London Ambulance Service NHS
NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 23rd JULY 2013 AT 10.00 – 12.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from: Jessica Cecil Caron Hitchen Sandra Adams			
10.00	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	3.	**Minutes of the Part I meeting held on 25th June 2013** To approve the minutes of the meeting held on 25th June 2013	Approval	RH	TAB 1
10.05	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
QUALITY GOVERNANCE AND RISK					
10.10	5.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	AG	TAB 3
10.20	6.	**Quality Report** 6.1 Quality Dashboard 6.2 Clinical Quality and Patient Safety Report, including Serious Incidents Update	Assurance	SL FM	TAB 4
10.35	7.	**Francis Report Progress Update** To approve the emerging themes and direction of travel	Approval	SL	TAB 5
10.45	8.	**Annual Infection Prevention and Control Report 2012/13** To approve the annual report for infection prevention and control	Assurance/ Approval	SL	TAB 6
10.50	9.	**Annual Safeguarding Report 2012/13** To approve the annual report for safeguarding	Assurance/ Approval	SL	TAB 7
10.55	10.	**Winterbourne View Gap Analysis and Action Plan** To note the Winterbourne View Gap Analysis and Action Plan	Information	SL	TAB 8
11.00	11.	**Finance Report** 11.1 Finance Report 11.2 Finance and Investment Committee Assurance Report from the meeting on 19th July 2013	Information Assurance	AG NM	TAB 9 Oral

GOVERNANCE					
11.15	12.	**Equality Annual Report 2012/13** To note the annual report and support the executive management team in agreeing future actions and objectives	Information	TC	TAB 10
11.20	13.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for July 2013	Approval	AR	TAB 11
11.25	14.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	Information	FG	TAB 12
BUSINESS ITEMS					
11.30	15.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 13
11.35	16.	**Update on Modernisation Programme** To receive an update on the Modernisation Programme	Information	AR	Oral
	17.	**Forward Planner** To receive the Trust Board forward planner	Information	FG	TAB 14
11.45	18.	**Any other business**		RG	
	19.	**Questions from members of the public**		RG	
12.00	20.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 24th September 2013. The Strategy Review and Planning Committee will be meeting on Tuesday 10th September2013.			

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 25th June 2013 at 09:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Roy Griffins (Chair)	Non-Executive Director
Ann Radmore	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Andrew Grimshaw	Director of Finance
John Jones	Non-Executive Director
Steve Lennox	Director of Health Promotion and Quality
Nick Martin	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Director of Strategy and Planning
Jane Chalmers	Director of Modernisation
Tony Crabtree	Acting Director of Workforce
Francesca Guy	Committee Secretary (minutes)
Jason Killens	Director of Service Delivery (North Thames)
Bob McFarland	Associate Non-Executive Director
Angie Patton	Head of Communications
Paul Woodrow	Director of Service Delivery (South Thames)
Vic Wynn	Acting Director of Information Management and Technology
Members of the Public:	
Malcolm Alexander	Patients' Forum
Mark Docherty	Director of LAS Commissioning
Chris Pritchard	Student Paramedic, LAS

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74. Welcome and Apologies

74.1 Apologies had been received from Richard Hunt and Caron Hitchen. Roy Griffins chaired the meeting on behalf of Richard Hunt.

75. Staff Story

75.1 Chris Pritchard joined the Trust Board to give an account of his experiences at the LAS. Chris was a third year student paramedic at the University of Hertfordshire and was currently completing his work experience at the LAS. Chris loved working for the LAS and felt that he was in a privileged position to be trusted by patients and to be able to give them the best possible care at a time when they were at their most vulnerable. Chris made the following observations from his time working at the LAS:

- Listening into Action was a positive initiative. The quality of the events had been excellent and staff felt that their views were being taken on board;

- There was a lack of diagnostic equipment, such as BM kits and tympanic thermometers, which made it difficult for staff to form a full clinical picture. This was particularly important when referring patients to an appropriate care pathway or when leaving the patient at home;
- Since 2010, there had been a noted decrease in calls that could be dealt with more appropriately by another healthcare provider, which was largely due to the fact that Clinical Telephone Advice was providing advice for calls with a lower MPDS determinant. This was positive as it meant that patients were receiving better, more appropriate care, however the service was still very busy with staff not being allocated rest breaks and finishing shifts late. There was a feeling amongst staff that more could be done to improve this situation;
- There was no clear policy on what was an adequate amount of rest between shifts which meant that on occasion staff were getting less than four hours sleep. This was rare, but could put patient care at risk;
- Staff now had protected time of 10 minutes at the start of each shift to undertake a vehicle check. This was sufficient time to check the key items of equipment required to provide a good, safe response to most calls. This did not allow enough time however to check emails or read the bulletins on the notice board and more could be done to improve communication to frontline staff. Staff did not have access to GRS from home which meant that it could sometimes be difficult to keep track of your shifts;
- Use of appropriate care pathways was positive as it meant that patients were provided with care that was more suitable to their needs. However there was a feeling amongst staff that if a patient had a negative outcome, it would be treated as a disciplinary matter, rather than a learning experience. East of England Ambulance Service had released a bulletin to state that they would support any member of staff who had referred a patient to an appropriate care pathway, as long as it could be clinically justified;
- There was a supportive culture amongst staff and whenever Chris had attended an emotionally difficult call he had found his crewmate and other frontline staff to be very supportive to everyone who had been involved. However there was a feeling amongst staff that managers did not understand what it was like to respond to difficult calls and, although Chris' own personal experience of support provided by his DSO had been very positive, there was concern that increased use of active area cover meant that staff would often not be at station and would therefore be unable to access this type of support;
- Chris had found the quality of his practice placements at LAS to be excellent and the opportunities provided to students very varied. However students were occasionally given very short notice about their placements and there was some variation in the quality of PPEDs;
- The BSC degree was a good option for anyone training to be a paramedic as students were exposed to research and audit;
- There was currently a lack of clear career progression and the proposal to have specialist paramedics was welcomed.

75.2 The Chair thanked Chris for telling his story and stated that his observations were very articulate and balanced. The Chair noted that staff usually did not have the opportunity to raise these types of issues to the Trust Board and asked Chris to whom he would normally escalate any concerns. Chris responded that staff often felt that it was difficult raise issues and usually did not report them higher than Team Leader or Duty Station Officer level.

75.3 Caroline Silver thanked Chris for attending the Trust Board and noted that his story demonstrated that basic improvements to communication could help to improve the staff experience. Chris agreed that access to GRS from home would be a benefit as it was difficult to keep track of shift changes. Jason commented that this was in development alongside the development of smart phone apps for staff. Paul Woodrow commented that this would allow staff to have more control over the shifts that they worked.

75.4 Ann Radmore asked what one thing would encourage Chris to stay working for the LAS. Chris

responded that he would like to see a clinical career structure that was robust and had development opportunities. There were currently no opportunities, with the exception of the Team Leader role, to progress past band 5 in a clinical role. Chris stated that he would like to develop to be able to provide specialist care to a subset of patients.

76. Declarations of Interest

76.1 Lizzy Bovill reported that she would be seconded to NHS England (London) from 1st July 2013 and potentially would be responsible for the performance management of NHS 111.

77. Minutes of the Part I meeting held on 4th June 2013

77.1 The minutes of the Part I meeting held on 4th June 2013 were approved subject to an amendment to paragraph 60.4.

78. Matters Arising

78.1 The following matters arising were discussed:

78.2 **135.1:** The action for the Trust Chair to discuss with Ann Radmore the proposal to award a commendation to a member of the public who had assisted the service was outstanding.

78.3 **15.4:** Antony Marsh, Chair of the Association of Ambulance Chief Executives, was part of a working group which sought to gather views on the review of urgent and emergency care from ambulance services nationally. The LAS would be responding to a call for evidence as part of the review.

78.4 **34.3:** Andrew would present a proposal for measuring value for money to the next meeting of the Finance and Investment Committee.

78.5 **59.9:** Tony Crabtree would provide a position update on the actions to address sickness absence at the Trust Board meeting on 23rd July 2013.

79. Integrated Board Performance Report

79.1 Andrew Grimshaw reported that more detailed metrics were being developed to feed into the scorecard. These would be included in next month's report alongside the actions that were being taken to address the issues identified. Further work needed to be done to improve data quality, although the data included in this report was broadly accurate. Andrew would also work with Steve Lennox to ensure that this report was aligned with the Quality Report.

79.2 Jessica Cecil noted that the workforce indicators had all shown a worsening position from last month and asked when this position could be expected to improve. Ann Radmore responded that training would improve first, with recruitment and retention improving towards the end of the year. The executive team was looking at ways to improve sickness absence levels, including the retendering of the occupational health contract.

79.1 John Jones commented that vacancies and sickness absence levels had a financial impact and therefore the Trust Board needed to understand what actions would be taken to ensure that the Trust was financially viable throughout the year. Ann Radmore responded that it was always known that this year would be difficult, but the current levels of sickness absence had not been anticipated. The executive team was looking to improve this situation as quickly as possible. Tony Crabtree added that there were some immediate actions that could be taken to improve the position and an action plan would be presented to a future Trust Board meeting.

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79.2 Caroline Silver asked whether current demand levels were within expectations. Jason responded that demand was up on last year and although it was within the forecasted thresholds, he acknowledged that the busiest period of the year was yet to come. Jason added that a detailed analysis of what was driving demand was being worked through and would be shared with commissioners. Paul Woodrow added that May 2012 was the busiest month of last year, so although demand was within the forecast trajectory, this had been drawn up against a high baseline. Ann Radmore commented that she had spoken to Public Health England and they had been supportive of the work the Trust was doing to understand demand.

80. Quality Report

Quality Report

80.1 Steve Lennox explained that the Quality Report had been reformatted following the Francis report to make it clear which indicators were current and which were behind time. Steve gave an update on each of the red rated indicators and noted that overall the position had changed very little from last month. The LAS remained in the upper quartile in 13 out of 23 of the national clinical quality indicators.

80.2 Paul Woodrow asked why the Category C indicators were rated red when the Trust was meeting the Category C performance target agreed by commissioners. There followed a discussion about the difference between performance as commissioned in the contract and the performance the Trust aspired to achieve to provide a quality service. Steve Lennox, Paul Woodrow and Jason Killens were asked to agree the quality target for Category C outside of the meeting.

ACTION: SL/PW/JK to agree the quality target for Category C.

DATE OF COMPLETION: 23rd July 2013

80.3 The Chair noted that the Quality Committee had also discussed whether it would be beneficial to look at benchmarking Category C performance against other ambulance services nationally.

80.4 Bob McFarland commented that the direction of travel was not clear for some of these indicators. Steve suggested that he could add arrows to indicate the direction of travel.

ACTION: SL to add arrows to the quality indicators to indicate the direction of travel.

DATE OF COMPLETION: 23rd July 2013

Clinical Quality and Patient Safety Report

80.5 Fionna Moore noted the following:

- The monthly stroke report had been published for April 2013, which showed that the Trust had attended approximately 1000 stroke calls in the month. The average on scene time had not shown a decrease, although the rate of thrombolysis was better in London than anywhere else in the country;
- The quarterly Major Trauma report had been published which showed that 11 patients a day on average were transported to a major trauma centre, some of whom had been overtriaged.

80.6 A number of questions had been submitted to the Trust Board from the Patients' Forum and the

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responses given were as follows:

80.7 1. Is the Trust satisfied that staff are sufficiently trained to carry out dynamic risk assessments prior to deciding whether to enter premises or call the metropolitan police. Have there been any significant issues regarding harm to patients since this new risk assessment system was introduced?

80.8 Paul Woodrow responded that all frontline staff were trained as part of their core training to carry out dynamic risk assessments for all calls they attended. In relation to the Locality Alert Register (LAR), the new register had four categories and the MPS would only automatically be dispatched to level 1 & 2 entries on the LAR. A revised operational policy had been published to reflect these changes and an appendix to that policy had a separate section in relation to carrying out a dynamic risk assessment where crews had been notified that the location they were attending appeared on the register. Paul was unaware of any significant incidents regarding harm to patients since the new policy had been introduced.

80.9 2. In view of the comments of the Coroner regarding care provided to Sarah Mulenga, is the Trust satisfied that the skill set of front line staff is now adequate to prevent a reoccurrence of the poor care received by this patient?

80.10 Fionna Moore responded that the root cause of this incident was not that the crew had received insufficient training, but that the crew had failed to follow their training. Fionna was content that the training provided would allow staff to undertake an adequate assessment. The crew involved in the Sarah Mulenga case were both third year students and were therefore qualified to work independently.

80.11 3. Will the Board ensure that governance arrangements are sufficiently robust to satisfy you that staff are well trained and supported to use de-escalation and alternatives to physical restraint, that the methods used are safe and that physical restraint incidents are reported and feed into ongoing organisational learning?

80.12 Steve Lennox responded that the LAS was currently reviewing the way it managed physical restraint of mental health patients.

80.13 4. In view of the continuing concern regarding mental health CPIs, is the Board satisfied that front line staff are receiving adequate training in relation to the care of patients with serious mental health problems?

80.14 Steve Lennox responded that Mental health training was currently included in the staff training programme.

80.15 5. What progress has been made by the Trust in enhancing care for patients with dementia? Is the Trust following the lead of other ambulance trusts that are working to reduce admission to hospital of patients with 'preventable ambulatory care sensitive conditions' and enhancing staff training in relation to assessing pain and taking clinical histories?

80.16 Steve Lennox responded that the Trust had looked into whether care of dementia patients could be part of a CQUIN, however it was found that these patients were currently being managed well and nothing was identified that would fundamentally improve the care of these patients.

80.17 6. Is the Board satisfied with the current level of reporting to the NRLS/NHS England (National Reporting and Learning Service)? Will the Board ensure that all staff are aware of the importance of reporting and learning from incidents?

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80.18 Sandra Adams responded that the number of incidents reported to NRLS was not routinely reported to the Trust Board, however the consistency of reporting to NRLS was measured in the CQC Quality Risk Profile which was reviewed by the Quality Committee and Risk, Compliance and Assurance Group. An error had been identified last summer and an in depth clinical review was then undertaken of all incidents reported to NRLS. The reporting systems had now improved to ensure that this type of error did not reoccur. Sandra stated that the number of incidents reported to NRLS could be reported to the Trust Board if this would be helpful. Steve Lennox added that learning from incidents would be covered as part of the action plan to address the recommendations in the Francis Report.

81. Quality Committee Assurance Report

81.1 The Chair noted that the Quality Committee meeting on 17th June was only just quorate but that the committee had nonetheless managed to have a useful discussion. The Chair suggested that the Trust Board review the role and function of the Quality Committee as part of the wider governance review. The Chair noted the following:

- The Quality Committee had reviewed the Quality Report, although it had been received late by the committee;
- The Winterbourne View gap analysis and action plan was reviewed and the committee asked for the action plan to be agreed by the Executive Management Team;
- The Quality Committee reviewed the Quality Account for 2012/13 and was happy to recommend that the Trust Board accepted the report;
- The committee received an update from the clinical audit and research team and on the Francis review;
- The committee reviewed the Quality Risk Profile published by the Care Quality Commission and asked whether LAS performance could be benchmarked against that of other ambulance trusts nationally;
- The Director of Finance had presented a revised process for monitoring the Cost Improvement Programme, which was agreed by the committee;
- The committee had not received the Board Assurance Framework at this meeting.

81.2 The Chair also noted that the Quality Committee had congratulated Fionna Moore for receiving an MBE in the Queen's birthday honours. The Trust Board also congratulated Fionna.

82. Quality Account 2012/13

82.1 Steve Lennox noted that the stakeholder comments had been received and incorporated into the report. The Trust Board approved the Quality Account for 2012/13.

83. LAS Response to Mental Health and Policing Report

83.1 Steve Lennox reported that, whilst the focus of the Mental Health and Policing Report was on the Metropolitan Police Service, there were a number of recommendations which had an impact on the LAS, most notably the recommendation to have a dedicated response for mental health patients. This recommendation would be challenging to deliver and would require significant investment from the commissioners. Ann Radmore added that, whilst the LAS recognised that mental health patients should not be conveyed to a hospital in a police van, it did not think that a dedicated response was achievable at this time. The LAS would continue to work with the commissioners, the Metropolitan Police Service and mental health trusts to develop an appropriate solution.

83.2 Jessica Cecil noted that Lord Adebowale was a non-executive director of NHS England and therefore the LAS needed to be able to demonstrate that it had the support of key stakeholders for the response to the recommendations.

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ACTION: SL to demonstrate that other stakeholders had agreed that the recommendation to have a dedicated response for mental health patients would be difficult to achieve.

DATE OF COMPLETION: 23rd July 2013

83.3 The Trust Board approved the response to the Mental Health and Policing Report and noted that it would be jointly signed by the commissioners and LAS.

83.4 Nick Martin joined the meeting.

84. Board Assurance Framework and Corporate Risk Register

84.1 Sandra explained that the Board Assurance Framework was a dynamic document and gave an overview of the key updates that had been made to the document since it last came to the Trust Board:

- A new risk relating to emergency calls received from the Metropolitan Police Service had been added;
- The risk concerning blankets had been removed and amalgamated into another risk with a lower rating;
- Two risks had been kept visible on the Board Assurance Framework, one relating to the Board and one to governance;
- CQC confirmed that it was satisfied with the progress made against the compliance issues identified but had indicated that there would be a further inspection on the remaining standards in the coming year;
- The sources of assurance had been updated to reflect the 2013/14 priority objectives, the modernisation programme and the finance risks. The priority objectives had also been mapped to the strategic risks.

84.2 Sandra reported that a serious incident had recently been declared relating to messages exchanged between MDTs and CommandPoint. This meant that the top-rated risk (risk 368) had been realised and was now an issue. Vic Wynn reported that the Information Management and Technology had put in an additional control to stop this type of incident recurring. The final implementation of the software change was due at the end of July 2013.

84.3 Jessica Cecil asked whether this risk would be closed once the software had been implemented. Vic responded that there would be a phase of monitoring following implementation before the risk would be closed.

84.4 Caroline Silver asked whether the serious incident could have been avoided if the appropriate measures had been put in place sooner and whether everything possible had been done to mitigate this risk. Vic responded that he expected these questions to be explored as part of the serious incident investigation. The controls that had been out in place should have mitigated this risk, but this was a different scenario, which had not been anticipated.

84.5 Caroline commented that this raised the question about whether the Trust was managing its top-rated risks as well as it should be and suggested that this was discussed at the next meeting of the Audit Committee.

ACTION: FG to add to the Audit Committee forward planner a discussion about risk management and specifically the process for managing risks that had become issues.

DATE OF COMPLETION: 23rd July 2013

84.6 The Trust Board discussed the remaining principal risks. Fionna Moore noted that risk 31 was a risk that the Trust would always face due to the nature of obstetric emergencies, however the consultant midwife was now delivering training at complex-level, which would help to mitigate the risk. Bob McFarland noted that this risk had been on the risk register for 11 years and asked whether it should now be accepted if every action had been taken to mitigate the risk. Sandra responded that the Trust Board needed to have a discussion about the level of risk it was prepared to accept. Caroline Silver commented that this had been discussed at the Audit Committee and it had been agreed that the Trust Board needed to have visibility of perennial risks as well as those that had been archived. This discussion had been part of the evolution of risk tolerance and awareness of the organisation.

84.7 Ann Radmore commented that the Trust did not have a formal relationship with NHS England and therefore asked Sandra to amend the key sources of assurance on page 11 of the Board Assurance Framework.

ACTION: SA to amend the assurances section of the Board Assurance Framework.

DATE OF COMPLETION: 23rd July 2013

84.8 Andrew Grimshaw asked whether there was anything missing from the Board Assurance Framework. Caroline stated that this question had been raised at the Audit Committee. Ann Radmore commented that the Trust needed a more dynamic approach to risk management, that was top-down as well as bottom-up, which would ensure that all risks were identified.

85. Finance Report

Month 2 Finance Report

85.1 Andrew Grimshaw commented that the Finance Report provided the core financial statements for month 2. A more detailed report had been provided for Part II.

85.2 Caroline Silver asked what progress had been made with the Cost Improvement Programme. Andrew responded that the governance structure had been revised and additional project management had been brought in to support the programme. A range of projects were delivering well, some were delivering but not to plan and a number of projects were not delivering. The focus was therefore on the areas where action needed to be taken. Consideration also needed to be given to the mitigating action should the full value of the CIP fail to be delivered through the original programmes.

Finance and Investment Committee

85.3 Nick Martin reported that the committee had reviewed the new format finance report and would receive a full report at the next meeting. The committee did not have any major concerns, but there were a number of factors which were having an impact on the financial position. These were overtime and use of third party providers; sickness absence levels; penalties for breaching hospital turnaround time targets and the ongoing review of human resources budgets and processes. There were also some concerns around the NHS 111 service and the delivery of the CQUINs. The

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committee had agreed that it would have a fuller update on the Grant Thornton baseline review at a future meeting as well as a more detailed report on procurement.

86. Report from Chief Executive

86.1 Ann Radmore reported that the LAS had responded to the request from the Independent Reconfiguration Plan to confirm that it would attend a joint evidence giving session in relation to the North West London Reconfiguration Programme (Shaping a Healthier Future). The LAS would also respond to a call for evidence as part of the Urgent and Emergency Care Review.

86.2 Ann reported that she had met with the Mayor of London, Boris Johnson, and they had agreed that Ann would continue to meet with the deputy mayor. Ann had also met with the Metropolitan Police Commissioner and had agreed that the three emergency services chiefs would continue to meet on a regular basis.

86.3 Listening into Action was progressing and staff were currently being asked to prioritise their top three projects out of the list of 12 projects identified.

86.4 The Chair was pleased to note that the LAS would be responding to the review of urgent and emergency care.

87. Update on Modernisation Programme

87.1 Ann Radmore reported that the formal response to the consultation was due to be circulated at the end of the week and would be sent to the unions. The most contentious issues were rest breaks, annual leave, the grading of A&E support staff and the proposals to progress EMTs towards paramedic registration.

87.2 Ann had met with the unions and had further meetings with UNISON and GMB this week to progress workstreams. Formal responses had been received from UNISON and GMB.

87.3 The out of service arrangements had been implemented and had received positive feedback.

87.4 Ann reported that the next steps were to confirm the process for the assessment of the A&E support pay banding and to continue to work in partnership with the unions. A further series of roadshows were planned for July to provide staff with an update on progress with both the modernisation programme and Listening into Action and to start the discussion with staff about strategy development.

88. Foundation Trust Update

88.1 Sandra Adams reported that she had received a letter from the NHS Trust Development Agency, confirming the outputs of the 2013/14 operating plan. Sandra and Steve had met with the NTDA to discuss the quality process, which had been revised following the Francis Report. The revised timelines would see the Trust commencing its formal application in April 2014 and making a submission to Monitor in February 2015. It was estimated that the Monitor stage would take 4 to 5 months and therefore the Trust would be authorised as a Foundation Trust in mid to late 2015.

88.2 Ann stated that it was important to understand what was meant by headroom and sustainability and this needed to be explored with the commissioners and NTDA.

88.3 The Trust Board approved the proposed timeline for the formal commencement of the Foundation Trust application in April 2014.

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89. Board Declarations – self-certification, compliance and board statements

89.1 Sandra Adams noted that there were no changes from the statements submitted to the previous Trust Board meeting. The Trust Board approved the submission of the Board declarations for June 2013.

90. Report from Trust Secretary

90.1 The Trust Board noted the report from the Trust Secretary and the register of interests.

91. Forward Planner

91.1 The Chair noted that the role of the Quality Committee would be discussed as part of the wider governance review.

92. Any other business

92.1 The Chair congratulated Lizzy Bovill for her secondment to NHS England (London) and wished her well in her new role.

93. Questions from members of the Public

93.1 There were no questions from members of the public.

94. Date of next meeting

94.1 The next meeting of the Trust Board will take place on Tuesday 23rd July 2013.

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Signed by the Chair

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ACTIONS

from the Meeting of the Trust Board held on 25th June 2013

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	AG/SA to review all aspects of charitable funds and to report back to the Trust Board in September 2013.
25/09/12	**135.1**	Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.	**RH**	RH to discuss with AR.
29/01/13	**15.4**	FM/AR to write to Sir Bruce Keogh to ask the LAS to be involved with the review of urgent and emergency services.	**FM/AR**	LAS has engaged with the call for evidence.
26/03/13	**34.3**	EMT to develop an index for measuring value for money.	**AG/EMT**	Proposal to be presented to the Trust Board, following discussion at the Finance and Investment Committee.
26/03/13	**45.2**	FG to add a presentation on the role of Health and Wellbeing Boards to the Trust Board forward planner.	**FG**	Commissioners to be invited to attend the Trust Board to give a presentation on how we are commissioned.
04/06/13	**59.9**	TC to present report on actions taken to address sickness absence to a future Trust Board meeting.	**TC**	Position update to be provided to the Trust Board on 23rd July 2013.

CLOSED ACTIONS

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
26/03/13	**32.5**	FW to ask SL to consider whether there was a qualitative way to monitor comparisons with other ambulance trusts.	**SL**	There is no structure currently in place, although SL is exploring options to do this on a quarterly basis. Action complete.
26/03/13	**37.5**	CH to ensure that the reporting of near misses was covered in the staff induction.	**CH**	Action complete.
26/03/13	**45.3**	AR to send JC her presentation on the structure of the NHS Trust Development Agency.	**AR**	Action complete.
04/06/13	**57.2**	FG/SA to schedule a presentation on the Volunteer Responder Charity into the Trust Board forward planner.	**FG/SA**	Added to the forward planner for 23rd July. Action complete.
04/06/13	**57.6**	AG to circulate Integrated Board Performance Report to Trust Board members.	**AG**	Action complete.
04/06/13	**60.9**	FG/SA to add discussion around demand management to the Trust Board forward planner	**FG/SA**	Added to the Strategy Review and Planning Committee agenda for September. Action complete.
04/06/13	**67.1**	SA to incorporate discussion on competition to future SRP or board development session.	**SA**	Added to the Strategy Review and Planning Committee agenda for September. Action complete.
25/06/13	**80.2**	SL/PW/JK to agree the quality target for Category C.	**SL/PW/JK**	Action complete.
25/06/13	**80.4**	SL to add arrows to the quality indicators to indicate the direction of travel.	**SL**	Action complete.
25/06/13	**83.2**	SL to demonstrate that other stakeholders had agreed that the recommendation to have a dedicated response for mental health patients would be difficult to achieve.	**SL**	Action complete.

Meeting Date	**Minute Date**	**Action Details**	**Responsibility**	**Progress and outcome**
25/06/13	**84.5**	FG to add to the Audit Committee forward planner a discussion about risk management and specifically the process for managing risks that had become issues.	**FG**	Action complete.
25/06/13	**84.7**	SA to amend the assurances section of the Board Assurance Framework.	**SA**	Action complete.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE
Trust Board

DATE: 23RD JULY 2013

PAPER FOR INFORMATION

Document Title:	Performance report month 03 (June 2013)
Report Author(s):	Andrew Grimshaw, Director of Finance
Lead Director:	Andrew Grimshaw, Director of Finance
Contact Details:	
Why is this coming to the Trust Board?	To provide the Board with an integrated view on performance.
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	The Trust Board is requested to note this paper.

Executive Summary

This paper provides a summary of the Trust's performance across a range of quality, performance, workforce and finance metrics.

Key issues for the Trust Board

Quality	
Performance	`
Workforce	
Value for Money	

Attachments

Performance Report Month 3 (June 2013)

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Quality Strategy
This paper supports the following domains of the quality strategy

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☒ Helping People
☒ Quality of Life
☒ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
☒ That we cannot maintain and deliver the core service along with the performance expected
☒ That we are unable to match financial resources with priorities
☒ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
INTEGRATED PERFORMANCE REPORT 2013/14: JUNE 2013 (MONTH 03)

Area	Rating	Comment
Quality	Green	**Largely on plan for the month**
Performance	Green	**Activity levels below plan overall, but performance in line with plan.**
Workforce	Red	**Continued high sickness, turnover and vacancies.**
Value for Money	Amber	**Some pressures resulting from high abstraction rates. CIP delivery below expectations.**

Summary commentary

Trust's performance remains consistent with last month, May Operationally, Category A performance remains above plan for the month, with performance being consistently at this level all month. It should be noted that category A activity levels are lower than expected in June. Category C performance has remained largely in line with the levels commissioned. Overall total incidents are up for quarter one. Quality measures are largely in line with plan.

Workforce measures continue to show high levels of sickness (although June has seen a slight reduction to 5.93%), with levels in frontline staff remaining at 6.5%. Turnover remained stable at 9.6%. Vacancies have increased to 9.76% across the Trust, although significant numbers of these are being covered by overtime and the use of agency and contracted staff. These issues are a major concern for the Trust and represent a significant risk to the Trust, both operationally and financially. Increasing recruitment and addressing sickness are a key priority for EMT.Core Skill Refresher training for operational staff commenced in the last week of May and it is intended to continue at a rate of 90 staff per week across Q2. Current booking and atendance rates indiacte that 60% of staff will have been trained by the end of November. This is currently under review.

Financial performance indicates an increased adverse variance from plan in , with the overall year to date adverse variance increasing to £298k. The main reason for this relates to higher than planned non-productive time (sickness and secondments), and the slow start to CIP delivery. The higher than planned staff costs represent the main threat to the delivery of the year end forecast. Additional support has been engaged to support the delivery of CIPs. Cash remains above plan.

QUALITY

	Target	Current month	Previous month	Year end forecast
1 Serious Incidents	1	**-**	**2**	
2 Complaints	80	**73**	**87**	
3 Call Answering	95.0%	**98.9%**	**99.3%**	
4 Treatment CPI	95.0%	**96.0%**	**98.0%**	
5 Infection control - hand hygiene	100.0%	**100.0%**	**100.0%**	
6 Infection Control - cleaning	100.0%	**88.8%**	**77.9%**	

PERFORMANCE

	Target	Current month	Previous month	Year end forecast
1 Category A	75.0%	**75.9%**	**77.7%**	75.3%
2 Category C1 (20 mins)	90.0%	**77.0%**	**77.5%**	
3 Cat A total incidents	42,563	**37,005**	**38,014**	
4 Cat A (red 1) incidents	1,430	**1,201**	**1,151**	
5 Cat A (red 2) incidents	41,133	**35,804**	**36,861**	
6 Demand Management Plan (A)		**78%**	**73%**	

WORKFORCE

	Target	Current month	Previous month	Year end forecast
1 Staff retention	8.5%	**9.60%**	**9.60%**	
2 Vacancies (%)	5.0%	**9.76%**	**9.50%**	
3 Vacancies (WTE)	241	**470**	**459**	
4 Sickness all staff	5.5%	**5.93%**	**6.05%**	
5 Frontline sickness		**6.50%**	**6.46%**	
6 Training (CSR)	65%			60%

VALUE FOR MONEY

	Target	Current month	Previous month	Year end forecast
1 EBITDA (£000)	4,634	**4,303**	**2,814**	18,450
2 Net surplus (£000)	303	**5**	- **18**	262
3 Cost Improvement Programme (£(	1,708	**1,574**	**1,014**	9,800
4 Capital expenditure (£000)	1,800	**697**	**116**	10,250
5 Monitor FRR	3	**3**	**3**	3
6 Cash balance (£000)	14,894	**17,486**	**15,747**	5,500

London Ambulance Service NHS

NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 JULY 2013

PAPER FOR ASSURANCE

Document Title:	**Quality Report (Dashboard)**
Report Author(s):	**Steve Lennox, Director of Health Promotion and Quality**
Lead Director:	**Steve Lennox, Director of Health Promotion and Quality**
Contact Details:	**Steve.Lennox@lond-Amb.nhs.uk**
Why is this coming to the Trust Board?	**Inform Trust Board current position against quality measures**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**Assure the Trust Board that the same levels of quality (within the monitored domains of the dashboard) are being maintained.**

Key issues and risks arising from this paper

Quality performance appears to be stable with no new issues. Performance for Cat C remains a risk for the organisation.

Executive Summary

At the June Trust Board the Board members requested that the direction of travel arrow be applied to the overall Trust dashboard rather than just to the DH comparative dashboard. This has been completed. Where an indicator is made up of more than one measure (for example Clinical Performance Indicator) the arrow reflects the worst position (in other words improvement arrows have not been shown if one of the elements is deteriorating).

The dashboard is a barometer of quality and provides one piece of assurance regarding the level of quality the service is providing. Other elements of assurance include, Assurance from the Quality Committee, Trust Board Members Observational Ride Outs, Patient Stories and Clinical Report.

This quality report suggests the same level of quality is being maintained. The indicators of amber or red RAG rating are;

On Scene Time = Red

Not all of the three elements were fully populated this month but from the Stroke On Scene times data we can see we are still not within our 30 minute target period. To try and understand this in more detail the Assistant Directors of Operations have commissioned a small pilot study into practice from Edmonton station to see if First Responders are actually creating a longer time on scene from the patient being viewed as “safe” as a professional is in attendance.

STEMI Care = Red
Pain Relief for patients with a low pain score remains the area of practice responsible for a RED RAG rating.

Stroke Care = Amber
This is made up of two measures. 60 minutes and the care bundle administered. Both are rated as Amber as we are close to our compliance figure but slightly below.

Not Conveyed to A&E =Amber
This is made up of two measures. 1) hear and treat and 2) see and treat. We are now seeing a month on month improvement in see and treat but a month on month slide for hear and treat.

Clinical Performance Indicators = Amber
The poorest compliance is “PRF copy left with patient” at 90% (target 95%). Each month CARU provide the data to complexes and the individual feedback to clinicians on their performance is taking place..

Airway Management = Amber
No significant issues with little change in compliance.

Lost Property = Amber
A slight drop in the number this month (51) just one case above trajectory.

