patients who were administered ondansetron needed it
- 99% received it via the appropriate route and 97% in the correct dose
- For 25% it was not clear how quickly ondansetron was administered
- 99% had their heart rate monitored before administration; 80% after
- 99% had their blood pressure measured before administration; 79% after
- 52% recorded the drug pack code

Recommended actions to improve patient assessment post-administration of ondansetron and recording of drug pack codes:

- Findings shared via a Clinical Update article and an infographic on the Service's intranet, Facebook page and as a poster at ambulance stations
- Additional infographic to highlight how ondansetron and other drugs should be given
- Real-time scenario based training encouraged so students have practice accurately recording giving concurrent drugs

Clinical Audit: Progress

Good progress continues to be made against the clinical audit work plan with two clinical audit reports due to be released in February:

- Continuous Re-contact (2015-17) which examined original discharge decisions made for patients who re-contacted 999 within 24 hours and were either pre-alerted to hospital or died
- The use of dexamethasone for croup

We are working on a further eight projects and facilitating five members of staff to undertake their own clinical audit projects. Two projects approved as part of the 2017-18 clinical audit work plan will be proposed for 2018-19 (Salbutamol and The use of pre-alerts).

Hear & Treat / 111 re-contact data is being collected and will be reported in the 2017/18 Annual Report

Research Actions & Outcomes

ARREST: The trial has started on the 15th January with the Critical Care APPs. The trial will be rolled out further once more hospitals are ready to welcome ARREST patients.

RIGHT-2: Participating paramedics are fully committed to the trial, and recruitment has clearly improved over the last months. 161 patients have been enrolled since the beginning of the study (contractual target =180 by end of May 2018).

AIR-CGM (Hypoglycaemia trial): The contract with Imperial College Hospital is being prepared. The trial in set up phase.

MPDS-Birth: The contract with the International Academies of Emergency Dispatched has been signed. The trial in set up phase.

Actions & Assurance

One clinical audit action was completed in December:

- Paediatric pain management has been included in CSR 2017.3 (mandatory training for all clinicians)

As a result of our Continuous Re-contact Clinical Audit, in January:

- 64 crews were recommended for feedback (32 positive & 32 constructive)
- 11 Clinical Advisors from the Clinical Hub were recommended for feedback (2 positive & 9 constructive)
- 1 EMD was recommended for constructive feedback

In addition, one potential incident was raised on Datix. Following review by SIG, it was deemed that LAS decision making was appropriate

CARU has been collaborating with the LAS Academy to improve the Evidence-based practice module.



Measures	Target / Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	67%	100%	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	130	15	24	14	↓	↘		LQ29b	
Rate of Complaints per 1,000 Incidents			0.8	0.9	0.9	0.8	↓	↘		LQ29c	
Positive Feedback Compliments			912	90	80	74	↓	↘		LQ29e	
Mental Health related calls as percentage of all calls			8%	7.6%	6.6%	7.2%	↑	↗			
Mental Health related MPS calls as percentage of all calls			2%	2.0%	1.7%	1.9%	↑	↗			
Mental Health related Incidents as percentage of all calls			5%	4.9%	3.7%	4.4%	↑	↗			
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.2%	0.3%	↑	↗			
Rate of Frequent Callers per 1,000 Calls			3.16	3.6	3.2	3.6	↑	↗			
CMC records viewed			3319	778	1458	307	↓	↘		LQ30	

Assurance

Since CMC app was included on iPads, the number of CMC records reviewed have continued to increase month on month but dropped from a record 1458 in December 2018 to 307 in January due to a more stringent data validation process. The Trust is working closely with CMC to simplify this process in order to return to, and improve upon the figures seen in December.

With aspirations for CMC to be in use by all NHS care providers across London, as mutually agreed by all CCG's, it is envisaged that access to patient care records by both operational and Clinical Hub staff will improve significantly for specialist patient groups such as End of Life Care, Patients requiring specific treatment, Emergency Department Care Plans and welfare concerns for babies yet to be born.

Frequent Callers

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



The national definition of a frequent caller is anyone aged 18+ years who:

- *Calls 5+ times in one month from a private dwelling; or*
- *Calls 12+ times over a three month period from a private dwelling*

Frequent Caller Team (FCaT) challenges:

- Insufficient staffing within the team to manage demand – a business case is being drafted, recommending additional staff.
- A Task & Finish group is now in progress re. the management and review of 'care plans', including Patient Specific Protocols, and Emergency Department plans.

Frequent Caller Team (FCaT) updates:

- Last month the Frequent Caller Management Database (FCMD) identified **619** new & existing frequent callers meeting the national definition. 100% of patients were matched with their NHS numbers. The FCMD can now produce quarterly reports.
- The Frequent Caller Team (FCaT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behaviour, call rates, and to agree multi-agency plans to reduce calls to LAS.
- FCaT attended the Ambulance Frequent Caller National Network, hosted by Yorkshire Ambulance Service. Each service provided an update on their service, systems & challenges, plus discussions on best practice, complex cases and an update on the General Data Protection Regulations (2018).
- FCaT and Metropolitan Police attended a meeting with Essex police to share good practice on frequent caller work.
- FCaT, Mental Health Lead, Safeguarding and Clinical Hub have set up a Frequent Caller Clinical Forum – an internal monthly forum to discuss complex cases and benefit from mutual learning.

Case study – Typical complex frequent caller with reduced call rate:

67 year old male living in his own house, with a lodger. Chronic alcohol use, wheelchair user (lower body paralysis), serious self-neglect concerns. 4 x homecare visits a day.

Regular falls result in LAS attending. Patient is often intoxicated when he falls and usually declines conveyance to hospital. Lodger provides patient with alcohol.

8 x safeguarding referrals made by ambulance crews in the past 4 months due to poor self-care and perceived lack of support from home carers and district nurses e.g. irregular visits, lack of support with catheter care, often sitting in soiled clothing. Refused referral to alcohol support team. Has not engaged in previous mental health assessments. Patient wishes to remain living at home. No concerns around capacity.

