London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 26th NOVEMBER 2013 AT 09.00 – 11.30
CONFERENCE ROOM, FIELDEN HOUSE, 28 LONDON BRIDGE STREET, LONDON SE1 9SG

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.00	1.	**Welcome and apologies for absence** Apologies received from:			
	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 24th September 2013** To approve the minutes of the meeting held on 24th September 2013	Approval	RH	TAB 1
09.05	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.10	5.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	Oral
QUALITY GOVERNANCE, RISK AND ASSURANCE					
09.15	6.	**Quality Report** 6.1 Quality Dashboard 6.2 Clinical Quality and Patient Safety Report including serious incidents update	Assurance	SL FM	TAB 3
09.30	7.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	AG	TAB 4
09.40	8.	**Board Assurance Framework and Corporate Risk Register** To review and provide feedback on the new Board Assurance Framework format	Assurance	SA	TAB 5
09.50	9.	**Finance Report** 9.1 Finance Report 9.2 Finance and Investment Committee Assurance Report from the meeting on 22nd November 2013	Information Assurance	AG NM	TAB 6
10.00	10.	**Quality Committee Assurance Report** To receive a report from the meeting on 23rd October 2013	Assurance	RG	TAB 7
10.10	11.	**Audit Committee Assurance Report** To receive a report from the Audit Committee on 4th November 2013	Assurance	CS	TAB 8

10.20	12.	**Mental Health Annual Report 2012/13** To receive the mental health annual report for 2012/13	Assurance	SL	TAB 9
BUSINESS ITEMS					
10.25	13.	**Winter 2013/14 Sustainability Planning**	Information	AR	TAB 10
10.45	14.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 11
10.50	15.	**Modernisation Programme** To receive an update on the Modernisation Programme	Information	JC	Oral
11.00	16.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for October 2013	Approval	SA	TAB 12
	17.	**Report from Trust Secretary** 17.1 To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal 17.2 To give approval for LAS to enter a contract over £1m for 21 Century Network	Information	SA VW”	TAB 13
	18.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 14
11.05	19.	**Patient Story** To hear an account of a patient story			
	20.	**Any other business**		RH	
	21.	**Questions from members of the public**		RH	
	22.	**Date of next meeting** The date of the next Trust Board meeting is Tuesday 17th December 2013			

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LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 24th September 2013 at 10:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Chairman
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Andrew Grimshaw	Director of Finance
John Jones	Non-Executive Director
Steve Lennox	Director of Nursing and Quality
Nick Martin	Non-Executive Director
Fionna Moore	Medical Director

In Attendance:

Sandra Adams	Director of Corporate Services
Jane Chalmers	Director of Modernisation
Tony Crabtree	Acting Director of Workforce
Francesca Guy	Committee Secretary (minutes)
Bob McFarland	Associate Non-Executive Director
Peter McKenna	Deputy Director of Service Delivery
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:

Simon Albert

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116. Welcome and Apologies

116.1 Apologies had been received from Ann Radmore, Caroline Silver and Jason Killens.

116.2 The Chair welcomed Peter McKenna to the meeting, who was attending on behalf of Jason Killens. The Chair welcomed Simon Albert to the meeting.

116.3 The Chair congratulated Paul Woodrow and Jason Killens for their recent appointments to Director of Performance and Director of Operations.

117. Staff Story

117.1 Steve Lennox explained that the member of staff who had been invited to tell his story to the Trust Board had unexpectedly been unable to attend today and therefore there was no staff story.

118. Declarations of Interest

118.1 There were no declarations of interest.

119. Minutes of the Part I meeting held on 23rd July 2013

119.1 The minutes of the Part I meeting on 23rd July 2013 were approved.

120. Matters Arising

120.1 The following actions were discussed:

120.2 **135.1:** The Chair reported that he had drafted a proposal for awarding a commendation to a member of the public who had assisted the service and he would circulate this to the Trust Board.

120.3 **101.10:** Angie Patton agreed to check whether the LAS website had been updated to explain that the LAS did not categorise complaints as upheld or not upheld.

120.4 **101.11:** Steve Lennox reported that he had looked at benchmarking LAS complaints with that of other ambulance trusts and that this would be reported in November's Clinical Quality and Patient Safety Report.

120.5 **102.2:** Action complete.

120.6 **103.5:** Action complete.

120.7 **106.3:** Andrew Grimshaw reported that a paper on non-productive time had been presented to the Finance and Investment Committee and he would provide a detailed update in the Part II meeting.

120.8 **112.1:** Francesca Guy reported that a presentation from the Association of Ambulance Chief Executives had been arranged for the December Trust Board meeting.