Re contact See & Treat = Red
This indicator has been gradually increasing over the year. Our best compliance was 4.9% and we are currently at 6.8%. ADO’s have been asked to consider actions at their Area Governance meetings.

Infection Control = Amber
Compliance with Deep Cleaning fell as the contractor had difficulty with staffing but this has now started to improve. Compliance currently 89% of vehicles deep cleaned.

Category C = Red
Category C response time is lower than we would like but we are in regular discussion with commissioners regarding performance. The Modernisation Programme is our main vehicle for delivery of improvement to cat C.

Handover to hospital = Red
This measures the quality impact on our patients of waiting to be received by A&E ay handover. This wok is being managed centrally by NHS England and our local commissioners.

Supervision of Staff = Amber
This is made up of two indicators. PPED which shows good compliance and OWR which at 162 in the month is our best compliance since April 2012.

Sickness = Red
Sickness is at 5.93% against a target of 5.5%. A separate review is being prepared for Trust Board.

Vacancy factor = Red
Vacancy across the Trust is at 9.5%. Not all these are clinical vacancies. Nevertheless the risk is being reviewed and corrective action is being led by the Modernisation Programme.

From this months dashboard the indicators of concern remain the same. These are

- On Scene Waiting Times. A piece of work is being undertaken at Edmonton to examine why we have been unable to reduce our on scene times to consistently below 30 minutes for the three groups of patients that we measure on scene time for.

- Cat C. This is receiving considerable focus and is the root benefit of the modernisation programme.
- Vacancy Factor. This is also being managed by the Modernisation programme.

Therefore, our areas of quality improvement remain as outlined within our Quality Account.

- Attitude & behaviour
- Experience of patients receiving a delay
- Experience of patients on an ACP
- Missing Equipment

These four areas will be added to the dashboard once we have agreed the metrics.

Attachments

Dashboard

****

Quality Strategy

This paper supports the following domains of the quality strategy

☐ Staff/Workforce
☐ Performance
☐ Environment
☐ Experience
☐ Helping People
☐ Quality of Life
☐ Preventing Death

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

✓ To improve the quality of care we provide to our patients
✓ To develop care with a highly skilled and representative workforce
☐ To provide value for money

2013/14 Priorities

✓ Modernisation Programme
☐ Communication and Engagement
✓ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

✓ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
✓ That we cannot maintain and deliver the core service along with the performance expected
✓ That we are unable to match financial resources with priorities
☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
✓ No

Key issues from the assessment:

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1. Quality Dashboard for July (May & February Measures) 2013

May 2013 | **OLDER (Feb)**

Domain 1. Preventing people from dying prematurely

May 2013:

Source	Measure	Trend
DH	Red 1 (A8)	↑
DH	Red 2 (A8)	↓
LAS	On scene Time	?
LAS	Basic Life Support	↓

OLDER (Feb):

Source	Measure	Trend
DH	Outcome from cardiac arrest	↑
DH	Return of spontaneous circulation	↑
DH	STEMI Care	↓
DH	Stroke Care	↓

Domain 2. Enhancing quality of life for people with long-term conditions

Source	Measure	Trend
DH	Not conveyed to A&E	↓
LAS	Clinical Performance Indicators	?

Domain 3. Helping people to recover from episodes of ill health or following injury

Source	Measure	Trend
DH	Time to Treatment	↓
LAS	Airway Management	↓

Domain 4. Ensuring people have a positive experience of care

Source	Measure	Trend
DH	Service Experience	?
LAS	Incidents	↑
LAS	Lost Property	↓
DH	Time taken to Answer 999	?
DH	Re Contact Rate	↑
DH	calls Abandoned	?

Domain 5. Treating & caring for people in a safe environment and protecting them from avoidable harm

Source	Measure	Trend
LAS	Infection Control	?
LAS	Safeguarding	↑
DH	A19	↑
LAS	C1	↑
LAS	C2	↑
LAS	C3	
LAS	C4	
LAS	Handover at Hospital	↓

Domain 7. Caring for the workforce

May 2013:

Source	Measure	Trend
LAS	Supervision of staff	↓
LAS	CPI Feedback Sessions	?
LAS	priority Training	↑
LAS	Vacancy factor	↑
LAS	3rd Party Providers	↑

OLDER (Feb):

Source	Measure	Trend	Status
LAS	Sickness	↑	
LAS	Temperature Check	N/A	N/A

2. Comparison Table

2.1 The following table identifies the Department of Health Indicators and our ranking against other Ambulance Trusts and our direction of travel. Our lowest and highest compliance scores are also illustrated.

2.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. We are upper quartile in 30 (last report 25, previous month 22) out of 46 areas.

	May Data for July Trust Board					YTD
	Comp-liance	Rank	Lowest	Highest	Comp-liance	Rank
A8 R1 Response Time	77.90%	4	71.70%	81.9%	77.80%	3
A8 R2 Response Time	77.70%	5	67.10%	81.50%	79.80%	1
A19 Response Time	98.50%	1	96.70%	99.00%	98.20%	1
ROSC (all)	33.70%	3	27.30%	36.40%	30.80%	2
ROSC (Utstein)	57.70%	4	45.70%	63.60%	54.90%	1
Time Taken to Answer 50th Percentile	0.00%	1	0.00%	0.00%	0.00%	1
Time Taken to Answer 95th Percentile	0.01	1	29	0.01	0.01%	1
Time Taken to Answer 99th Percentile	0.01	1	1.46	0.02	0.08%	1
Time to Treatment 50th Percentile	5.42%	6	6.11%	5.36%	5.47%	5
Time to Treatment 95th Percentile	13.42%	1	16.90%	12.70%	13.58%	2
Time to Treatment 99th Percentile	20.36%	2	19.40%	27.30%	21.24%	2
Outcome from cardiac Arrest Survival	11.40%	3	6.30%	11.40%	8.10%	5
Outcome from cardiac Arrest Survival (Utstein)	36.00%	3	16.30%	37.00%	27.50%	3
STEMI Outcome 150 minutes	93.60%	4	84.30%	94.90%	92.50%	2
STEMI Outcome Care Bundle	65.50%	11	63.10%	69.20%	67.10%	12
Stroke Outcome 60 minutes	65.40%	3	61.6%	75.80%	68.20%	4
Stroke Care Outcome Bundle	92.90%	9	92.10%	95.70%	93.80%	11
Calls Closed with CTA	5.30%	6	5.30%	6.90%	5.70%	6
Non A&E	31.20%	8	26.6%	33.30%	30.60%	8
Re Contact rate CTA	2.50%	1	3.40%	2.20%	2.90%	1
Re Contact rate See & Treat	6.80%	3	6.1%	4.90%	6.80%	2
Re Contact rate Frequent callers	2.40%	4	2.5%	2.61%	2.40%	3
999 Calls Abandoned	0.00%	1	0.0%	0.10%	0.00%	1
Service Experience						

3. Conclusions

3.1 The DH dashboard has seen an improvement against other Trusts.

3.2 From this months dashboard the indicators of concern remain the same. These are

- On Scene Waiting Times. A piece of work is being undertaken at Edmonton to examine why we have been unable to reduce our on scene times to consistently below 30 minutes for the three groups of patients that we measure on scene time for.
- Cat C. This is receiving considerable focus and is the root benefit of the modernisation programme.
- Vacancy Factor. This is also being managed by the Modernisation programme.

3.3 Therefore, our areas of quality improvement remain as outlined within our Quality Account.

- Attitude & behaviour
- Experience of patients receiving a delay
- Experience of patients on an ACP
- Missing Equipment

3.4 These four areas will be added to the dashboard once we have agreed the metrics.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

PAPER FOR INFORMATION

Document Title:	**Clinical Quality and Patient Safety Report**
Report Author(s):	**Fionna Moore / Steve Lennox**
Lead Director:	**Fionna Moore / Steve Lennox**
Contact Details:	
Why is this coming to the Trust Board?	**Information only**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☒ Other: Elements of this report have been presented to other groups
Recommendation for the Trust Board:	**Information only**

Key issues and risks arising from this paper

- The most recent cardiac and stroke reports have been released.
- CPI completion remains high for the eighth month running. The Mental Health CPI has for the first month increased to just above the minimum expected compliance level.
- The most recent patient experiences department report is included which shows less complaints when compared the previous months.
- The locality alert register continues to have a similar number of addresses held on it, although slightly less than the figures reported in June.
- DMP use has remained high throughout the month of June. This poses great risk as the levels are escalated. June saw an increase in the use of DMPD.
- The Trust has not received any rule 43 recommendations since the last report to Trust Board.

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. The report identifies both areas for improvement and also success. Trust Board can be assured that the service is providing good quality care to its patients. The Board should note that the use of DMP and escalation of REAP levels impacts on the both the delivery of training, and on the delivery of operational workplace reviews. This could pose a risk if it continues.

Attachments

None

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Quality Strategy
This paper supports the following domains of the quality strategy

- ☒ Staff/Workforce
- ☒ Performance
- ☐ Environment
- ☒ Experience
- ☒ Helping People
- ☒ Quality of Life
- ☒ Preventing Death

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This paper supports the mitigation of the following strategic risks:

- ☒ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
- ☒ That we cannot maintain and deliver the core service along with the performance expected
- ☐ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – July 2013

Clinical Directors' Joint Report

Summary

This report is structured using the Quality Domains of the Quality Dashboard. However, it also reports on issues wider than those measures.

This report identifies both successes and areas where improvement is required. The Trust Board can take some assurance that the service is maintaining a high quality service to its patients. However, there is concern over utilisation and increasing call numbers seen by the Trust in recent months. This concern is coupled with the need for training time and the introduction of the new National Clinical Guidelines and drugs which are due to be released. Without appropriate training time, the release of the guidelines will have to be stalled, as will the implementation of the new drugs the Trust is adopting. This will impact on the care that is provided to our patients.

Quality Domains

Quality Domain 1: Preventing People from Dying Prematurely

The Clinical Audit and Research Unit (CARU) produce quarterly activity updates summarising the progress of projects being undertaken within or facilitated by the unit. The Clinical Audit Activity update summarises the key changes in core clinical audits, continual audit activity, clinical performance indicators (CPIs) and national clinical audits. The Research Activity Update outlines new research projects and changes to active research and non-research projects, as well as any publications.

May's Cardiac Care Pack has been published and can be found at the following link:
Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '13-March '14\Cardiac Care Pack (May '13)-Cardiac Arrest only.pdf
The report is currently only data on Cardiac Arrest due to ongoing staff shortages.

May's Stroke report has been published and can be found at the following link:
Clinical Audit & Research Unit\Stroke Reports\Monthly Reports\Apr '13- Mar '14\Stroke Care Pack (May'13).pdf

Quality Domain 2: Enhancing quality of life for people with long-term conditions

Mental Health

Some concern has been raised recently regarding the two mental health indicators that are reported within Trust Board reports. 1) The staff recording the use of the capacity tool and 2) staff documenting that they have considered safeguarding.

These two measures are chosen to act as a high level measure. Sitting below this are a number of other indicators that record the care we deliver to Mental Health patients. The latest full data set is given here to assure that mental health compliance is higher than just these two indicators suggest.

Aspect of care	Compliance
Assessment of the patient's ability to communicate	84%
Assessment of the patient's behaviour	92%
Assessment of the patient's thoughts	89%
Blood glucose (BM) recorded	89%
Capacity tool used	97%
Current Psychiatrist/Community Psychiatric Nurse/Care or Approved Social Worker	86%
Description of the patient's appearance	70%
First set of observations recorded and time logged (hh:mm, AVPU, Resp rate, Resp depth, O_2 sats, Pulse rate, Pulse character, BP and colour)	96%
History of current event	99%
Medical history	99%
Psychiatric history	98%
Safeguarding referral considered for all children in the household	97%
Safeguarding referral for patient considered	52%
Grand Total	**88%**

Quality Domain 3: Helping people to recover from episodes of ill health or following injury

Clinical Performance Indicator completion and compliance

The CPI completion rates remain high for the 9th month running. In comparison to May 2012, the completion rate for May 2013 is increased by 26%. Since the introduction of the Mental Health CPI, the Trust has seen consistently low compliance rates to the audit. However, May has seen the overall compliance rate for this audit increase to above the minimum expected compliance rate of 95%. The West area managed to achieve a compliance rate of 100% to this audit which is a fantastic achievement.

Full CPI reports can be accessed at:

Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2013-14\Monthly Reports 2013-14

CPI Completion May 2012 to May 2013.

Area	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
East	82%	82%	79%	72%	88%	96%	97%	95%	95%	93%	97%	100%	99%
South	46%	42%	62%	87%	99%	98%	98%	100%	100%	100%	97%	100%	99%
West	93%	88%	92%	98%	98%	97%	99%	100%	100%	99%	100%	99%	96%
LAS	**72%**	**70%**	**77%**	**87%**	**96%**	**97%**	**98%**	**98%**	**99%**	**97%**	**98%**	**99%**	**98%**

CPI Compliance May 2013

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	100%	98%	100%	97%	96%	100%	99%
South	100%	100%	100%	100%	94%	99%	100%
West	100%	97%	100%	97%	100%	95%	95%
LAS Total	**100%**	**98%**	**100%**	**98%**	**96%**	**98%**	**98%**

CPI Compliance April 2013

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	95%	95%	97%	85%	96%	97%
South	97%	96%	97%	98%	88%	97%	98%
West	98%	96%	97%	98%	89%	97%	98%
LAS Total	**98%**	**96%**	**96%**	**97%**	**88%**	**96%**	**97%**

CARU Interim update March-May 2013

The Interim update for CARU has been published for the period March-May 2013. The full report is available if required.

Adrenaline 1:1,000 re-audit

The clinical audit and research department undertook a re-audit of the use of Adrenaline 1:1,000 for the treatment of anaphylaxis and life threatening asthma. The re-audit shows the percentage of patients receiving this drug via the correct route and the correct dosage has increased. However, there are a number of patients who receive Adrenaline when not indicated. The full report can be found at:
X:\Clinical Audit & Research Unit\Clinical Audit Reports\Adrenaline re-audit

NICE Guidelines June 2013

The NICE guidelines for June 2013 have been released. From the document released, two of the references are relevant to frontline ambulance practice.

CG161 – Falls: assessment and prevention of falls in older people
This guidance states that older people who have contact with healthcare professionals should be asked as a matter of course, whether they have fallen in the past year and should also be asked about the frequency, context and characteristics of the fall/s. It goes on to state that older people who require medical attention because of a fall, those who report recurrent falls, or those who demonstrate an abnormal gait should be offered a falls risk assessment.

CG162 – Stroke rehabilitation: Long-term rehabilitation after Stroke
This guidance states that patients diagnosed with stroke and who have disability following the stroke should have rehabilitation in a dedicated stroke rehabilitation unit, with access to a multi-disciplinary team. Although as an ambulance Trust, this guidance isn't immediately relevant; the Hyper Acute Stroke Units (HASU's) that stroke patients are transported to by frontline crews will be

expected to follow this guidance and will therefore impact on the treatment of this patient group whom we have regular contact with.

Quality Domain 4: Ensuring people have a positive experience of care

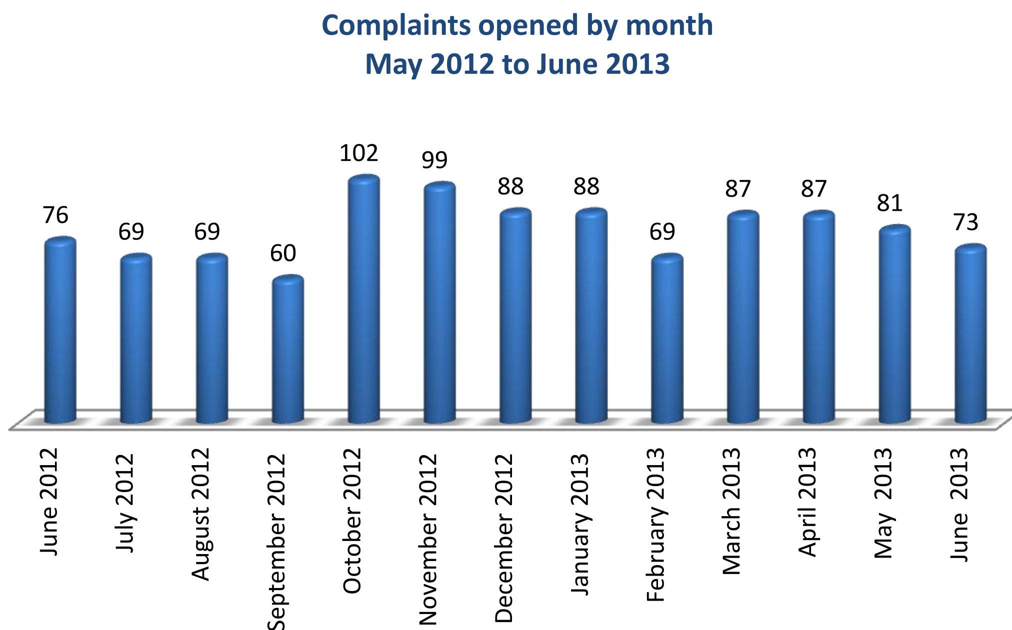
Patient Experiences

COMPLAINTS

Complaint Volume

The number of Complaints received totalled 73, slightly lower than May but reflective of the 2012/13 monthly and seasonal average.

14 complaints involved other Trusts/agencies including 6 Acute Trusts, 3 x 111 providers, 2 x NHS Direct and the remainder GPs, CCGs and other Ambulance Trusts.



8 related to driving issues and 7 were not our service. 23 of the 73 complaints have been closed

Complaint Themes

Complaints relating to the delay and staff attitude & behaviour continue to be the dominant themes.

Complaints by subject	May	June
Delay	37	29
Attitude and behaviour	26	18
Road handling	12	8
Treatment	2	3
Non-conveyance	0	6
Conveyance	2	2
Not our service	1	7
High Risk Address Referral	1	0
Patient Injury or Damage to Property	0	0
Totals:	**81**	**73**

Case examples

Validity of 999 call

A patient was upset that the ambulance crew questioned him about his symptoms; the patient felt them to be challenging the validity of his 999 call. (C7840). The patient was also upset that the crew blamed injuries to his legs on playing rugby when in fact they had been caused when the crew removed the patient from the ambulance. Feedback was provided to the crew to ensure that the capacity tool be used in future and that an incident report form is completed when a patient sustains an injury whilst in their care.

Possible patient care plan

A patient was concerned at the manner in which her 999 call was managed. There was also confusion that after she had made her own way to hospital on the advice of CTA, an ambulance did actually attend. (C7848). The patient was advised that her Consultant would have been able to arrange an ambulance and that she should further liaise with the Consultant and to discuss the emergency component of her care plan.

Complying with GP clinical opinion

A 999 call was received from the GP stating that the patient may have suffered a stroke. When the ambulance crew arrived they assessed the patient's condition using the recognised diagnostic tool (FAST assessment). The patient was concerned that the crew disputed the GP's diagnosis. Feedback was provided to the crew in a reflective practice exercise to highlight other signs and symptoms associated with stroke and the balance between reassuring a patient and being misleading.

Performance/Quality

78 cases were closed during June. As at 4 July 127 complaints remain open or re-opened.
The remainder are under enquiry pending further information from complexes, the Medical Directorate or the Quality Assurance department. Complainants are advised by email or telephone call whenever a delay in responding is anticipated.

Closure rates for 2013 are demonstrated in the table below. This evidences that cases are being closed more quickly. However, a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = 27 July 2013.

Month	0-25 days	0-35 days	0-40 days	0-45 days	0-60 days	0-80 days	0-100 days	Total closed in timeframes given	Total complaints received
2013 01	23	10	6	10	20	12	7	88	88
2013 02	22	7	5	11	15	8	1	69	69
2013 03	35	10	5	14	18	2	1	85	88
2013 04	32	10	9	13	11	0	0	75	86
2013 05	21	4	0	0	0	0	0	25	81
2013 06	23	0	0	0	0	0	0	23	73
Totals:	156	41	25	48	64	22	9	365	485

Comeback responses

Year	Numbers of comeback responses recorded
09/10	9
10/11	4
11/12	12
12/13	37
13/14	3
Totals:	**65**

There were no re-opened cases in June.

Health Service Ombudsman

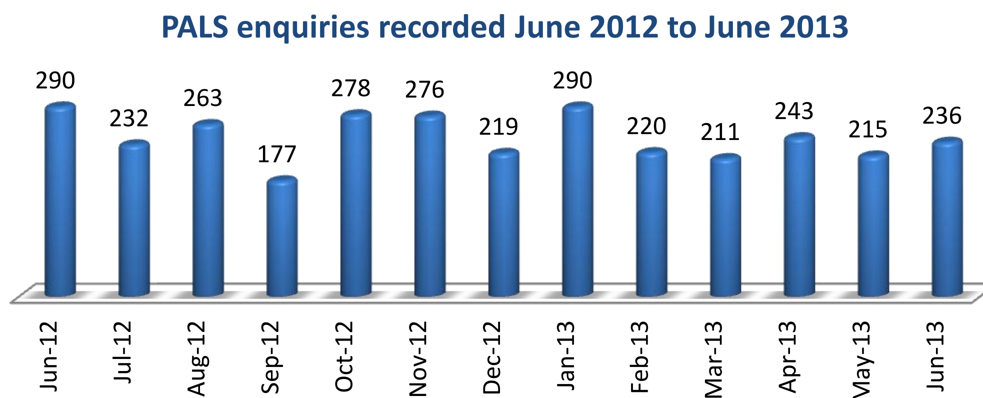
Recent activity:

June-13		
Datix reference	**Current status**	**Outcome**
C7134	Further letter sent to PHSO clarifying issues 09 Jan 2013	Response awaited from PHSO (acknowledged 15 Jan 2013)
C7054	Request for file May 2013.	Currently awaiting allocation by the Ombudsman to one of their case officers
C7425	File requested by Ombudsman 18 March 2013	Acknowledgment from Ombudsman 06 June 2013 –awaiting response
C7528	File requested by PHSO 16 April	Documents provided 17 April. DMP procedure provided to HSO 07 June 2013
C7562	Complainant has approached the PHSO who has informed LAS	File with Ombudsman on 16 April 2013
C7614	File requested by PHSO	Documents provided 05 June 2013 – outcome awaited

PALS

PALS Volume

The number of PALS enquiries remains stable.



The total PALS enquiries received in the past 6 years is as follows:

Financial Year	Total PALS
08-Sep	5606
09-Oct	5674
10-Nov	6031
11-Dec	6264
Dec-13	5714
13/14 (to date)	1342
Totals:	**30631**

PALS Themes

Once again, consistent themes about destination hospital, medical record requests, information and requests for policy and procedure.

PALS June 2013	
Information/Enquiries	181
Lost Property	41
Appreciation	6
Clinical	3
Access	1
Delay	1
Non-physical abuse	1
External Incident Report - EOC	1
Incident Report - GP Surgery	1
Totals:	**236**

Lost property

In June = 41 requests; 3 items were traced by PED and the others referred to local stations. 11 referrals do not have a recorded outcome. Local PIM's now have access to the lost property spreadsheet.

Quality Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Clinical RIB Page

Following concerns from training staff in particular, a trial of a 'clinical page' in the RIB once a month is being trialled. It was felt that too many Medical Directorate bulletins were being released which could lead to important messages being missed. These bulletins will now only be used when the information is vital for staff to know immediately. All other information will be collated and distributed monthly (the first RIB of the month). This issue will also reference any Medical Directorate bulletins that may have been released in the past month. It is hoped that this will make it easier to find bulletins and specific information, and should also ensure that important messages are not lost.

Safeguarding

There is nothing of significance to report this month

Serious Incidents

14 serious incidents were considered by the serious incident group during the months of May and June. Of these, 2 were declared as Serious Incidents, 10 were not declared, and the remaining 2 are awaiting further investigation.

The first serious incident declared in June surrounds the premature closure of a call which resulted in the call being held for a considerable amount of time. A further call was received to the same address for the young male now in Cardiac Arrest. The patient died. A fault has been found within the airwave and commandpoint link and has a temporary fix. The incident is now under investigation.

The second serious incident declared during June surrounds the delayed despatch of an ambulance and subsequent delay in treatment to a patient who was reported to have had a seizure and was not responding appropriately. The call was incorrectly triaged, and was not re-triaged correctly when further calls were received. The final call received which resulted in despatch was received from the patient's partner who had been contacted by a 2yr old child on scene. The call was triaged as a Red2, and after gaining access to the property via the police, the patient was found in cardiac arrest.

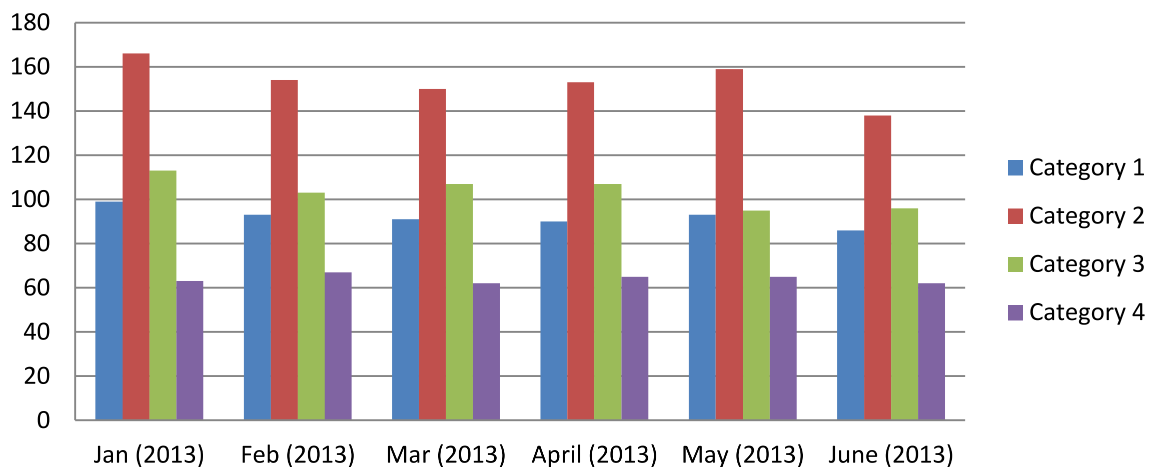
NHS Central Alerting System (CAS)

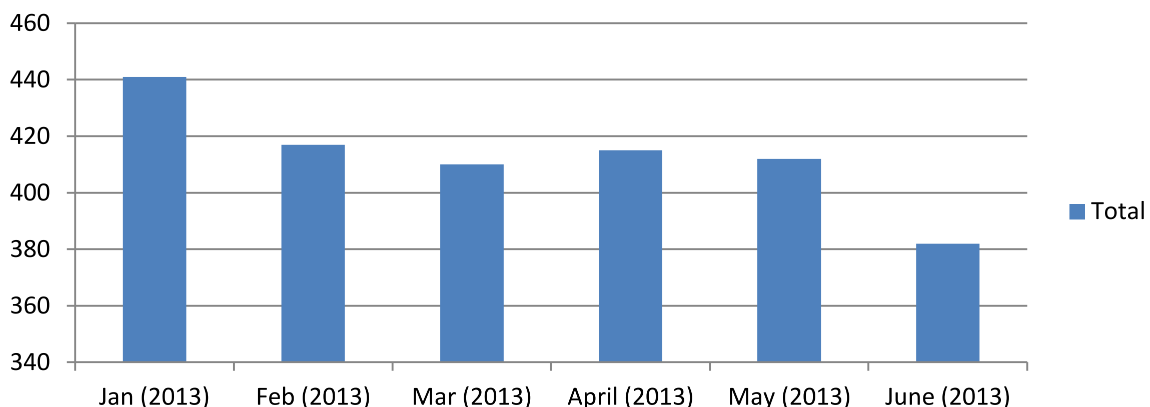
There were 14 CAS reports released during the month of June. These have been reviewed by the safety and risk department and none have any relevance to the Trust. No action is therefore required.

Locality Alert Register

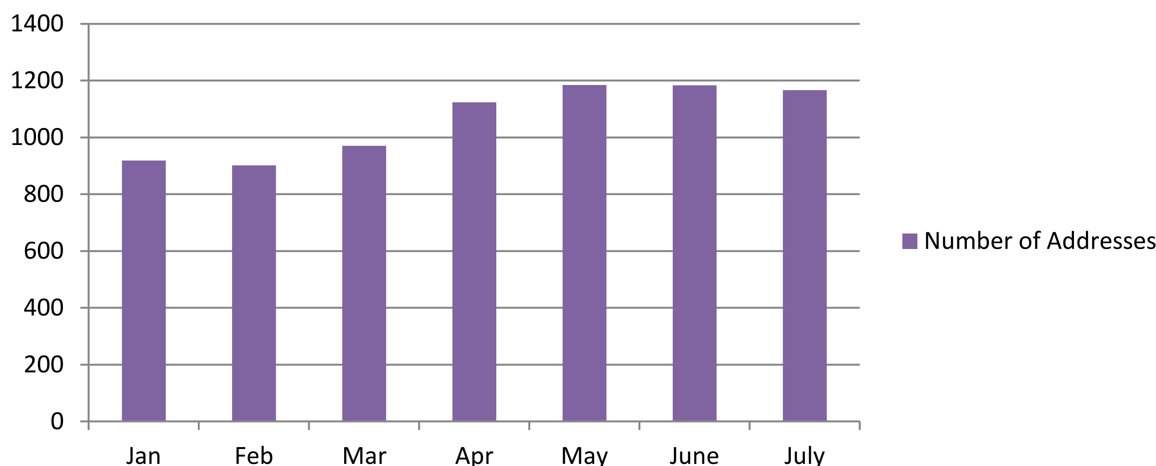
There are currently 382 addresses on the LAR register. These are broken down as follows:

CATEGORY 1: 86
CATEGORY 2: 138
CATEGORY 3: 96
CATEGORY 4: 62





The Trust has notification of 1166 high risk addresses from the Metropolitan Police. Crews are reminded to complete a dynamic risk assessment on their arrival to the address. This month sees the total of these addresses falling for the first time since February. However, when compared to the figures reported in January, there has still been a significant increase.



Demand Management Plan

The purpose of DMP is to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to respond to periods of high pressure, due to unforeseen demands, poor resourcing or on occasion where capacity does not exist to absorb unexpected patient demand.
DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement in the Control Room, with clinical 'floor walkers' available to assist call handlers, and by ringing calls back to provide advice, to re-triage and on occasion to negotiate alternative means of transport or follow up. It is also mitigated by regular senior clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the DMP invoked.

DMP use May and June 2013

Month	Number of Occasions	Stage B (in hours)	Stage C (in hours)	Stage D (in hours)	Stage >D (in hours)	Ambulances reprioritised	No-send at point of contact
May	13	136.5	7	6.76	0	3671	625
June	19	117.25	20.75	7.75	0	3532	901

DMP use during the months of May and June were similar in hours of use. However of note, the use of DMP C increased significantly in June to that used in May. The number of patients informed of a no-send at point of contact also increased when compared to those informed of a no-send in May at point of the 999 call.

Medicines Management

Following the last report to EMT surrounding two incidences of morphine being taken home, both of these incidents have been formally reported to the NHS England (London Region) Accountable Officer in the Q1 Controlled Drugs Report that was submitted on the 4th July 2013.

There have been no unannounced visits by the Metropolitan Police, but given the above two incidents the Senior Clinical Adviser to the Medical Director, has been in contact with the Met Police CD Liaison Officer and will be arranging some visits.

Following on from the item reported in the last report surrounding the supply of pre-filled Atropine syringes, we are arranging to have a face to face meeting with Aurum Pharmaceuticals. This is to gain assurances regarding their supply chain and their quality assurance framework(s). This meeting is yet to take place.

Education and training on the "New JRCALC" drugs, (Ondansetron, Dexamethasone, Tranexamic Acid & IV Paracetamol), has started and it is intended that all the new drugs will be placed into drugs bags from mid July.

We have issued advice to staff via the new Clinical Section of the RIB regarding the use of adrenaline 1:1,000 in anaphylaxis/asthma. This follows a series of incidents where this drug has been incorrectly administered via the intravenous, rather than the intramuscular route.

The next meeting of the Medicines Management Group will be held on 24th July 2013.

Rule 43 Reports

There have been no rule 43 recommendations received by the Trust since the last report to Trust Board.

Rising Tide

Review and re-launch of the LAS Journal Club

The Clinical Audit & Research Unit (CARU) has been running a Journal Club since 2007. It was originally designed in conjunction with a Paramedic with the aim of raising awareness of research relevant to pre-hospital care and encouraging debate about the impact of research on patient care. The journal club is advertised using the RIB and is open to all members of staff irrespective of role in the Service. In advance of each meeting, members are sent one to two research papers related to an area of current interest along with a reading guide. Discussions at the meeting – guided by the Chair (usually a member of the Medical Directorate) – focus on the main findings of the paper, whether the findings can be trusted, and how the research could impact on our practice.

Recently, attendance numbers have declined and we received informal feedback that some frontline staff were deterred by the presumed academic nature and format of the Journal Club. In May 2013, CARU undertook a survey of previous attendees of the LAS Journal Club in order to gain feedback on what staff hoped to gain from the session and how we could improve future sessions. Surveys were completed by 14 people.

The most common reasons for attending Journal Club were to gain exposure to the latest research relating to the work of the ambulance service (86%) and to gain new clinical knowledge (79%). Staff liked the informal nature of the session and being able to discuss scenarios with colleagues, the Medical Directorate and CARU. Suggested improvements included emphasising that attendees won't be "picked on" to ask questions, that no understanding of statistics is required, and having an LAS expert to lead discussions.

The responses suggested that a move to an evidence-based clinical practice session would be welcomed. Therefore, the Journal Club will be re-launched in September as an Evidence for Practice session hosted by members of the Medical Directorate with support from CARU. The sessions will focus on research behind changes to guidelines and other hot topics. Staff will also be invited to bring related case studies to the sessions for discussion to allow greater interaction from participants.