Calls to 999 spiked from November 2017 (56 calls). Patient is very verbally aggressive/ racist to professionals visiting the home. Patient will intermittently refuse carers from visiting, resulting in personal care tasks not being completed for long periods. District Nurses refuse to visit to due patient's abusive behaviour.

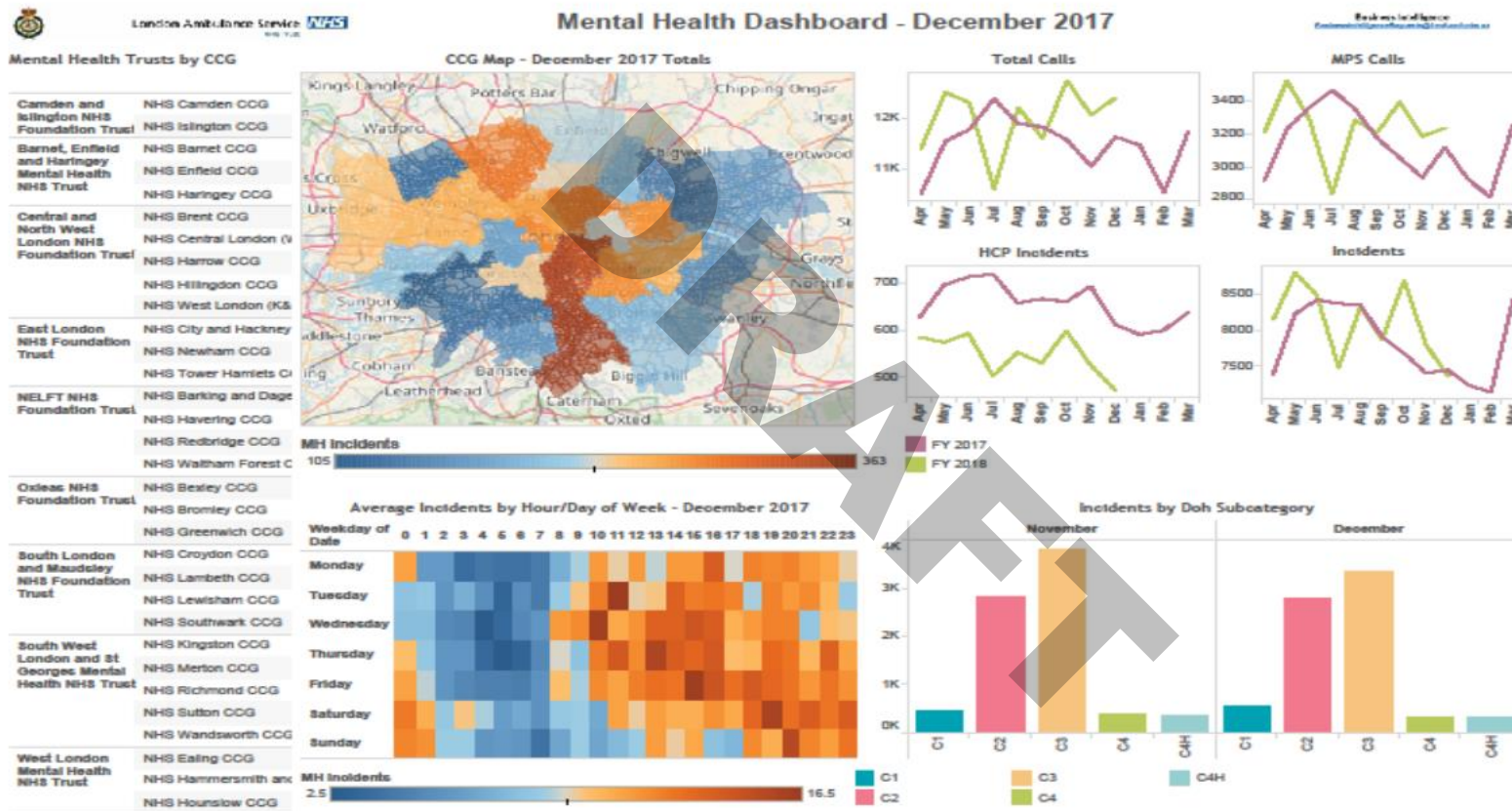
Liaison with the Community Matron, Social Worker and GP resulted in a professionals meeting and a subsequent home visit with LAS. The visit identified the need for a further occupational therapy re-assessment to assist with further adaptations/improve patient's safety when mobilising. Patient's alcohol use has reduced slightly. Patient's calls have reduced since intervention (8 calls in January 2018). FCaT continue to monitor calls. A larger multi-disciplinary meeting with patient, home carers, and patient's family is being planned to ensure a multi-agency plan is in place.

Frequent Callers

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



Cluster	CCG	Patients	Calls last month	Calls last quarter	Calls last 12 months	% of patients with NHS no.
NE	BARKING AND DAGENHAM CCG	15	95	333	910	100%
NC	BARNET CCG	32	730	2060	6052	100%
SE	BEXLEY CCG	15	102	322	1150	100%
NW	BRENT CCG	19	236	518	1203	100%
SE	BROMLEY CCG	16	106	313	870	100%
NC	CAMDEN CCG	19	181	539	1366	100%
NW	CENTRAL LONDON (WESTMINSTER) CCG	18	157	513	1436	100%
NE	CITY AND HACKNEY CCG	38	423	1181	3151	100%
SW	CROYDON CCG	25	524	1418	6871	100%
NW	EALING CCG	33	474	1205	3483	100%
NC	ENFIELD CCG	20	215	599	1131	100%
SE	GREENWICH CCG	19	196	543	1535	100%
NW	HAMMERSMITH AND FULHAM CCG	22	222	554	1651	100%
NC	HARINGEY CCG	31	376	923	2830	100%
NW	HARROW CCG	11	173	414	1057	100%
NE	HAVERING CCG	12	263	634	1877	100%
NW	HILLINGDON CCG	18	205	538	1944	100%
NW	HOUNSLOW CCG	15	156	410	2159	100%
NC	ISLINGTON CCG	23	227	705	1973	100%
SW	KINGSTON CCG	8	60	132	384	100%
SE	LAMBETH CCG	23	203	567	1708	100%
SE	LEWISHAM CCG	16	151	538	1511	100%
SW	MERTON CCG	11	96	239	802	100%
NE	NEWHAM CCG	23	219	602	1366	100%
NE	REDBRIDGE CCG	15	135	436	1059	100%
SW	RICHMOND CCG	11	93	327	857	100%
SE	SOUTHWARK CCG	25	206	741	2632	100%
SW	SUTTON CCG	18	158	391	1100	100%
NE	TOWER HAMLETS CCG	20	238	469	1281	100%
NE	WALTHAM FOREST CCG	18	266	834	2207	100%
SW	WANDSWORTH CCG	13	117	371	967	100%
NW	WEST LONDON CCG	17	165	544	1290	100%
Top 5						
NC	BARNET CCG	M	181	1141	3758	
SW	CROYDON CCG	M	246	750	4781	
NE	WALTHAM FOREST CCG	M	13	266	1125	
NW	EALING CCG	F	110	254	415	
NW	EALING CCG	F	34	244	1068	