120.9 The following matters arising were discussed:

120.10 **101.5:** Roy Griffins commented that he was aware that Category C performance was not contractually required and therefore benchmarking with other ambulance trusts was difficult, however he thought that it would be useful if there was a way of doing this informally as it would be an effective tool for measuring the benefits of the modernisation programme. Paul Woodrow agreed to follow this up.

ACTION: PW to look into whether there was an informal way of benchmarking Category C performance with other ambulance services.

DATE OF COMPLETION: 26th November 2013

121. Report from the Trust Chairman

121.1 The Chair reported that progress had been made in recruiting to the new structure and a number of interviews had been held since the last meeting, all of which had been handled well. The Trust had been in a position to make appointments, which had been approved by the NHS Trust Development Agency. Further interviews for the remaining director posts would be held shortly.

121.2 The Chair reported that the Trust would also need to recruit two non-executive directors, who would replace Caroline Silver and Roy Griffins once their term of office came to an end in March 2014. The plan was to appoint the non-executive directors on an associate basis with a view to them assuming full non-executive roles in March 2014. This would allow them to have a comprehensive handover to the position.

121.3 The Chair had attended a meeting hosted by the Association of Ambulance Chief Executives (AACE) to discuss NHS 111. AACE had also commissioned a piece of work to look at how competition law impacted on ambulance trusts. This demonstrated that NHS trusts were subject to all the provisions of competition law, which had an impact on opportunities for sharing information and benchmarking performance. Bob McFarland commented that it was difficult to see how this would be reconciled with the principles of transparency and co-operation advocated by Francis and Berwick.

121.4 The Chair reported that he had visited Yorkshire Ambulance Service to understand their approach to workforce modernisation and running NHS 111 services. The Chair planned to do more of these types of visits on a regular basis.

121.5 The Chair gave an update on the key items of discussion at the Strategy Review and Planning Committee on 10th September and in particular noted the work that had been undertaken to fully review the requirements of the Francis and Berwick reports. The Committee had also begun the discussions around the development of the strategy and reviewed the proposals for the governance structure.

121.6 The Chair noted that a number of issues were highlighted in the Trust Board pack, such as workforce turnover, an increase in sickness levels and Category A and C performance, which collectively gave an early warning sign in performance. The Trust Board needed to understand the extent of these issues, particularly in the run up to winter and it was agreed that an additional meeting would be held to discuss this.

122. <u>Integrated Board Performance Report</u>

122.1 Andrew Grimshaw reported that an additional page had been added to the Integrated Board Performance Report to highlight the downward trends. This was work in progress and he welcomed any feedback from the Trust Board.

122.2 Andrew stated that the Chair's earlier comments summarised the performance position. The Trust Board noted that there were a significant number of red and amber rated indicators and asked whether there were action plans in place to address these issues. Andrew responded that the Executive Management Team was focussed on recruitment, retention, sickness absence, the financial position and was in the process of developing recovery plans. The Trust Board would have greater visibility of these action plans going forward.

122.3 Jessica Cecil noted that use of the Demand Management Plan had increased in August, whilst the number of Category A incidents had decreased. This suggested that the service's productivity was declining. Andrew Grimshaw responded that this was largely due to the amount of staff taking annual leave in August, which meant that the Trust was significantly down on productive staff. The Trust Board should see this trend reverse in September. Consideration would be given to reviewing the annual leave policy and whether training should be delivered in August.

122.4 Paul Woodrow reported that he was working with Tony Crabtree to develop an action plan on recruitment, retention, sickness absence and non-productive staff and had identified three key actions for each of these areas. Additional staff would be joining the Trust in October from the university turnout. This, together with reduced annual leave, would mean that productivity should increase by the winter.

122.5 The Chair summarised the discussion by stated that the Integrated Board Performance Report showed an unacceptable position and the Trust Board needed to understand the trajectory for improvement and monitor the month on month progress. An additional board meeting would,

therefore, be held.

122.6 Sandra Adams commented that the Trust Board needed to understand the risks arising from this report, for example what objectives the Trust would fail to achieve if the position did not improve.

123. Quality Report

Quality Report

123.1 Steve Lennox noted that there were a number of errors in the RAG rating of the Quality Report and these were:

- Return of spontaneous circulation – which should be rated amber
- STEMI care – which should be rated amber
- Re-contact rate – which should be rated amber
- Infection control – which should be rated red

123.2 Steve explained that going forward the dashboard would be completed by Management Information, which would allow him greater opportunity to analyse the position and identify the actions to improve any issues that had been flagged. Steve explained that the Executive Management Team had asked him to consider whether there was any link between on scene times, re-contact rate for see and treat and the relatively low levels of see and treat.

123.3 Jessica Cecil asked whether the on scene time target was realistic and when the Trust would have a better understanding of what was causing longer on scene times. Fionna Moore responded that there had been a drive to improve the quality of documentation but that this needed to be balanced with providing quality patient care. For some patients spending longer on scene was beneficial, however for time critical patients on scene times needed to be reduced as much as possible.