Public Health

The Director of Health Promotion & Quality recently attended an event hosted by Public Health England on MERS Coronovirus. It is clear that there is still more work to be done in understanding this virus and the mode of transmission. The implications for Ambulance Trusts has not been widely considered however the new infection Control lead (starting August 1) will be asked to focus on this as an early objective.

Fionna Moore	**Steve Lennox**
Medical Director	**Director of Quality & Health Promotion**

London Ambulance Service NHS

NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 JULY 2013

PAPER FOR APPROVAL

Document Title:	**Francis Report Draft Action Plan)**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.Lennox@Lond-Amb.nhs.uk**
Why is this coming to the Trust Board?	**Approve emerging themes and direction of travel.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve emerging themes and direction of travel**

Key issues and risks arising from this paper

Patient quality is at the heart of this action plan. However, the action plan is also likely to feature within the Trust Development Agency's monitoring processes as we progress to Foundation Trust status.

Executive Summary

In 2013 the second Francis Report was published into the deaths at Mid Staffordshire Hospital. All Trust's have been asked to consider the report and apply any learning to their own organisation and develop a subsequent action plan.

The majority of Trust Board members participated in a series of 1:1 meetings as part of our gap analysis and based on this process a draft action plan has been developed.

The action plan is presented in a way that links the recommendations directly to Francis. A summary of all the actions is supplied in Appendix I. The dark blue shaded boxes are directly lifted from Francis. The mid blue is the gap analysis and the light blue boxes are our first thoughts on possible actions.

The full gap analysis is not published here. The themes are presented, and on some occasions only a single view was expressed. The report has recorded the views as expressed in the review.

The subsequent actions have been discussed at the Executive Management Team Meeting but each individual action has not yet been approved by the relevant director. This action plan is presented to Trust Board to obtain approval for the direction of travel and the themes that are emerging. Those themes are;

1) Governance
2) Culture
3) Staff involvement
4) Leadership
5) Accountability
6) Learning from Experience
7) Professionalization
8) Staff support and supervision
9) Performance
10) Being open
11) Education & practice

A further discussion is planned at Strategy, Review and Planning Committee where the Board will have another opportunity to identify actions.

Discussion at the Executive Management team revealed that attention needs to be paid to the actions regarding commissioners especially in identifying how, together with the Director for Ambulance Commissioning, we can achieve more local engagement.

In addition, there are a number of actions that refer to the "push and pull" of performance and quality and a suggestion that we move to a more balanced focus. Clearly some of this focus is nationally driven and this needs much further thought on what is achievable and how.

Attachments

Action Plan

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Quality Strategy
This paper supports the following domains of the quality strategy

- ✓ Staff/Workforce
- ✓ Performance
- ✓ Environment
- ✓ Experience
- ✓ Helping People
- ✓ Quality of Life
- ✓ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
- ✓ To improve the quality of care we provide to our patients
- ✓ To develop care with a highly skilled and representative workforce
- ☐ To provide value for money

2013/14 Priorities
- ☐ Modernisation Programme
- ☐ Communication and Engagement
- ✓ Sustain performance to ensure safe service to patients
- ☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

- ✓ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
- ✓ That we cannot maintain and deliver the core service along with the performance expected
- ✓ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ✓ No

Key issues from the assessment:

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Rec No.	Theme	Recommendation	Chapter
	Accountability for implementing the recommendations		
1	Implementing the recommendations Recommendations	It is recommended that; • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions	**Introduction**
2		The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires ; • a common set of core values and standards shared throughout the system • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards • A system which recognises and applies the values of transparency, honesty and candour • Freely available, useful, reliable and full information on attainment of the values and standards • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system	**20**

Gap Analysis

The gap analysis revealed that whilst our vision and values were a strength at the time they haven't been revisited for a number of years and appear quite tired. Little evidence that they really drive behaviour and act as a "steer" to our staff.

We need to be much clearer how our decisions affect patients and explain this to our staff rather than assume the rationale is understood.

Very little evidence about staff feeling and staff thoughts presented at Trust Board

Action No.	Action	Director	Owner	Due Date (End of)
A1	Publish the action plan on the Trust Web site & publish at least an annual update **Governance**	Director of Nursing & Quality	TBC	August 2013
A2	Refresh the Trusts Vision & Values **Culture**	Chief Executive & Chair	TBC	December 2013
A3	Consider opportunities (for adding into this action plan) on how the values can drive behaviour across the organisation **Culture**	Director of Workforce	TBC	March 2014
A4	Ensure delivery of Listening in Action. **Staff Involvement**	Chief Executive	Head of LiA	March 2014
A5	Introduce a Staff Experience report to Trust Board. **Staff Involvement**	Director of Nursing & Quality	TBC	July 2013
A6	Ensure leadership qualities are assessment as part of the recruitment of all clinical appointments above paramedic level. **Leadership**	Director of Workforce	TBC	December 2013

Rec No.	Theme	Recommendation			Chapter
	Putting the patient first – patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic right				
3	Clarity of values and principles	• The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.			**21**
4		• The core values expressed in the constitution should be given priority of place and the over riding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.			**21**
5		in reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves • They will do everything in their power to protect patients from avoidable harm • They will be honest and open with patients regardless of the consequences for themselves • Where they are unable to provide the assistance a patient needs they will direct them where possible to those who can do so • They will apply the NHS values in all their work			**21**
6		The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.			**21**
7		All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.			**21**
8		Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.			**21**
	Gap Analysis				
	The gap analysis revealed that most people were assured that the interaction at the patient side was patient focussed. However, organisational systems do not appear to always support patient first. This is particularly evident when considering the time spent solving the needs of our patients who are most urgent and the time spent solving the needs of those who are less urgent. Cat A gets more time than Cat C. Policies can be vague on the real benefit to patients and we need to ensure our staff understand why the policy is as it is. Issues regarding where accountability and patient advocacy sit. Who champions the patient perspective at station level? It appears that we put performance first and do not explain why to our staff. However, is this really due to safety or a £5 million fine and severe government criticism.				
Action No.	**Action**		**Director**	**Owner**	**Due Date (End of)**
B1	Ensure "Patient First" philosophy within the Trusts Vision and Values. **Culture**		Chief Executive & Chair	TBC	December 2013

B2	Rota review to ensure the staffing of clinical rotas put patients first (modernisation) **Culture**	Director of Modernisation	TBC	April 2014
B3	Contracts of employment to explicitly include reference to the values of the constitution **Culture**	Director of Workforce	TBC	December 2014
B4	Ensure procurement contracts explicitly state the values and behaviours expected of contractors **Culture**	Finance Director	TBC	December 2013
B5	Identify who has 24 hour responsibility for the standards of care (and other standards) at a station level **Accountability**	Director of Operations (lead) in conjunction with the Clinical Directors	TBC	March 2014
B6	Ensure all committee Terms of Reference (except Audit & Remuneration Committees) address public involvement in their agenda **Learning from Experience**	Director of Corporate Services	TBC	December 2013
B7	Ensure the impact on patients of all decision making is completed on Trust “Front Sheets” **Learning from Experience**	Director of Corporate Services	TBC	December 2013
B8	Improve engagement with a number of “Healthwatch” organisations **Learning from Experience**	Director of Nursing & Quality	TBC	March 2014
B9	Explore ideas how our clinical staff can introduce themselves by name to patients (name badge or introduction) **Culture**	Director of Operations	TBC	March 2014
B10	Patient representation on the appointments panel of senior clinical and managerial roles **Culture**	Director of Workforce	TBC	December 2013
B11	Actions that move the Trust from a culture of discipline to accountability **Culture**	Director of Workforce	TBC	September 2014
B12	Consider if a Patient Engagement Strategy is needed **Learning from Experience**	Director of Nursing & Quality in association with Director of Corporate Services	TBC	March 2014

Rec No.	Theme	Recommendation	Chapter
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.		
9		The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.	**21**
10		The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.	
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	
	Gap Analysis		
	Policies are developed centrally. Maybe development of staff engagement forums. Non executive directors do not receive information regarding serious breach in policy until the situation has been investigated. More to be done on the management of incidents. Not convinced we capture all the clinical incidents.		

Action No.	Action	Director	Owner	Due Date (End of)
C1	Ensure all new clinical policies have evidence of staff engagement in their creation. **Staff Involvement**	Medical Director	TBC	March 2014
C2	Ensure all new clinical procedures or clinical guidelines have evidence of staff engagement in their creation. **Staff Involvement**	Director of Paramedic Practice and Education	TBC	March 2014
C3	At least four clinical audits per year that monitors compliance with clinical guidelines **Governance**	Medical Director	TBC	March 2014
C4	Ensure staff receive feedback on all clinical incident reporting **Governance**	Director of Workforce	TBC	September 2014
C5	Develop system for informing whole Trust Board when an SI has occurred **Governance**	Director of Corporate Services	TBC	September 2013
C6	Review current incident management process and resources	Director of Corporate	TBC	December 2013

	assigned to incident management. Process must have clear clinical involvement in the assessment of the clinical impact of the incident and the Trust wide communication of the learning. **Governance**	Services in association with Finance Director, Medical Director and Director of Nursing		
C7	Consider bringing together all clinical feedback mechanisms (complaints, patient involvement, patient engagement, clinical incidents, SIs under a single directorate) **Governance**	Chief Executive	TBC	December 2013

Rec No.	Theme	Recommendation	Chapter
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.		
13	The nature of standards	Standards should be divided into: • Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; • Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification	**21**
14		In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards and the provision and publication of accurate information about compliance with the fundamental and enhanced standards.	**9**
15		All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of working system but also a demonstration that it is being used to good effect.	**11**
16	Responsibility for setting standards	The Government, through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider.	**21**
17		The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	**21**
18		It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.	**21**
	Gap Analysis		
	-No specific gaps identified except our standards were developed before the new commissioning arrangements.		

Action No.	Action	Director	Owner	Due Date (End of)

D1	Agree with commissioners a set of behavioural standards **Culture**	Director of Paramedic Practice and Education	TBC	December 2013
D2	Agree with commissioners our safety standards **Culture**	Medical Director	TBC	December 2013
D3	Agree with commissioners our quality standards **Culture**	Director of Nursing & Quality	TBC	December 2013
D4	Explore opportunities for creating stronger links with the College of Paramedics **Professionalisation**	Director of Paramedic Practice and Education	TBC	December 2014
D5	Consider the use of peer review to develop a learning & sharing culture across the service. **Culture**	Director of Nursing & Quality	TBC	March 2013

Rec No.	Theme	Recommendation	Chapter
	Responsibility for, and effectiveness of, healthcare standards		
19	Gaps between the understood functions of separate regulators	There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.	**10**
20	Responsibility for regulating and monitoring compliance	The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing compliance with any enhanced standards but for regulating the accuracy of information about compliance with them.	**21**
21		The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern.	**21**
22		The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.	**21**
23		The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialities, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff patient ratios.	**21**
24		Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.	**21**
25		It should be considered the duty of all speciality professional bodies, ideally together which the National Institute for Health and Clinical Excellence, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance.	**21**
26		In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of polices and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.	**9**
27		The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been	**9**

		remedied. It requires a focus on identifying what is wrong, not on praising what is right.	
28	Sanctions and interventions for non-compliance	Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.	**21**
29		It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.	**21**
30	Interim measures	The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation.	**9**
31		Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but no being bound by, the views or actions of other regulators.	**10**
32		Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigations required to make a final determination is undertaken.	**10**
33		Insofar as healthcare regulators consider they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers.	**10**
34		Where a provider is under regulatory investigations, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.	**9**
35	Need to share information between regulators	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extends to all intelligence which when pieced together with that possessed by partner organisations may raise a level of concern. Work should be done on a template of the sort of information each organisation would find helpful.	**9**
36	Use of information for effective regulation	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	**9**
37	Us of information about compliance by	Trusts Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is	**11**

	regulator from: • Quality accounts	not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	
38	• Complaints	The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.	**11**
39		The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.	**11**
40		It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	**11**
41	• Patient safety alerts	The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action require to implement them. Information sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to the NHS Commissioning Board.	**11**
42	• Serious untoward incidents	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	**11**
43	• Media	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.	**6**
44		Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented.	**11**
45	• Inquests	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners .	**11**
46	• Quality and risk profiles	The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.	**11**
47	• Foundation trust governors, scrutiny committees	The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.	**11**
48		The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission.	**11**
49	Enhancement of monitoring and the	Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained	**11**

	importance of inspection	from: • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections	
50		The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.	**11**
51		The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principle to the independent sector, as well as to the NHS.	**11**
52		The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.	**11**
53	Care Quality Commission independence, strategy and culture	Any change to the Care Quality Commission's role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.	**11**
54		Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role.	**11**
55		The Care Quality Commission should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement effectively, in accordance with the principles outlined in this report.	**11**
56		The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date.	**11**
57		The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the Trust described in this report, and in the report of the first inquiry, and open the evaluation for public scrutiny.	**11**
58		Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for a patients' consultative council with which issues could be discussed to obtain a patient perspective directly.	**11**
59		Consideration should be given to the introduction of a category of nominated board members from representatives of the professions, for example, the Academy of Medical Royal Colleges, a representative of nursing and allied healthcare professionals, and patient representative groups.	**11**
	Gap Analysis		
	We need to focus more on the detail of the issue rather than just the specific subject area but also need to focus on the learning. Getting better with narrative but need to look for opportunities for more narrative and more opportunities to learn from patients.		

	Staff not well supervised. OWR mnot always delivered and yet this is our monitoring tool.			
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
E1	Commit to the OWR programme and develop actions that facilitate delivery of OWR for all clinical staff **Staff Support & Supervision**	Director of Operations	TBC	March 2014
E2	Develop a programme of patient engagement (? Focus groups with patients with long term conditions) that actively tout feedback from patients **Learning from experience**	Director of Nursing & Quality	TBC	December 2013
E3	Move performance metrics towards reporting the numbers where delivery was not complaint with set standard rather than % compliance **Performance**	Director of Performance	TBC	December 2013
E4	Investigation of non compliance (Serious Incidents) should be regarded as a priority and formulate procedures to ensure all Sis are completed within target time **Learning from Experience**	Director of Corporate Services	TBC	October 2013
E5	Investigation of non compliance by staff (Disciplinary) should be regarded as a priority and formulate procedures to ensure all investigations are completed within target time **Learning from Experience**	Director of Workforce	TBC	October 2013
E6	Quality Account to contain a balance of non compliance and compliance and not solely focus on positive messages (may be national guidance during 2013) **Being Open**	Director of Nursing & Quality	TBC	June 2014
E7	Explore opportunities to include narrative data within performance monitoring. Especially for complaints and patient experience. **Performance**	Director of Performance & Director of Nursing & Quality	TBC	April 2014
E8	Ensure media monitoring is incorporated into Trust quality monitoring processes **Learning from Experience**	Director of Nursing & Quality in association with the Director of Communications	TBC	October 2013
E9	All learning from SIs and inquests is disseminated across all clinical areas and evidence that transferable lessons have been considered **Learning from Experience**	Director of Corporate Services	TBC	October 2013
E10	Identify a process for sharing "top complaint themes" with our clinical staff. **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013

Rec No.	Theme	Recommendation	Chapter
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions		
60	Consolidation of regulatory functions	The Secretary of Sate should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.	**11** **10**
61		A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after thorough planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. It would be vital to retain the corporate memory of both organisations.	**11** **10**
62	Improved patient focus	For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.	**11** **10**
63	Improved transparency	Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.	**10**
64	Authorisation of foundations trusts	The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which incorporate the relevant departments of Monitor.	**4**
65	Quality of care as a pre-condition for foundation trust applications	The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.	**4**
66	Improving contribution of stakeholder opinions	The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: • Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards; • An accessible record of responses received is maintained: • The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.	**4**
67	Focus on compliance with fundamental standards	The NHS Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.	**4**
68		No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of Health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.	**4**

69		The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.	**4**
70	Duty of utmost good faith	A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.	**4**
71	Role of Secretary of State	The Secretary of State's support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.	**4**
72	Assessment process for authorisation	The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.	**4**
73	Need for constructive working with other parts of the system	The Department of Health's regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained.	**10**
74	Enhancement of role of governors	Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public's views about the services offered.	**10**
75		The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	**10**
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	**10**
77		Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose and challenge deficiencies in the quality of the foundation trust's services.	**10**
78		The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence (pursuant to section 39A of the National Health Service Act 2006 as amended), or other ready access to external assistance.	**10**
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	**10**

80		A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundations trust's constitution.	**11**
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	**11**
82		Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.	**10**
83		If a 'fit and proper person test' is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and the procedure it would follow to ensure due process.	**10**
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	**10**
85		Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office; and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.	**10**
86	Requirement of training of directors	A requirement should be imposed on foundations trusts to have in place an adequate programme for the training and continued development of directors.	**10**
	Gap Analysis		

Action No.	**Action** No specific gaps identified	**Director**	**Owner**	**Due Date (End of)**
F1	Consider how we can demonstrate compliance with the requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors **Governance**	Director of Corporate Services	TBC	April 2014
F2	Include within he Trusts constitution that a director will be disqualified if found to be incompetent or having behaviour considered as serious misconduct. **Governance**	Director of Corporate Services	TBC	April 2014
F3	To have in place an adequate programme for the training and continued development of directors. **Governance**	Director of Workforce in association with the Director of Corporate Services	TBC	October 2013
F4	To consider how to apply the "Fit & Proper Person" test to the Director appointments. **Leadership**	Chief executive & Chair	TBC	March 2014

Rec No.	Theme	Recommendation	Chapter
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings		
87	Ensuring the utility of a health and safety function in a clinical setting	The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a	**13**
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	**13**
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	**13**
90	Assistance in deciding on prosecutions	In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the Health and Safety Executive should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.	**13**
	Gap Analysis		
	No gaps identified		

Action No.	Action	Director	Owner	Due Date (End of)
G1				

Rec No.	Theme	Recommendation	Chapter
	Enhancement of the role of supportive agencies		
91	**NHS Litigation Authority** Improvement of risk management	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	**15**
92		The financial incentives as levels below level 3 should be adjusted to maximise the motivation to reach level 3.	**15**
93		The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the trust.	**15**
94	Evidence-based assessment	As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information.	**15**
95	Information sharing	As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.	**15**
96		The NHS Litigation Authority should make some prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.	**15**
97	**National Patient Safety Agency functions**	The National Patient Safety Agency's resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator.	**17**
98		Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	**17**
99		The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incident has been properly reported and invaluable where it has not been.	**17**
100		Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with.	**17**
101		While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.	**17**
102	Transparency, use and sharing of	Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or others facilitated in that task.	**17**

	information		
103		The National Patient Safety Agency or its successor should regularly share information with Monitor.	**17**
104		The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other.	**17**
105		Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.	**17**
106	Health Protection Agency Coordination and publication of providers' information on healthcare associated infections	The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre	**16**
107	Sharing concerns	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, or those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.	16
108	Support for other agencies	Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers'' infection control.	16
	Gap Analysis		
	Evidence of impact assessment and clinical director approval when changing the workforce and skill mix not always evident.		

Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
H1	Ensure risk assessments are completed to expected standards (clinical sign off) when changing the skill mix of the workforce **Governance**	Director of Operations	TBC	December 2013

Rec No.	Theme	Recommendation	Chapter
	Effective Complaints Handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.		
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints: constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned	3
116	Support for complaints	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response, should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be share confidentially with the Commissioner and the Care Quality Commission.	3

119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	3
121		The Care Quality Commission should have means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	3
122	Handling large-scale complaints	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	3

	Gap Analysis			
	Need to be more empathetic on what it means to wait for an ambulance. Complaint themes not clearly linked to the other “learning” work streams, particularly incident reporting. Don’t seem to capture “observations of poor care” well. Some staff don’t understand why patients complain and the impact of challenging a patient who is unwell or anxious. Need to share information across work streams Need to share with commissioners more			
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
I1	Strengthen the evidence the Trust is learning from patient feedback by tracking in a report changes made due to feedback **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I2	Publish a summary of complaint stories on Trust Web Site **Being Open**	Director of Nursing & Quality	TBC	December 2013
I3	Ensure staff across the organisation are aware as to what patients are complaining about **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I4	Complaint reporting to be a core feature of monitoring by commissioners **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I5	Develop complex level scorecard for complaints and share with local Healthwatch and OSC organisations **Being Open**	Director of Nursing & Quality	TBC	March 2014
I6	Share complaint information as close to the real time as possible with commissioners **Being Open**	Director of Nursing & Quality	TBC	December 2013

Rec No.	Theme	Recommendation	Chapter
	Commissioning for Standards		
123	Responsibility for monitoring delivery of standards and quality	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialise services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GPs duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	7
124	Duty to require and monitor delivery of fundamental standards	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub-standard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	7
125	Responsibility for requiring and monitoring delivery of enhanced standards	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with standards of development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing for clinicians and the organisations for which they work.	7
126	Preserving corporate memory	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.	7
127	Resources for Scrutiny	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	**7**
128	Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.	**7**
129	Ensuring assessment and enforcement of fundamental standards through contracts	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonable necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	**7**
130	Relative position of commissioner and	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers	**7**

	provider	and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	
131	Development of alternative sources of provision	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	**7**
132	Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and usable information from which the safety and quality of service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	**7**
133	Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	**7**
134	Role of commissioners in provision of support for complaints	Consideration should be given to whether commissioners should be given responsibility for commissioning patients’ advocates and support services for complaints against providers.	**7**
135	Public accountability of commissioners and public engagement	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. • There should be lay members of the commissioner’s board • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.	**7**
136		Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	**7**
137	Intervention and sanctions for	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of	**7**

	substandard or unsafe services	harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.		
	Gap Analysis			
	No gaps identified			
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
J1				

Rec No.	Theme	Recommendation			Chapter
	Local scrutiny				
138		Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.			**7**
	Gap Analysis				
	No gaps identified				
Action No.	**Action**		**Director**	**Owner**	**Due Date (End of)**
K					

Rec No.	Theme	Recommendation	Chapter
	Performance management and strategic oversight		
139	The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	**8**
140	Performance managers working constructively with regulators	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	**8**
141	Taking responsibility for quality	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interest of patient safety.	**8**
142	Clear lines of responsibility supported by good information flows.	For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	**8**
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	**8**
144	Need for ownership of quality metrics at a strategic level	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	**8**
	Gap Analysis		
	Need a performance culture that moves us away from just looking at 2 targets but performance in the round Need to define our standards and have a set of minimum safety standards for our vehicles and equipment Commissioners can not demand things that are not purchased. Need to be able to say "no" and think more like a FT Need different safety and quality standards We have metrics in place but they are not showing sustained improvement. Need metrics about urgent care; for example, what happens when we leave patients on the floor for hours, how do we record this? Need a culture of continuous improvement rather than a culture of "made the grade"		

Action No.	Action	Director	Owner	Due Date (End of)
L1	Need to develop a culture of continuous improvement and identify specific actions for this **Performance**	Director of Performance	TBC	March 2014
L2	Need to develop and agree performance metrics in all function areas **Performance**	Director of Performance	TBC	September 2013

L3	Need to ensure training reflects performance values and that our staff understand performance **Performance**	Director of Performance in association with Director of Paramedic Practice and Education and Director of Communications	TBC	March 2014

Rec No.	Theme	Recommendation			Chapter
	Patient, public and local scrutiny				
145	Structure of Local Healthwatch	There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and scrutiny.*			**6**
146	Finance and oversight of Local Healthwatch	Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.			**6**
147	Coordination of local public scrutiny bodies	Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.			**6**
148	Training	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.			**6**
149	Expert assistance	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.			**6**
150	Inspection powers	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.			**6**
151	Complaints to MPs	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.			**6**
	Gap Analysis				
	No gaps identified				
Action No.	**Action**		**Director**	**Owner**	**Due Date (End of)**
M1	Need to develop a plan for engagement with healthwatch **Learning from Experience**		Director of Nursing & Quality	TBC	December 2013

Rec No.	Theme	Recommendation	Chapter
	Medical training and education		
152	Medical training	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	**18**
153		The Secretary of State should by statutory instrument specify all medical education and training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisation which provide regulated training.	**18**
154		The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.	**18**
155		The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required, • There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.	**18**
156		The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.	**18**
157	Matters to be reported to the General Medical Council	The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.	**18**
158	Training and training establishments as a source of safety information	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	**18**

159		Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.	**18**
160		Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	**18**
161		Training visits should make an important contribution to the protection of patients: • Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used. • Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. • The opportunity can be taken to share and disseminate good practice with trainers and management. Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.	**18**
162		The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.	**18**
163	Safe staff numbers and skills	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	**18**
164	Approved practice settings	The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.	**18**
165		The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.	**18**
166		The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.	**18**
167		The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.	**18**

168		The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for post graduate training.	**18**
169	Role of the Department of Health and the National Quality Board	The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators.	**18**
170	Health Education England	Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.	**18**
171	Deans	All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.	**18**
172	Proficiency in English language	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	**18**
	Gap Analysis		
	We have gaps in understanding what its like to be a student in the organisation and how we capture the feedback from students We need to be sure our training reflects the values of the Trust We do not rotate our students frequently enough so they do not cross fertilise their learning How do we capture the student thoughts when they identify as station as poor		

Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
N1	Create student engagement group **Learning from Experience**	Director of Nursing & Quality in association with Director of Operations and Director of Paramedic Practice & Education	TBC	March 2014
N2	Involve more service staff in training and education. Especially staff identified as subject experts. This could mean a new approach to education when all training posts have a service delivery element **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N3	Develop a culture of learning from patients and involve patients in training **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N4	Ensure training and trainers reflects the values of the Trust **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N5	Directors to “drop in” to training sessions and be included in the “ride out” methodology of observing our service in action **Culture**	Director of Corporate Services		

Rec No.	Theme	Recommendation	Chapter
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.		
173	**Principles of openness, transparency and candour**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	**22**
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	**22**
175		Full and truthful answers, must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if decreased, to any lawfully entitled personal representative).	**22**
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	**22**
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	**22**
178	**Implementation of the duty** Ensuring consistency of obligations under the duty of openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	**22**
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	**22**
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open,* the guidance published by the National Patient Safety Agency.	**22**
181	**Enforcement of the duty** Statutory duties of candour in relation to harm to patients	A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request:	**22**

		• On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.	
182	Statutory duty of openness and transparency	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	**22**
183	Criminal liability	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: • Knowingly to obstruct another in the performance of these statutory duties: • To provide information to a patient or nearest relative intending to mislead them about such an incident: • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	**22**
184	Enforcement by the Care Quality Commission	Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.	**22**
	Gap Analysis		
	Starting to be far more open. Modernisation Programme is a line in the sand as we are openly talking about our inability to deliver a quality service all of the time. Need a culture where it is acceptable to make a genuine mistake and report it. People fear mistakes lead to punishment. Need to ensure all our staff understand this and understand we are accountable to the public.		

Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
O1	Incident & SI reporting and documentation needs to reflect and record the dialogue undertaken with the patient **Being Open**	Director of Corporate Services	TBC	April 2014
O2	Consider how the Trust web site can assist us with “being open” requirements **Being Open**	Director of Communications	TBC	April 2014

Rec No.	Theme	Recommendation	Chapter
	Nursing		
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: o Possession of the appropriate values, attitudes and behaviours; o Ability and motivation to enable them to put the welfare of others above their own interests; o Drive to maintain, develop and improve their own standards and abilities; o Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: o Recognition of achievement; o Regular, comprehensive feedback on performance and concerns; o Encouraging them to report concerns and to give priority to patient well-being;	**23**
186	Practical hands-on training and experience	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	**23**
187		There should be a national entry-level requirement that student nurses spend a minimum period of time; at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	**23**
188	Aptitude test for compassion and caring	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	**23**
189	Consistent training	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination.	**23**
190	National standards	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of fundamental aspects of compassionate care.	**23**
191	Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	**23**

192	Strong nursing voice	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council.	**23**
193	Standards for appraisal and support	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	**23**
194		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	**23**
195	Nurse leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team.	**23**
196		The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	**23**
197		Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	**23**
198	Measuring cultural health	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which building the experience and feedback of nursing staff using a robust methodology, such as the 'cultural barometer'.	**23**
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present ant every interaction between a doctor and an allocated patient.	**23**
200		Consideration should be given to the creation of a status of Registered Older Person's Nurse	**23**
201	Strengthening the nursing professional voice	The Royal College of Nursing should consider whether it should formally divide its 'Royal College' functions and its employee representative/trade union functions between two bodies rather than behind internal 'Chinese walls'.	**23**
202		Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	**23**

203		A forum for all directors of nursing both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.	**23**
204		All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	**23**
205		Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	**23**
206		The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues or equivalent authority to that provided by the Chief Medical Officer.	**23**
207	Strengthening identification of healthcare support workers and nurses	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	**23**
208		Commissioning arrangements should require provider organisation to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	**23**
209	Registration of healthcare support workers	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship).	**23**
210	Code of conduct for healthcare support workers	There should be a national code of conduct for healthcare support workers.	**23**
211	Training standards for healthcare support workers	There should be a common set of national standards for the education and training of healthcare support workers.	**23**
212		The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisation and the public.	**23**
213		Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from hard. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	**23**

	Gap Analysis			
	We have to reflect on our acceptance that training is not an option when busy Need a cultural shift that being a professional is not just during paid time Education or staff development is not explicit in our priorities or our vision We have a good CPI process which can be built upon and we need to improve the feedback element Need to move our culture towards a culture of managing professionals rather than managing a resource allowing a stronger staff voice in decision making Do we ensure our recruitment processes recruit people with the right values. Constant concern that we can not deliver training Don't have a robust system for recording who has done what training			
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
P1	Ensure the review of our vision and values considers the place of education **Education & Practice**	Chair in association with Chief Executive	TBC	April 2014
P2	Need to develop continuity plans that ensure training can be delivered during sustained periods of high demand **Education & Practice**	Director of Operations	TBC	March 2014
P3	Need to maximise the different methodologies that can be applied to the delivery of training. **Education & Practice**	Director of Paramedic Practice & Education	TBC	March 2014
P4	Need to consider how enhanced IT can assist with the delivery of training **Education & Practice**	Director of IMT	TBC	March 2014
P5	Need to ensure the development of our healthcare support staff features within annual training needs analysis **Education & Training**	Director of Paramedic Practice & Education	TBC	March 2014
P6	Ensure clinical development is a professional issue is explicit within the Trust's clinical strategy **Professionalisation**	Director of Strategy & Transformation in association with the Director of Paramedic Practice & Education	TBC	March 2014
P7	Need a plan for having a robust system for recording training compliance **Governance**	Director of IMT	TBC	March 2014
P8	Needs to be a meet the Executive representation at Induction **Culture**	Director of Corporate Services	TBC	March 2014
P9	Implement a Clinical Career Structure for clinical staff which emphasises the leadership qualities of senior staff **Education & Practice**	Director of Modernisation in association with the Medical Director, Director of Nursing & Quality, Director of Paramedic Practice & Education and Director of Operations	TBC	September 2014
P10	Those identified with a 24 hour responsibility for care standards should be visible and work in a supervisory rather than delivery way	Director of Operations	TBC	September 2014

	Governance			
P11	Need to consider "pairing" of clinical staff to ensure cross fertilisation of skills and people exchange learning. **Education & Practice**	Director of Operations	TBC	September 2014
P12	Need clearer visual distinction between roles that is understandable to the public **Professionalisation**	Director of Operations in association with the Director of Paramedic Practice and Education	TBC	September 2014
P13	Ensure the six Cs strategy is included in the Clinical Strategy **Culture**	Director of Strategy & Transformation	TBC	March 2014
P14	Appraisal system needs to add value to the personal development and feedback to individual clinicians and be prioritised by the Trust **Staff Support and Supervision**	Director of Workforce in association with the Director of Operations	TBC	March 2014
P15	Introduce into appraisal system the need for paramedics to produce an annual learning portfolio **Education & Practice**	Director of Workforce in association with the Director of Operations	TBC	March 2014
P16	Develop plan to ensure all clinical staff receive leadership training **Leadership**	Director of Paramedic Practice & Education	TBC	March 2014
P17	Consider an internal regulation process for non registered professionals **Professionalisation**	Director of Workforce	TBC	September 2014

Rec No.	Theme	Recommendation	Chapter
	Leadership		
214	Shared training	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.	**24**
215	Shared code of ethics	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	**24**
216	Leadership framework	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	**24**
217	Common selection criteria	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.	**24**
218	Enforcement of standards and accountability	Serious non-compliance with the code, and in particular, non-compliance leading to actual or ;potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them for holding such positions in future.	**24**
219	A regulator as an alternative	An alternative option to enforcing compliance with a management code of conduct , with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.	**24**
220	Accreditation	A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initially, the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.	**24**
221	Ensuring common standards of competence and compliance	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, or equivalent rigour to that applied to foundations trusts.	**24**
	Gap Analysis		
	No gaps identified		

Action No.	Action	Director	Owner	Due Date (End of)
Q				

Rec No.	Theme	Recommendation	Chapter
	Professional regulation of fitness to practice		
222	**General Medical Council** Systemic investigation where needed	The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.	**12**
223	Enhanced resources	If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.	**12**
224	Information sharing	Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.	**12**
225	Peer reviews	The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.	**12**
226	**Nursing and Midwifery Council** Investigations of systemic concerns	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enable to work closely with the systems regulators and to share their information and analyses on the working of systems in organisation in which nurse are active. It should not have to wait until disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	**12**
227		The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	**12**
228	Administrative reform	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this inquiry, is still found by others reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	**12**
229	Revalidation	It is desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as, providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	**12**