Call handlers A presentation was given in relation to mental health training and awareness amongst call handlers.

Three sessions were held with staff at Waterloo and Bow to give them a confidential space to raise concerns and discuss challenges. Actions arising include:

- Revised role of the Registered Mental Health Nurse to intercept calls if on the line for >10 minutes.
- Devise questions using co-production with our expert patient reference group to for call handlers to use to support safe call termination.
- Call handler course to be revised to include a focussed section on mental health calls.

Safeguarding 2 x audits being undertaken in relation to safeguarding – to assess the increases in paediatric mental health referrals and to review the increase in referrals relating to parental mental health and the prevalence of these being in relation to females only.

Recruitment High number of quality applicants (47) for the Registered Mental Health Nurse posts, shortlisting underway and a clinical assessment centre taking place.

LA5 (Mental Capacity) – task and finish group will convene to review policies etc. at feed back at the mental health February meeting.

MH response car test shift completed to ensure processes working correctly. 4 patients seen in 5 hours and none conveyed including standing down Crew and Police. Pilot due to commence in Q4.

Dementia trial under way in the North Central sector to increase staff awareness of communication skills , 78.48% of staff have completed CSR dementia friends training.

Schwartz Rounds – these are to be implemented across the LAS to improve staff wellbeing and patient care – training course Thursday 19th April, 7 staff from LAS attending.

PFD – an overview of the learning and actions agreed from a Pan London perspective in relation to the Thompson PFD will be provided to QOG.

NETs – additional mental health training requested by NETS staff as the number of mental health specific calls they are attending as part of the mental health service continue to increase



Events on database	Events attended	Interested staff
58	56	1234

Temple Mill Primary School – 11th January – CA

"A fantastic visit by CA, the children enjoyed trying on the jackets and helmets and asked a lot of questions. CH was informative but very friendly. All the children were engaged, thank you."

Coombe Hill Junior School – 24th January – WH

"I just wanted to say thank you so much to WH for coming to our school yesterday. He gave a really engaging assembly to 420 pupils and they responded really well. Not only has he educated our pupils on how and when to use the ambulance service but he has also inspired some of our young people to want to follow in this career path themselves. Please pass on our thanks and appreciation."

Key Updates

- Two of our Public Education Officers have been working on multi-agency knife crime projects. "No Knives, Better Lives" is aimed at young people who have either already committed an offence or are at risk of offending. Sessions are held in the Old Bailey and are hosted by a senior judge. Sessions are still being held in Pupil Referral Units, targeting challenged children who have been excluded from school, to teach them about CPR, blood loss and the risks of carrying knives.
- The Trust Dementia Project developed by a Public Education Officer is being rolled out in the north-central area and to NETS staff. An information pack has been produced for staff about dementia, and is encouraging them to find out key information about patients with dementia from their carers and relatives, which they can then use in communication with the patient.

Staff Awards

The Trust has been selected as a finalist in 3 out of 8 categories for the 2018 Control Room Awards;

Lifetime Achievement Award – Jules Lockett
Leader of the Year – Jules Lockett
Team of the Year – EOC

The winners will be announced at the APD Communications Control Room Awards ceremony on Thursday, March 8, at the De Vere Orchard Hotel in Nottingham

Staff Recognition

A group of over 20 staff from across the Service came together at CrossFit Central London for a fitness session run by professional coaches.

The idea to begin the group started on LiA Facebook with Paramedic Ross Aitchison gauging interest from colleagues. He then got into discussions with local gyms and found CrossFit Central London who volunteered to run two free sessions a month for the Service.

Two staff recently met with the Chief Executive Officer to celebrate their 35 year anniversary of service. Paramedic Susan Patey has spent her 35 years providing frontline patient care and Carole Bascoe, who initially started her career as a nurse, before moving to NHS Direct joined the LAS 111 team as a work based learning facilitator.