123.4 Paul Woodrow reported that an audit was being undertaken at Chase Farm to understand why it had been difficult to reduce on scene times. The evaluation report would come to the Executive Management team in the first week of October and it was expected that this would provide some valuable information about what was causing long on scene times.

123.5 Jessica Cecil suggested that the Trust Board would benefit from a more detailed analysis of the Quality report on a quarterly basis.

Clinical Quality and Patient Safety Report

123.6 Fionna Moore noted the following:

- The Annual Cardiac Arrest Report for 2012/13 had been published which demonstrated that the LAS continued to perform well. A presentation would be given at the AGM;
- The first of the six clinical update modules for Team Leaders had commenced;
- Four new drugs (Ondansetron, Dexamethasone, Tranexamic Acid and IV Paracetamol) had been introduced into the drugs bags;
- The Medicines Management Group continued to explore options for minimising drug errors.

123.7 Roy Griffins noted that three serious incidents had been declared and asked how this compared with the previous year. Sandra responded that this was comparable with last year's figures. As part of the actions to address the recommendations made in the Francis and Berwick reports, comparative data would be drawn up to identify key themes from serious incidents and whether they highlighted a new risk in the system.

123.8 Bob McFarland noted that compliance with the mental health Clinical Performance indicator was below target. Steve responded that this report only reported against two of the elements of the CPI and that the key issue was crews failing to document that they had considered a safeguarding referral when treating a mental health patient.

124. Francis and Berwick Update

124.1 Steve Lennox commented that this paper updated the Trust Board on the discussion at the Strategy Review and Planning Committee and the decision to change the approach to focus on the recommendations and themes for consideration primarily in the Berwick Report, whilst retaining the learning from the Francis gap analysis.

124.2 John Jones asked how progress against these recommendations would be measured. Steve responded that he anticipated that, as progress was made, vacancies and staff turnover should start to improve.

124.3 The Trust Board noted that the Patients' Forum had submitted three questions in relation to the Francis and Berwick reports:

1. In relation to "Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge", will the Board ensure that all front line staff feel able to speak out openly and freely when they are concerned about the safety, quality and effectiveness of services? It is well known that most staff will not speak openly because they fear repercussions.
2. In relation to "Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts" will the Board take steps to better publicise their meetings and the opportunity for the public to raise questions at Board meetings? A regular public dialogue with Board members would be welcome.
3. In relation to "All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care" will the Board support the work of the Patients' Forum to set up user groups to continuously receive comment from patients and carers, e.g. in relation to mental health, diabetes, dementia and sickle cell?

124.4 The Trust Board agreed that it would seek to address all these recommendations as part of the response to the Francis and Berwick reports. The Chair asked whether there was anything more that could be done to increase public and patient engagement with the Trust Board. Steve Lennox responded that the Trust needed to be smarter at engaging with Healthwatch through the Community Involvement Officers. The Chair stated that he would like to discuss patient engagement further at a future Trust Board or Strategy Review and Planning Committee.

ACTION: FG to add patient engagement to the forward planner of the Trust Board or Strategy Review and Planning Committee.

DATE OF COMPLETION: 26th November 2013

124.5 Roy Griffins reported that the Quality Committee had agreed the proposal to have a patient representative on the committee and had asked for a role description to be drawn up.

124.6 Sandra Adams commented that it was important to understand how best to engage and involve patient representatives and to support them on the board and committees so that the patient voice had an impact.

125. Annual Patient Experiences Report 2012/13

125.1 Steve Lennox asked that the Trust Board noted the annual patient experiences report for 2012/13.

125.2 Jessica Cecil asked whether there was any action that could be taken to reduce the number of complaints about lost property. Steve Lennox responded that crews cleaned the ambulance after each patient and would therefore find any item that the patient had left behind. It was therefore more likely that the LAS was unable to prove that it had not lost a patient's property, rather than being responsible for the loss of a patient's property. Staff had been asked to use the patient property bags, but usage was still low.

125.3 Jessica asked how significant complaints about attitude and behaviour should be considered by the board. Steve Lennox responded that an action plan had been agreed, but had not yet been launched. The most significant factor in complaints about attitude and behaviour was crews questioning the validity of the 999 call. The LAS did, however, compare favourably with other ambulance services and Steve was therefore reasonably assured that the LAS workforce was not disrespectful to patients.