230	Profile	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	**12**
231	Coordination with internal procedures	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	**12**
232	Employment liaison officers	The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	**12**
233	**For joint action** Profile	Wile both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.	**12**
234	Cooperation with the Care Quality Commission	Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there would be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.	**12**
235	Joint proceedings	The Professional Standards Authority for Health and Social Care (PSA) (formally the Council for Healthcare Regulator Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professional regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.	**12**
	Gap Analysis		
	No gaps identified		

Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
R				

Rec No.	Theme	Recommendation	Chapter
	Caring for the elderly Approaches applicable to all patients but requiring special attention of the elderly		
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patients' case, so that patients and their supporters are clear who is in overall charge of a patient's care.	**25**
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	**25**
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	**25**
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	**25**
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	**25**
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	**25**
242	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	**25**
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they care taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	**25**

	Gap Analysis			
	Still do not have electronic recording			
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
S1	Revisit electronic PRF and have proposal in place **Governance**	Director of IM&T	TBC	April 2014

Rec No.	Theme	Recommendation	Chapter
	Information		
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form usable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	**26**
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	**26**
246	Comparable quality accounts	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisation publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	**26**
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	**26**
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	**26**
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	**26**
250		It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.	**26**

251	Regulatory oversight of quality account	The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.	**26**
252	Access to data	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	**26**
253	Access to quality and risk profile	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	**26**
254	Access for public and patient comments	While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.	**26**
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near 'real time' as possible, even if later adjustments have to be made.	**26**
256	Follow up of patients	A proactive system for following up patient shortly after discharge would not only be good 'customer service' it would probably provide a wider range of responses and feedback on their care.	**26**
257	Role of Health and Social Care Information Centre	The Information Centre should be tasked wit the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent.	**26**
258		The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.	**26**
259		The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints.	**26**
260	Information standards	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would therefore, be desirable for the data to be supplied to, and processed by, the information centre and, through them, made publicly available in the same way as other quality related information.	**26**
261		The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.	**26**
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards. • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges.	**26**

		Information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	
263		It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialities.	**26**
264		In the case of each specialty a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	**26**
265		The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice.	**26**
266		In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them.	**26**
267		All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	**26**
268	Resources	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	**26**
269	Improving and assuring accuracy	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	**26**
270		There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	**26**
271		To the extend that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.	**26**
272	`	There is a demonstrable need for an accreditation system to be available for healthcare relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012; it should be used as soon as practicable.	**26**
	Gap Analysis		
	No routine meetings between hospitals and LAS to discuss clinical issues and share information Currently do not get outcome data from Trusts		

Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
T1	Need to establish routine meetings between local LAS staff and A&E clinical team that looks at patients outcome and case studies and can also identify inappropriate conveyance and examine alternatives	Medical Director in association with Director of Operations	TBC	September 2014

	Education & Practice			
T2	Develop plan for obtaining outcome data from NHS Trusts **Education & Practice**	Director of IM&T in association with Director of Nursing & Quality and Medical Director	TBC	April 2014
T3	Consider the need to have an individual responsible for information and data quality **Governance**	Chief executive	TBC	December 2014
T4	Consider how the Trust can follow up discharged patients **Education & Practice**	Director of Operations	TBC	September 2014

Rec No.	Theme	Recommendation	Chapter
	Coroners and inquests Making more of the coronial process in healthcare related deaths		
273	Information to coroners	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable to coroner to perform his function, unless a director is personally satisfied what withholding the information is justified in the public interest.	**14** **22**
274		There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	**2**
275	Independent medical examiners	It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.	**14**
276		Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.	**14**
277	Death certification	National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	**14**
278		It should be a routine part of an independent medical examiner's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	**14**
279		So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	**14**
280	Appropriate and sensitive contact with bereaved families	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	**14**
281		It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.	**14**
282	Information for, and from, inquests	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.	**14**
283		Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family.	**14**
284	Appointment of assistant deputy coroners	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	**14**
285	Appointment of assistant deputy coroners	The Chief Corner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	**14**
	Gap Analysis		
	Medical opinions are usually in house		

Action No.	Action	Director	Owner	Due Date (End of)
U1	Consider the use of external medical opinions when investigating a patient death **Governance**	Medical Director	TBC	March 2014

Rec No.	Theme	Recommendation	Chapter
	Department of Health Leadership		
286	Impact assessments before structural change	Impact and risk assessment should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues: • What is the precise issue or concern in respect of which change is necessary? • Can the policy objective identified by achieved by modifications within the existing structure? • How are the successful aspects of the existing system to be incorporated and continued in the new system? • How are the existing skills which are relevant to the new system to be transferred to it? • How is the existing corporate and individual knowledge base to be preserved, transferred and exploited? • How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change? • How are necessary functions to be performed effectively during any transitional period? • What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?	**19**
287		The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the pubic and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report.	**19**
288	Clinical input	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	**19**
289	Experience on the front line	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department	**19**
290		The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.	**19**
	Gap Analysis		
	No gaps identified		

Action No.	Action	Director	Owner	Due Date (End of)
V				

Appendix I Actions by Subject

Governance				
Action No.	**Action**	**Director**	**Owner**	**Due Date (End of)**
A1	Publish the action plan on the Trust Web site & publish at least an annual update **Governance**	Director of Nursing & Quality	TBC	August 2013
C3	At least four clinical audits per year that monitors compliance with clinical guidelines **Governance**	Medical Director	TBC	March 2014
C4	Ensure staff receive feedback on all clinical incident reporting **Governance**	Director of Workforce	TBC	September 2014
C5	Develop system for informing whole Trust Board when an SI has occurred **Governance**	Director of Corporate Services	TBC	September 2013
C6	Review current incident management process and resources assigned to incident management. Process must have clear clinical involvement in the assessment of the clinical impact of the incident and the Trust wide communication of the learning. **Governance**	Director of Corporate Services in association with Finance Director, Medical Director and Director of Nursing	TBC	December 2013
C7	Consider bringing together all clinical feedback mechanisms (complaints, patient involvement, patient engagement, clinical incidents, SIs under a single directorate) **Governance**	Chief Executive	TBC	December 2013
F1	Consider how we can demonstrate compliance with the requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors **Governance**	Director of Corporate Services	TBC	April 2014
F2	Include within he Trusts constitution that a director will be disqualified if found to be incompetent or having behaviour considered as serious misconduct. **Governance**	Director of Corporate Services	TBC	April 2014
F3	To have in place an adequate programme for the training and continued development of directors.**Governance**	Director of Workforce in association with the Director of Corporate Services	TBC	October 2013
H1	Ensure risk assessments are completed to expected standards (clinical sign off) when changing the skill mix of the workforce **Governance**	Director of Operations	TBC	December 2013
F1	Consider how we can demonstrate compliance with the requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors **Governance**	Director of Corporate Services	TBC	April 2014

F2	Include within he Trusts constitution that a director will be disqualified if found to be incompetent or having behaviour considered as serious misconduct. **Governance**	Director of Corporate Services	TBC	April 2014
F3	To have in place an adequate programme for the training and continued development of directors.**Governance**	Director of Workforce in association with the Director of Corporate Services	TBC	October 2013
H1	Ensure risk assessments are completed to expected standards when changing the skill mix of the workforce **Governance**	Director of Operations	TBC	December 2013
P7	Need a plan for having a robust system for recording training compliance **Governance**	Director of IMT	TBC	March 2014
P10	Those identified with a 24 hour responsibility for care standards should be visible and work in a supervisory rather than delivery way **Governance**	Director of Operations	TBC	September 2014
S1	Revisit electronic PRF and have proposal in place **Governance**	Director of IM&T	TBC	April 2014
T3	Consider the need to have an individual responsible for information and data quality **Governance**	Chief executive	TBC	December 2014
U1	Consider the use of external medical opinions when investigating a patient death **Governance**	Medical Director	TBC	March 2014

CULTURE				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
A2	Refresh the Trusts Vision & Values **Culture**	Chief Executive & Chair	TBC	December 2013
A3	Consider opportunities (for adding into this action plan) on how the values can drive behaviour across the organisation **Culture**	Director of Workforce	TBC	March 2014
B1	Ensure "Patient First" philosophy within the Trusts Vision and Values. **Culture**	Chief Executive & Chair	TBC	December 2013
B2	Rota review to ensure the staffing of clinical rotas put patients first (modernisation) **Culture**	Director of Modernisation	TBC	April 2014
B3	Contracts of employment to explicitly include reference to the values of the constitution **Culture**	Director of Workforce	TBC	December 2014
B4	Ensure procurement contracts explicitly state the values and behaviours expected of contractors **Culture**	Finance Director	TBC	December 2013
B9	Explore ideas how our clinical staff can introduce themselves by name to patients (name badge or introduction) **Culture**	Director of Operations	TBC	March 2014
B10	Patient representation on the appointments panel of senior clinical and managerial roles **Culture**	Director of Workforce	TBC	December 2013
B11	Actions that move the Trust from a culture of discipline to accountability **Culture**	Director of Workforce	TBC	September 2014
D1	Agree with commissioners a set of behavioural standards **Culture**	Director of Paramedic Practice and Education	TBC	December 2013
D2	Agree with commissioners our safety standards **Culture**	Medical Director	TBC	December 2013
D3	Agree with commissioners our quality standards **Culture**	Director of Nursing & Quality	TBC	December 2013
D5	Consider the use of peer review to develop a learning & sharing culture across the service. **Culture**	Director of Nursing & Quality	TBC	March 2013
N2	Involve more service staff in training and education. Especially staff identified as subject experts. This could mean a new approach to education when all training posts have a service delivery element **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N3	Develop a culture of learning from patients and involve patients in training **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N4	Ensure training and trainers reflects the values of the Trust **Culture**	Director of Paramedic Practice & Education	TBC	September 2014
N5	Directors to "drop in" to training sessions and be included in the "ride out" methodology of observing our service in action **Culture**	Director of Corporate Services		
P8	Needs to be a meet the Executive representation at Induction **Culture**	Director of Corporate Services	TBC	March 2014

P13	Ensure the six Cs strategy is included in the Clinical Strategy **Culture**	Director of Strategy & Transformation	TBC	March 2014

Staff Involvement				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
A4	Ensure delivery of the Listening in Action project. **Staff Involvement**	Chief Executive	Head of LiA	March 2014
A5	Introduce a Staff Experience report to Trust Board. **Staff Involvement**	Director of Nursing & Quality	TBC	July 2013
C1	Ensure all new clinical policies have evidence of staff engagement in their creation. **Staff Involvement**	Medical Director	TBC	March 2014
C2	Ensure all new clinical procedures or clinical guidelines have evidence of staff engagement in their creation. **Staff Involvement**	Director of Paramedic Practice and Education	TBC	March 2014

Leadership				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
A6	Ensure leadership qualities are assessment as part of the recruitment of all clinical appointments above paramedic level. **Leadership**	Director of Workforce	TBC	December 2013
P16	Develop plan to ensure all clinical staff receive leadership training **Leadership**	Director of Paramedic Practice & Education	TBC	March 2014
F4	To consider how to apply the “Fit & Proper Person” test to the Director appointments. **Leadership**	Chief executive & Chair	TBC	March 2014

Accountability				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
B5	Identify who has 24 hour responsibility for the standards of care (and other standards) at a station level **Accountability**	Director of Operations (lead) in conjunction with the Clinical Directors	TBC	March 2014

Learning from Experience				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
B6	Ensure all committee Terms of Reference (except Audit & Remuneration Committees) address public involvement in their agenda **Learning from Experience**	Director of Corporate Services	TBC	December 2013
B7	Ensure the impact on patients of all decision making is completed on Trust “Front Sheets” **Learning from Experience**	Director of Corporate Services	TBC	December 2013
B8	Improve engagement with a number of “Healthwatch” organisations **Learning from Experience**	Director of Nursing & Quality	TBC	March 2014
B12	Consider if a Patient Engagement Strategy is needed **Learning from Experience**	Director of Nursing & Quality in association with Director of Corporate Services	TBC	March 2014
E2	Develop a programme of patient engagement (? Focus groups with patients with long term conditions) that actively tout feedback from patients **Learning from experience**	Director of Nursing & Quality	TBC	December 2013
E4	Investigation of non compliance (Serious Incidents) should be regarded as a priority and formulate procedures to ensure all Sis are completed within target time **Learning from Experience**	Director of Corporate Services	TBC	October 2013
E4	Investigation of non compliance (Serious Incidents) should be regarded as a priority and formulate procedures to ensure all Sis are completed within target time **Learning from Experience**	Director of Corporate Services	TBC	October 2013
E5	Investigation of non compliance by staff (Disciplinary) should be regarded as a priority and formulate procedures to ensure all investigations are completed within target time **Learning from Experience**	Director of Workforce	TBC	October 2013
E8	Ensure media monitoring is incorporated into Trust quality monitoring processes **Learning from Experience**	Director of Nursing & Quality	TBC	October 2013
E9	All learning from SIs and inquests is disseminated across all clinical areas and evidence that transferable lessons have been considered **Learning from Experience**	Director of Corporate Services	TBC	October 2013
E10	Identify a process for sharing “top complaint themes” with our clinical staff. **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I1	Strengthen the evidence the Trust is learning from patient feedback by tracking in a report changes made due to feedback **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I3	Ensure staff across the organisation are aware as to what patients are complaining about **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
I4	Complaint reporting to be a core feature of monitoring by	Director of Nursing &	TBC	December 2013

	commissioners **Learning from Experience**	Quality		
M1	Need to develop a plan for engagement with healthwatch **Learning from Experience**	Director of Nursing & Quality	TBC	December 2013
N1	Create student engagement group **Learning from Experience**	Director of Nursing & Quality in association with Director of Operations and Director of Paramedic Practice & Education	TBC	March 2014

Professionalisation				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
D4	Explore opportunities for creating stronger links with the College of Paramedics **Professionalisation**	Director of Paramedic Practice and Education	TBC	December 2014
P6	Ensure clinical development is a professional issue is explicit within the Trust's clinical strategy **Professionalisation**	Director of Strategy & Transformation in association with the Director of Paramedic Practice & Education	TBC	March 2014
P12	Need clearer visual distinction between roles that is understandable to the public **Professionalisation**	Director of Operations in association with the Director of Paramedic Practice and Education	TBC	September 2014
P17	Consider an internal regulation process for non registered professionals **Professionalisation**	Director of Workforce	TBC	September 2014

Staff Support & Supervision				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
E1	Commit to the OWR programme and develop actions that facilitate delivery of OWR for all clinical staff **Staff Support & Supervision**	Director of Operations	TBC	March 2014
P14	Appraisal system needs to add value to the personal development and feedback to individual clinicians and be prioritised by the Trust **Staff Support and Supervision**	Director of Workforce in association with the Director of Operations	TBC	March 2014

Performance				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
E3	Move performance metrics towards reporting the numbers where delivery was not complaint with set standard rather than % compliance **Performance**	Director of Performance	TBC	December 2013
E7	Explore opportunities to include narrative data within performance monitoring. Especially for complaints and patient experience. **Performance**	Director of Performance & Director of Nursing & Quality	TBC	April 2014
L1	Need to develop a culture of continuous improvement and identify specific actions for this **Performance**	Director of Performance	TBC	March 2014
L2	Need to develop and agree performance metrics in all function areas **Performance**	Director of Performance	TBC	September 2013
L3	Need to ensure training reflects performance values and that our staff understand performance **Performance**	Director of Performance in association with Director of Paramedic Practice and Education and Director of Communications	TBC	March 2014

Being Open				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
E6	Quality Account to contain a balance of non compliance and compliance and not solely focus on positive messages (may be national guidance during 2013) **Being Open**	Director of Nursing & Quality	TBC	June 2014
I2	Publish a summary of complaint stories on Trust Web Site **Being Open**	Director of Nursing & Quality	TBC	December 2013
I5	Develop complex level scorecard for complaints and share with local Healthwatch and OSC organisations **Being Open**	Director of Nursing & Quality	TBC	March 2014
I6	Share complaint information as close to the real time as possible with commissioners **Being Open**	Director of Nursing & Quality	TBC	December 2013
O1	Incident & SI reporting and documentation needs to reflect and record the dialogue undertaken with the patient **Being Open**	Director of Corporate Services	TBC	April 2014
O2	Consider how the Trust web site can assist us with “being open” requirements **Being Open**	Director of Communications	TBC	April 2014

Education & Practice				
Action No.	**Action**	**Director**	Owner	**Due Date (End of)**
P1	Ensure the review of our vision and values considers the place of education **Education & Practice**	Chair in association with Chief Executive	TBC	April 2014
P2	Need to develop continuity plans that ensure training can be delivered during sustained periods of high demand **Education & Practice**	Director of Operations	TBC	March 2014
P3	Need to maximise the different methodologies that can be applied to the delivery of training. **Education & Practice**	Director of Paramedic Practice & Education	TBC	March 2014
P4	Need to consider how enhanced IT can assist with the delivery of training **Education & Practice**	Director of IMT	TBC	March 2014
P5	Need to ensure the development of our healthcare support staff features within annual training needs analysis **Education & Training**	Director of Paramedic Practice & Education	TBC	March 2014
P9	Implement a Clinical Career Structure for clinical staff which emphasises the leadership qualities of senior staff **Education & Practice**	Director of Modernisation in association with the Medical Director, Director of Nursing & Quality, Director of Paramedic Practice & Education and Director of Operations	TBC	September 2014
P11	Need to consider "pairing" of clinical staff to ensure cross fertilisation of skills and people exchange learning. **Education & Practice**	Director of Operations	TBC	September 2014
P15	Introduce into appraisal system the need for paramedics to produce an annual learning portfolio **Education & Practice**	Director of Workforce in association with the Director of Operations	TBC	March 2014
T1	Need to establish routine meetings between local LAS staff and A&E clinical team that looks at patients outcome and case studies and can also identify inappropriate conveyance and examine alternatives **Education & Practice**	Medical Director in association with Director of Operations	TBC	September 2014
T2	Develop plan for obtaining outcome data from NHS Trusts **Education & Practice**	Director of Nursing & Quality in association with Medical Director	TBC	April 2014
T4	Consider how the Trust can follow up discharged patients **Education & Practice**	Director of Operations	TBC	September 2014

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 JULY 2013

PAPER FOR APPROVAL

Document Title:	**Annual Infection Prevention & Control Report**
Report Author(s):	**Shane Platt, Trevor Hubbard, Steve Lennox**
Lead Director:	**Steve Lennox**
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Why is this coming to the Trust Board?	**Approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☒ Quality Committee ☐ Audit Committee ☒ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the annual report**

Key issues and risks arising from this paper

Patient safety and clinical outcomes are compromised if poor infection control practice is present in an organisation.

Executive Summary

It is a statutory requirement that the Director of Infection Prevention and Control produces an annual report for Trust Board.

The report illustrates the positive developments within Infection prevention and Control during the year. The process for audit is now embedded although these results now need to be triangulated for consistency and accuracy and will feature in the 2013 work plan.

The report contains a review of the infection prevention and control risks during the year and these have been reviewed at every meeting. The biggest concern for the committee members has been the challenge of releasing staff for training during 2012/13. This is being addressed this year through a workbook and discussion at this year's CSR.

Attachments

Annual Infection Prevention and Control Report 2012/13

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	Quality Strategy
	This paper supports the following domains of the quality strategy
☐	Staff/Workforce
☐	Performance
✓	Environment
☐	Experience
☐	Helping People
☐	Quality of Life
☐	Preventing Death
	LAS Strategic Goals and Priorities
	This paper supports the achievement of the following strategic goals and priorities:
	LAS Strategic Goals
✓	To improve the quality of care we provide to our patients
✓	To develop care with a highly skilled and representative workforce
☐	To provide value for money
	2013/14 Priorities
✓	Modernisation Programme
☐	Communication and Engagement
☐	Sustain performance to ensure safe service to patients
☐	Building sustainable financial position for 14/15 and beyond
	Risk Implications
	This paper supports the mitigation of the following strategic risks:
✓	That we fail to effectively fulfil responsibilities to deliver high quality and safe care
✓	That we cannot maintain and deliver the core service along with the performance expected
✓	That we are unable to match financial resources with priorities
☐	That our strategic direction and pace of innovation to achieve this are compromised
	Equality Analysis
	Has an Equality Analysis been carried out?
☐	Yes
✓	No
	Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Infection Prevention & Control
Annual Report 2012 / 2013

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1 Introduction

This is the annual report for Infection Prevention and Control (IPC) within the London Ambulance Service NHS Trust from the Director of Infection Prevention Control (DIPC). This report is to inform the Board of the progress made against the Care Quality Commission standards, and the Department of Health 'Health and Social Care Act 2008' during the last 12 months, and to outline the IPC programme for 2013 / 2014.

The report provides information of the ongoing commitment of the Trust to entrench IPC principles and practices throughout the service and shows the significant improvements the Trust has made in this respect.

Appendix I is supplied to give an insight on how the balance scorecard has been developed during the year an Appendix 2 is the full infection prevention & control action plan for information.

2 Background

For prevention and control of infection to be effective within the Trust a culture of service wide ownership needs to be embedded in everyday practice by all levels of staff groups. Success in infection prevention and the control of contagions depends upon creating a managed environment that minimises the risk of infection to patients, staff and the public as well as compliance with relevant national and local standards, guidelines and policies.

Using personal accountability, skilled and competent staff, transparent and integrated working practices, and clear management processes a sustained approach to IPC can be achieved.

2.1 Health and Social Care Act 2008 (revised 2010): Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department of Health).

Section 21 of the Health and Social Care Act (2008) enables the Secretary of State for Health to issue a revised code of practice. The code contains statutory guidance about compliance with the registration requirement for cleanliness and infection control. The Act states that the code must be taken into account by the Care Quality Commission when decisions are made regarding the cleanliness and infection control standards required to achieve registration.

During December 2010 the Department of Health published a revised Code of Practice on the Prevention and Control of Infections and Related Guidance. The new code focuses on 10 areas as opposed to the previous 9, due to the addition of Criterion 4. The revised Criteria are detailed in Table 1 (below). Although the exact wording of the majority of requirements has been revised, the general meaning and purpose remain the same with no new requirements detailed.

Table 1 – Revised Code of Practice Criteria

Criterion	Requirement	Current LAS Standard (April 2013)
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	Green
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Green
3	Provide suitable accurate information on infections to service users and their visitors.	Green
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Green
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Green
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	Green
7	Provide or secure adequate isolation facilities.	Not Applicable
8	Secure adequate access to laboratory support as appropriate.	Not Applicable
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Green
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Red

We have achieved green in most criteria; the only exceptions are 7 & 8, which are not applicable to the Trust and Criteria 10, where the information for immunisation records was not made readily available to IPC.

2.2 The Operating Framework for the NHS in England 2012-2013

The NHS Operating Framework recognises that there is still scope to drive Healthcare Associated Infections down further and states: '*Protecting the safety of our patients is of paramount importance. The zero tolerance approach to all avoidable HCAIs will continue. All NHS commissioners and providers should identify and agree plans for reducing MRSA bloodstream and Clostridium difficile infections in line with the national objectives*'. The Trust sees this as a priority and is currently working towards achieving this standard.

2.3 NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts (2011 – 2012)

The NHS Litigation Authority is a Special Health Authority, established in 1995 to administer the Clinical Negligence Scheme for Trusts and thereby provide a means for NHS organisations to fund the cost of clinical negligence claims. Infection Prevention and Control was removed from these standards as it was recognised that these were being addressed by the Care Quality Commission Regulations and the Health and Social Care Act 2008 (amended 2010).

3 Board Assurance

It is mandated that each NHS organization has a designated Director for Infection Prevention and Control (DIPC) and that the post reports directly to the Chief Executive Officer and the Trust Board. The Director of Health Promotion and Quality has been designated as the Trust's Director of Infection Prevention and Control with lead responsibility within the Trust for IPC. The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national guidance.

4 Performance Monitoring

4.1 Infection Prevention and Control Committee

The aim of the Infection Prevention and Control Committee is to provide assurance to the Trust Board that all services are provided in a clean and safe environment through the effective performance monitoring of key performance indicators. It provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust.

The group is responsible for providing assurance to the Director of Infection Prevention and Control. It monitors compliance with the Health and Social Care Act 2008 (amended 2010) via monthly updates from complexes relating to the IPC audits for vehicles, premises and observed practice, deep clean status of vehicles, training attendance and reported sharps incidents, which this year was broken down into two categories; Razor Injuries and Used Sharps Incidents . The Infection Prevention and Control Committee receives recommendations from other key groups including the Clinical Equipment Group, Vehicle Working Group, Clinical Decontamination Group and Corporate Health and Safety, and plays a key role in performance managing and policy implementation.

4.2.1 Director of Infection Prevention and Control

It is the responsibility and role of the DIPC to:

- Report directly to the Chief Executive Officer, Senior Management Group and the Trust Board to ensure that any changes in legislation or national guidance are made known to the organisation.
- Ensure that the Trust provides adequate resources to secure effective prevention and control of healthcare acquired infections.
- Ensure that appropriate actions relating to the prevention and control of infection are taken following recommendations from the Senior Management Group or Trust Board.
- Ensure that the Trust Board receives regular reports (including key performance indicator reports).
- Be responsible for the Infection Control Team within the Trust.

4.2.2 Ambulance Operations Manager for Infection Prevention and Control

The Ambulance Operations Manager for IPC has delegated responsibility from the DIPC to provide infection control advice to all disciplines within the Ambulance Trust on a day to day basis.

- To produce written reports on compliance with the Health & Social Care Act 2008 for the Care Quality Commission registration requirements and ensure that accurate records are kept.
- To advise line managers within the Trust on the implementation of agreed policies in their areas.
- To report to the Trust Infection Control Steering Group and other appropriate committees within the trust’s Governance structure as necessary.
- To undertake under the direction from the Head of Operational Support and Assistant Director of Corporate Services research for evidence based practice and clinical effectiveness and the planning of future services and training needs.

4.2.3 Practice Learning Manager West

The Practice Learning Manager for the West has been delegated as the Training Lead for IPC; this role encompasses the development of training packages, input into the content of policies regarding training and IPC, ensure IPC is embedded into training and practice of all staff and represents the training department in the various sub groups.

4.2.4 Infection Control Champions

The Infection Control Champion role was introduced to provide all staff with a local link at complex or department level. Infection Control Champions have received additional training and have an increased awareness of IPC procedures. The Infection Control Champions also undertake audits to assist the entry of IPC statistics to the Trust X:/ drive. The role will be further developed to also build stronger relationships with local Trusts and organisations to increase the community awareness of IPC and its benefits.

4.3 Infection Prevention and Control Annual Programme Report / Work Programme

The Trust has shown that it has taken on board and implemented the IPC recommendations from both internal and external reviews such as the Department of Health / Care Quality Commission improvement visit. The Performance Accelerator governance table, which is in place to assure the DH/Care Quality Committee and NHSLA that the Trust is meeting all its required criteria. The Hygiene Code section of this governance tool indicates a significant increase in achieving the desired targets within the last 12 months.

4.4 Policy Review and Development

All IPC policies and procedures have been reviewed and updated as appropriate during 2012-2013 following national guidance and legislation. All policies and procedures are available both as a hard copy on every complex, and on The Pulse which has its own dedicated IPC section. The IPC team has also developed new policies for the Transportation of Specimens, Decontamination Policy and a new Management of Sharps Policy. There has also been a review and revision of the IPC Policy to come into line with NHSLA Level 2.

4.5 Education

The Trust has ensured on-going training of all staff with a variety of IPC updates; these have been delivered face to face on Clinical Skills Refresher courses, bulletins via The Pulse and Routine Information Bulletin, communication briefings and will be reinforced with the rollout of a new IPC Training Workbook.

There is also an e-learning module available on the Skills for Life website which has been redesigned with the assistance of West London University to incorporate ambulance work. Station notice boards have also been utilized to ensure that the key IPC information is easily accessible to all staff. The IPC team are responsible for ensuring that all IPC education material is up-to-date and reflects current best practice for the Trust in line with national guidance. Hand hygiene and 'bare below the elbow' has been a core theme throughout all training packages and compliance with this is monitored with an Audit Tool and recorded on the IPC area of the Trust X:/ drive.

The 'All-in-1' mandatory and refresher course for all non-clinical staff has been delivered successfully, being organised via the Learning and Development team.

Training Officers, Clinical Tutors and Team Leaders have been given the responsibility for the delivery of IPC training packages at station level, the record of this training has been entered on the Trust X:/ drive, summary details are listed in table 2 below. IPC education forms part of the Trust's mandatory education programme and also for the induction of new starters.

Table 2a – Complex Training Figures

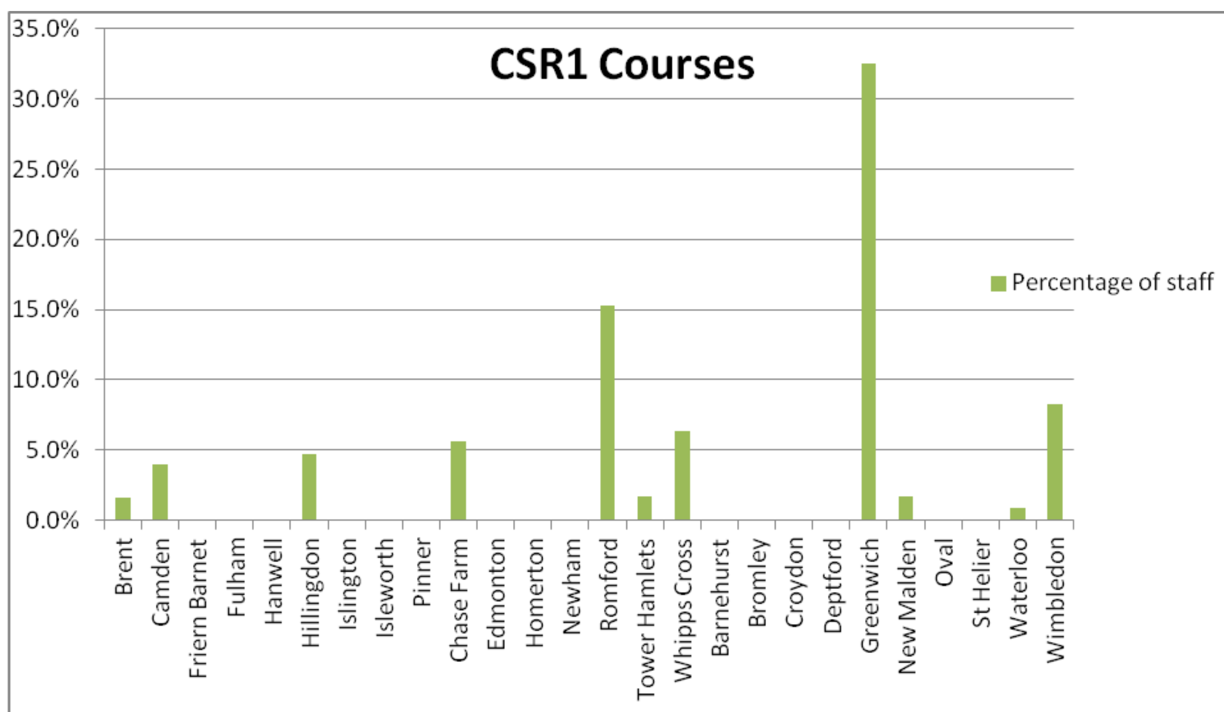

Table 2b – Complex Training Figures

Complex	**Percentage of staff attending CSR1_2012/13**
Barnehurst	0
Brent	1.6
Bromley	0
Camden	4.0
Chase Farm	5.6
Croydon	0
Deptford	0
Edmonton	0
Friern Barnet	0
Fulham	0
Greenwich	32.5
Hanwell	0
Hillingdon	4.7
Homerton	0
Isleworth	0
Islington	0
New Malden	1.7
Newham	0
Oval	0

Pinner	0
Romford	15.3
St Helier	0
Tower Hamlets	1.7
Waterloo	0.9
Whipps Cross	6.3
Wimbledon	8.3

4.6 Third Party Contractors

The Trust has ensured through regular meetings and reviews that the two new contractors, Lakethorne (premises cleaning) and Rentokil-Initial (vehicle preparation) are also taking responsibility, in part for infection prevention and control. The inspection of their IPC training and monitoring is assessed and reviewed by the Trust IPC team.

Third party providers are required to provide evidence that they are fully compliant with the Care Quality Commission's Essential Standards related to the quality and safety of care. These are set out in the Health and Social Care Act 2008 (amended 2010). In addition the IPC team attends the relevant performance management meetings with the third party providers to capture the aspects of IPC compliance.

4.7 Annual Audit Programme

The IPC annual audit programme has been very successful in providing Board Assurance in order to declare compliance with the Health and Social Care Act 2008 (amended 2010).

The audit schedule is operated on a monthly basis, with each complex reporting compliance within a strict timeframe and populating the data on the infection control balance scorecard (this scorecard was directly presented to the board during an escalated phase in 2010-2011).See Appendix 1.

This scorecard and audit programme has enabled the trust to identify key trends in non compliance and take any required action to address this in a swift and timely manner.

The monthly audit results are RAG rated and published on the Trust X:/ drive.

The RAG rated score is calculated below:

GREEN	≥ 85%	Compliant
AMBER	75.1 – 84.9%	Partially Compliant, action required
RED	≤ 75%	Minimal Compliance, Urgent action required

4.7.1 Mapping Improvement

There have been many vast improvements in the reporting of hygiene, cleaning and training in the last 12 months. The Audit Programme has ensured easier access to the reporting and sharing of information for IPC. A few comparisons that can be made are shown in the table below;

Area of Audit	Year to end March 2012	Year to end March 2013	Difference
Hand Hygiene (Compliance)	Avg 85.6%	Avg 100%	Increase of 14.4%*
IPC Training (Compliance)	Avg 58.3%	Avg 3.2%	Decrease of 55.1%
Vehicle Audits (Received)	880	4487	Increase of 3607 *
Premises Audits (Received)	209	291	Increase of 82*

*This marked increase is due to the new AOM system that is in place which ensures that all complexes have an easier and more secure way of entering data for IPC compliance.