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley



Performance January – January 2018 Review

Sum of Incidents	Column Labels														
			Mar-	Apr-	May-						Oct-	Nov-		Grand	
Row Labels	Jan-17	Feb-17	17	17	17	Jun-17	Jul-17	Aug-17	Sep-17	17	17	Dec-17	Jan-18	Total	
0	23	26	36	22	27	35	26	25	27	34	33	36	40	390	
1	19	28	32	26	29	36	32	35	29	21	26	30	27	370	
2	24	33	38	29	37	23	29	31	34	36	28	32	37	411	
3	36	40	26	29	44	21	33	39	26	25	31	33	29	412	
4	29	32	38	31	23	24	19	34	30	31	41	33	54	419	
5	29	26	36	25	17	27	31	23	25	20	27	30	31	347	
6	28	30	31	27	37	15	31	12	27	31	30	33	42	374	
7	33	32	24	34	35	36	36	26	29	33	28	28	32	406	
8	33	26	24	32	44	37	32	36	38	35	32	48	38	455	
9	30	35	36	24	30	25	35	24	32	35	23	37	34	400	
10	25	22	34	22	22	26	20	29	31	30	19	34	29	343	
11	29	23	26	22	32	24	27	27	20	26	30	34	30	350	
12	18	25	27	23	26	32	28	37	29	21	31	30	29	356	
13	27	22	11	33	34	23	27	16	25	29	30	38	20	335	
14	25	21	30	22	35	25	26	35	22	12	34	23	23	333	
15	27	14	24	24	28	16	25	29	33	31	26	28	30	335	
16	31	23	33	18	32	36	29	28	29	25	27	35	27	373	
17	29	26	29	28	38	31	25	21	29	19	26	24	28	353	
18	24	29	33	16	29	34	19	13	32	16	29	33	31	338	
19	23	28	23	23	24	39	27	33	28	19	24	32	22	345	
20	27	39	32	39	30	24	30	34	37	19	29	34	38	412	
21	18	13	31	32	26	24	24	29	36	27	23	40	26	349	
22	37	42	30	25	32	30	37	30	23	20	29	25	31	391	
23	34	19	40	35	31	33	28	42	23	35	43	30	32	425	
Grand Total	658	654	724	641	742	676	676	688	694	630	699	780	760	9022	

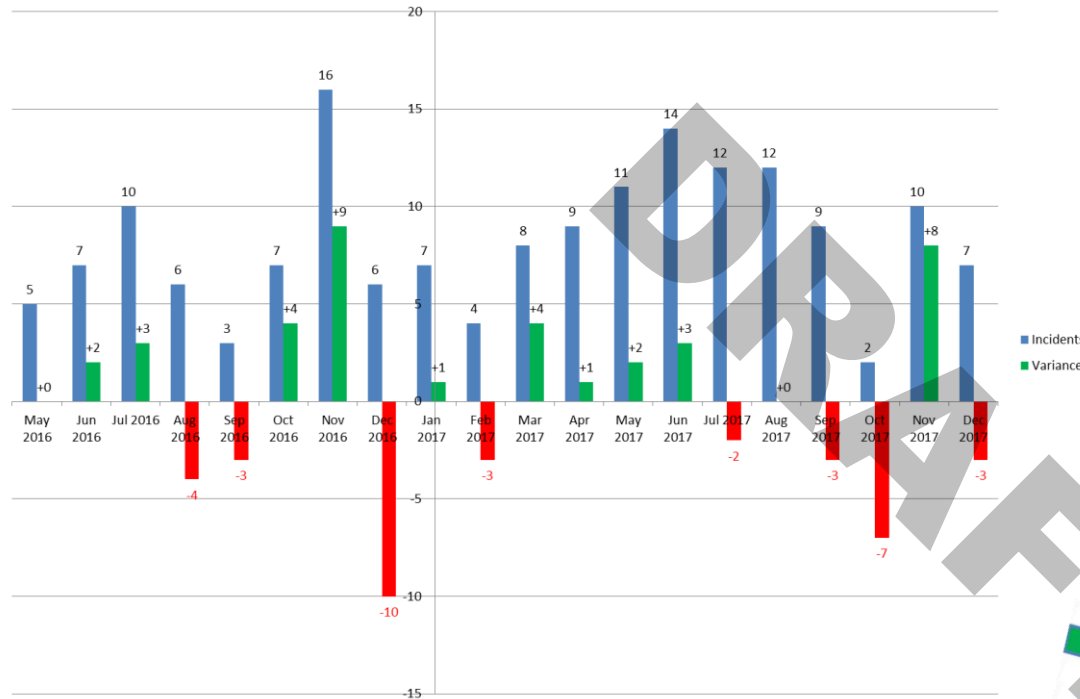
2017 Average calls per month – 688.5
January 2018 variance - ↑10%
New Years Baby Born with LAS 06:26

Clinical Performance

- Birth imminent calls – 23%
- Bleeding after 24 weeks - 31%
- Baby born/baby head out - 200



Maternity Incidents by Month with Variance on previous Month



Success

- Practice Lead for Pre Hospital Maternity Care – 2 posts banded at 8A
- Data modelling underway for Maternity Pioneer Service
- “Map my Maternity” project – developing MiDOS and EOC information around maternity units and referral points currently running
- Initial evaluation of CSR.2017.3 – benefit of hands-on practice to resuscitation
- “Whose Shoes” – User and Staff Engagement workshop to be costed to roll out in the Maternity Pioneer Service

Maternity Complaints – Jan 2018

1. No report – Propose a Deep Dive into Maternity Incidents from 2017 including lessons shared for the organisation

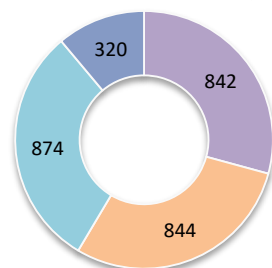
Maternity Incidents – Jan 2018

No harm identified from incidents
Themes include – NHS 111 Advice to take aspirin
Delay to locating correct location due to pre alert not passed (phone not answered)



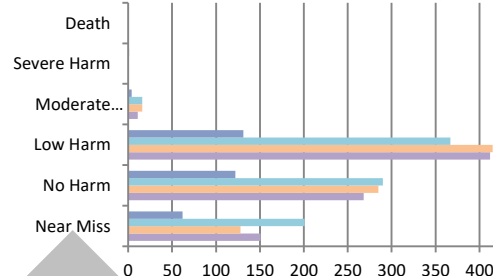
Health & Safety Scorecard – Q4 (January 2018)

Number of H&S incidents by Quarter



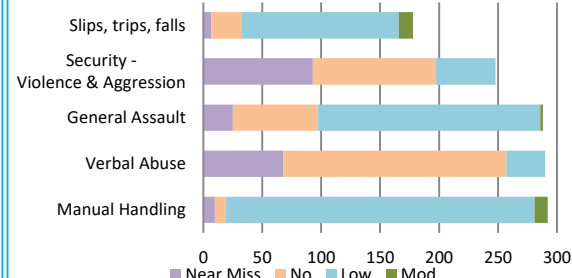
2880 health and safety related incidents have been reported during 2017/18. 16 additional incidents (covering Q1 & Q3) were reported in Jan'18. Total YTD H&S incidents account for 40% of all incidents reported Trust-wide during the year.