125.4 The Trust Board noted the Annual Patient Experience Report for 2012/13.

126. Quality Committee Assurance Report

126.1 Roy Griffins noted that he had chaired the meeting on 21st August remotely and wanted to see more opportunities to join meetings remotely. Roy noted that the committee had discussed the following:

- The committee's role in quality oversight and how this related to the governance review;
- The Cost Improvement Programme. The Quality Committee had noted that the quality monitoring process that was now in place was robust;
- Quality issues related to the step-in arrangements for NHS 111 services. The Quality Committee wanted assurance that a quality monitoring process was in place and that the Executive Management Team was fully cognisant of any risks associated with taking on the service.

126.2 Roy noted that, as previously discussed, the Quality Committee had discussed the need for a patient representative. Roy also recommended having a commissioner representative on the committee.

127. Audit Committee Assurance Report

127.1 John Jones reported that the Audit Committee had met on 5th September and discussed the following:

- The governance review and the proposals for the new structure. The Audit Committee discussed its role in relation to the oversight of risk and supported the general direction of travel with regards to the proposed governance structure;
- The Audit Committee agreed that the LAS charitable funds should be subject to an independent examination rather than a full audit. This was the most cost-effective option given the size of the funds;
- The internal audit reports for risk management, serious incidents and performance reporting. The Audit Committee found the format and level of detail in the internal audit reports reassuring, however there were some concerns about the serious incidents audit which had been assessed as providing limited assurance. The Audit Committee was assured however that action was being taken in response to the recommendations made.

127.2 John commented that the Audit Committee Annual Report for 2012/13 had been received and demonstrated that the committee had discharged its duties over the course of the year in line with its terms of reference.

127.3 The External Auditor's Annual Audit Letter 2012/13 had been presented at the Audit Committee meeting on 5th September and had been accepted. The Trust Board noted the External Auditor's Annual Audit Letter.

127.4 In response to a question from the Chair, John confirmed that the relationship with the new internal auditors was working well.

128. Finance Report

Finance Update

128.1 Andrew Grimshaw noted that the financial position had shown a slight improvement in-month. The Chair noted improved Patient Transport Services performance and wanted to congratulate PTS on this performance.

Report from the Finance and Investment Committee

128.2 Nick Martin noted the following:

- The Finance and Investment Committee had noted the timetable for reporting compliance and noted that this was aligned with the Trust Board timetable. The committee commended the finance team for preparing the figures a week in advance;
- Expenditure was in line with plan despite overall activity being 4% below forecast. Andrew Grimshaw had presented a paper on the risks and mitigating actions and the committee was confident that the issue would be addressed. The committee would review relief rates on a monthly basis.

128.3 Sandra commented that Caroline Silver had raised a concern about the Finance and Investment Committee meeting monthly as there was a risk that the committee would become too operationally focussed as opposed to providing the appropriate level of assurance to the Trust Board. Nick Martin responded that the intention was to revert to meeting bi-monthly but had agreed to meet monthly due to the current financial position.

129. Governance Review

129.1 Sandra Adams explained that the proposals for the governance structure were the culmination of several months' worth of work including feedback from the key committees. In the proposed structure, the Audit Committee would have responsibility for the oversight of risk processes, the Executive Management Team would have responsibility for the management of business risk and the Senior Management Team would have day to day responsibility for the corporate risk management process. In the revised structure, each committee would have an executive lead and the annual corporate priorities would be linked to the committees. The proposed structure would allow for greater delineation between performance and assurance. It was proposed that this structure was implemented from 1st October and that each of the committee reviewed its terms of reference prior to the next Trust Board meeting.

129.2 The Chair noted that the Trust Board was required to appoint non-executive director leads for a number of areas. Non-executive directors were asked to contact the Chair if they were interested in leading a particular area.

ACTION: Non-executive directors to contact the Chair if they had a particular interested in leading a particular area for the Trust Board.

DATE OF COMPLETION: 26th November 2013

129.3 Roy Griffins noted that there might be a conflict of interest in an executive director leading the committee that related to their functional area. The Chair suggested that the governance structure should be implemented as outlined but that this issue should be kept under review.

129.4 The Trust Board approved the board governance proposals.

130. Report from Chief Executive

130.1 The Chair noted that the joint proposal between Lincolnshire Fire and Rescue and East Midlands Ambulance Service NHS Trust for firefighters to convey emergency patients to emergency departments had been discussed at last week's Association of Ambulance Chief Executive's meeting. This was the first formal proposal which would see the fire service taking on an aspect of the ambulance service's work and concern was raised at the AACE meeting that this could signify the start of a process of bringing together the fire and ambulance services. The ambulance chairs were keen to emphasise that the ambulance services' role was wider than responding to emergencies and did not support any organisational integration with the fire service.

131. Modernisation Programme

131.1 Jane Chalmers noted that the paper updated the board on progress with the Modernisation Programme. The Chair asked what progress had been made with the deployment of A&E Support staff. Jane responded that this was currently in the planning stage and that she anticipated that A&E Support staff would be deployed by the end of the calendar year.