It has shown that the increases are a vast improvement, where the only decrease is in the area of training, this is due to many factors including response priority, suspension of training during major events held in London over the summer of 2012 and service pressures.

4.8 Area IPC Audit Proforma

The area IPC audit proformas are presented to the Infection Prevention Control Committee in order to gain assurance of individual area and complex compliance. Any exceptions are notified and action plans developed to address any shortfalls.

4.9 Audit Tools

The IPC team has re-evaluated the audit tools with the result that there are now 5 audit tools. These are;

- Observed Practice (Hand hygiene compliance)
- A&E vehicle cleanliness
- Premises Cleanliness
- Quarterly IPC Audit (LA12)
- Admin Site Audit (LA12a)

4.10 Deep Clean

The Trust has recognised that cleanliness in the patient environment is paramount for patient safety and reducing the likelihood of Healthcare Associated Infections. The Trust has ensured that every complex has access to staff that perform deep cleaning of all vehicles and equipment. The Trust implemented a 6 weekly deep clean schedule for vehicles. This proved to be very successful in maintaining a high level of cleanliness in our vehicles. During February 2012 a new 6 weekly deep cleaning schedule was introduced with all patient carrying vehicles being cleaned every 6 weeks. Each complex has responsibility for ensuring that 100% of its vehicles are cleaned within the timeframe. The results of the deep clean programme are presented to the IPCC where any exception is also reported. The deep clean compliance figures form part of the IPC Key Performance Indicators and are therefore key in attaining compliance with the Health and Social Care Act 2008 (amended 2010).

5 Decontamination

The Trust has Edward Potter, ADO Fleet and Logistics as the nominated Decontamination Lead. The Decontamination Lead works in partnership with the Ambulance Operations Manager IPC to ensure a comprehensive approach to medical devices management, procurement of, and the suitability of cleaning products. The AOM for IPC team chairs the Equipment Working Group.

6 Communications Strategy

An IPC communications strategy was launched to assist in embedding IPC Policies and Procedures into everyday practice throughout the Trust. The strategy has utilised a mix of communication formats to get the right messages across to staff in a timely manner. This has resulted in staff being able to access information both remotely and whilst on station. Key subject areas are;

- Hand Hygiene
- Appropriate Glove Usage
- Sharps Awareness
- Seasonal Flu Vaccinations
- Norovirus
- Audits
- Personal Protective Equipment
- Vehicle Cleanliness
- Category 4 Infections
- Communicable Diseases

7 Hand Hygiene

Effective hand hygiene continues to be promoted by the IPC team and is evidenced through the hand hygiene procedure which is available to all staff via the Infection Prevention and Control page on The Pulse, the IPC Toolkit, Induction and Essential Education programmes and hand hygiene posters. Monitoring of clinicians compliance takes place via the IPC Observed Practice Audit Tool and Clinical Supervision, spot check visits to hospitals by the IPC team and some external feedback from hospital staff conducting audits. The results from the Observed Practice audits for the year have shown a significant improvement. Work is ongoing to address the issue of appropriate glove usage and is part for the new IPC Training Workbook.

8 Occupational Health Department

Occupational Health is provided to the Trust by Guys and St Thomas' Occupational Health Department and is performance managed through the Human Resources department. Guys and St Thomas' Occupational Health Department are a contributing member of the Safety and Risk team providing quarterly data on needle stick injuries, vaccinations, post exposure prophylaxis and any skin allergies due to glove or alcohol gel usage. To support frontline staff and reduce the incidence and impact of vaccine preventable illness in the work place, Guys and St Thomas' Occupational Health Department has liaised with Human Resources to ensure that staff are appropriately immunised, there is an on-going risk regarding previous staff immunisation records prior to Guys and St Thomas' Occupational Health Department taking responsibility for the Trust which is being investigated by Human Resources and feedback to the IPC team.

A task and finish group has developed recommendations that are now being drafted for presentation to the senior management team on how we can improve our position in this area.

9 Needlestick Injuries

The Safety and Risk Department has provided the figures for the type and total of needlestick injuries. The current procedure for the reporting of needlestick injuries has been updated and is found in the new Management of Sharps Policy. The full procedure and process for the treatment and reporting of such injuries can be found on The Pulse, on complex or in the IPC Training Workbook.

There were a total of 87 (21 unused 66 used) reported needlestick injuries during the year 2011/2012, this has increased to 104 (56 Razor and 48 used sharp) in 2012/2013. The cause of needlestick injuries varies; the most common incidents are during the disposal process. The appropriate training has been identified and provided to the members of staff where necessary.

Reported used sharps injuries has fallen by 18 (27.2%) in 2012/13, the overall increase was due to the rise in clean razor injuries which was due to the manufacturer changing the design without notice. A new type of razor has been rolled out across the Trust.

10 Seasonal Influenza

The 2012/13 flu season saw us achieve a lower vaccination rate amongst staff compared to last year's seasonal flu period. Nearly 1550 staff were vaccinated across the Trust, around 28% of the workforce. This compares to last year's 40%.

This was acknowledged by the LAS being invited to present "Flu vaccination and healthcare workers; how to improve compliance" at a national conference in May 2012. This was undertaken by Paul Williams the pandemic flu lead at LAS.

Our success can be contributed to a number of factors including;

- Early preparation in 2012.
- The use of Ambulance service personnel in a national communications campaign. The staff involved were London Ambulance staff and came from Control services, Operations, Fleet and Logistics and Support Services.
- We were fortunate to be able to utilise a member of staff on restricted duties who was instrumental in maintaining the programme administration.
- A mild winter and low levels of flu activity contributed to staff being able to access the vaccine, supported by a network of complex based vaccinator clinics.
- The work of the dedicated member of communications department staff was crucial in allowing us to access as many staff as possible through the widest range of media.

Work is underway to prepare for next season which will include providing more mobile vaccine clinics and building on the national communications provided this year from NHS Employers.

11 Serious Incidents and Complaints

There have been no complaints regarding infection prevention and control issues in the past financial year 2012/13

In 2012 the trust saw a rise in the number of sharps incidents relating to razor injuries some of which have led to legal claims against the service. On identification of the issue the HIPC and clinical lead for procurement identified the root cause as a change in manufacture of the razor provided by the company of which we were not informed. This led to the safety guard on the razor being easily dislodged and resulting in injury to staff, albeit from a clean sharp.

An alternative razor provider was sought along with a change to the sharps bin to provide a wider aperture for the razor to ensure a whole system improvement to

process. This has been introduced across the organization and there has been a subsequent drop in incidents reported.

A serious incident was raised as a result of an identified issue with the immunisation of staff for protection against Hepatitis B as part of the recruitment and training of new clinical staff. One cohort of A&E support trainees was identified as potentially having missed their HBV vaccinations which led to a review of the process and a check to ensure that all staff have adequate immunisation. This was coupled with an outbreak of Measles in London which had resulted in a small number of staff contracting this through occupational exposure. The Consultant for Communicable Disease Control of the local Health Protection Unit wrote to the DIPC to reiterate the importance of immunisation of staff to protect them from Measles and identifying that some staff may not be protected and would need to attend Occupational Health for vaccination.

The Assistant Director of Workforce Development and Support has led a task and finish group to scope the current problems and ensure that future immunisation of staff is recorded and that the Occupational Health Department have accurate records of staff immunity and lead on immunisation and vaccination of staff in future. This group is ongoing and is due for completion in May 2013.

12 External Partnerships

The IPC team works with many external sources to assist in the smooth implementation of the latest IPC policies and procedures. Some of our IPC partners in 2012/13 include;

- NASICN – National Ambulance Service Infection Control Network
- HPA – Health Protection Agency
- BCAS - British Columbia Ambulance Service
- IPS – Infection Prevention Society
- RCN – Royal College of Nursing
- NICE – National Institute for Clinical Excellence
- DH – Department of Health

13 Achievements in 2012-2013

The report has already identified a number of achievements in improving infection prevention and control within the Trust. However, the LAS have also played a part in shaping the national picture in infection prevention and control prevention. These are detailed below

- Visit by the Care Quality Commission with no issues raised on IPC portfolio
- The development of a nationally agreed pathway for the management of patients with an acute onset diarrhea - LAS and SCAS have led on this
- Promotion of the pathway at national conference as poster presentation
- Successful overview and conclusion of the Olympics, Jubilee Celebrations and various festivals and links with the HPA for surveillance of possible IPC issues

- IPC AOM sat as an expert on the Advisory Committee on Dangerous Pathogens for the Management of Hazard Group 4 VHF infectious diseases
- IPC AOM sat as an expert on DH working group on biological threats to the Olympics
- Completion of Trust wide spot check audits on all stations
- An audit at the Headquarters building as a trial to gain a baseline for future audits of administration sites
- Introduction of Adenosine Triphosphate (ATP) swabbing
- Successful trial and introduction of the Clinell Spill Wipe
- Attendance at several conventions including; National IPS conference in Liverpool, WMAS National Ambulance Service Patient Safety Conference, Resource Waste Management(RWM), IPS Ambulance forum national conference in Birmingham, Carbenapem Resistance Symposium
- Review of Category 4 procedures and production of operational procedure
- New policy for the management of sharps implemented – revision of hand hygiene and infection prevention and control policy

14 Communicable Diseases

A number of incidents and outbreaks have occurred which have affected London in 2012/13. As always there is an impact on service delivery of these and the need to inform staff and provide advice and support when these occur.

London has seen a continued outbreak of Measles which has also spread nationally, in particular Merseyside, North East and Wales and with greater population movement across the UK this has spread to most areas.

Pertussis (Whooping Cough) has been prevalent this year and has affected adults as well as young children. A video of an adult with Pertussis was posted on the Pulse to raise awareness amongst staff.

A novel coronavirus was identified in the Middle East and one of the first international cases was seen in London. The HART team were involved in the initial swabbing of close contacts and we have worked closely with the HPA in the movement of patients and support of contacts in the community.

A case of Crimean Congo Haemorrhagic Fever (CCHF) was identified in Glasgow and we were notified of the possible repatriation of the patient to the High Security Unit at the Royal Free which is a role undertaken by the LAS HART nationally. The patient was subsequently transported by the RAF due to his deteriorating condition and a review has taken place of the transfer arrangements for future patients and the LAS have been actively involved in this.

More recently an evolving novel avian influenza with a high mortality rate in humans has been identified in China and as a precaution the trust is reviewing the procedures and ensuring that our pandemic stockpile is current and appropriate.

15 Conclusion

Patient safety is a top priority for the Trust and IPC is an integral part in achieving this. The Trust has shown its commitment to IPC by the systems and processes implemented during 2012-2013. Trust staff has worked hard to achieve the IPC objectives for the year. This has now set the foundations for taking the IPC agenda forward. Making and sustaining improvements in the experience patients have whilst in our care through focusing on safety and quality will be the primary focus for the forthcoming year.

Appendix 1; IPC Balance Scorecard

			Hand Hygiene		Training	Cleaning/Environment					Feedback		
	Complex	Trajectory	Hand Hygiene AOM	Hand Hygiene Other	Infection Control Training	Vehicle Audits (4 Required) AOM	Premises Audits AOM	Quarterly Audit compliance	VP Deep Clean A&E	ICT Team Inspection	Flu Vaccine Uptake	Razor Incidents	Used Sharps Incidents
Last Date of Data Set			Mar-13	Mar-13	2012/13 CSR1	Mar-13	Mar-13	Q4	Mar-13	2012/13	Oct12 - Mar 13	2012/13	2012/13
West	Brent		100%		1.6%	19	97%	87%	89	83%	24 (15%)	3	3
West	Camden		100%	17%	4.0%	26	100.00%	92%	70	73%	78 (74%)	3	4
West	Friern Barnet		100%	48%	0.0%	16	100.00%	96%	87	95%	39 (32%)	0	0
West	Fulham		100%		0.0%	17	100%	100%	89	81%	63 (63%)	3	0
West	Hanwell		100%		0.0%	4	97%	85%	93	92%	24 (22%)	3	0
West	Hillingdon		100%		4.7%	12	87.40%	96%	94	85%	67 (50%)	0	1
West	Islington		100%	25%	0.0%	4	98%	95%	50	84%	Camden	Camden	Camden
West	Isleworth		100%		0.0%	9	100%	99%	87	69%	42 (32%)	3	2
West	Pinner		100%		0.0%	39	94.40%	97%	59	87%	59 (47%)	1	1
East	Chase Farm		100%	65%	5.6%	15	100.00%	92%	70	85%	35 (38%)	1	3
East	Edmonton		100%		0.0%	10	93.90%	94%	84	92%	45 (27%)	8	4
East	Homerton		100%		0.0%	4	100%	95%	64	81%	22 (14%)	1	0
East	Newham		100%	43%	0.0%	3	94.00%	73%	88	75%	20 (18%)	5	4
East	Romford		100%		15.3%	4	100.00%	96%	69	78%	63 (47%)	5	1
East	Tower Hamlets		100%		1.7%	5	93.00%	95%	80	89%	12 (15%)	3	0
East	Whipps Cross		100%		6.3%	8	72.00%	88%	84	86%	38 (21%)	4	5
South	Barnehurst		100%		0.0%	8	97.00%	94%	85	88%	6 (4%)	0	3
South	Bromley		100%	50%	0.0%	4	96.00%	80%	72	81%	73 (55%)	4	4
South	Croydon		100%		0.0%	4	95.60%	90%	89	92%	26 (16%)	0	1
South	Deptford		100%		0.0%	10	98.30%	99%	86	90%	32 (34%)	1	3
South	Greenwich		100%	33%	32.5%	7	91.00%	99%	86	94%	65 (38%)	4	1
South	New Malden		100%		1.7%	14	100.00%	88%	54	85%	42 (42%)	1	1
South	Oval		100%	27%	0.0%	8	93.00%	97%	100	65%	11 (12%)	1	1
South	St Helier		100%	47%	0.0%	6	100%	87%	65	98%	45 (37%)	0	1
South	Waterloo		100%	45%	0.9%	4	98%	94%	65	70%	38 (27%)	1	2
South	Wimbledon		100%	29%	8.3%	8	97.60%	88%	77	87%	17 (21%)	1	3
LAS	Other										449(41%)		
LAS	ED Centres							100%		85%			
LAS	PTS							100%					
COLUMN TOTAL								89.4	78.30%	Avg. 85%	1443(34%)	56	48

Appendix 2; 2013 Action Plan.

Delivery Plan

Summary of Workstreams and Status

Created 20 December 2010 (updated 05.02.2013)

Workstream	R.A.G "20012 Year Start	R.A.G Recent Feb 2013
Workstream 1 (incorporating WS 9). There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen (Risk Register &CQC). There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient (Risk Register)	Amber	Red
Workstream 2. There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained. (Risk Register & CQC).	Amber	Green
Workstream 4. There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection. (Risk Register & CQC) & The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)		Red
Workstream 6. There is a risk that the Trust does not provide adequate infection prevention and control training to all staff which may lead to healthcare associated infections.	Amber	Red
Workstream 8. There is a risk of infection to staff due to sharps injury (Risk Register).		Green
Workstream 12. Infection Control Champions (Previous Action Plan)	Amber	Amber
Workstream 15. Improving Hand Hygiene Compliance (Balance Scorecard January 2011		Green

Completed Workstreams		
WS	Description	Date Reviewed/Completed
1	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen. (Risk Register & CQC)	
2	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.. (Risk Register & CQC)	
3	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust. (Risk Register)	Feb 2012
4	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection (Risk Register & CQC) and Workstream 7. The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)	
5	There is a risk that the lack of displayed/available cleaning schedules may mean that the staff and public are not aware of cleaning protocols (Risk Register &CQC).	Nov 2011
6	There is a risk that the Trust does not provide adequate infection prevention and control training to all staff which may lead to healthcare associated infections. (Risk Register &CQC)	
7	The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)	May 2011 – now part of WS4
8	There is a risk of infection to staff due to sharps injury. (Risk Register)	
9	There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient. (Risk Register)	Feb 2012 – now part of WS1
10	Trust not currently aware of Hand Hygiene Compliance (CQC and DH)	Nov 2011
11	Improve Deep Clean Compliance (Dashboard)	Nov 2011
12	Infection Control Champions (Previous Action Plan)	
13	Flu Planning	Nov 2011
14	Patient Environment Action Group (Previous Action Plan)	Nov 2011
15	Improving Hand Hygiene Compliance (Balance Scorecard)	
16	Equipment Supply (following Staff Survey results)	Apr 2011

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 JULY 2013

PAPER FOR APPROVAL

Document Title:	**Safeguarding (Annual Report)**
Report Author(s):	**Steve Lennox, Alan Taylor, Lysa Walder, Kuda Dimbi, Alan Hay, David Williams**
Lead Director:	**Steve Lennox, Director of Health Promotion and Quality**
Contact Details:	**Steve.Lennox@lond-Amb.nhs.uk**
Why is this coming to the Trust Board?	**Mandatory annual report to inform the Trust Board on safeguarding issues across the Trust**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☒ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the annual report**

Key issues and risks arising from this paper

Clinical safety
Safeguarding is an assessed CQC domain.

Executive Summary

The attached report is the Annual Safeguarding Report for the Trust. This includes a section that outlines the work undertaken as a response to the Savile enquiry.

The report reflects progress with Safeguarding and a number of issues have been strengthened. Training was the biggest gap in 2012 but the risk is mitigated by the number of staff who undertook training in the preceding years and this is being addressed in the current year.

The Trust now has a relationship with the Tri Borough Safeguarding Boards which has strengthened our governance and accountability with safeguarding.

Attachments

Safeguarding Annual Report 2012/13

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Quality Strategy
This paper supports the following domains of the quality strategy

- ☐ Staff/Workforce
- ☐ Performance
- ✓ Environment
- ☐ Experience
- ☐ Helping People
- ☐ Quality of Life
- ☐ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
- ✓ To improve the quality of care we provide to our patients
- ✓ To develop care with a highly skilled and representative workforce
- ☐ To provide value for money

2013/14 Priorities
- ☐ Modernisation Programme
- ☐ Communication and Engagement
- ✓ Sustain performance to ensure safe service to patients
- ☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

- ✓ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
- ✓ That we cannot maintain and deliver the core service along with the performance expected
- ✓ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ✓ No

Key issues from the assessment:

London Ambulance Service NHS

NHS Trust

Annual Safeguarding Report

2012/13

1.0 Introduction & Background

1.1 On internal assessment the LAS is compliant with CQC standards for safeguarding. Concerns regarding training compliance are being mitigated by a plan to commence Level 1 via e learning by the end of 2013 and level 2 training has recommenced post Olympics.

How is the London Ambulance Service responding to Safeguarding?

1.2 The largest part of the Trust's safeguarding workload is the safeguarding adults. These generate more referrals than children. Within adults there are certain vulnerable groups in which we need to focus attention; mental illness and learning disabilities.

1.3 The Trust manages the Safeguarding agenda through a number of work streams. These are; Adults, Children, People with Learning Disabilities, People with Mental Illness and Prevent and maintains a scorecard of compliance (March 2013 scorecare attached as Appendix I).

1.4 We have a named lead for safeguarding children, safeguarding adults, mental health and Prevent. We have no designated lead for learning disabilities but the safeguarding adults lead covers the strategic issues.

2.0 Safeguarding Arrangements

2.1 The safeguarding committee drives the Trusts' action plans for safeguarding children and adults and the committee meets every two months.

2.2 The Trust has a number of roles within the organisation that have a specific safeguarding remit.

- Executive Lead: Steve Lennox, Director of Health Promotion & Quality
- Head of Safeguarding Children: Lysa Walder
- Head of Safeguarding Adults: Alan Taylor
- Safeguarding Officer: Dawn Mountier
- Educational lead: Gary Ralph, Practice Learning Manager
- Lead for referrals: Alan Hay, Emergency Bed Services Manager

- Lead for mental health: Kudakwami Dimbi, Clinical Advisor
- Lead for Prevent: David Williams, Emergency Planning Advisor

2.3 There are nominated safeguarding leads at complex level that have a specific remit in leading, championing, or managing safeguarding for the Trust at a local level, this involves attending safeguarding meetings and feeding back to staff and the safeguarding team.

3.0 Safeguarding Governance Arrangements

3.1 The Safeguarding Committee reports to the Clinical Quality, Safety, and Effectiveness Committee and makes a short report at every second meeting. The Clinical Quality, Safety, and Effectiveness Committee reports safeguarding to the Quality Committee unless there is a direct report from the Safeguarding Committee to the Quality Committee.

3.2 The Designated Nurse from our commissioning team is a member of the Safeguarding Committee.

3.3 The Coalition Government has published its Vetting and Barring Scheme Review, but until new legislation to implement the changes is introduced, the current safeguarding responsibilities remain.

3.4 The Trust has an obligation to inform the Local Authority Designated Officer (LADO) of any concerns regarding our staff made in regard to children and the Safeguarding Adult Manager where the concern relates to adults. In the 2011/12 Safeguarding Report we reported no incidents. However, we changed the function to be a centralised function at the start of 2012/13. In 2013/13 there were 7 occasions. Suggesting the centralised system is strengthening the governance regarding allegations against staff.

Partnership Working

3.5 It is a statutory requirement for the Trust to attend Local Safeguarding Children Boards.

3.6 The Director of Health Promotion & Quality is a member of the Tri Borough Safeguarding Board. Locally, at individual complex level, attendance at LSCB and SAB has improved with identified leads at all complexes. The Heads of Safeguarding receive feedback from local leads on attendance and local safeguarding issues. A hub and spoke model is being developed for the monitoring of attendance and the feeding into the corporate system any local learning. The Head of Safeguarding Adults has also attended the London Safeguarding Adults Chairs meeting to improve engagement with

partners and is also a member of the London Safeguarding Adult Network (LSAN).

4.0 Education & Training

4.1 Education requirements are broken into Induction, Level 1, 2 and 3 training depending upon the degree of contact an individual employee has with children. The Trust undertakes both safeguarding adults and safeguarding children training within the same safeguarding session.

4.2 Induction Training

The Trust has a two day induction training programme for all members of staff and Safeguarding has a 30minute session on this as per recommendations in the intercollegiate document 2010.

Level 1 Training

4.3 There is a plan to undertake level 1 training via on on-line package. The on-line package is a national package and is of no cost to the organisation. However, OLM is still not available to be able to record those who complete training and a decision has been taken by the Heads of Safeguarding in conjunction with the E Learning Manager to pilot the introduction with a small cohort of staff. There may be a cost implication in the administration of the system, this is currently being explored.

Level 2 Training

4.4 The Trust has systems and processes in place to ensure a methodical & systematic approach to core training (which includes Safeguarding) for all ‘front line’ ambulance staff. This approach includes the processes to analyse training needs, plan, develop, deliver and evaluate core training, and assesses the implementation of the training on the Trust. The Olympic preparations took the greatest need on training last year.

4.5 The Trust reviewed the core training requirements and produced a Training Needs Analysis (TNA) for all staff in line with legislation, national and professional guidance, in order to inform ongoing policy development and underpin design and delivery of appropriate Core Training programmes, in the correct volumes and at the correct levels.

4.6 A gap in training was identified with several staff groups, those who voluntarily respond for the Trust, Private Providers, Patient Transport Service, Taxis and Control Room Services Staff. This has been addressed and training and/or guidance approved for these groups by working with the groups concerned to ensure that safeguarding at Level 2 is integral to their training for staff. Control Room Services Staff have had a bespoke package developed for their specific requirements. Contracts with all Private Providers have been revised to include Safeguarding. Within Patient Transport Services the gap has been identified and will be addressed during the coming year through training.

4.7 Current guidance means the Trust specify Safeguarding Children & Adults training as mandatory.

4.8 It has been difficult to obtain accurate training completion compliance figures and it is hoped that when OLM is implemented this will be resolved.

4.9 In 2012/2013 19% of the Trust's clinical staff received level 2 training. However, as the standard is that all staff should receive training every three years this is currently not a significant risk as previous years compliance was strong. The safeguarding training is in the 2013/14 CSR training package and is currently being delivered.

Level 3 Training

4.10 Level 3 training was delivered to 58 key staff during the year. Staff were from Patient Experience Department, Emergency Bed Services, EOC, CIOs, PPI, and the Clinical & Quality Directorate. Training was delivered by the Named Professional for Safeguarding Children and the Named Professional for Safeguarding Adults for the Trust. These teams were targeted as they have a role in supporting front-line staff with safeguarding concerns. To date 78% of the Patient Experience Team have had level 3 training, 38% of the Emergency bed team and 70% of the Clinical & Quality Directorate.

4.11 The Board received bespoke training in January 2013.

5.1 In addition to the statutory training 200 staff from other UK Ambulance services who supported the Olympic cohort at the 2012 Olympics and Paralympic Games were provided with training in safeguarding procedures in London. The Trust also provided the 500 strong Olympic cohort of staff with a pocket guide to safeguarding, and details of how to manage any potential safeguarding alerts that might arise during the 2012 Games.

5.2 No safeguarding referrals were made by the 2012 Games cohort.

5.0 Raising Awareness

5.3 One important aspect of Safeguarding is the need to raise awareness and a number of events and processes have taken place this year.

5.4 We are holding our first Safeguarding conference in June 2013 for staff from all levels of the service.

5.5 The Trust have also produced a pocket Safeguarding guide book for all front line staff which is being rolled out across the Trust in June.

5.6 We have developed a safeguarding information area on the Trust intranet, which provides information on safeguarding and useful links to external organisations.

5.7 We have three pages on the Trust web pages dedicated to the public and professionals and provide access to reports and information about the Trusts safeguarding work.

5.8 The Trust has also produced “Easy Read” Safeguarding leaflets and has an “Easy Read” safeguarding section on the Trusts web site.

6.0 Audit

6.1 The Trust Section 11 mandatory audit against compliance with safeguarding standards has been completed for 2012/13. This audit is essentially a self assessment against the expected standards associated with safeguarding. The Trust also a wider self assessment of safeguarding adults work and reported this to the SHA.

7.0 Quality

7.1 The Trust has undertaken a number of initiatives to improve quality. Quality controls in referrals have been introduced (this is reported in section 9) and a number of other initiatives have also been developed. These are as follows:

- The balance scorecard is now embedded into the work of the safeguarding committee and used to monitoring safeguarding practice
- The Trust has action plans in place for
    a. Children
    b. Adults
    c. Learning Disability
    d. Mental Health
- The Safeguarding Committee has representation from Operations with the addition of the Assistant Director of Operations (East) and a representative from control services
- The Trust has external members (Metropolitan police & Designated Nurse) and a patient representation on the Safeguarding Committee.
- A monthly Safeguarding report will be produced from July 2013 and shared with leads within the Trust and partner agencies.

8.0 Supervision

8.1 The main vehicle for providing supervision is through the Operational Work place Reviews (OWR). These include Safeguarding elements and gave an opportunity for Team Leaders to assess knowledge and awareness of safeguarding issues and the understanding of the policies and processes in place during an observational shift with frontline staff.

8.2 Formal safeguarding supervision is being delivered for EBS, Clinical Hub and Local Safeguarding representatives.

8.3 Safeguarding supervision is provided for staff who have been found to have missed a safeguarding referral through the Staff Safeguarding Action Plan.

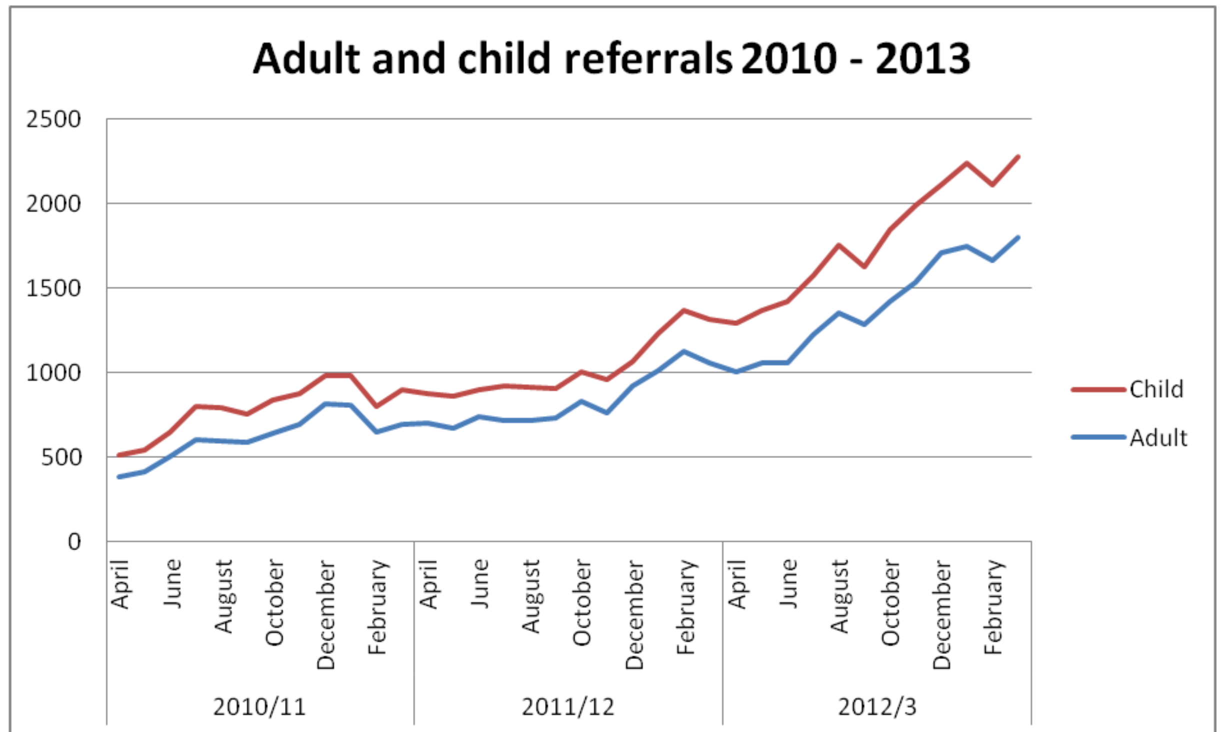
9.0 Referrals

9.1 Referral is the Trust's main contribution to the wider safeguarding agenda. By identifying potential safeguarding issues in the exercise of their main duties, and notifying local authorities the Trust is able to make a significant contribution to the welfare of children and adults at risk.

9.2 Referrals have continued to rise this year, both in absolute numbers and also as a share of all Trust incidents. This year saw a total of 21,619 referrals, an increase of 75% on last year's total of 12,337. The % of total incidents resulting in referral increased from 1.2% last year to 1.9% this year. This is a slightly smaller increase of 60% and represents the rate of increase with the effect of the baseline increase in activity stripped out, and it is a better indication of the increase in the safeguarding aspect of the Trust's business. Both increases are steep, and there is every expectation that they will continue to rise. For this reason it will become necessary in 2013/2014 to look at what can be done to optimise this rate of increase, and to properly resource it. The reasons for the increase are various but basically boil down to training, effective leadership of the Safeguarding agenda at service and complex level (particularly where new CIO's have engaged very effectively), and some external factors harder to quantify such as the cutting or withdrawal of some social services resources.

9.3 Figure 1 demonstrates the number of referrals made across a three year period.

Figure 1: Total Safeguarding Referrals 2010-2013



9.4 We do not currently know how this compares with other ambulance services but will attempt to have a comparative figure in the near future.

9.5 Delays in referrals have generally improved. Only about 3.5% of referrals are delayed more than a couple of hours after the incident, and the bulk of these delays are concentrated in a few complexes. This is an improvement on last year's total of 6%. Work is being undertaken to manage this problem at complex level, and we expect to see further improvements.

9.6 The Trust continues to receive very little in the way of feedback from Local Authorities. This is a statutory obligation and features highly in Munro's review.

9.7 The main development this year has been the commencement of the telephone referral trial. Two complexes, Whipps Cross and Homerton have been able to make referrals directly over the phone to EBS staff. Interim informal evaluation suggests this has been broadly successful with an increase in quality, legibility and uniformity of referrals and a considerable saving in VOR. There remain however complex questions to answer as to how this would be rolled out across the Trust, as it would require a considerable investment in EBS's call-handling capacity. A formal Evaluation will be submitted to the Safeguarding Committee in July 2013.

10.0 Incidents

10.1 The Safeguarding Officer works with external agencies such as local authorities and other Trust departments, in order to ensure that the Trust is compliant with its statutory responsibilities set out in the Children Act 2004 and duties under the No Secrets guidance.

10.2 Of the 784 enquires that were dealt with in 2012/2013, 242 resulted in the Trust being asked to undertake further enquiry; such as attending and contributing to meetings, the completion of reports for Incidents, Independent Management Reviews or Form B's.

10.3 12 of these progressed to be Serious Case Reviews and 3 Domestic Homicide Reviews. 1 had recommendations for the Trust. These recommendations are essentially regarding missed opportunities to make referrals and are addressed with individual members of staff through reflective practice.

11.0 Serious Incidents

11.1 There was 1 Serious Incident with a safeguarding element in 2012/13. Spontaneous breech labour at home with difficulties, the mother was taken to hospital where the baby was born. The baby was later transferred to another hospital where they died 2 weeks later. 2 x hospitals also declared an SI with 2 further hospitals contributing to the investigation.

12.0 Employment Practice

12.1 All appropriate Trust employees have undergone a disclosure and barring process. The Trust undertakes an enhanced disclosure and barring check and ISA checks on appropriate recruitment and role changes. 563 checks were completed for 2012/13.

12.2 The Trust needs to continue to improve the guidance on how to manage concerns regarding employees. Guidance is available from the London procedures and has now been incorporated into the Trust's own Safeguarding Policy.

12.3 As a result of recommendation from the Winterbourne View Serious Case Review the Trust needs to review contracts to make Whistle blowing a condition of employment.