Accidents & Incidents by Severity



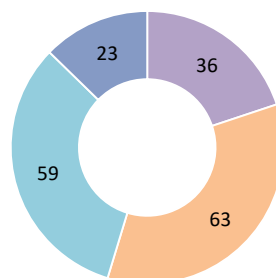
1373 (46%) of the H&S related incidents reported during 2017/18 resulted in low harm. 47 (1.6%) incidents resulted in Moderate Harm. 1507 (52%) of the incidents were reported as 'No Harm/Near misses'.

Top 5 Incident Sub-Categories by Severity (YTD)

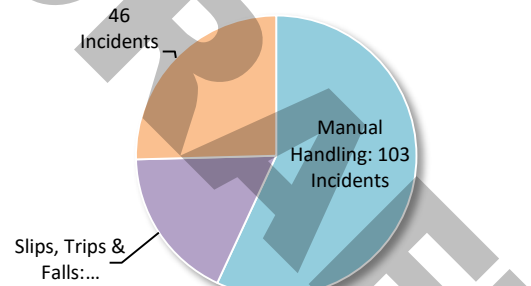


Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

RIDDOR Reportable Incidents by Quarter



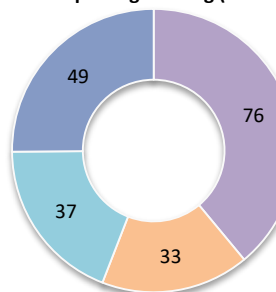
RIDDOR Reportable Incidents by Cause (YTD)



Key Updates:

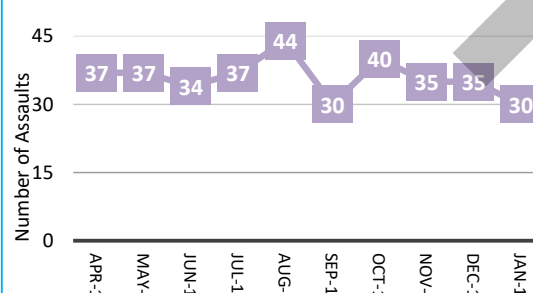
1. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Practical MH refresher training will be provided for all frontline operational staff from CSR 1 – April 2018.
2. The Color tagging of Mangar Elks has commenced to minimize issues of compatibility reported Trust-wide. 12 weekly maintenance plan has been implemented for all equipment including tail lifts and track chairs supported by 6 weekly visual inspection checks to identify and rectify faults/defects.
3. No trends identified with increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
4. Prototypes of the proposed integrated Vehicle based ALS and first response bags are currently on trial across the Trust.
5. Fire risk assessment contract – under tender. Fire Marshal training being organised for nominated representatives between February/March 2018.
6. Audit of Trust-wide H&S arrangements to assess progress made since the June 2017 independent H&S review commenced on 29/01/2018.

RIDDOR Reporting Timelag (Average Days)



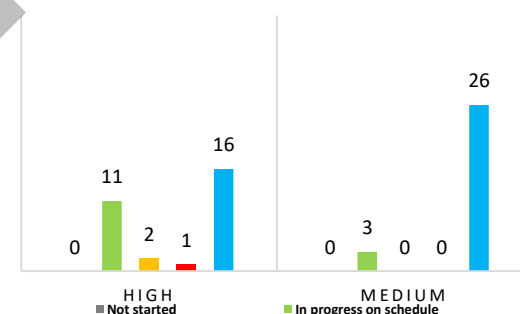
7. The average time lag for reporting RIDDOR incidents across the Trust in January was 49 days. This exceeds the statutory reporting timeline of 15 days for most RIDDOR incidents. **In January 2018, 9 out of the 23 RIDDOR incidents were reported out of time.**

Assaults on Staff by Patients

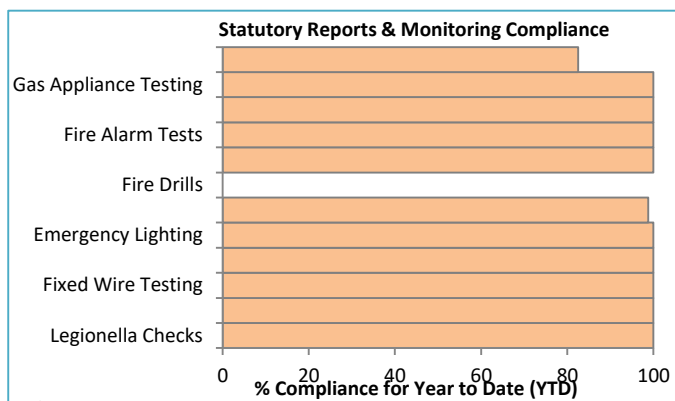
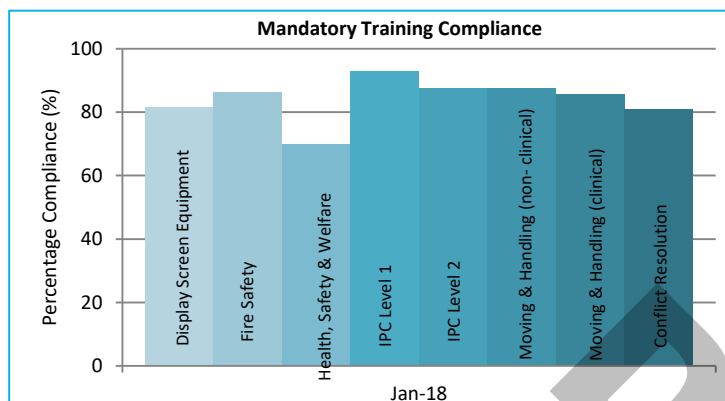


8. Assaults on staff by patients make up 31% of the violence, abuse and assault incidents reported in 2017/18. The most common underlying causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Status of H&S Review Action Plan



9. 42 of the 59 actions recommended have been completed.
 • 16 actions are currently in progress with 4 actions due to be completed by 28/02/2018.
 • 1 action is overdue.