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

132.1 Sandra Adams noted that the board declaration reported the same position as in previous months. The Audit Committee had asked that a process for applying the fit and proper persons test to current board members was in place by October 2013. Sandra Adams had sought external advice on this matter. External advice had also been sought on competition oversight and this would be discussed further as part of a board development or strategy session. Sandra reported that, following an unannounced inspection in August, the Trust had achieved compliance against all of the CQC standards, including those where minor and moderate non-compliance issues had previously been identified. The Chair congratulated everyone who had contributed to this achievement.

132.2 The Trust Board approved the submission of the board declarations for August 2013.

133. Report from Trust Secretary

133.1 The Trust Board noted the report from the Trust Secretary. Sandra Adams explained that the transaction referred to Bounds Green ambulance station site which the Trust had occupied for over 30 years.

134. Forward Planner

134.1 Sandra Adams asked the chairs of the committees to confirm that the months identified for meetings in 2014 were correct.

ACTION: Chairs of sub-committees to confirm that the months identified for meetings in 2014 were correct.

DATE OF COMPLETION: 26th November 2013

134.2 The Chair noted that once the dates of these meetings had been arranged, Trust Board members needed to view these as fixed.

135. Any other business

135.1 There were no items of other business.

136. Questions from members of the Public

136.1 There were no questions from the member of the public.

137. Date of next meeting

137.1 The next meeting of the Trust Board is on Tuesday 26th November 2013.

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Signed by the Chair

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ACTIONS

from the Meeting of the Trust Board held on 24th September 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 November 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**	Draft proposal drawn up. To be circulated to the Trust Board.
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. . Paper to be presented to October FIC.
23/07/13	**101.10**	AP/SL to explain on the LAS website that the Trust did not categorise complaints as upheld or not upheld.	**AP/SL**	AP to confirm whether this action was complete.
23/07/13	**106.3**	AG to present a paper on non-productive time to a future Part II Trust Board meeting.	**AG**	Paper going to Sept FIC. Further discussion at EMT before paper to October Trust Board
24/09/13	**120.10**	PW to look into whether there was an informal way of benchmarking Category C performance with other ambulance services.	**PW**	
24/09/13	**124.4**	FG to add patient engagement to the forward planner of the Trust Board or Strategy Review and Planning Committee.	**FG**	Added to SRP forward planner for 25/02/14.
24/09/13	**129.2**	Non-executive directors to contact the Chair if they had a particular interested in leading a particular area for the Trust Board.	**NEDs**	
24/09/13	**134.1**	Chairs of sub-committees to confirm that the months identified for meetings in 2014 were correct.	**Committee Chairs**	

ACTIONS

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
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**	Fionna Moore was invited to attend 2 workshops developing models for the Urgent and Emergency care review on 20th August and 5th September. Action complete.
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. Action complete.
23/07/13	**101.11**	SL to ask his counterparts at other ambulance services how they managed complaints.	**SL**	Action complete.
23/07/13	**103.5**	SL to clarify in the Annual Infection Prevention and Control Report for 2012/13 that the Trust had not delivered CSR training last year and did not therefore deliver infection prevention and control training.	**SL**	Action complete.
23/07/13	**112.1**	FG to schedule a presentation from the Association of Ambulance Chief Executives for a future Trust Board meeting.	**FG**	Arranged for December TB meeting. Action complete.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 NOVEMBER 2013

PAPER FOR ASSURANCE

Document Title:	**Quality Report (Dashboard)**
Report Author(s):	**Steve Lennox, Director of Nursing and Quality**
Lead Director:	**Steve Lennox, Director of Nursing 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 but attention is drawn to service experience and incidents being RED on the internal dashboard. Performance for Cat C remains a risk for the organisation.

Executive Summary

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 that overall the same level of quality is being maintained. The indicators of amber or red RAG rating are;

Cat A8 (Red 1 & 2) RAG Rated RED
Please see performance reporting.

Outcome from Cardiac Arrest (STD)
Slightly below the target level of 7% with a compliance of 6.6%. This is an unreliable measure due to the low volumes and requires a longer analysis. The compliance over time does not suggest an issue.

On Scene Time RED
On Scene time has been reviewed and a paper was discussed at EMT that suggests that there is no evidence of harm and that the main time measures (job cycle) are captured in two other

indicators. A proposal will be presented to Quality Committee to replace the indicator with something more meaningful to quality.

STEMI Care AMBER
This indicator continues to improve and we are now more in line with other ambulance services (recognising we don't all count the same thing). .

Stroke care 60 Minutes AMBER
159 patients did not get to a HASU within 60 minutes. This is being monitored and a focus will be placed on whole job cycle time rather than on scene times in the coming months..