12.4. Safeguarding Adult and Children policies have now been reviewed. They take in to account national and local best practice and DH and legal frameworks. They include guidance on whistle blowing and instances where there are concerns for managing allegations against children and adults to the LADO/ALADO

12.5. Training on safeguarding is delivered to all frontline staff, including managers, control services, PTS, CFR, ER, EBS and PED,

12.6 It is recommended that all partner agencies including taxi services, VCS and volunteers must subscribe to the DBS and agree to the LAS accessing updated records on a regular basis.

12.7 The indemnity form to be completed by all observers including volunteers, celebrities and others includes guidance on unsupervised access to patients.

12.8 The current taxi service contract is in the final version and includes safeguarding. All taxi drivers are disclosure and barring checked. Unaccompanied children are not conveyed by taxi.

13.0 Safeguarding Children

13.1 The safeguarding of children is monitored by the Trust's Safeguarding Committee and they monitor the implementation of the children action plan which is led by the Head of Safeguarding Children. This is divided into a number of work streams.

Work stream A1 Risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral. ***Status: open***

13.2 This is identified on the Trust Risk Register. Missed opportunities to make safeguarding referrals are collated and added to Datix, Feedback provided to staff from Team Leaders or Complex Trainers to support learning around safeguarding issues.

13.3 Operational Workplace Reviews, our main vehicle for supervision, is now undertaken regularly at all complexes although the Trust is not yet meeting the expected trajectory for 2012-2013. This includes safeguarding.

13.4 Referrals made for safeguarding children are increasing in numbers and continue to be of a better quality/legibility. In addition they are being made in an increasingly timely manner.

13.5 However, as this remains a risk for the Trust and we continue to see a small number of missed referrals, 18 for 2012/13.

Workstream A2. Re-designation of Named Professional. ***Status: closed***

13.6 The named professional role was re-designated during 2011/2012 to the newly established position of Head of Safeguarding Children,

Workstream A3 Partnership Working. ***Status: open***

13.7 The Head of Safeguarding Children has met most of the local reps across London to establish a benchmark of safeguarding awareness, training, and

attendance at LSCB meetings. This information has been collated in a database and provides a framework to build on.

13.8 Safeguarding is included in the new Social media Policy currently being drafted.

13.9 We still have work to do in ensuring local engagement takes place and this is a key area of focus for the Head of Safeguarding. Therefore this remains open on the action plan.

Workstream A4 Education and Development. ***Status: Open***

13.10 Training undertaken as detailed in the previous training section of this report.

Workstream A5. Supervision. (Commissioned Standards & CQC) ***Status: Open***

13.11 Supervision is now being addressed through OWR but there are a few outstanding actions so this work stream remains open.

Workstream A6. Clinical Governance and Risk Management. (Commissioned Standards, CQC & SIT Visit) ***Status: Open***

13.12 The majority of actions have been closed the remaining action is to ensure the High Risk Register procedures reflect safeguarding practice.

Workstream A8 Procedures and Guidance. ***Status: Open***

13.13 The Safeguarding Children Policy has been completed and the management of Intoxicated Minors has been added (this was a CQUIN requirement for 2012-2013) and strengthening of the guidance on staff involved in safeguarding allegations. This will be available to staff from July 2013.

Workstream A9.Annual Report. (Commissioned Standards & CQC) ***Status: Closed***

13.14 This report meets the requirements of this work stream

Workstream A10. Audit. (Commissioned Standards, CQC & SIT visit ***Status: Open***

13.15 The head of Safeguarding Children has completed the Section 11 Audit. This is our self assessment against mandatory and statutory elements.

Workstream A11. Unable to assure that the current taxi contract accommodates the guidelines for regulated activity (Risk Register) ***Status: Closed***

13.16 Taxi contracts now have Safeguarding written in.

Workstream C. Learning from Serious Case Review Recommendations. ***Status: permanently Open***

13.17 Articles providing information to inform staff about best practice in safeguarding children are regularly published in the LAS News. They are anonymous cases based on action plans that result from SCRs.

14.0 Safeguarding Adults

Safeguarding Adults and Assurance Framework

14.1 In March 2011, the Department of Health published a Safeguarding Adults and Assurance Framework to enable health Trusts to identify how well they are meeting their safeguarding adult responsibilities. This served as a gap analysis tool for the Trust and identified that (using a scale of 1 – 4, with 1 being 'not effective') 16 out of 20 measures were self graded as effective.

14.2 Areas for improvement include partnership working, improving transparency, contracts and procurement, all of which are included in the action plan for development, this was validated by the Tri Borough and by NHS London.

14.3 The Safeguarding Adults Action plan is monitored by the Safeguarding Committee and is divided into workstreams.

Workstream A, Strategy and Planning. ***Status: Open***

14.4 There is a Strategic Plan for Safeguarding Adults that includes Prevent and it is an integral part of quality. The Trust has action plans in place and are reviewed and monitored regularly at appropriate committees. The Trust currently only undertakes Prevent training to targeted staff groups.

Workstream B, Systems for prevention; responses; reporting & learning. ***Status: Open***

14.5 B1. The Trust has internal Safeguarding Adult procedures that are consistent with the local multi agency Safeguarding Adults procedures including Prevent. The revised Adult policy agreed at Safeguarding Committee and is going to EQIA on 29 May2013.
B2. The Trust has guidance and processes to govern the use of restriction and restraint and where DoLS should be considered. The Trust has guidance on assisting the police with restraint as the Trust's practice is not to restrain patients. A DVD produced on Positional Asphyxia and guidance issued to staff, reviewing with mental health lead guidance in relation to restraint. The Trust is currently reviewing it stance and guidance on restraint, historically the service states it does not restrict or restrain patients, when there are clearly occasions when staff have to.

14.6 B3. Services can demonstrate patient/user led decisions about their Safeguarding and that interventions are person centred. Staff trained on consent and safeguarding. A small audit undertaken showed consent not

sort in a high percentage of those forms checked. The Trust is currently undertaking a review of referral process and form used. The Form is to be redesigned to make the need for consent more explicit to staff. Training materials have also been updated to cover the need for consent to refer a patient and when it may be acceptable not to have consent. The Trust is also considering feasibility of a telephone audit of patients who granted consent.

Workstream C, Workforce, culture and capability. ***Status: Open***

14.7 C1. The Trust's workforce has the capacity and capability to

C1.1 Meet the needs of patients who may be at particular risk of harm.

C1.2 Respond to Safeguarding concerns. Workforce plans moving organisation towards a greater ratio of registered professionals who can make autonomous decisions. Safeguarding training for all "frontline staff", training at level 2 being provided to Emergency Operations Control staff to identify and respond to any safeguarding issues that arise over the phone. It is agreed that Safeguarding articles will be published quarterly in Clinical Updates since December 2012. The Trust has a dedicated safeguarding email address and web pages to provide safeguarding information. The trust is holding their first Safeguarding conference in June and have produced Safeguarding pocket books for front line staff.

14.8 C2. The Trust provides training to enable the workforce to safeguard adults. The organisation has an approved Prevent Health Wrap Trainer and sessions are delivered to staff. Core Skills Refresher (CSR) Safeguarding materials were reviewed in January 2013. CSR is currently being delivered to front line staff. Patient Transport Service (PTS) to begin CSR training in July 2013. All staff joining the Trust now receives Safeguarding induction. The Heads of Safeguarding have met with leads for Voluntary Responders and Private Providers to train them to deliver Safeguarding level 2 to these staff which began in March 2013. Limited Prevent training has been provided by the Trust's Prevent Trainer.

14.9 C3. The Trust Safeguards adults by addressing staff performance concerns, a whistle blowing policy is in place. Currently no real Safeguarding adults have been tested on the internal system. The Trust's managers have been reminded of the need to inform only the Executive Lead if any Safeguarding concerns are raised against a member of staff.

Workstream D, Partnership & Collaberative working. ***Status: Open***

14.10 D1.The Trust works in partnership to Safeguarding adults. This includes local multi agency partnerships involved in the Prevent agenda, including channel, metropolitan police and local authorities. We have designated local Safeguarding leads on complexes who attend local board meetings, who feedback information to the Safeguarding team. The Head of Safeguarding Adults has met with the chairs of Safeguarding Adults board (SAB). The Safeguarding Officer liaises with local authority colleagues to

ensure attendance at Rapid Response Meetings, Serious Case Reviews and provides documentation including Individual Management Review, Form B's, Incident Report etc. Representation from the Metropolitan Police and Designated Nurse from CCG attend our Safeguarding Committee Meetings. Prevent trainer attends multi agency Prevent meetings.

Workstream E, Learning from Incidents, SI's, SCR's, Complaints, Reports and Publications. ***Status: Open***

14.11 E1. There are a number of actions for the Trust from the Winterbourne View, Serious Care Review recommendations. These will be detailed in full in the Adult Safeguarding Action Plan and include;

E.1.1 Review contracts of employment and make whistle blowing a condition of employment. The Trust is currently considering how to proceed.

E1.2 Develop Easy Read complaints information. The Patient Experiences Department is currently in the process of developing on line easy read pages.

E1.3 Share Safeguarding alerts and regular callers/attendance at the same location with other organisations. This is probably the most difficult recommendation to achieve, as it does not only require a change in the internal processes but will also involve agreement with other organisations or thresholds and processes for providing this information.

14.12 E2. An Incident Sub Group of the Safeguarding Committee has been set up to look at incidents in more detail and ensure actions are being followed up.

15 Learning Disability

15.1 The Trust has been extremely successful in its work with learning disabilities. A self assessment, led by the SHA, was undertaken during 2011-2012 and the outcome for the Trust was extremely positive with evidence that the Trust prioritises learning disability. The recent patient story at Trust Board is an example of the evidence produced. Again the Trust's action plan is divided into work streams. The Committee has just completed all outstanding actions. The committee will not be meeting for another year.

16 Mental Health

16.1 The Mental Health CPI which was developed in collaboration with the Trust's clinical leads in mental health and launched on the 1 April 2012 has been successful. Although completion rates are still not as high as the Trust would expect, it is hoped that this is because it is a new CPI and as staff become more familiar with it, completion rates should rise. A strategy was being developed to improve compliance rates with this CPI.

16.2 One of the recommendations which came out of the clinical audit of the care given to patients with a suspected or diagnosed mental health disorder by the Trust was that the Trust should provide training to ambulance crews so that they are familiar with the definition of the term ‘neglect’ and of a ‘vulnerable adult’ included in the Trust’s procedure document ‘TP-019 Suspected Abuse of Vulnerable Adults Procedure’. This training should educate crews to consider safeguarding when attending a patient with a mental health disorder and the procedures surrounding the completion of a safeguarding referral. As the CSR 3 could not be delivered, a decision was made to extend the current CSR2 hours with 1.5 hours on mental health. The added bits include the MH CPI consideration of a safeguarding referral.

16.3 A full update is reported in the Trust’s Annual Mental Health Report 2012-2013.

17 Prevent

17.1 Prevent is one of the strands of the Governments counter-terrorism strategy, CONTEST. The PREVENT strand seeks to stop people from becoming terrorists or supporting terrorism.

17.2 The revised PREVENT strategy was released in 2011, and aimed to incorporate all of the partner organisations that could potentially influence radicalisation in the community. 16 of the 31 boroughs in London were identified as high priority in the new strategy, showing the importance of all London Health organisations in the overall delivery of the plan.

17.3 The health Workshop for Raising Awareness of Prevent (WRAP) training is currently delivered by one of the Emergency Planning Resilience Officers in the trust, and is designed to illustrate the correct methods for raising concerns about individuals in the pre-criminal space, who are at risk from radicalisation.

17.4 The training has been provided to 30 staff across the trust, mostly in Central Operations and Emergency Preparedness, although the intent is that this training will be provided to all operational staff.

18 Multi-Agency Risk Assessment Conferences

18.1 Looking ahead to 2013/2014 the requirements of MARAC will be introduced. Multi-Agency Risk Assessment Conferences (MARACs) are meetings where information about high risk domestic abuse victims (Those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year.

18.2 Clearly our role in such cases is limited but is not insignificant. So far the Trust has successfully negotiated the acceptance of not attending the conferences (unless specifically required to do so) but the Trust is obligated to share the information it holds in a similar way to undertaking an Independent Management Review.

18.3 However, the Trust is approaching a first wave pilot to test the processes and as the “go live” approaches the true commitment and numbers of information requests is emerging.

- Domestic violence is the leading cause of morbidity for woman aged 19-44 – greater than cancer, war and motor vehicle accidents.
- In England and Wales, two women a week die at the hands of their domestic violence abuser.
- Home office figures published in February 2008 reveal that thirty three children were murdered by their parents in the previous year.
- Amongst a group of pregnant women attending primary care in East London, 5% reported that domestic abuse had at sometime in the past caused them to miscarry.

18.4 It takes about 20 minutes to complete a request (this has been tested by MI with a few case studies). The numbers of information requests are expected to be approximately 693 a month. This is based on the fact that the national MARAC figures for last year were 55,489 cases. The Trust is currently considering its options for this.

19 Savile Enquiry

19.1 The Trust received a letter from Sir David Nicholson asking each Trust to consider the implications of the Savile enquiry for each organisation.

19.2 The Trust has conducted a review and this is found in Appendix II. The overview has shown that overall the Trust is in a position to provide good assurance those policies and procedures are in place to protect Adults at risk and Children. Some further more specific detailed work on policies in relation to MOUs/ Volunteer credentials may be required to provide evidential assurance that robust procedures are in place for all staff, volunteers and visitors to the Trust

20 Summary

20.1 Overall a self assessment reveals that the Trust is compliant with CQC standards for Safeguarding.

20.2 The Safeguarding portfolio has significantly strengthened during the course of the year. The scorecard is embedded into the work of the committee and appears as a RAG rated measure on the Trusts Quality Dashboard.

Safeguarding

20.3 The Indicators within the scorecard are demonstrating improvements during the course of the year.

20.4 All four Action Plans are progressing very well but the need to establish the committee for Vulnerable & Disadvantaged Groups would help strengthen external scrutiny.

20.5 There is a gap within level 1 safeguarding training and the Trust needs to complete its annual section 11 audit.

20.6 The trust needs to focus more attention on Prevent and ensure it has a well understood process for referrals.

20.7 MARAC requirements need careful consideration.

Appendix I

Safeguarding Balance Scorecard

March 2013 Dashboard

March: Total referrals as a % of incidents	March: Quality (referrals delayed in receipt)	Cumulative: Total referrals as a % of incidents	Cumulative: Quality (referrals delayed in receipt)
1.25% or more	0 - 5%	1.25% or more	0 - 5%
0.75 - 1.25%	5 - 10%	0.75 - 1.25%	5 - 10%
0 - 0.75%	10% or more	0 - 0.75%	10% or m

		March					Cumulative					Training 2010-2011 (April 2010-Feb 2011 Missing Final Month data)			Training 2011-2012 (April 2011-March 2012)			Training 2012-2013 (CSR Training Commenced Oct 2012)			Partnership		Issues		Audit
	Complex	Numbers (Child)	Numbers (Adult)	Total referrals as a % of incidents	Quality (referrals delayed in receipt)		Numbers (Child)	Numbers (Adult)	Total referrals as a % of incidents	Quality (referrals delayed in receipt)		Level 1 Training Compliance	Level 2 Training Compliance	Level 3 Training Compliance	Level 1 Training Compliance	Level 2 Training Compliance	Level 3 Training Compliance	Level 1 Training Compliance	Level 2 Training Compliance	Level 3 Training Compliance	LSCB Rep	Champion	IMR	Complaints	
West	Brent	13	87	2.06%	0	0.00%	170	705	1.65%	29	3.31%		59.1%	NA		70.2%	NA		1.6%	NA	Jon Knott	Hannah Storer	0	0	
West	Camden	10	50	2.30%	0	0.00%	89	465	1.67%	10	1.81%		43.4%	NA		54.9%	NA		4.0%	NA	Natasha Wills	Patrick Brooks	0	0	
West	Islington	5	43	2.29%	0	0.00%	75	367	1.82%	8	1.81%		86.9%	NA		16.4%	NA		0.0%	NA	Natasha Willis	Patrick Brooks	0	0	
West	Friern Barnet	8	45	1.73%	3	5.66%	104	427	1.45%	11	2.07%		62.0%	NA		42.9%	NA		0.0%	NA	Sean Brinicombe	Ruth Williams	0	0	
West	Fulham	6	41	1.69%	3	6.38%	78	460	1.64%	29	5.39%		72.3%	NA		16.0%	NA		0.0%	NA	Paul Smith		0	0	
West	Hanwell	21	72	2.96%	2	2.15%	262	929	3.09%	22	1.85%		71.1%	NA		51.3%	NA		0.0%	NA	Stuart Crichton		0	0	
West	Hillingdon	9	71	2.17%	2	2.50%	187	688	2.00%	12	1.37%		43.1%	NA		77.4%	NA		4.7%	NA	Chris Miles		0	0	
West	Isleworth	19	60	2.46%	7	8.86%	216	638	2.16%	37	4.33%		57.6%	NA		75.0%	NA		0.0%	NA	Damien Marchese		0	0	
West	Pinner	22	76	2.55%	0	0.00%	235	738	2.19%	8	0.82%		63.6%	NA		111.2%	NA		0.0%	NA	Martin Bowdler	Paul Bushell	0	0	
	West	**113**	**545**	2.25%	17	2.84%	**1416**	**5417**	1.96%	**166**	2.53%														
East	Chase Farm	9	41	2.06%	1	2.00%	112	350	1.76%	4	0.87%		94.1%	NA		28.7%	NA		5.6%	NA	Janice Lyons	Angela Jardine	0	0	
East	Edmonton	37	144	3.90%	2	1.10%	327	1431	3.22%	30	1.71%		61.0%	NA		57.0%	NA		0.0%	NA	Jo Scott Jones		0	0	
East	Homerton (City & Hackney)	33	64	2.28%	7	7.22%	193	684	1.87%	58	6.61%		68.8%	NA		71.2%	NA		0.0%	NA	Nick Yard	Nick Osborne	0	0	
East	Newham	13	45	1.82%	2	3.45%	135	404	1.47%	24	4.45%		69.3%	NA		62.2%	NA		0.0%	NA	Carmel Prior	Alan Tokely	0	0	
East	Romford	17	41	1.52%	4	6.90%	193	509	1.59%	103	14.67%		62.2%	NA		51.2%	NA		15.3%	NA	Carmel Walling	Sonia Williams	0	0	
East	Tower Hamlets	14	29	1.72%	1	2.33%	94	243	1.22%	21	6.23%		82.9%	NA		27.3%	NA		1.7%	NA	Paul Ward	Tanya Lee	0	0	
East	Whipps Cross	26	98	2.16%	3	2.42%	279	1036	2.10%	56	4.26%		68.8%	NA		66.9%	NA		6.3%	NA	Amanda Wheaton	Simon Hewson	0	0	
	East	**149**	**462**	2.21%	20	3.63%	**1333**	**4657**	1.93%	**296**	3.77%														
South	Barnehurst	23	88	2.78%	0	0.00%	230	943	2.64%	33	2.81%		18.0%	NA		20.4%	NA		0.0%	NA	Martin Cook	Julie Carpenter	0	0	
South	Bromley	21	67	2.60%	0	0.00%	187	671	2.28%	30	3.50%		62.5%	NA		20.9%	NA		0.0%	NA	Tracy Pidgeon	Conal Percy	0	0	
South	Croydon	31	100	3.06%	4	3.05%	368	775	2.27%	59	5.16%		75.0%	NA		69.2%	NA		0.0%	NA	Vicki Hirst	Jo Millard	0	0	
South	Deptford	22	57	2.75%	1	1.27%	111	459	1.77%	7	1.23%		79.7%	NA		80.0%	NA		0.0%	NA	Graham Norton		0	0	
South	Greenwich	15	88	2.44%	1	0.97%	243	894	2.42%	12	1.06%		117.6%	NA		19.5%	NA		32.5%	NA	Andy Maxted	Tony Wilkinson	0	0	
South	New Malden	17	55	2.41%	0	0.00%	115	506	1.82%	16	2.58%		70.7%	NA		65.2%	NA		1.7%	NA		Taff Roberts	0	0	
South	Oval	9	41	2.10%	3	6.00%	116	394	1.78%	33	6.47%		123.1%	NA		76.7%	NA		0.0%	NA			0	0	
South	St Helier	28	86	3.34%	1	0.88%	231	701	2.23%	17	1.82%		79.6%	NA		81.1%	NA		0.0%	NA	Bill Arkell	Andrea Fransen	1	0	
South	Waterloo	14	71	2.45%	3	3.53%	117	503	1.43%	25	4.03%		97.0%	NA		66.4%	NA		0.9%	NA	Phil Powell		0	0	
South	Wimbledon	9	54	2.43%	1	1.59%	111	364	1.71%	6	1.26%		96.4%	NA		104.9%	NA		8.3%	NA		Taff Roberts	0	0	
	South	189	707	**2.38%**	**14**	**1.73%**	1829	6210	1.97%	238	2.99%														
Control	Other	85	27				743	578				N/A	N/A	?	N/A	N/A		N/A	N/A						
Corporate	PED											N/A	N/A	?	N/A	N/A		N/A	N/A	78.50%					
Corporate	EBS											N/A	N/A	?	N/A	N/A		N/A	N/A	38.00%					
Corporate	C&Q Directorate											N/A	N/A	?	N/A	N/A		N/A	N/A	70%	Steve Lennox				
	Trust Total	**849**	**1741**	2.28%	**51**	2.73%	**5321**	**16862**	2.00%	**700**	3.10%		**70%**			**72%**									
	LAS TOTAL	**2590**					**22183**																1		

Appendix II

Savile Review

Safeguarding

1. INTRODUCTION

The purpose of this review is to the provide the Executive Management Team and Trust Board with an overview of the letter received 13th November 2012 from the Chief Executive of the NHS in respect of the 'Savile allegations'. It will provide an overview of the Trusts processes and highlight any implications for LAS and how these may be addressed via current or planned initiatives in order to provide assurance that our policies and procedures are robust.

2. BACKGROUND

A letter from Sir David Nicholson, NHS Chief Executive was sent to all Chairs and Chief Executives of NHS Trusts and Foundation Trusts in England on the 12th November 2012.

This letter is in relation to the 'Savile Allegations'. In this letter it states that "The Secretary of State has appointed Kate Lampard, a Barrister and Vice Chair of NHS South of England, to provide assurance that the Department and the relevant NHS Organisations are following a robust process aimed at protecting the interests of patients. She will also look, as part of that work, at NHS wide procedures, in the light of the findings of the review, to see whether they need tightening. When this work has concluded the DOH will share any learning relevant for the wider system across the Service as a whole".

The letter also states "In the meantime Trusts are asked to take this opportunity to review, with your Boards, and working as necessary with local agencies, your own arrangements and practices relating to Vulnerable people, particularly in relation to: safeguarding: access to patients (including that afforded volunteers or celebrities: and listening to and acting on patient concerns".

The Trust's review considered these arrangements as reassurance to the EMT and the Trust Board that LAS continues to meet the needs of its patients and prioritise the provision of a safe environment for their care.

Due to the timing of this request and the urgency of the response required, a high level overview was undertaken. It is anticipated however, that the results of this will require continuous review of the Trusts policies and procedures.

3. CURRENT SITUATION

Safeguarding

The Safeguarding Children and Young People and Safeguarding Adults at Risk Policies have just been reviewed. These policies take into account the national and local best practice as well as DH guidance and legal frameworks.
London Ambulance Service (LAS) now has robust procedures in place for referring of at risk persons who come to the Trust's notice which is supported by a dedicated Safeguarding Team. All frontline LAS staff are trained in safeguarding as well as managers, corporate staff, control staff, PTS, EBS and PED. This is updated as part of the mandatory training programme ensuring that the latest learning and guidance is known and understood.

Safeguarding

Any concerns regarding a person who may be at risk can be raised in confidence and are passed to Children or Adults Social Care for further action via the Emergency Bed Service (EBS). These may be patients in our care, relatives, staff, or patients in other healthcare organisations that we observe. Monthly safeguarding indicators highlight good quality standards of referral, Incident management is monitored and reported through the appropriate committees.

Assurance – High

Access to Patients
LAS Staff: Due to the nature of Pre-hospital care all LAS staff (including students) who are in contact with or deal with patients and/or their personal information are checked to ensure that they do not pose a risk to the patients in their care. Enhanced CRB checks have been standard practice for all new patient facing staff including PTS, EOC, and Safeguarding staff. Enhanced CRB checks have also been carried out on all existing operational staff. HR have policies in place which address the actions to be carried out if the check identifies a staff member or potential staff member who has been or on the sex offenders list or may have been subject to other convictions which may cause concern.

CRBs are only as good as the day they are undertaken and there is an obligation on staff to inform the Trust of any issues/ concerns they have or where this information has changed. Governing bodies ie HCPC, CIPD, of registered professionals have also codes of conduct which staff must adhere to as part of their registration.

Impact and Actions for LAS: The impact of the new DBS procedure is under review to ensure that the integrity of LAS checking processes is maintained.

Assurance - High

Community First Responders: Since 2011 recruitment for our volunteers follows the NHS standards of employment – in essence they follow the same selection and recruitment process as any member of staff joining LAS. These include the enhanced CRB check.

Volunteers that provide training –such as “Heartstart UK” courses attend schools and various public events delivering the course. They cannot attend schools unless they have the enhanced CRB and should at all times be supervised by teachers.
The Community First Responders (CFR) managers are actively updating CRBs as these may have been done many years previous.

There is also a “duty of care” rule which stops CFRs attending Children under the age of 12yrs (current age limit is under review). With the introduction of the CFR desk and new structure this has stopped ECCs from sending CFRs to inappropriate calls. The CFR code set has been approved and implemented through the formal LAS system, any changes to code sets must now go through this formal sign off procedure. This ensures that we have robust governance and management arrangement in place in order to safeguard the patient, the trust and the responder.

Impact and actions for LAS: It is recommended that the Trust supports the recommendation that all volunteers must subscribe to the DBS update service and agree to the LAS accessing their updated records on a regular basis

Assurance – High

Volunteer Car Service (VCS) and Taxi Service*:* The current Taxi Contracts are currently in their final version and specifically include safeguarding. All contracted taxi drivers and volunteer car drivers are CRB checked. With the VCS this is a requirement, alongside production of satisfactory insurance documentation prior to us using them. With the taxi companies it is a requirement of their registration with the relevant authority for their license.

Assurance – High

Volunteer Aid Societies (St John/ Red Cross etc.)*:* Across the Trust each of the areas Volunteer Aid Societies have Memorandums of Understanding (MOU) or Service Level Agreements (SLA) with LAS. In these documents it stipulates that they come under the CQC regulated activities of care and must meet the same standards as the Host Trust. They will be adequately trained and qualified, insured and 'will conduct ambulance support work in line with all procedures related to regulated additional requirements'. There is no specific mention however in the examples seen how the staff are recruited and what checks are made prior to them joining the VAS.

Impact and actions for LAS: Clarification and confirmation required should be documented as part of the MOU review process.

Assurance – High

Air Ambulance*:* Paramedics on the Air Ambulances are registered with the HCPC and appropriate DBS checks are made as part of recruitment. The Paramedics on the London Air Ambulance are part of LAS staff and are included in our CRB procedures. The London Air Ambulance are self governed however under their MOU with ourselves they will also have to confirm that their medical staff are 'cleared' to care for patients to our standards. **What about HEMS observers?*

Impact and actions for LAS: Clarification and confirmation required should be documented as part of the MOU review process.

Assurance - High

Volunteers/ Others/ Celebrities*:* On occasion others may be spending time within the Trust. These may be out with the crews ie Student Nurses, Fire-fighters, Military Medics, Paramedic students. All these would require authorisation from their own organisation and it would be expected that these staff already undertake the relevant checks as part of their role. The organisation would have an obligation to tell LAS of any issues they may have as part of any contract/MOU we may have with them.

The Trust also has several School placement students in the Trust each year on work experience. Due to the age of the student they do not go out on to PES however can go out on PTS and also have been in Control Centres/ Support Centres/ PTS Planning. It should be normal practice that the schools and students are written to explaining the confidential nature of the work we undertake and the sensitive information they may see.

Impact and actions for LAS: Policy to be reviewed to ensure this is specific in relation to obligations from other organisations and that the relevant checks are carried out and confirmed before they come to work with the Trust. Ensure that this covers all groups including celebrities and 'others.'

Assurance - Limited

Listening and Acting on Patient Concerns: LAS has good systems and policies in place in respect of listening to Patients. Lots of work has been undertaken to ensure that all groups of patients are listened to as part of the LAS Communications Strategy and PPE Team. This include patient feedback questionnaires, forums etc. Complaints and allegations against our staff are taken very seriously and are fully investigated. These may come in via a complaint, external incident, Safeguarding concern, whistleblowing etc. A thorough non-judgemental investigation is undertaken and appropriate action taken where necessary including; potential suspension whilst the investigation is undertaken, disciplinary action, and police involvement if necessary. If a Paramedic was found to have allegations against them upheld they would also be referred to the HCPC for further investigation and potential removal of their registration.

Impact and actions for LAS: Trust Policies need to have more structured procedures documented specifically in relation to informing LADO (local Authority Designated Officer) for managing allegations against children and Safeguarding Adult Manager

Assurance - High

It is anticipated that the results of this will require a further review of the Trusts policies and procedures and some additional recommendations and actions may be identified.

Any actions and recommendations following this review will be added to the relevant Directorates action plans for 2013 – 2014 and monitored via the Safeguarding action plan through the CGMG.

4. LEGAL IMPLICATIONS

There are associated legal implications for the Board in non-compliance of these obligations. These are referenced in common law, local and national guidance's and include:

- No Secrets 2008
- Mental Capacity Act 2005,
- MCA 2005 Deprivation of Liberty Safeguards: Codes of Practice 2008
- Independent Safeguarding Authority 2006: Legislative updates 2009
- Health & Social Care Act 2008 (Registration Requirements)
- Care Quality Commission's Registration Outcome 7

- Working together 2010
- Children Act 1989 / 2004
- Protection of Freedom Act 2012

Should the Trust become exposed to non-compliance, the legal implications would and could include:

1. Regulatory actions taken against the Trust arising from non or unsatisfactory activities to safeguard and promote the welfare of adults and Children;
2. Adverse Public Enquiries through the inability to participate in serious case reviews.

5. CONCLUSION

This brief overview has shown that overall the Trust is in a position to provide good assurance those policies and procedures are in place to protect Adults at risk and Children. Some further more specific detailed work on policies in relation to MOUs/ Volunteer credentials may be required to provide evidential assurance that robust procedures are in place for all staff, volunteers and visitors to the Trust.

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London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

PAPER FOR INFORMATION

Document Title:	**Winterbourne View Gap Analysis and Action Plan**
Report Author(s):	**Alan Taylor, Steve Lennox**
Lead Director:	**Steve Lennox, Director of Health Promotion and Quality**
Contact Details:	**Gap analysis and action plan**
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☒ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the gap analysis and action plan**

Key issues and risks arising from this paper

Safeguarding

Executive Summary

After the transmission of the BBC Panorama Undercover Care: the Abuse Exposed in May 2011, which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adults with learning disabilities and autism, South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review. The Review was based on information provided by Castlebeck Care (Teeside) Ltd, the NHS South of England and others who were involved in the care and management of patients at Winterbourne View.

Patients from Winterbourne View attended A&E on 76 occasions during the period investigated, yet no referrals where received.

The main areas for action are

- Exploring how best to collate and share safeguarding alerts from same location with LA.
- Developing "Easy Read" complaints information.
- Reviewing contracts, to make whistle blowing a condition of employment.

The Tri Borough report is also attached as agreed by all member organisations of the Tri Borough board.

Attachments

Winterbourne View Gap Analysis and Action Plan

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Quality Strategy
This paper supports the following domains of the quality strategy

☐ Staff/Workforce
☐ Performance
☒ Environment
☐ Experience
☐ Helping People
☐ Quality of Life
☐ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☐ To develop care with a highly skilled and representative workforce
☐ To provide value for money

2013/14 Priorities
☐ Modernisation Programme
☐ Communication and Engagement
☐ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
☐ That we cannot maintain and deliver the core service along with the performance expected
☐ That we are unable to match financial resources with priorities
☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

Key issues from the assessment:

Report on recommendations from South Gloucestershire Safeguarding Adults Board Serious Case Review (SCR) into Winterbourne View Hospital

Introduction

After the transmission of the BBC Panorama Undercover Care: the Abuse Exposed in May 2011, which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adults with learning disabilities and autism, South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review. The Review was based on information provided by Castlebeck Care (Teeside) Ltd, the NHS South of England and others who were involved in the care and management of patients at Winterbourne View.

Patients from Winterbourne View attended A&E on 76 occasions during the period investigated, yet no referrals where received.

Following publication of the review the Department for Health requested that all Trusts review the procedures in light of the findings and make any necessary changes to ensure that the lessons are learned across the NHS. As an ambulance trust we need to demonstrate we have acted on and learnt the lessons of Winterbourne View Hospital.

This report *outline* the actions required to be taken by the London Ambulance Service NHS Trust (LAS) as a result of the recommendations from the Winterbourne View Hospital SCR.

The LAS has been an active member of the Tri Borough (Hammersmith and Fulham, Kensington and Chelsea, and Westminster) Adult safeguarding boards review of lessons learnt from Winterbourne View. This was attended by Carmel Dodson-brown, Assistant Director Support Services.

There are a number of identified actions required; full details are in the table below however the main areas are

- Exploring how best to collate and share safeguarding alerts from same location with LA.
- Developing "Easy Read" complaints information.
- Reviewing contracts, to make whistle blowing a condition of employment.

The first point is the most challenging for the trust and executives will need to consider what safeguarding information to share and how best to achieve this in a meaningful way.