Trust-wide compliance in January 2018 for 3 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					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Q3			Q4		
						Oct	Nov	Dec	Jan		
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	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Audit of Trust-wide H&S arrangements to assess progress made since the independent H&S review conducted in June 2017 commenced on 29 th January 2018.
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	9	Key training in practical manual handling has been delivered to Clinical Tutors in the Clinical Education Department. Practical manual handling refresher training to be provided from CSR 1 – April 2018. Business Case to replace all version 1 Mangar Elk approved. 12 – weekly maintenance programme implemented for all track chairs and tail lifts.
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	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 approved 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	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	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	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. LSMS in regular liaison with staff and sites where security related incidents have been reported. Where required, incidents are reported to the Metropolitan Police for investigation.
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	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. Recruitment ongoing however with difficulty finding interim staff (at the right level) to match the roles available within the team.

Sector Heat Map: Quality Data



CQC	Key Performance Indicator	NW	NC	NE	SW	SE	LAS	
							Target	Ranges
SAFETY	Hand Hygiene OWR compliance	68%	67%	93%	100%	97%	90%	
	Rate of Patient related Adverse Events per 1,000 Incidents	1.4	2.6	1.9	1.5	2.6	5	
	Rate of Staff related Adverse Events per 1,000 Incidents	2.5	3.9	4.1	3.6	2.7	3	
	Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	0	
	Percentage of Incidents reported within 4 days of incident occurring	98%	95%	98%	96%	94%	85%	
	Potential Serious Incidents referred to SI Group	5	2	4	1	5		
	Serious Incidents declared in-month	2	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	19.4%	5.4%	0.0%	10.0%	11.5%	0%	
	Needle Stick Injuries as % of Staff Adverse Events	4%	2%	1%	0%	2%	0%	
	Missing Equipment Incidents as % of all reported incidents	3%	0%	3%	5%	3%		
	Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	12%	9%	10%	12%	5%		
	Safeguarding Adults & Children Level 1	93%	96%	95%	97%	97%	90%	
EFFECTIVENESS	Safeguarding Adults & Children Level 2 - Clinical	89%	87%	89%	94%	93%	90%	
	Percentage of staff completing Core Skills Refresher 2017.1 (cumulative)	85%	89%	83%	88%	88%	90%	
	* ROSC at Hospital (AQI)	31.3%	30.9%	31.9%	32.8%	35.8%		
	* STEMI care bundle (AQI)	65.4%	70.0%	72.0%	78.4%	76.5%		
	* Stroke to HASU within 60 minutes (AQI)	56.8%	40.6%	52.2%	56.0%	45.4%	65%	
	* Stroke Care Bundle (AQI)	97.1%	98.5%	97.7%	93.8%	97.0%	98%	
	** Survival to Discharge (AQI)	-	-	-	-	-		
	* CPI - Completion Rate (% of CPI audits undertaken)	92%	99%	89%	97%	86%		
	* CPI - Percentage of Staff receiving ONE Feedback Session YTD	43.7%	51.9%	47.7%	47.8%	44.4%		
	* Documented Care - Cardiac Arrest Compliance (CPI audit)	98%	97%	98%	99%	97%	95%	
	* Documented Care - Discharged at Scene Compliance (CPI audit)	97%	98%	97%	98%	96%	95%	
	* Documented Care - Mental Health Compliance (CPI audit)	94%	95%	90%	94%	92%	95%	
	* Documented Care - Severe Sepsis Compliance (CPI audit)	98%	97%	97%	98%	97%	95%	
	* Documented Care - Difficulty In Breathing Compliance (CPI audit)	96%	96%	96%	97%	96%	95%	
	* Documented Care - Glycaemic Emergencies Compliance (CPI audit)	-	-	-	-	-	95%	
CARING	Rate of Complaints per 1,000 Incidents	0.5	0.1	0.4	0.3	0.4		
	Mental Health Related Incidents	7%	8%	7%	7%	8%		
	Mental Health Related HCP Incidents	0.4%	0.5%	0.4%	0.6%	0.6%		
	Rate of Frequent Callers per 1,000 Calls	7.3	8.7	6.6	6.9	5.4		

* data shown refers to Jan-18

** data shown refers to Jul-17

Learning from Incidents

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



Learning from Incidents

- A deep dive into the response time associated with chest pain calls was undertaken by senior clinicians within the Medical Directorate. This review will be incorporated into the clinical review of ARP.
- A new learning from serious incidents presentation has been developed and delivered to the paramedic trainees currently enrolled on the paramedic academy course. This session is to be incorporated into the core modules for each course in the future.
- Findings from the quarterly thematic review were incorporated into an intensive EOC action plan for Trust wide learning assisted in the formation of actions specifically relating to incidents within EOC
- A change in the management of patients presenting with chest pain was signed off by the Medical Director which requires all pre-hospital clinicians to convey patients presenting with atraumatic chest pain
- Emergency Operations Centre bulletin was disseminated to refer staff to the newly revised OP/060 policy (Control Service Call Taking Procedure) which details the process to be followed when accepting calls from other ambulance services
- An external audit by KMPG was undertaken to review the revised serious incident process within the Quality Governance and Assurance department. The outcome of the report concluded significant assurance in the new process and deadline targets

Incidents

<u>SI update</u>	Incidents reviewed In January	SIs declared In January	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	49	8	23	7	12	0	4
Trend on previous month	↑	↑	↑	↔	↓	↔	↓

Serious Incidents & Incidents

- The 4th Serious Incident training session went ahead as planned in January. A further 15 managers were trained under the new SI process. The next training session is planned for 23rd Feb 2018 and currently has 20 managers attending.
- The Quality, Governance and Assurance Team have quality assurance and closed in excess of 700 incidents within the last month and sent approximately 200 incidents back to investigating managers for further information.
- Weekly overdue incident and unapproved risk reports continue to be shared with senior managers across the Trust.