Basic Life Support AMBER
This is 1 minute above the compliance figure. This indicator is usually compliant.

Not Conveyed hear & Treat RED
This deterioration is due to the changes taking place in CTA. We expect the position to change in December.
Not Conveyed see & Treat AMBER
Slight drop having had a gradual incline for the past 6 months. No explanation for the drop at present.

Clinical Performance Indicators AMBER
PRF copy left with patient and ethnicity coding fell below the 95% level. These are not significant clinical concerns in isolation.

Service Experience RED
No specific target attached to this indicator but with complaints at 125 for the month and at a rate of 0.09% this needs flagging. There are no new themes emerging from the complaints with delay and attitude and behaviour featuring significantly.

Incidents RED
The rate for incidents has increased but has not reached the levels of November 2012 and the month saw 4 Sis declared. Not a measure of quality in itself but an indication of pressurew within the system and needs monitoring next month.

Lost Property
Lost property disappointingly rose to 61 cases. This is routinely reported to CQSEC but no further action at present.

Re-contact Rate See & Treat AMBER
This has been linked to on scene times and control are undertaking a small examination into the reasons why we are being re-contacted. It could be a direct result of us undertaking more See & Treat and asking patients to re-contact us. This needs to be understood further.

Experience of People Subject to delay RED
The number of complaints significantly increased in September and October. The action plan sits within control and progress is being chased by the ADO.

Infection Control – Cleaning AMBER
The target is for all vehicles to be deep cleaned within 6 weeks. The compliance figure was not met in September.

Cat C
Please see performance reporting.

Supervision OWR –RED
OWR has fallen back due to the challenges with capacity.

Vacancy Factor 10.8% RED

Whilst improved this still represents the biggest risk to quality. Being monitored through modernisation work and winter planning.

From this months dashboard the indicators of concern are:

- Service experience and incidents. These will be closely monitored.
- 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

Attachments

Quality dashboard

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

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 November (September & June Measures) 2013

	July 2013		OLDER (April)	
Domain 1. Preventing people from dying prematurely				
DH	Red 1 (A8)	↓	DH Outcome from cardiac arrest	↓
DH	Red 2 (A8)	↓	DH Return of spontaneous circulation	↑
LAS	On scene Time	↓	DH STEMI Care	↓
LAS	Basic Life Support	↔	DH Stroke Care	↓
Domain 2. Enhancing quality of life for people with long-term conditions				
DH	Not conveyed to A&E	↔		
LAS	Clinical Performance Indicators	↔		
Domain 3. Helping people to recover from episodes of ill health or following injury				
DH	Time to Treatment	↓		
LAS	Airway Management	↑		
Domain 4. Ensuring people have a positive experience of care				
DH	Service Experience	↓		
LAS	Incidents	↓		
LAS	Lost Property	↓		
DH	Time taken to Answer 999	↔		
DH	Re Contact Rate	↓		
DH	calls Abandoned	↔		
LAS	Experience (delay)	↓		
LAS	Attitude & Behaviour	↓		
LAS	Experience (ACP)	↑		
Domain 5. Treating & caring for people in a safe environment and protecting them from avoidable harm				
LAS	Infection Control	↑		
LAS	Safeguarding	↓		
DH	A19	↓		
LAS	C1	↑		
LAS	C2	↑		
LAS	C3	↑		
LAS	C4	↓		
LAS	Handover at Hospital			
Domain 6. Caring for the workforce				
LAS	Supervision of staff	↔	LAS Sickness	↑
LAS	CPI Feedback Sessions	↔	LAS Temperature Check N/A	N/A
LAS	priority Training	↑		
LAS	Vacancy factor	↑		
LAS	3rd Party Providers	↑		

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 22 (last report 18) out of 46 areas.