It is recommended that a group be established monitored by the safeguarding committee, that can make the changes required and establish the links required with the local authorities to ensure sharing of information on safeguarding trends and patterns is both appropriate and secure.

Easy read information on safeguarding is currently being developed on the service website, along with easy read information on "how to make a complaint". Once complete consideration will be given to producing Easy read leaflets for the public.

The Department of Workforce and Organisational Development needs to look at making whistle Blowing a condition of employment in contracts.

All actions will be recorded in the Safeguarding Adult action plan and will be monitored and reviewed by the LAS Safeguarding Group.

Details of all the recommendation from the review that require action by the LAS are detailed below.

Recommendations from the South Gloucestershire Safeguarding Adults Board Serious Case Review of Winterbourne View Hospital

Serious Case Review Recommendations	LAS current practice	LAS Action Required	Owner	Date to be completed
2. Recommendation: The principle of investing in and promoting *good quality, local services…. Providing intensive community support with only limited use of in-patient services* (Department of Health 2012) should be adopted and monitored by Clinical Commissioning Groups and NHS Commissioning Boards.	Local pathways established for mental health, for people with a learning disability we advocate that they are conveyed to the most appropriate hospital.	Continue to work with health partners to ensure effective use of pathways and use of most appropriate hospital for patients with Learning disability	Kudawashe Dimbi	December 2013
2. The role of commissioning organisations in initiating patient admissions to Winterbourne View Hospital				
5. Recommendation: The NHS Commissioning Board should seek ongoing assurance that the practice of commissioning of NHS services for adults with learning disabilities, autism, behaviour with challenges and mental health problems is explicitly attentive to reducing inequalities.	Training provided to some staff on Learning Disabilities and Autism, as well as mental health. Trust has a Mental Health group.	LAS Continuing to look to raise awareness and training of staff to reduce inequalities.	Bill O' Neil & Kudawashe Dimbi	March 2014
3. The circumstances and management of the whistle blowing notification				
1.Recommendation: There should be a condition of employment on all health and social care practitioners (registered and unregistered) to report operational concerns to (i) the Chief Executives and Boards of hospitals,	Trust has whistle blowing policy. Not currently a condition of employment	HR to consider building into employment contracts condition of whistle blowing and how staff should report, and to whom.	Julie Cook	September 2013

(ii) the regulator.				
2. Recommendation: All registered health and social care employers should be required to advise their employees in their contracts to whom they can whistle blow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. This should include information about provision in the Employment Rights Act 1996 which gives protection to those making disclosures in the public interest.	Not currently in contracts	HR to consider building into employment contracts condition of whistle blowing and how staff should report, and to whom. Whistle blowing policy details response that employee can anticipate should be issued to all staff on joining the trust.	Julie Cook	September 2013
6. The existence and treatment of other forms of alert that might cause concern				
1.Recommendation: Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures - in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009	LAS has a current complaints procedure but does not take account of the needs of disabilities who have communication difficulties	PED to develop 1. easy read complaints information on trust website, 2. Provide easy read leaflets on how to make a complaint	Levi Sinden	September 2013
2. Recommendation: The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and	The LAS does not advocate restraint.	Restraint is only used for the safety of the patient due to clinical need i.e. suspected spinal cord injury and or in transporting a patient to and from the ambulance or during	Kudakwashe Dimbi & Dave Whitmore	September 2013

treatment units. An investment comparable to the banning of the corporal punishment of children is required. The use of restrictive physical intervention "as a last resort" characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.		transportation in a moving vehicle. Need to clarify our position to include where we restrict movement on medical grounds.		
3. Recommendation: Clinical Commissioning Groups should explore how Accident and Emergency can detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A&E departments, including it in their annual review of Clinical Quality Indicators.	At present there is no overview of patterns or trends on alerts made into LA. Frequent Caller unit highlights small percentage of frequent callers on our service. .	Emergency Bed Service (where referrals are handled), Emergency Operations Centre and Frequent Caller Unit to set up task group to consider how this can be achieved and any cost implications.	Sue Meehan & Alan Hay	December 2013
7. The role of the Care Quality Commission as the regulator of in-patient care at Winterbourne View Hospital				
4. Recommendation: The requirements concerning a service's *Statement of Purpose* and the supporting guidance should be strengthened to aid clarity. The CQC, through its Mental Health Act monitoring responsibilities, should consider giving particular focus to (i) the way in which hospital managers (as defined in the MHA 1983) discharge their responsibilities, and (ii) evidence that hospitals are engaged in the activities they are registered to provide.	Service currently developing a clinical and quality strategy using this national document as a framework which details six core values/behaviours essential to delivering a high standard of care. These are: Care, Compassion, Competence, Communication, Courage, Commitment	Ensure Mental Health is part of clinical strategy and provide strong guidance in relation to mental health.	Kudakwashe Dimbi	December 2013

9. Recommendation: the CQC must encourage whistleblowers to raise the alarm and then securely receive, log and take action when concerns are raised. They should report on actions arising from whistle blowing notifications in its annual *State of Care* report.	LAS has whistle blowing policy and encourages staff to report concerns.	Trust board to consider reporting on actions arising from whistle blowing in it's annual report.	Julie Cook	March 2014

This report will be discussed and approved at the next Safeguarding Board meeting on 12th June. Further actions will then be monitored on the Safeguarding Adults Action Plan.

Author Alan Taylor

Approved by Carmel Dodson –Brown and Steve Lennox 27th March 2013

Agreed by Safeguarding Committee 12th June 2013

Agreed by Owners 2nd July

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London Ambulance Service **NHS**
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

PAPER FOR INFORMATION

Document Title:	**Finance Report 2013/14 Month 3: June 2013**
Report Author(s):	**Andrew Grimshaw, Director of Finance**
Lead Director:	**Andrew Grimshaw, Director of Finance**
Contact Details:	**andrew.grimshaw@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

Executive Summary

- In month surplus £0.02m. Year to date deficit £0.005m.
- Year to date £0.3m adverse variance from plan;
    - Management of operational staff – especially relief factor
    - CIP delivery
- EFL variance due to higher than planned cash balance
- Cash is £2.7m higher than planned. This is mainly due to an increase in trade creditors as the trust has a high volume of unapproved invoices.
- The Trust would expect to score an FRR of 3 against the Monitor metrics.
- The Trust expects to meet its CRL target of £10.2m. Capital spend in the June month has increased due to the purchase of PTS vehicles originally planned for Month 2.

Attachments

Finance Report 2013/14 Month 3: June 2013

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Quality Strategy
This paper supports the following domains of the quality strategy

- ☒ Staff/Workforce
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- ☒ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Finance Report 2013/14
Month 3: June

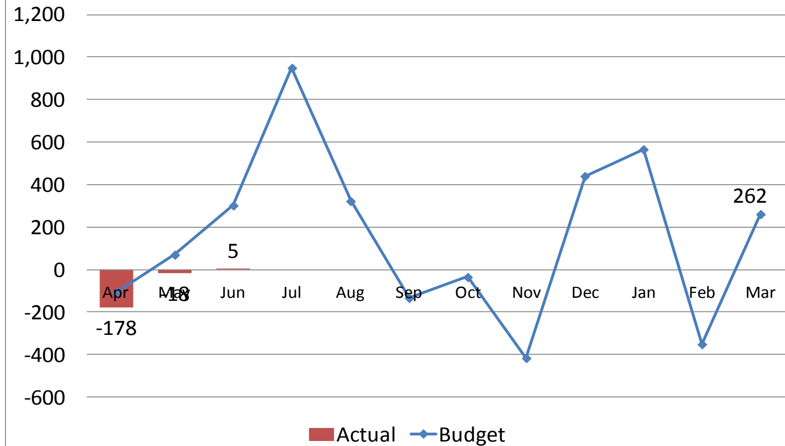
Trust Board: Part 1
23rd July 2013.

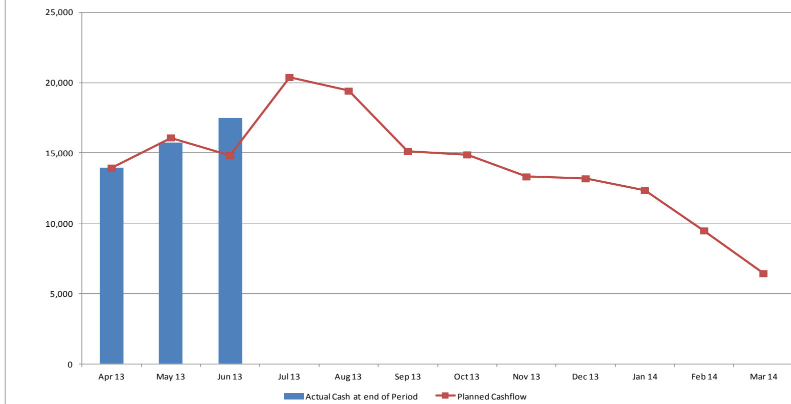
Andrew Grimshaw
Finance Director

Executive Summary

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the trust reported a £0.02m surplus which was £0.2m behind plan. YTD the trust is showing a £0.01m adverse position which is £0.3m off plan. The trust still expects to deliver its £0.3m year end surplus position. The shortfall in YTD surplus is driven by a number of factors including excess relief costs in operational staff groups. In addition budgets have been re-phased £0.2m to reflect improved analysis of budgetary requirements.	**AMBER**	**GREEN**
Income	Income is £0.3m adrift in month and £0.8m adverse YTD. The forecast position is £3.2m adverse. Risks to the full year position include shortfall in core income (currently managed through reserves), and Hospital Turnaround Penalties (YTD £55k impact adverse). Mitigation has been seen in the form of better than expected PTS performance due to additional contract income £0.2m YTD	**GREEN**	**GREEN**
Expenditure	In month favourable £0.1m, YTD favourable £0.5m. The forecast position is £1.9m favourable this is driven by vacancies in pay. Operational pay is currently £0.6m adverse YTD when 3rd Party is included, and this is not sustainable in the longer term. The modernisation programme will result in improved working in Frontline, and increased recruitment will act to reduce high cost PAS and overtime. Costs in excess of relief rates remain the major concern. In addition non pay budgets have been realigned and re-phased which has reduce Q1 budget by £0.2m	**AMBER**	**AMBER**
CIPs	Currently reporting behind schedule YTD of £134k due to start up delays. Additional PMO support has been put in place to support the delivery of CIPs going forward and further opportunities are being explored and developed.	**AMBER**	**AMBER**
Balance Sheet	Overall no major concerns at this stage, The land and buildings were revalued as at 1st April 2013 by the District Valuer. The impact on the balance sheet was a £1.9m increase in non current assets, a £1.6m increase in the revaluation reserve and a £0.3m impairment credit to the statement of comprehensive income. Debtors are higher than plan due to delays in receipts from CCGs and Trusts. This is seen as a process problem resulting from the move to CCGs rather than a reflection of non-payment.	**GREEN**	**GREEN**
Cashflow	Cash is £2.7m higher than plan. This is mainly due to an increase in trade creditors as the trust has a high volume of unapproved invoices. Delays in capital expenditure have also acted to retain cash. Debtors are higher than planned due to delays in receipts from CCGs and Trusts.	**GREEN**	**GREEN**

Executive Summary - Key Financial Metrics





Description	Month 3 - June 2013			Year to Date			FY 2013/14		
	Budg	Act	Var	Budg	Act	Var	Budg	Fcast	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Dept Health									
Surplus	192	22	(170)	303	5	(298)	262	262	0
EFL	1,248	(1,739)	(2,987)	(9,357)	(12,032)	(2,675)	(2,288)	(2,288)	0
CRL	895	582	(313)	1,800	697	(1,103)	10,250	10,250	0
Suppliers paid within 30 days - NHS	95%	64%	-31.0%	95%	48%	-47.0%	95%	48%	-47.0%
Suppliers paid within 30 days - Non NHS	95%	88%	-7.0%	95%	75%	-20.0%	95%	75%	-20.0%
Monitor									
EBITDA %	6.7%	6.1%	-0.6%	6.3%	5.9%	-0.4%	6.4%	6.0%	-0.4%
Net Surplus	192	22	(170)	303	5	(298)	262	262	0
Return on Assets	0.88%	0.79%	(0)	0.88%	0.79%	(0)	3.37%	5.98%	
Liquidity Days	(8.25)	(8.21)	0	(8.25)	(8.21)	0	(8.22)	(8.19)	
Monitor net rating		3			3				

- In month surplus £0.02m. Year to date deficit £0.005m.
- Year to date £0.3m adverse variance from plan;
  - Management of operational staff – especially relief factor
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- EFL variance due to higher than planned cash balance
- Cash is £2.7m higher than planned. This is mainly due to an increase in trade creditors as the trust has a high volume of unapproved invoices.
- The Trust would expect to score an FRR of 3 against the Monitor metrics.
- The Trust expects to meet its CRL target of £10.2m. Capital spend in the June month has increased due to the purchase of PTS vehicles originally planned for Month 2.

Statement of Comprehensive Income

Month 3 - June 2013			Description	Year to Date			FY 2013/14		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			Income						
21,969	21,984	15	Emergency & Urgent care	65,368	65,314	(55)	262,415	262,331	(85)
2,646	2,369	(277)	Other	8,015	7,272	(743)	32,170	29,089	(3,080)
24,615	**24,353**	**(262)**	**Subtotal**	**73,383**	**72,586**	**(797)**	**294,585**	**291,420**	**(3,165)**
			Operating Expense						
17,399	17,236	164	Pay	52,710	51,255	1,456	214,656	206,447	8,209
5,559	5,628	(69)	Non Pay	16,039	17,028	(989)	61,219	67,518	(6,299)
22,959	**22,864**	**95**	**Subtotal**	**68,749**	**68,283**	**466**	**275,875**	**273,965**	**1,910**
1,657	**1,489**	**(168)**	**EBITDA**	**4,634**	**4,303**	**(331)**	**18,711**	**17,455**	**(1,255)**
6.7%	6.1%	0.6%	**EBITDA margin**	6.3%	5.9%	0.4%	6.4%	6.0%	39.7%
			Depreciation & Financial						
1,093	1,114	(21)	Depreciation	3,216	3,237	(21)	13,990	12,947	1,043
326	326	0	PDC Dividend	979	979	0	3,915	3,915	0
45	26	19	Interest	136	83	53	543	331	213
1,465	**1,467**	**(2)**	**Subtotal**	**4,331**	**4,298**	**33**	**18,449**	**17,193**	**1,256**
192	**22**	**(170)**	**Net Surplus/(Deficit)**	**303**	**5**	**(298)**	**262**	**262**	**0**
0.8%	0.1%	0.7%	**Net margin**	0.4%	0.0%	0.4%	0.1%	0.1%	0.0%

- The Year end forecast is for a surplus of £0.3m
- The YTD trend has worsened to £0.3m adverse, primarily due to lower levels of budget in month.
- Overtime and PAS amounts have reduced in month but this relates primarily to corrections in the accounting methodology and not reductions in spend.
- Income is adverse due to lower than planned central income (£1.1m) offset by improved PTS performance (£0.2m) and other variable income benefits (£0.1m)
- Pay is showing a favourable position overall due to vacancies across the trust. However frontline pay (including PAS usage) is showing a £0.6m overspend YTD. A major factor in the total frontline cost overspend is the management of relief which is running significantly higher than plan.
- Non Pay is £0.2m favourable YTD (when PAS is excluded)
- Depreciation and Financial Charges are on track

- *Note: The reported position excludes a 12/13 year end impairment correction of £336k (favourable). This was noted as unadjusted within the 2012/13 Final Accounts. This is excluded from the Trust 13/14 financial performance total reported to the NTDA and so it is excluded here.*

Divisional Expenditure (excludes income)

Month 3 - June 2013			Description	Year to Date			FY 2013/14		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			Operational						
13,735	13,158	577	A&E	43,563	43,234	329	173,263	170,636	2,627
2,215	2,051	164	EOC	6,765	6,107	658	27,318	24,429	2,889
2,513	2,752	(239)	Operational Support	5,553	5,419	134	22,785	21,676	1,109
18,463	**17,961**	**502**	**Subtotal**	**55,881**	**54,760**	**1,121**	**223,367**	**216,742**	**6,626**
574	**535**	**39**	**PTS**	**1,646**	**1,611**	**35**	**6,372**	**6,444**	**(73)**
			Support Services						
292	254	39	Chief Executive	887	796	91	3,572	3,185	387
1,216	1,264	(48)	Corporate Services	3,649	3,779	(130)	14,490	15,115	(625)
193	189	4	Strategic Development	578	564	13	2,172	2,258	(85)
253	166	86	Finance	638	606	31	2,597	2,592	4
1,375	2,072	(697)	Central Corporate	3,552	4,584	(1,032)	16,481	21,297	(4,815)
951	874	76	IM&T	2,852	2,805	47	11,455	11,218	236
902	839	62	HR & OD	2,782	2,545	237	11,357	10,179	1,178
84	74	11	Healthcare Promotion & Quality	253	236	17	1,012	945	67
121	103	19	Medical	364	296	68	1,449	1,184	265
5,386	**5,835**	**(449)**	**Subtotal**	**15,554**	**16,210**	**(657)**	**64,584**	**67,972**	**(3,387)**
24,423	**24,331**	**92**	**TOTAL**	**73,080**	**72,581**	**499**	**294,323**	**291,158**	**3,166**
24,615	*24,353*	*-262*	*Income Memorandum*	*73,383*	*72,586*	*-797*	*294,585*	*291,420*	*-3,165*
192	***22***	***(170)***	***NET POSITION MEMORANDUM***	***303***	***5***	***(298)***	***262***	***262***	***0***

- The main driver of performance is the Operational division; this represents 75% of total expenditure.
- The main reason for Operational budget being favourable to plan relates to:
  - Ongoing EOC vacancies (e.g. CHUB)
  - Operational Support – underspends in medical consumables and vehicle maintenance (this is under review)
  - Unallocated CIP not yet attributed to Divisions
- PTS is broadly on plan
- Within support services:
  - Central Corporate includes the adverse reserves position supporting income shortfalls and projected increases in non pay spend
  - HR & OD is favourable primarily because of vacancies across the department (including training officers) and delays in spend in the modernisation programme.
- CIPs are still all retained within Central Corporate. This is acting to increase the adverse position for this division and increase favourable variances in others. Work is underway to “hardwire” CIPs to the correct locations.

The divisional structure will be adjusted to incorporate the new corporate structure as required

Statement of Position

	Mar-13	Apr-13	May-13	Jun-13	Jun-13		
	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000			
Non Current Assets							
Property, Plant & Equip	119,021	118,240	117,414	119,201	117,985	(1,216)	-1.03%
Intangible Assets	13,628	13,478	13,328	13,061	13,248	187	1.41%
Trade & Other Receivables	0	0	0	0	0	0	
Subtotal	132,649	131,718	130,742	132,262	131,233	(1,029)	0.38%
Current Assets							
Inventories	3,264	3,176	3,310	3,217	3,264	47	1.44%
Trade & Other Receivables	16,075	18,604	15,797	14,875	12,521	(2,354)	-18.80%
Cash & cash equivalents	5,500	13,968	15,747	17,486	14,894	(2,592)	-17.40%
Total Current Assets	24,839	35,748	34,854	35,578	30,679	(4,899)	-34.76%
Total Assets	157,488	167,466	165,596	167,840	161,912	(5,928)	-3.66%
Current Liabilities							
Trade and Other Payables	(24,546)	(34,792)	(32,694)	(33,091)	(28,756)	4,335	-15.08%
Provisions	(2,098)	(1,000)	(1,000)	(2,098)	(2,098)	0	0.00%
Borrowings	(309)	(263)	(263)	(263)	(283)	(20)	7.07%
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,197)	(37,299)	(35,201)	(36,696)	(32,381)	4,315	-15.08%
Non Current Assets plus/less net current assets/Liabilities	129,291	130,167	130,395	131,144	(1,702)	(584)	-49.84%
Non Current Liabilities							
Trade and Other Payables	0	0	0	0	0	0	
Provisions	(8,731)	(9,766)	(9,853)	(8,839)	(8,804)	35	-0.40%
Borrowings	(641)	(661)	(641)	(427)	(641)	(214)	33.39%
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	(4,343)	(4,343)	(4,343)	(4,343)	(4,343)	0	0.00%
Total Non Current Liabilities	(13,715)	(14,770)	(14,837)	(13,609)	(13,788)	(179)	0.00%
Total Assets Employed	115,576	115,397	115,558	117,535	115,743	(1,792)	-49.46%
Financed by Taxpayers Equity							
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	0	0.00%
Retained Earnings	20,053	19,874	20,035	20,395	20,220	(175)	-0.87%
Revaluation Reserve	33,426	33,426	33,426	35,043	33,426	(1,617)	-4.84%
Other Reserves	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	115,576	115,397	115,558	117,535	115,743	(1,792)	-5.70%

- Non current assets: land & buildings have been revalued as at 1st April 2013, as noted at the 2012/13 year end. This resulted in an overall increase in land and buildings of £1.9m. This is partly offset by the capital programme being £1.0m behind plan.

- Current assets . Trade and other receivables are higher due to delays in securing payment of HART invoices from 5 CCGs. This results from process issues within the CCGs. Cash is £2.7m higher than planned due to a higher than planned creditor balances offset by a higher than planned debtor balances . Receivables (Debtors) comprise principally trade debtors £2.8m, prepayments £5.2m, other debtors £3.6m and accrued income £3.3m.

- Current Liabilities . Creditors is higher than planned due to higher trade payables £2.3m and accrual £1.9m balances. The trust has a high volume of unapproved invoices due to goods being delivered not being receipted for promptly and delays in orders being requested by internal users for invoices received for the trust. Current Liabilities comprise principally trade payables (creditors) £9.2m, Accruals £8.6m, Deferred Income £5.0m, Other Creditors £6.1m, HMRC £4.2m, Borrowings £1.5m and provisions £2.1m.

- Borrowings - No new loans were taken out during the year. In June t he trust return 50 old ambulances that we surplus to requirement. A cost benefit analysis showed it was cheaper to terminate the leases early that to continue to maintain them to the end of the contract. This has acted to improve the level of non-current borrowings.

- The revaluation reserve has increased by £1.6m as a result of the revaluation. of land and buildings

- A forecast statement of position will be prepared at Month 4 July

Capital Expenditure

Month 3 - June 2013			Description	Year to Date			FY 2013/14		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			General						
(100)	(55)	(45)	Other	0	(18)	18	0	0	0
(100)	**(55)**	**(45)**	**Subtotal**	**0**	**(18)**	**18**	**0**	**0**	**0**
			Fleet						
25	0	25	DCA	25	0	25	4,500	4,500	0
0	35	(35)	FRU	17	75	(58)	296	296	0
25	516	(491)	PTS	751	516	235	751	751	0
620	0	620	Other Fleet	620	51	569	1,952	1,952	0
670	**551**	**119**	**Subtotal**	**1,413**	**642**	**771**	**7,499**	**7,499**	**0**
			Estates						
0	0	0	New	0	0	0	0	0	0
0	0	0	Refurb	0	3	(3)	0	0	0
100	15	85	Other	100	20	80	650	650	0
100	**15**	**85**	**Subtotal**	**100**	**23**	**77**	**650**	**650**	**0**
			IM&T						
100	70	30	Hardware	100	64	36	1,392	1,392	0
125	0	125	Software	187	(15)	202	709	709	0
225	**70**	**155**	**Subtotal**	**287**	**49**	**238**	**2,101**	**2,101**	**0**
895	**582**	**313**	**Gross Capital Expenditure**	**1,800**	**697**	**1,103**	**10,250**	**10,250**	**0**
			Disposals						
0	0	0	Estates	0	0	0	0	0	0
0	0	0	Fleet	0	0	0	0	0	0
0	**0**	**0**	**Subtotal**	**0**	**0**	**0**	**0**	**0**	**0**
895	**582**	**313**	**Net Capital Expenditure**	**1,800**	**697**	**1,103**	**10,250**	**10,250**	**0**

- Assumption in plan projects carried forward from 2012/13 would conclude in months 1 and 2. This has not occurred. Each project being followed up.
- Receipt of PTS vehicles £0.5m in Month 3 has increased the YTD spend
- Ongoing delay in spend for Other Non Ambulance Vehicle Programmes, IT projects and Estates maintenance.
- Some emergent Capital programmes to be factored in by end of Q1. Overall programme has been confirmed, see Financial Plan paper.

Cashflow Statement

	In Month Movement			YTD Move	YTD Plan	Var
	Apr-13	May-13	Jun-13	Jun-13	Jun-13	Jun-13
	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000
Opening Balance	5,500	13,968	15,747	**5,500**	**5,500**	**0**
Operating Surplus	1,187	1,625	1,488	4,300	4,421	121
(Increase)/decrease in current assets	(2,441)	2,673	1,015	1,247	3,729	2,482
Increase/(decrease) in current liabilities	9,316	(2,420)	1,008	7,904	3,814	(4,090)
Increase/(decrease) in provisions	1,035	87	(1,014)	108	73	(35)
Net cash inflow/(outflow) from operating activities	9,097	1,965	2,497	13,559	12,037	(1,522)
Cashflow inflow/outflow from operating activities	**9,097**	**1,965**	**2,497**	**13,559**	**12,037**	**(1,522)**
Returns on investments and servicing finance	(13)	(11)	(11)	(35)	(38)	(3)
Capital Expenditure	(590)	(155)	(533)	(1,278)	(2,642)	(1,364)
Dividend paid	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0
Financing repaid	(26)	(20)	(214)	(260)	(27)	233
				0	0	0
Cashflow inflow/outflow from financing	**(629)**	**(186)**	**(758)**	**(1,573)**	(2,707)	**(1,134)**
Movement	8,468	1,779	1,739	11,986	9,330	(2,656)
Closing Cash Balance	**13,968**	**15,747**	**17,486**	**17,486**	**14,830**	**(2,656)**

The cash balance as at June 2013 is £17.5m, this is £2.7m above plan.

- Variance on current assets is £2.5m
  Current assets movement was lower than planned due to higher prepayments £1.8m and debtors £0.7m balances.

- Variance on current liabilities is (£4.1m)
  Current liabilities movement was higher than planned due to higher trade creditor £2.3m and accrual £1.9m balances. The trust has a high volume of unapproved invoices. Deferred Income balance was £0.3m lower than planned.

- The lower than planned Capital Expenditure payments is due to slippage on the capital programme. Capital Expenditure payments total £1.3m in year.

- Financing, the Trust paid £0.3m in loan principle and termination costs on its finance leases in year. In June the trust returned 50 old ambulances that were surplus to requirement. A cost benefit analysis showed it was cheaper to terminate the leases early than to continue to maintain them to the end of the contract.

- A forecast cashflow statement will be prepared at Month 4 (July).

London Ambulance Service **NHS**
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 JULY 2013

PAPER FOR NOTING

Document Title:	**Annual Equality Report 2012-13**
Report Author(s):	**Janice Markey, Equality and Inclusion Manager**
Lead Director:	**Tony Crabtree**
Contact Details:	**Tony.Crabtree@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Requirement under the Equality Act 2010**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To note the contents and support the EMT in agreeing future actions and objectives**

Executive Summary:

This comprehensive report provides detail on progress on equality and inclusion issues in the Trust for the year 2012-13, highlighting any key areas of under-representation for the Trust, improvements made and required in the collection and provision of management information on service delivery and patient profiling and the Trust's workforce and suggested initiatives to be considered to address any gaps in line with the requirements of the Equality Act 2010 and the new public sector duty.

The report also updates Trust Board on action taken since submission of the last Annual Equality report (11/12).

In this last year the Trust successfully applied to become one of the first Stonewall national Health Champions and climbed 72 places in its annual application to the Stonewall Workplace Equality Index, becoming the top-performing ambulance Trust and emergency service for the second year running, as well as being the third highest-placed NHS Trust in what was regarded as the most competitive field to date. The Trust also gained third place on the Stonewall Health Equality Index. These attainments are in recognition of the Trust's equality policies, practices and experience of staff with regard to employment of gay, lesbian and bisexual staff, engagement, training, decision making, procurement and service delivery It should be noted that these policies also reflect our general approach to the broader diversity arena and this serves as validation of the Trust's approach to equality and inclusion across the board.

In addition, the Trust continued to implement key equality objectives produced in line with the national NHS Equality Delivery System and the Equality Act 2010 and to support its Staff Diversity Forums. Further equality and inclusion training was delivered to specific groups of staff, as well as

to Senior Managers' Conference and the Trust Board and more targeted training is planned for the coming year.

Key issues for the Trust Board

The Trust needs to continue its progress to attract a workforce reflective of the communities it serves, as the current representation of women, BME staff and disabled people is below the Census 2011 estimate for London, while overall representation in terms of other protected characteristic groups is not yet know, pending changes to the national ESR. Positive action initiatives to attract and encourage more BME people to apply to the Trust are planned over the coming year and these will be monitored to determine any necessary follow-up action.

Good progress has been made with the implementation of the Trust's equality objectives, in line with the requirements on it from the Equality Act 2010 Public Sector Duty and the National NHS Equality Delivery System. The objective relating to Complaints, Objective 2 - "We will improve the process for capturing equalities data in the area of patient complaints to ensure that more than 50 per cent of complainants have provided relevant details and begin to monitor trends in complaints from black and minority ethnic (BME) service users in 2012/13" - has been completed, while the training element of Objective 1 - "We will ensure that the satisfaction rates with our Transport Service are equitable for both women and men using the service and for all our service users, regardless of sexual orientation" - has been delivered and a patient survey redesigned, which will capture users' perceptions of the service. Objective 4 – "The Equality and Inclusion Steering Group will appoint champions for each of the protected characteristic groups (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, religion or belief, sex, sexual orientation) by 2014, to ensure that the interests of these groups are protected and promoted with regard to staff, patients, service users and other stakeholders in line with the requirements of the Equality Act 2010" – will be achieved over the coming year and progress will also be made against the remaining objective 3 – "We will act on the results of the staff survey and develop both corporate and localised actions to improve key problems identified by 2016" . A formal review of the Trust's objectives will take place in 2016, in line with the requirements of the Equality Act 2010

The Trust Board are asked to note the contents of this report and its recommendations.

Attachments

Annual Equality Report 2012-13

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Quality Strategy
This paper supports the following domains of the quality strategy

- ☒ Staff/Workforce
- ☐ Performance
- ☐ Environment
- ☐ Experience
- ☐ Helping People
- ☐ Quality of Life
- ☐ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

- ☐ To improve the quality of care we provide to our patients
- ☒ To develop care with a highly skilled and representative workforce
- ☐ To provide value for money

2013/14 Priorities

- ☐ Modernisation Programme
- ☐ Communication and Engagement
- ☐ Sustain performance to ensure safe service to patients
- ☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

- ☐ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
- ☐ That we cannot maintain and deliver the core service along with the performance expected
- ☐ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No – not applicable

Key issues from the assessment:

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LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD
Date of Meeting: 23 July 2013

EXECUTIVE SUMMARY OF ANNUAL EQUALITY REPORT 2012-13

1 INTRODUCTION

1.1. This report provides an executive summary of the Annual Equality Report 2012-13, which will be available on the Trust's website, as well as in alternative formats and community languages on request.

1.2. The last Annual Equality Report, covering the period from April 1 2011 to March 31 2012, was received by the Trust Board in August 2013.

2. PROGRESS SINCE LAST REPORT

2.1. The Trust has again been very active on the equality and inclusion front over the last year, taking forward a number of important and high-profile initiatives.

2.2. The Trust has signed up to the new NHS Equality Delivery System. In line with this and the provisions of the Equality Act 2010 Public Sector Duty, the Trust engaged extensively with a wide range of internal and external stakeholders on its proposed equality objectives and published these in April 2012. The Trust continued to be represented on the Outer North East London Equalities partnership group, to ensure regular face-to-face engagement with service users from protected characteristic groups. The new equality objectives are being mainstreamed into the business planning of the Trust.

2.3. Specific, targeted workshops on Equality and Inclusion were provided to managers and staff in May and June 2012. A briefing was provided to Senior Managers' Conference and the Trust Board in May 2012. Further targeted sessions to the Managers' and Admin Staff conferences and specific, targeted workshops are planned. The second module of the Trust's e- learning programme was launched in July 2012.

2.4. Briefings to project teams on the use of the Trust's updated Equality Analysis form and guidance continue to be provided by the Equality and Inclusion Team and all equality analyses are published on the Trust's website.

2.5. The Trust applied and was selected as one of the first national Stonewall Health Champions in the country. A Health Champions Programme action plan was worked up in conjunction with Stonewall and successfully implemented, with details published on the Trust's website.

2.6. Following its application to the 2013 Stonewall Workplace Equality Index, the Trust again featured as a Top 100 Employer, coming 22nd, the

third highest NHS Trust and for the second year the top ambulance service in the country.

2.7. Following its first ever submission to the new Stonewall Health Equality Index, the Trust came third out of all applicants, again the highest-performing ambulance service in the country.

2.8. The Trust's Staff Forums, the LGB Staff Forum, Deaf Awareness Forum and Enable continue to be supported in their work by the Trust, with the Chairs of the forums invited to meetings of the Equality and Inclusion Steering Group, to discuss the aims and objectives of the forums for the coming year.
Over the previous year the Deaf Awareness Forum has participated in Deaf Awareness Week, Learn to Sign week and the annual Deaf Day at City Lit, undertaken a survey amongst England's NHS Ambulance Trusts to determine the level of activity within the deaf community and continued to raise deaf awareness amongst Trust staff . Also in 2012-13 the Trust's Deaf Awareness Forum made a video, which is featured on the Trust's website and the Trust's YouTube page, to enable the British Sign Language users of our services to access information in BSL.