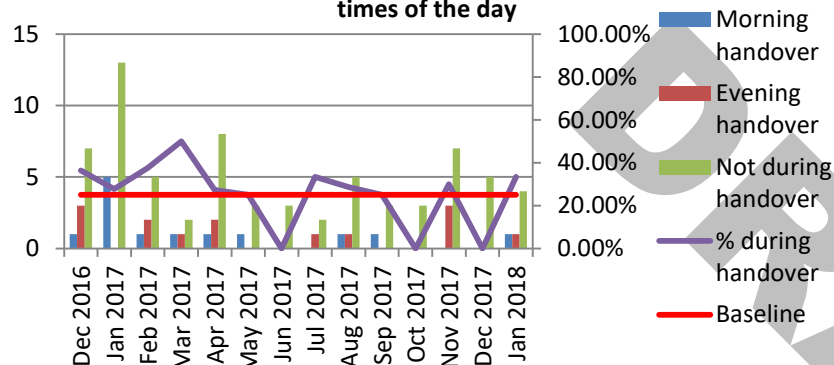
Learning from Incidents

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



Serious Incidents occurring during shift changeover

Serious Incident occurring at shift changeover time vs other times of the day



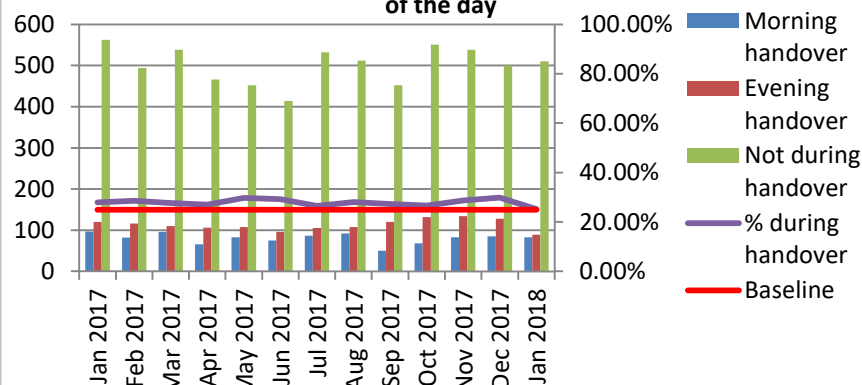
Actions relating to Serious Incident Investigations

SI action plan update (relating to closed overdue SI investigations):

- 17 actions are currently overdue (reduction of 11 from last month).
- Weekly reminder emails continue to be sent from the Quality, Governance and Assurance Team and non-compliance continues to be escalated
- Areas of concern include:
 - IM&T – one action
 - LAS111 – two actions
 - Sector operations – ten actions
 - Fleet and logistics – one action

All Incidents occurring during shift changeover

All incidents occurring at shift changeover time vs other times of the day



Reported incidents relating to calls received during shift changeover

- Eight serious incidents were declared in January 2018. Of these two concerned calls that had been received during the pre-determined handover period.
- Neither calls received a delayed response as a direct result to the time the call was received.
- A preliminary review of the incidents has shown that one incident related to the incorrect management of the 999 call the other was declared due to a potential failed discharge.
- The chart to the left demonstrates a slight reduction in incidents that occurred during the pre-determined handover times compared to the previous month and is currently level with the 25% baseline.

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 January, LAS were requested to attend Inquests to give oral evidence on 3 occasions, 1 less than for the month of December.
- No Prevention of Future Death (PFD) reports were received in January.
- An Inquest listed for 15/16 January where medicine management concerns were raised returned a Conclusion of Natural Causes. Following disclosure to the Coroner of 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, no witnesses were required from the Trust to give live evidence.

Inquests – figures and learning

- Following receipt of a PFD report received by the LAS, London Mental Health Transformation Board & other organisations/individuals in September 2017, The MH Transformation Board met in January. A paper was presented by the Regional Lead for 111 and Integrated Urgent care which collated concerns from across the system with recommendations for planned work including:-
 - a) developing & implementing a multi agency model of care for mental health patients in crisis.
 - b) improving the exchange of information between stakeholders across the system.
- A high-level action plan has been provided for both areas & delivery will be monitored by NHS England (London Region).

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).
- For the same Quarter in 2016/2017 NHS Resolution had 35 claims against LAS open under their Clinical Negligence Scheme for Trusts & 78 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- For the same Quarter in 2015/2016 NHS Resolution had 32 claims against LAS open under their Clinical Negligence Scheme for Trusts & 84 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).

Actions

- Completed:
- The Policy & Procedure for the Development & Management of Procedural Documents (TP001) is being reviewed & will include identifying who the target staff are for particular protocol/guidance as part of the update. With the introduction of mobile devices the potential for obtaining electronic signatures from staff confirming receipt & perusal of documents will be possible.
- Ongoing:
- 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
 - A pre-trial report received from Panel Solicitors in January, suggested that signs should be displayed on ambulance stations/garages advising staff not to walk between ambulances given the tight space & how closely they are parked together. This is being discussed with the Head of Health & Safety.