	May Data for July Trust Board					YTD
	Comp liance	Rank	Lowest	Highest	Comp liance	Rank
A8 R1 Response Time	72.40%	8	71.70%	81.90%	76.70%	6
A8 R2 Response Time	70.80%	9	67.10%	81.50%	74.70%	7
A19 Response Time	97.20%	2	96.70%	99.00%	97.90%	1
ROSC (all)	32.10%	2	26.10%	36.40%	28.90%	3
ROSC (Utstein)	68.10%	2	45.70%	68.10%	57.30%	2
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	0.12	1	1.46	0.02	0.10	1
Time to Treatment 50th Percentile	6.24	9	6.11	5.36	6.00	8
Time to Treatment 95th Percentile	15.54	2	16.90	12.70	14.34	2
Time to Treatment 99th Percentile	26.18	2	19.40%	27.30	22.56	2
Outcome from cardiac Arrest Survival	6.60%	8	6.30%	11.40%	7.40%	8
Outcome from cardiac Arrest Survival (Utstein)	25.00%	5	16.30%	37.00%	24.20%	5
STEMI Outcome 150 minutes	95.20%	4	84.30%	95.20%	94.00%	3
STEMI Outcome Care Bundle	79.00%	8	63.10%	79.00%	77.50%	6
Stroke Outcome 60 minutes	67.70%	5	61.60%	75.80%	67.30%	3
Stroke Care Outcome Bundle	94.40%	10	92.10%	95.70%	94.60%	8
Calls Closed with CTA	4.50%	7	4.5%	6.90%	5.00%	6
Non A&E	31.30%	8	26.60%	33.30%	31.70%	8
Re Contact rate CTA	2.10%	1	3.40%	2.10%	2.70%	1
Re Contact rate See & Treat	6.60%	10	6.60%	4.90%	6.60%	10
Re Contact rate Frequent callers	2.20%	5	2.50%	2.61%	2.20%	5
999 Calls Abandoned	0.00%	1	0.00%	0.10%	0.00%	1
Service Experience						

3. Conclusions

3.1 The DH dashboard is stable. However, the internal dashboard has two RED RAG indicators in incidents and service experience reflecting a small increase in reported incidents and reported Sis (4 Sis) and a significant rise in complaints at 125 for the month. This will be monitored closely next month.

3.2 The work reported to the last Trust Board that was considering the “on scene” indicators has suggested the indicator for time on scene is not a robust quality measure and a proposal will be presented to Quality Committee to replace the indicator.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 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:	**Approval of the Trust's Research and Development Operational Capability Statement for 2013/14.**

Key issues and risks arising from this paper

- There is a risk that delays responding to lower priority 999 calls, due to a sustained increase in demand as winter approaches, may lead to serious adverse patient outcomes.

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures.

- **Demand Management Plan:** Use of DMP remains high. Decrease in the use of DMP D in October compared to September. No escalation past DMP stage D.
- **Clinical Performance Indicators:** Sustained decrease in CPI completion rate over the past five months and now at the lowest level in the past four years. Overall CPI compliance remains >96%, except for mental health (90%).
- **Cycle 11 National Asthma Clinical Performance Indicator Audit:** The Trust has achieved a significant increase in compliance against the CPI, compared to Cycle 10.
- **2013 UK Ambulance Service Clinical Practice Guidelines:** The Trust will implement and use the 2013 Guidelines from 1 December 2013.
- **Overdose Clinical Audit:** A clinical audit examining responses to lower priority overdose calls reveals that delays occur nearly 50% of cases.

- **Prevention of Future Deaths Reports:** The Trust has received three Prevention of Future Deaths Reports (formerly Rule 43 Reports) from HM Coroner since the last Trust Board report.
- **Medicines Management:** There have been no reportable controlled drugs incidents or unannounced visits by the police. The Q2 report to the NHS England (London Region) Controlled Drugs Local Intelligence Network (LIN) has been submitted. This was a 'nil' report.
- **High Risk Register:** There are a total of 354 addresses on the Locality Alert Register. There has been a slight increase in the number of category one alerts. The number of alerts from the Metropolitan Police Service continues to fall very gradually.
- **Complaints:** The Trust received the highest number of complaints to-date in October, totalling 125. 48% of complaints received by Patient Experiences Department concerned delays.
- **Serious Incidents:** Six SIs have been declared since the last report to Trust Board.

Attachments
Clinical Quality and Patient Safety Report

****

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

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

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

Clinical Quality & Patient Safety Report – November 2013

Clinical Directors' Joint Report

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

Quality Domain 1: Preventing people from dying prematurely

Clinical Audit and Research

Research and Development Operational Capability Statement for 2013/14

The Trust's Research and Development Operational Capability Statement for 2013/14 has been completed. As part of the National Institute for Health Research (NIHR) Research Support Services Programme, each NHS organisation is required to publish a Research and Development Operational Capability Statement (RDOCS).

This Statement provides a Board level approved operational framework which sets out how the organisation plans to meet its research related responsibilities/requirements as stated in the Research Governance Framework, Clinical Trials Regulations, Operating Framework for the NHS in England, Handbook to the NHS Constitution and other relevant guidance and regulations.

The statement also provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest. The statement is a tool to improve effectiveness and collaborations in research activities

The statement requires formal approval from the Trust Board prior to submission (attached at appendix 1).

Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports – September 2013

The Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports (Cardiac Care Pack) for September 2013 have been published. The full report is available on request.