The Trust's LGBT forum has been at the forefront of a wide range of high-profile initiatives, including the Trust's involvement in the Stonewall Health Champions programme, its annual application to the Stonewall Workplace Equality Index and Health Equality Index. The Chairs of the forum facilitated at an LGB service user group meeting in March co-hosted with Stonewall and have launched the first ever national LGB&T Ambulance Forum, following extensive national consultation. The forum has a very visible presence each year at London Pride – in July 2012 over 70 Trust staff, including a Cycle Responder Unit, took part in the World Pride parade in London together with colleagues from other Ambulance services - and is represented also at Brighton Pride and other key LGBT events. In early 2013 the forum engaged with Trust staff on potential LGBT allies, staff confident and supportive of the LGBT community and their issues, a major initiative actively supported by Stonewall.
Work is underway to run a series of joint Staff Forum events, to encourage new members to sign up and look at the possible establishment of further forums, including a BME Forum, depending on staff interest.

2.9. Following up on the Trust's work to implement the national Equality delivery system, considerable work was undertaken to assist with the implementation of two key equality objectives. In this past year, the training element of the PTS objective was carried out, which should lead to the successful achievement of the objective: "We will ensure that the satisfaction rates with our Patient Transport Service are equitable for both women and men using the service and for all our service users, regardless of sexual orientation." Objective 2 has also been achieved: "We will improve the process for capturing equalities data in the area of

patient complaints to ensure that more than 50 per cent of complainants have provided relevant details and begin to monitor trends in complaints from black and minority ethnic (BME) service users in 2012-13."

2.10. The Trust has continued to have a profile in equalities media, including publications of the protected characteristic communities, as well as to be an active member of all the leading employers' equality forums in the UK, Stonewall, the Business Disability Forum, Opportunity Now and Race for Opportunity, the Employers' Network for Equality and Inclusion and Carers UK, enabling it to share and model best practice.

2.11. The Equality and Inclusion Steering Group, comprising Directors and Heads of Service from the key departments of the Trust Patients' Forum/LINks and staff side partner representation, continues to meet every two months to actively support and oversee the progress of all equality and inclusion work in the Trust.

3. ACTIVITIES AND SERVICES OF THE TRUST

In line with the commitment in the Trust's Equality and Inclusion Strategy to "provide first-class health care to all our diverse patients and service users" and to "ensure that all our patients and service users receive fair and equal access to our health care service" with "everyone treated with dignity and respect," the Trust has been looking innovatively over this past year for ways of improving its services. In March 2013 the Trust co-hosted with Stonewall an LGB service user group meeting as part of its activities to progress its Health Champions Programme. The meeting looked at the perceptions of service users on the service, whether they had come across any obstacles to accessing our services, their perceptions of our staff and the ways in which they wished the Trust to engage with them in future. The meeting was very positive with all of those attending indicating their willingness to engage further with the Trust on key initiatives. A report has been compiled, which will shortly be sent out to participants and to those who were unable to attend on the night but who wished to be part of an ongoing engagement group, and will be published on the Trust website.

Also in 2012-13 the Trust's Deaf Awareness Forum made a video, which is featured on the Trust's website and the Trust's YouTube page, to enable the British Sign Language users of our services to access information in BSL. Engagement with these communities and the other diverse communities the Trust serves will continue to be at the heart of Trust activities.

The Trust continues to promote accessible publications, with Easyread versions of the Equality and Inclusion Strategy and Health Prompt Cards displayed prominently on its website.

London Ambulance Service NHS Trust was proud to actively support the London 2012 Games. Around 400 frontline staff, including some from other NHS ambulance services around the country, worked alongside the organisers to provide high-quality medical care to people from across the world attending the Games, including spectators, athletes, officials and the

media. 66 ambulances were dedicated to the Games, in addition to normal vehicles and the Trust also had extra cycle responders on duty in busy hotspots such as St. Pancras and Stratford train stations, with teams of paramedics working on foot and able to get through crowds quickly. The Trust continued to ensure that a good service was provided to our patients and service users in London at what was an extremely busy time.
To ensure that our frontline staff were able to provide a world class service to our disabled visitors and competitors in the London 2012 Games, service-user led training was delivered to staff involved in the Games, drawing on the expertise of a wide range of leading disability organizations including Mencap and the Back-up Trust. It is envisaged that this training will be rolled out further across the Trust.

The PTS and Patient Experiences Services within the Trust worked hard to successfully implement key equalities objectives and enhance service user satisfaction. In the Emergency Bed Service a new referral form is being piloted as part of a telephone referral trial, which includes specific reference to more protected characteristics including gender and sexuality. This trial will be formally evaluated in July 2013 and its results reported to the Trust's Safeguarding Committee and EMT. The Clinical Advice Service are looking at a new software alternative, which will allow the enhanced capturing of information across protected characteristic groups. An updating of the Patient Report Form will follow the release of the new Equalities Monitoring Guidance awaited from the Department of Health, which will further improve patient profiling. The Trust's PPI and Public Education Department was again extremely active over 2012-13, organising or taking part in over 1000 PPI and Public Education activities across London in diverse communities.

4. WORKFORCE PROFILE

In a time following a recruitment freeze, workforce statistics closely reflected the previous year. Current representation of BME staff in the Trust stands at 9.3%, the same as the previous year, with 8.6% of all BME staff (8.5% of all senior managers) at Senior Management Grade, a decrease on the previous year when 10% of BME staff were at senior management level, 9.4% of all staff at that level. This is still well below the Census 2011 percentage of 40.2% BME residents in the capital. Monitoring of new starters shows an improvement on workforce representation: 11.98% in 2012-13 were from BME groups (38 staff, up from 29 the previous year).
The representation of women in the Trust 43.2% is an increase on the previous year (42.6%), but still below the Census estimate of 50.7% in London. However, the new starter representation is higher at 54.3% (84 members of staff – the same number as in the previous year). Only seven percent of women are at senior management level (32.4% of all staff), which is a decrease on the previous year (7.4% of women were at senior management grade, 31.9% of all staff at that level).
The number of staff declaring themselves disabled remains very low (22 – 0.5%) of the total Trust workforce, in comparison with the Census 2011 percentage of London residents reporting limiting long-term illness of 14.2% (the closest indicator to disability, as there are no specific census data on this). However, a very high number of staff refused to say (40%) with 19.2%

defining themselves as not disabled. More work needs to be done to ensure that the disability status of staff is covered, which is likely to be addressed through changes to the national ESR system or through an internal staff data refresh, conducted at regular intervals.
Applicants to the Trust showed a greater willingness than previous years to complete the religion/belief and sexual orientation fields. With the introduction of new ESR fields or further Staff Data Refreshes, these equalities statistics will be able to be captured, along with further protected characteristic group information, in future reports.

Of the staff leaving the Trust in 2012-13 11% were BME staff, 44.9% women and 0.2% disabled staff.

In the light of the newly released Census statistics it is clear that more work needs to be done to make the Trust's workforce truly reflective of the communities it serves, a key aim of the Trust's Equality and Inclusion Strategy.

Under-representation of BME staff is a familiar issue for other ambulance services in the country and West Midlands NHS Trust has recently commissioned the University of Worcester to do some research into why BME people appear not to be viewing the ambulance service as an attractive career option. Results from this study as well as work with community leaders and the voluntary sector in London should assist the Trust with identifying and removing any possible obstacles to BME people taking up employment with the Trust in future. The re-establishment of a BME Staff Diversity Forum should also be an enabling factor in driving this forward.

Analysis by the Recruitment Manager has revealed that the highest number of BME people applying to the Trust come from Black African backgrounds (11.5%) but that over 80% of these fail at the short listing stage. To address this, in line with the Trust's Positive Action Strategy, a positive action Recruitment Awareness event is planned, to which unsuccessful BME applicants will be invited. At this event the Recruitment Manager and Equality and Inclusion Team, alongside BME colleagues in different roles throughout the Trust, will be explaining to applicants how the recruitment process works and working interactively with applicants to get them to develop supporting statements which demonstrate how they meet the criteria of the post they are applying to. They will also be given the opportunity to apply online on the day. It is envisaged that this kind of workshop will be rolled out further to people from other protected characteristic groups currently under-represented in the Trust.

The Trust has continued to have a visible profile in a wide range of equalities media, presenting a welcoming image to people from protected characteristic groups. It has also continued to be an active member of all the leading employers' equality forums in the UK, Stonewall, the Business Disability Forum, Opportunity Now and Race for Opportunity, the Employers' Network for Equality and Inclusion and Carers UK, enabling it to share and model best practice.

The full Annual Equality Report 2012-13 provides detailed information on access to and delivery of key services, key activities of the Trust, as well as on the workforce profile, including breakdown by grade/rank, staff group, length of service, pay band, age, starters and leavers, promotions, employee relations activity, training and development and staff engagement.

5. CONCLUSION

In an extremely busy year leading up to a wide range of high-profile and unique events, which the service was involved in, including the Queen's Diamond Jubilee and the London 2012 Games, the Trust has continued to be very proactive on the equality and inclusion front: enhancing its engagement with communities from protected characteristic groups; investigating areas needing further improvement in the collection and analysis of Data; setting up more initiatives directly intended to make the Trust's workforce more representative of the communities it serves; providing targeted training for its staff and enhancing the quality of the services it provides to its patients and service users. The Trust's profile has been further enhanced by its nomination as one of the first national Stonewall Health Champions as well as its rankings on the Stonewall Workplace Equality Index and Health Equality Index. This provides a solid basis for the Trust's equality and inclusion work for the coming years.

6. RECOMMENDATIONS

To ensure that the Trust continues to be proactive in its equality and inclusion work and compliant with the requirements of the Equality Act 2010, it is recommended that the LAS continue to use the EDS, including focusing activity on the four key objectives and continue to monitor and report on progress against them.

BACKGROUND PAPERS

Annual Equality Report 2012-13

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
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Lead Director:	**Richard Hunt/Ann Radmore**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Approval of the monthly self certification requirements for submission to the NHS Trust Development Authority**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the submission of the Board declarations for July 2013**

Key issues and risks arising from this paper

The Trust Board will be held to account by the NHS Trust Development Authority for compliance with the new provider licence requirements and the Board statements.

Executive Summary

The Trust Board is asked to approve submission of the declarations, noting that we remain fully compliant with each statement and condition except for the following:

1. Compliance Monitor

The Compliance Monitor document refers to the conditions within the new provider licence which comes into effect from 1st April 2014 but against which we are being monitored now.
http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-8

In terms of compliance, we declared compliance against all conditions with the exception of:

G4 – fit and proper persons as governors and directors: condition G4.3 will require amendment to executive director contracts;
C2 – competition oversight: the Trust Board has yet to discuss and consider competition regulation in the new NHS environment and this will be added to the board development or strategy sessions being planned for 2013/14.

2. Board Statements

This declaration is a series of statements against clinical quality, finance and governance. The description of each statement is included in the document and further detail can be found in the Accountability Framework.

We declared compliance against all with the exception of:

Clinical quality 2: CQC compliance: we identified this as a risk as the Trust is in the process of implementing the action plans to address the minor and moderate non-compliance issues addressed by the CQC in December 2012. A meeting took place with the CQC for 11th June to discuss progress against the action plans.

Attachments

None – submissions are the same as April, May and June 2013 as previously reviewed by Trust Board.

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☐ Helping People
☐ Quality of Life
☐ Preventing Death

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
☒ That we cannot maintain and deliver the core service along with the performance expected
☒ That we are unable to match financial resources with priorities
☒ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy, Committee Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**francesca.guy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 18th June 2013 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

This report is intended to inform the Trust Board about key transactions thereby ensuring compliance with Standing Orders and Standing Financial Instructions.

Executive Summary

One tender has been received, opened and entered into the tender book since 18th June 2013:

- Tyres
  Tenders received and opened on 24th June 2013:

  Lot 2 – Supply and fit of car, 4x4 and van tyres:
  ATS Euromaster Ltd
  Goodyear Dunlop Tyres UK Ltd
  Kwik Fit Fleet
  Michelin Tyre Plc
  National Tyres Service Ltd

  Lot 4 – Supply and Fit of motorcycle tyres:
  Goodyear Dunlop Tyres UK Ltd
  Kwik Fit Fleet
  Michelin Tyre Plc

There have been no new entries to the Register for the Use of the Trust Seal since 18th June 2013.

Attachments

None.

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Quality Strategy
This paper supports the following domains of the quality strategy

☐ Staff/Workforce
☐ Performance
☐ Clinical Intervention
☐ Safety
☐ Clinical Outcomes
☐ Dignity
☐ Satisfaction

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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2013/14 Priorities
☐ Modernisation Programme
☐ Communication and Engagement
☐ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper links to the following strategic risks:

☐ That we fail to effectively fulfil care/safety responsibilities
☐ That we cannot maintain and deliver the core service along with the performance expected
☒ That we are unable to match financial resources with priorities
☒ That our strategic direction and pace of innovation to achieve this are compromised

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD JULY 2013

PAPER FOR INFORMATION

Document Title:	**Chief Executive's Report**
Report Author(s):	**Ann Radmore, Chief Executive**
Lead Director:	**Ann Radmore, Chief Executive**
Contact Details:	
Why is this coming to the Trust Board?	**For Information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper
Nil

Executive Summary

1. Spending Review 2013

On 26 June 2013, the Chancellor announced the Spending Review 2013. In relation to the NHS, spending will be protected in 2015/16, with an additional £2bn a year shifted from the NHS to join up local health and social care services. A more detailed analysis of the impact on the NHS can be found here

http://www.nhsconfed.org/priorities/latestnews/Pages/spending-review.aspx

A response to the Spending Review from Sir David Nicholson can be found here:

http://www.england.nhs.uk/2013/06/26/spend-rview-2015-16/

2. Blue Light Services

a. On 25 June 13, The All Party Parliamentary Group published a paper called 'Improving Efficiency, Interoperability and Resilience of our Blue Light Services.'

The paper explores how in the future the Blue Light Services might work together differently to enhance resilience and interoperability whilst also delivering some efficiencies. A copy of the report can be found via the following link

http://henryjacksonsociety.org/wp-content/uploads/2013/06/Blue-light-Report_LR.pdf

b. During a speech to the Reform Think Tank on 8 July 2013, the policing and criminal justice minister Damian Green suggested that police forces and Police and Crime Commissioners (PCCs) should continue to explore ways to collaborate and he said it was time to "start thinking about" PCCs overseeing both the fire and ambulance services. Details of Press Coverage to date can be found at the following link

http://www.publicservice.co.uk/news_story.asp?id=23403

A copy of the speech is being sought

c. The Association of Ambulance Chief Executives (AACE) was invited to provide a Response to Communities and Local Government Select Committee inquiry on Sir Ken Knights Review into Fire and Rescue Services. A copy of the response is attached to this report

3. Kings Fund Review of Health and Social Care

The Kings Fund has launched a major review of health and social care under the leadership of in independent commission chaired by Kate Barker. More details can be found by following this link:

http://www.kingsfund.org.uk/blog/2013/06/what-next-health-and-social-care-england

4. Modernisation Implementation Team

A modernisation implementation team has been established. It will be jointly led by Jane Chalmers (Director of Modernisation) and Paul Woodrow (Director of Service Delivery (South). Jane and Paul will give the team strong leadership with considerable experience of both delivering big projects and the operational complexities of our service. They will now bring together a number of staff to focus on the delivery of the changes. I envisage the team will operate until the autumn in this way.

5. Interim Director of Strategy

As the Board will be aware, the Trust needs to work on the development of a strategy over the next 6 months. To support this, Dr Barbara Green has been 'engaged' as Interim Director of Strategy and she will be working with us for 2.5 days a week for the next few months.

Barbara has a worked extensively in the NHS in both operational and more strategic roles including with ambulance services outside London and recently in the implementation of the Trauma arrangements in the North West.

6. External Events

a. On 28 June 2013, the Chief Executive attended the Metropolitan Police Annual Ceremony of Remembrance and laid a wreath on behalf of the Service.

b. On 10 July 2013, the Chief Executive attended a training exercise at the Metropolitan Police Specialist Training Centre. The purpose of the exercise, was to allow members of the Service to train alongside their Metropolitan Police colleagues in how to respond to major incidents

c. On 18 July 2013, the Chief Executive spoke at the London Regional Emergency Care Event which was attended by over 200 delegates from across the London Health Economy. The subject of the presentation was 'The Role of the London Ambulance Service'

Attachments
AACE submission to the Communities and Local Government Select Committee inquiry on Facing the Future: Findings from the Sir Ken Knight Review into Efficiency in Fire and Rescue Services

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Quality Strategy
This paper supports the following domains of the quality strategy

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Risk Implications
This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil responsibilities to deliver high quality and safe care
☒ That we cannot maintain and deliver the core service along with the performance expected
☒ That we are unable to match financial resources with priorities
☒ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

Key issues from the assessment:

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ASSOCIATION OF
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AACE submission to the Communities and Local Government Select Committee inquiry on Facing the Future: Findings from the Sir Ken Knight Review into Efficiency in Fire and Rescue Services

Association of Ambulance Chief Executives (AACE)

The Association of Ambulance Chief Executives (AACE) provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central resource of information about NHS ambulance services.

The primary focus of the AACE is the ongoing development of the English ambulance service and the improvement of patient care.

Background

This statement has been prepared by the Association of Ambulance Chief Executives (AACE) to assist the Select Committee following the report by Sir Ken Knight into Efficiency in Fire and Rescue Services (FRS's).

AACE recognises that FRS's undertake a very wide range of specialist roles and that call reductions gained from extensive prevention work and subsequent decline in deaths and injuries from fires is enviable. It is also recognised that other agencies, the ambulance service included would benefit from even closer working with FRS's in some areas. However AACE is of the view that the true benefits realisation would only be possible once a detailed piece of robust independent research had been completed across all organisations involved. This would need to be undertaken, by an independent body to ascertain where true efficiency gains could be identified and implemented with a strong evidence base.

Existing Joint Working Arrangements

There are numerous examples of joint working between ambulance services and their police fire and rescue counterpart organisations across England. The primary motivations for joint working have historically been the improvement of care for service-users and joined-up, responsive service provision. In some areas of joint working cost reduction is not a motivation nor is it ever likely to be achieved; when co-responding, for example, a fire and rescue or police service response will never actually negate the requirement for an ambulance service response thus savings will not be made but the assurance of a timely response will be enhanced. Where appropriate, cost savings and improved efficiency have been sought and achieved; more work needs to be done, however, to quantify where financial benefit has been realised.

Furthermore, despite the shared arena within which police, fire and rescue and ambulance services sometimes operate; the differences between the organisations and service they deliver also needs to be recognised. The English ambulance service has a very lean management structure and its evolution into its current ten-service structure has been in part driven by increasing efficiencies and gaining cost savings, which have been realised. Demand for Ambulance services increase on an annual basis and they are delivered in the context of an ever-reducing financial envelope. New opportunities for cost savings and reduced spend are sought on an on-going basis to maximise returns for patients, however, the differing contexts within which the blue light services operate must be considered when determining where long-term gains and savings can most effectively be made.

Ambulance Trusts already work very closely with Fire and Rescue Services and Police Services to a lesser or greater degree around the country e.g.

- Joint training and exercising
- Shared use of Control room buildings
- Shared use of Fire Stations
- Defibrillators placed on Fire appliances
- Co-responding by Fire Service Personnel to 999 calls to ambulance services, particularly in rural communities

Set out at the end of this submission are some examples from around England of work that has either already been implemented, or is planned.

Financial Position

The Ambulance Service has embraced rationalisation and has reduced the numbers of Ambulance Trusts from 31 (2005) to 10 (2013). This rationalisation has facilitated considerable cost savings and efficiencies across a number of areas including management costs, support service costs and procurement. Management costs in particular have been significantly reduced overall and a whole range of other operating efficiencies have been achieved across England.

Unpicking these established arrangements and re-introducing them across 45 Fire and Rescue organisations would inevitably increase costs.

Overall costs for the English Fire and Rescue Services are in the region of £2.3 billion annually compared to £1.6 billion for the Ambulance Sector.

Response rates and efficiency

The ambulance service deals with approximately 25,000 calls a day at peak, whilst the fire and rescue service handles circa 1,700 calls (2013).

Speed of response is a significant indicator for the Ambulance Service as are clinical quality indicators, which are benchmarked nationally and include: outcome from acute ST-elevation myocardial infarction; outcome from cardiac arrest; outcome following stroke; proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate). Response times alone provide a one-dimensional view of a multi-dimensional service.

In terms of efficiency, the ambulance service's utilisation rate is running at circa 60%. This means that for 60% of the available hours worked by an ambulance professional they are actively engaged on dealing with emergency calls.

On a national level, ambulance and fire and rescue services' workload can be compared as follows for 2011/12:-

- UK ambulance services received 8,490,000 emergency calls
- UK fire and rescue services received 584,500 emergency calls
- Total ambulance service calls increased by 5.1% (compared to 2010-11)
- Total fire and rescue calls decreased by 7% (compared to 2010-11)

The increase in calls for ambulance services between 2010/11 and 2011/12 equates to 410,000, which ambulance services have absorbed year on year.

Clinical context

The Ambulance Service is both an emergency service and a fundamental NHS service provider. The patient's NHS journey commonly starts with a 999 call answered by Ambulance Service Emergency Medical Dispatcher (EMD) operating a sophisticated telephone triage system which determines the medical priority for the patient and assigns an appropriate response within an appropriate time frame. In many cases this is accompanied by on-going telephone advice on how to maintain and stabilise the patient's condition prior to the arrival of the ambulance response. Furthermore, up to one third of the NHS 111 contracts in England are or are likely to be held by the Ambulance Service.

NHS professionals are embedded within this system with paramedics and nurses working alongside each other within ambulance control rooms advising patients. Telemedicine systems are often in place putting NHS paramedics in touch with NHS emergency consultants to enable more complex procedures to be carried out in the field. The NHS is embedded within local communities with networks of ambulance community first responders reacting to emergencies backed up by paramedics and emergency medical technicians. Professional ambulance clinicians are able to ensure the best possible treatment and advice is given to patients, ensuring continuity of care is started and facilitated throughout the NHS system. Fracturing this system by separating out components of it to different providers would undoubtedly lead to a worse service for patients as well as undermine the flexibility of the current system.

Ambulance services feel strongly that patients would prefer to have their healthcare delivered by an organisation that sits within the NHS as opposed to outside it. Ambulance service public satisfaction surveys have always shown that circa 95% of the public are very satisfied with ambulance service provision. The totality and quality of the patient care provided obviously has a direct impact upon both satisfaction and patient outcomes. The ambulance sector has introduced a suite of Ambulance Quality Indicators designed to measure patient outcomes and not just response times. These are underpinned by complex and well established medical oversight and governance processes.

Ambulance services are responsible for managing the demands placed upon them by the 999 system, general practitioner (GP) admissions and inter-hospital transfers together with a Patient Transport Service (PTS) component in most Trusts. Relationships with clinical commissioning groups, acute trusts and primary care providers are key to their safe and effective delivery and these relationships are well developed within the ambulance sector. Ambulance services engage extensively both locally and nationally with the NHS and would seek to continue this so to ensure no major risks are presented to the rest of the NHS.

As part of this role, ambulance services are required to forewarn the wider NHS of impacts which will affect normal service delivery up to and including the declaration of a major incident. This is underpinned by considerable legislative and governance processes. As an NHS funded provider of care, ambulance services are required under the Health and Social Care Bill to be registered as a provider of health care with the Care Quality Commission (CQC), which is underpinned by considerable compliance requirements and very robust governance arrangements. This in turn demands that high level clinical oversight is maintained and Ambulance Trust Boards must have a Medical Director and a Nursing Director to lead on these issues.

In addition to the complexities of the healthcare system and the ambulance service's fundamental role within it (as outlined above), there has been considerable evolution of the role played by ambulance services over the past few years. Road traffic collisions and life threatening emergency incidents now represent a very small proportion of the ambulance service's workload. Closer working with the Fire and Rescue Service would therefore not be relevant for the majority of calls. The focus is increasingly on urgent care and the development of more appropriate patient pathways, a focus which can only be achieved through close collaboration and partnership-working with other elements of the NHS. Any attempt to move ambulance services away from the NHS would have a negative impact on these developments and in all likelihood would lead to more patients being taken to already overstretched Emergency Departments.

The recent introduction of a national ambulance Hazardous Area Response Team (HART) capability across England has been an excellent example of close working and cooperation between the Fire and Rescue services and Ambulance services. It has brought the ability for ambulance professionals to bring definitive care to patients inside contaminated and dangerous areas and has saved many lives since its introduction.

HART train in collaboration with fire and rescue services, as they do with other emergency services and agencies, for some parts of their education, and in the main this training has been led by the ambulance service. It is vital to recognise that being part of the NHS facilitates joint training and exercising whilst encouraging cross-fertilisation of ideas by different NHS clinicians meeting and sharing best practice. Should the ambulance service no longer sit within the NHS, maintenance of these clinicians' skills would be at risk as exposure/access to the wider range of medical disciplines, organisations and individuals would lessen.

Complexity and culture

Only circa 2.6% of all 999 calls to the ambulance service are to RTCs and fires, of those only about a third of RTC's attended by the ambulance service require the assistance of the Fire Service. Furthermore, less than 10% of emergency calls to the Ambulance Service also require the attendance of the police. In other words, approximately 90% of emergency calls to the Ambulance Service are dealt with by the Ambulance Service without the attendance of Police or Fire Services.

The ambulance sector has a proven ability to work cohesively across England providing a consistent level of service delivery and patient care. Established systems are in place which allows Chief Executive Officers (CEOs) and Chairs to work closely with ten national director groups to help shape national strategy and implement policy in a consistent manner. Mutual aid arrangements are very well developed allowing a national ambulance sector response to a crisis or to large national events like the 2012 Olympic and Paralympic Games.

Ambulance Trusts have embraced new technology and modernised working practices to deliver highly efficient, flexible response regimes based on sophisticated analysis of demand patterns. In doing so they have managed to improve response times and patient outcomes, absorb significant increases in workload year on year, and also deliver challenging cost improvement programmes. This has resulted in lean efficient organisations with low overheads and a track record of delivery.

Each Ambulance Trust operates entirely independently with its own management structures and support staff costs, and in most instances operates its own control room. Mutual aid arrangements exist between ambulance services and fire and rescue services.

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Examples of existing or planned Joint Working

West Midlands Ambulance Service

West Midlands Ambulance Service (WMAS) shares a total of 47 operational sites with other emergency services. This includes the use of police and fire and rescue service sites as reporting posts for small teams of paramedics (community paramedic schemes), or as response posts for double-crewed emergency ambulances and paramedic rapid response vehicles to stand-by as part of WMAS's deployment model.

- Co-location, co-responding and defibrillators

WMAS operational areas	Fire and rescue service station shared with ambulance service	Fire and rescue appliance fitted with AED	Co-responding schemes
Birmingham	15	60	0
Black Country	11	(combined with above)	0
Coventry and Warwickshire	8 (2 fire and rescue services cover West Midlands; Coventry: 4; Warwickshire: 4)	Coventry: 4 Warwickshire: 0	0
Staffordshire	32	47	1
West Mercia	1	21	0
Total	67	132	1

Specific examples:-

- Tally Ho (Police service) Event Control Suite – blue-light multi-agency site
- Birmingham Multi-agency Emergency Service Unit (MAESU) meets monthly to ensure all areas of emergency preparedness and special operations dovetail with each other
- Stafford Civil Contingencies Unit (CCU) – as above but office space shared on permanent basis

- Education and training

- Joint use of education resources between WMAS and other blue light services, including tri-services facilities at Ryton and Winterbourne Gunner

- Hazard Area Response Team (HART) operatives taught breathing apparatus (BA) and inland water skills by fire and rescue services

- WMAS delivery of triage training to BHX (airport) Fire and Rescue Ltd personnel

- Joint blue-light delivery of training: Marauding Terrorist Firearms Attack (MTFA); Multi-Agency Gold Incident Command (MAGIC); Chemical, Biological, Radiological and Nuclear Gold and Silver courses

- Exercising

  - A number of joint exercises have taken place over the last 12 months; key exercises are:-

  * Amber 1 (May 12) and 2 (May 13): national mutual aid exercises

  * Annual major incident plan exercises: all three services

  * MTFA exercises: on-going

  * CBRN: on-going through ‘shield’ exercise process

  * Exercise Triton: flooding

  * Exercise Clean Care: National Atlantic Treaty Organisation wide (NATO)

London Ambulance Service

The London Ambulance Service (LAS) works closely with the London Fire Brigade (LFB) and Metropolitan Police Service (MPS). Examples include:-

- Delivery of medical training to British Transport Police: a Memorandum of Understanding (MoU) is in place for medical training for an initial response to incidents on the tube network; the LAS charges a nominal fee for this

- Defibrillators – City of London: a mature scheme is in place for City Police to respond to medical emergencies with Automatic External Defibrillator (AED) equipped cars and bicycles; 10-12 machines are in operation within the square mile; no cost is incurred by the LAS

- ‘Train-the-trainers’ in casualty care: the LAS has an MoU with the LFB to train-the-trainers in casualty care for cascade; on-going quality assurance provided by LAS consultant paramedic and senior trainers

The LAS is currently involved in on-going discussions with the LFB to explore future opportunities for collaboration with a view to reducing costs and improving efficiency. The focus will be on the following areas:-

- Estates: including potentially renting space in the LFB offices; shared or sole use of fire stations for operational ambulance/super stations
- Joint procurement: for assets such as fuel, stationary, IT equipment, vehicles etc.
- Support services: for example, Payroll, IT support etc.

Yorkshire Ambulance Service

Historically, the Yorkshire Ambulance Service (YAS) has had limited collaboration with police and fire services, however, existing pockets of effective co-working include:-

- Static medical units: joint-work with police services in city centres of Friday and Saturday nights
- Co-responding: 'Polamb' – police officer riding with rapid response vehicle in city centres (South Yorkshire and West Yorkshire)
- Training: medical training provided by ambulance services for police firearm units
- Clinical governance: introduced for fire and rescue services (Yorkshire and Humberside)

In addition, over the last six months, a formal process of engagement has commenced with blue light services to support quality of services and reduction in joint operating costs.

Proposals have been made to the joint Chief Fire Officer, Yorkshire and Humberside, in relation to:-

- Estate collaboration
    - Procurement of new joint premises (South Yorkshire)
- Co-location of sites
    - Joint services co-location (mainly standby at Pontefract, West Yorkshire)
    - Future co-location (North Yorkshire Police co-locating at YAS site)
    - Stand-by: ambulance service on fire service sites, including some 5 star stand-by cabins on fire and rescue service premises
- Fire service co-responding
    - Pilot underway (Pocklington, Humberside) and further schemes being sought (South Yorkshire and Humberside)

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- Support/back office functions
  - Discussions underway with police services in relation to training facilities and shared back office functions (West Yorkshire)

Although the above are all in the early stages, the ambulance service chief executive officer and fire and rescue service and police counterparts have agreed that elements of the joint work outlined will be evident across all blue light services in the region. Once progressed further, the identification of cost savings will be sought, which is one of the driving motivators for co-working.

Summary

CFOA and AACE already have strong engagement at a national level to exploring opportunities for increasing the already good work being undertaken in most areas of the country

AACE supports the need for efficiencies in public sector organisations and is therefore committed to assisting others in realising efficiencies as ambulance services have already.

There are already strong examples of Blue Light Services working together e.g. Joint Emergency Services Interoperability Programme (JESIP) which is looking closely at how the services work more closely at serious and major incidents.

Both AACE and CFOA are committed to working together to take both Ambulance Services and Fire and Rescue Services forward in a sustainable way.

Martin Flaherty OBE
Managing Director
Association of Ambulance Chief Executives
8th July 2013

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London Ambulance Service NHS
NHS Trust

TRUST BOARD FORWARD PLANNER 2013

23rd July 2013

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Annual Infection Prevention and Control Report 2012/13** **Annual Patient Experiences Report 2012/13** **Annual Safeguarding Report 2012/13** **Francis Report Progress Update**	Report from Chief Executive Officer Community First Responder presentation	Report from Finance and Investment Committee Annual Equality Report 2012/13 Governance Review Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee – 9th July Quality Committee – 21st August	Jason Killens Jessica Cecil

24th September 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **BAF and Corporate Risk Register – Quarter 2 documents** **Audit Committee Assurance Report** **Annual Report of the Audit Committee** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer HDD2 Report and Action Plan Performance reporting approach (AG) Charity Funds	Annual Corporate Social Responsibility Report Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 2nd September Finance and Investment Committee – 10th September	

26th November 2013

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Update on Safeguarding (Alan Tayler and Lysa Walder to attend)**	Report from Chief Executive Officer	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Audit Committee - 4th November Finance and Investment Committee – 12th November Quality Committee – 23rd October	

17th December 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents** **Reports from Executive Directors (COO, DoF, DoHR)**		Report from Trust Secretary Trust Board Forward Planner	Quality Committee – 11th December	

MEETINGS CALENDAR FOR 2014

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**22**		**23**		**25**	**16**	9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Strategy Review and Planning	Trust Chair		**25**		**29**					**2**	**28**			9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Annual General Meeting	Trust Chair									**23**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													
Remuneration Committee	Trust Chair						**3**							14.00 - 15.00
Audit Committee	Caroline Silver (NED)			**x**		**x**	**x**			**x**		**x**		TBC
Finance and Investment Committee	Trust Chair	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	TBC
Quality Committee	Beryl McGrath (NED)		**x**		**x**		**x**		**x**		**x**		**x**	TBC (usually third Wednesday of the month)
Clinical Quality Safety and Effectiveness Committee	Medical Director	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually third week of the month)
Learning From Experience Group	Director of Quality and Health Promotion		**x**			**x**			**x**			**x**		TBC (usually first week of the month)
Risk Compliance & Assurance Group (RCAG)	Director of Finance	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually first/second week of month)
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00**												9.00 - 11.00