Learning from Complaints

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



Top 5 key complaints themes : January 2017 to January 2018

Complaints by subject 2015/17	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Total
Delay	36	16	27	21	17	16	14	26	9	22	33	19	17	273
Conduct	26	27	36	16	19	24	19	19	16	17	25	20	22	286
Road handling	7	9	16	12	11	13	14	10	7	14	9	7	6	135
Treatment	3	3	5	1	2	5	1	7	5	16	8	9	8	73
Non-conveyance	1	3	4	3	0	4	12	0	1	6	1	7	6	48
Total these subjects	73	58	88	53	49	62	60	62	38	75	76	62	59	815
Overall Totals	90	74	105	66	70	76	73	86	51	94	85	84	74	1028

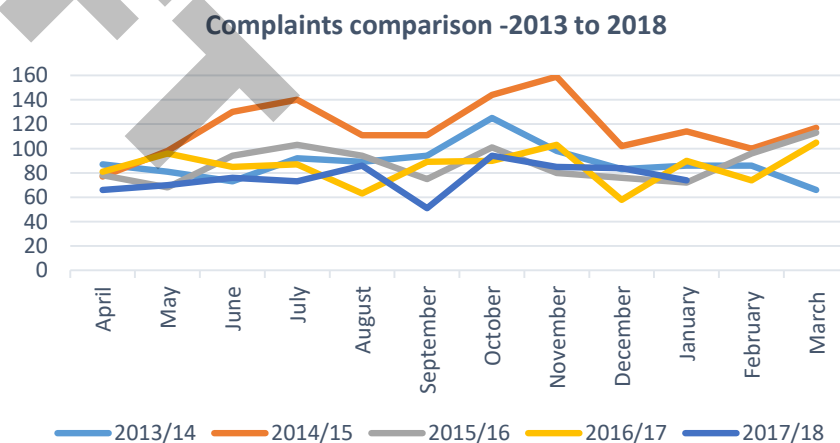
Assurance and learning

- During January we received 74 complaints. 8 of these were classed as HCP issues on behalf of the patient and 15 were from LAS111.
- A number of the 111 complaints related to the unavailability of a doctor to call back in a timely manner. These have been shared with the relevant Commissioning group
- Of the 98 complaints which were closed, 7 were upheld and 18 partially upheld – examples in next slide
- There were 7 Quality Alerts in January. This is expected to rise when we update the website for HCP's – estimated launch is April
- During this month 22 complaints related Category 2 in ARP, 14 were related to Category 3, 6 to Cat 4 and 1 to Cat 1. The other complaints were either before ARP or not CAD related. We will be preparing a quarterly summary with G&A

Review of January 2018

- The number of complaints relating to 'delay' has decreased over the annual average of 19 per month. Complaints where the main head of complaint relates to conduct and behaviour are now higher than delays
- Complaint numbers are currently 0.08% of calls attended by the Trust
- We have added 'Quality Alert' as a sub category in Datix with measured time frames to ensure a timely response
- We will be adding timeframes for internal stakeholders into Datix so that we can share our targets and to improve throughput
- The new Data Protection regulations (which are still being developed) will impact on subject access requests. We recommend that the Trust undertakes some training as the impact of the revised regulations is that document requests will no longer be chargeable and may impact on the numbers of those.

Complaint summary 2013/14 to 2017/18



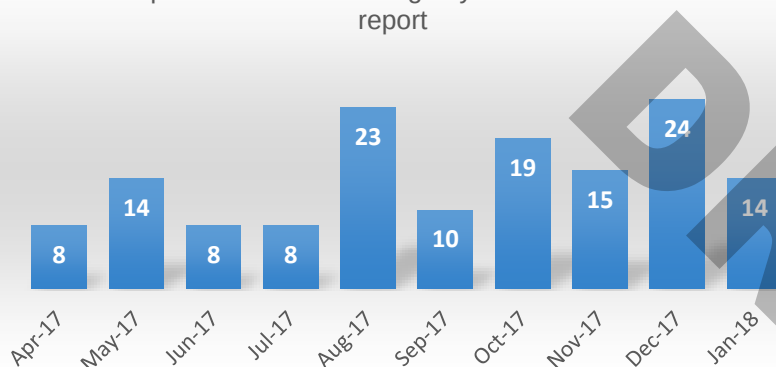
Learning from Complaints

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



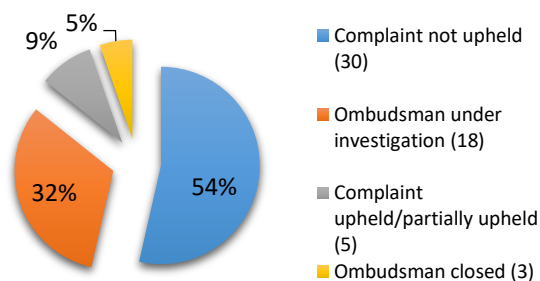
Performance against 35 day response target (January)

Complaints over 35 working days at the time of the report



Overview of Ombudsman cases 2015-2017

Complaint files requested by the Ombudsman
June 2015 to January 2018



Assurance and learning – case examples

Case example one:

Complaint from patient that the attending ambulance staff took her home but did not help her into her property despite being hardly able to walk. We explained that it would have been more compassionate and safer practice to have ensured the patient was able to make it into her home. In addition, the assessment record does not make any reference to any assessment of the patient's hip, which should have been completed.

Case example two:

Complaint from patient's sister who is concerned at the aggressive attitude of the call handler.

The call handler did not adhere to protocols which may have prevented the conflicting answers you gave and the triage assessment to be conducted more quickly. She deviated from the prescribed questioning, omitted to use the breathing detector tool and failed to verify the location. She did not display appropriate customer service skills and should not have given precise details of the responding ambulance resource, as it is possible they could have been re-directed to another 999 call so this was misleading. An apology was offered and reflective practice arranged

Case example three:

Complaint from patient who is upset that the attending medic did not administer a nebuliser after she suffered an asthma attack. Extensive feedback will be given to the Paramedic by the local management team, with an emphasis on the importance of recording the assessment record to an optimum level. They will also jointly review the treatment protocols in relation to patients with symptoms similar to the patient's presenting symptoms

Case example four:

Complaint from patient's husband who is concerned at the delay in providing a critical transfer ambulance for his wife who was experiencing a placental abruption. The Quality Assurance evaluation confirms that from the information provided all 999 calls were largely managed in accordance with our protocols, although some shortcomings have been identified and the Clinical Hub should have applied an upgrade after 60 minutes as they misunderstood their responsibilities within the new guidance in line the ARP. This does not mean that an ambulance would have arrived sooner, however it does increase the likelihood of that. An exceptional bulletin has been issued at all staff.