Key Findings:

- Defibrillator data download rate decreased to less than 1%.
- 30% of cardiac arrest patients (in cases where resuscitation was started) gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital.
- An advanced airway management device was placed successfully in 87% of cardiac arrest patients where resuscitation was attempted. Of these patients, 96% had end-tidal CO_2 measured and documented on the PRF.
- 99% of STEMI patients were transported to the most appropriate destination.
- Average on-scene time for STEMI remains prolonged (41 minutes)▲

- Overall call to arrival at hospital time for STEMI has remained at 66 minutes compared to the previous month.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) decreased from 80% to 74%. The primary reason for a full care bundle not being provided remains the analgesia component.

Stroke Care Pack – September 2013

The September 2013 Stroke Care Pack has been published. The full report is available on request.

Key Findings:

- 95% (n=852) of all suspected stroke patients received a complete pre-hospital care bundle (complete FAST assessment, blood pressure and blood glucose measurement)
- 99% (n=816) of FAST positive patients were transported to the most appropriate destination.
- Average time spent on-scene remains in excess of the 30 minute Trust target▲ in 46% of cases where a patient is potentially eligible for thrombolysis.
- The percentage of patients who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes remains 68%.

▲ Hospital turn-around times for priority calls are now recorded separately within the Individual Performance Management database. It is anticipated that this change will decrease on-scene times for time critical patients as clinicians will be able to utilise time at hospital to complete a PRF (versus on-scene) without an adverse affect on their IPM data.

Clinical audit examining the response sent to patients who have taken an intentional overdose (October 2013)

The clinical audit reviewed 50 cases of intentional overdose during August 2013. The report highlights that lower priority (C2/C3) calls receive a delayed response in 44-45% of cases. This presents a significant clinical risk and one which has resulted in a number of Serious Incidents being declared by the Trust. A further research project and clinical audit are proposed, and an implementation plan to prioritise overdose patients during times of increased demand is being produced.

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

Mental Health

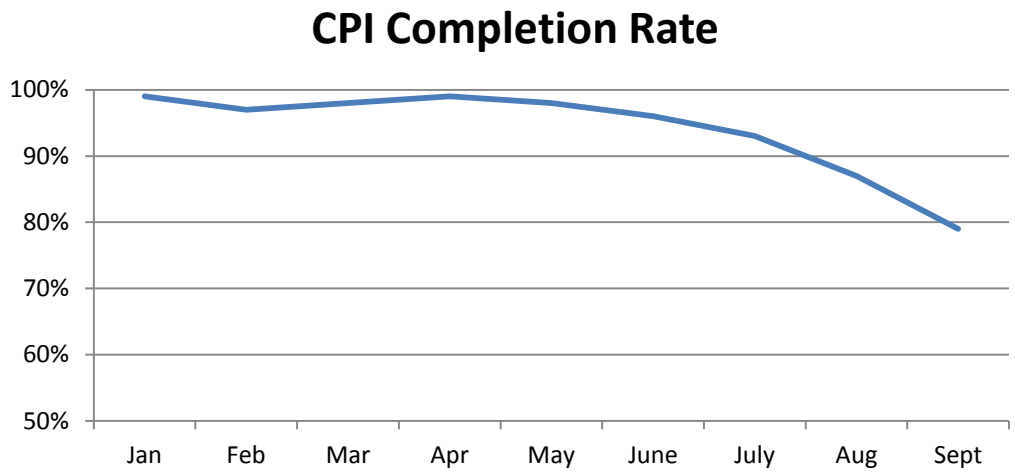
The Trust has now joined the Pan London Dementia Action Alliance. A Dementia Action Alliance (DAA) is a membership of organisations committed to improving their approaches to people living with dementia. It is the coming together of organisations who have signed the National Dementia Declaration; a set of seven outcomes informed by people with dementia and their family carers. The Declaration provides an ambitious and achievable vision of how people with dementia and their families can be supported by society to live well with the condition.

Alliance members work towards delivering this vision through committing to actions within their organisation and undertaking joint programmes of work. The Pan-London Dementia Action Alliance asks organisations to sign up to the National Dementia Declaration and develop an action plan to improve the lives of people with dementia.

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

Clinical Performance Indicator completion and compliance

CPI completion rate in September fell to the lowest rate in the past **four years**. 12 Complexes achieved a 100% completion rate. Hillingdon Complex achieved a CPI completion rate of only 7%.



The Trust has exceeded the expected number of CPI feedback sessions provided to staff. 2918 (out of an expected 2772[†]) CPI feedback sessions have been completed year-to-date.

The East and South Areas met their expected feedback session targets for September; the West Area have so far delivered 90% of their target feedback session. Fourteen out of twenty three Complexes and HART exceeded their expected feedback session target this month.

[†] Expected target is based on each member of staff receiving two face-to-face feedback sessions a year. The value is calculated using ESR and CPI database data. By the end of Q2 (September 2013), all Complex staff should have received at least one feedback session in order to allow Complexes to meet their targets.

Full CPI reports are available on request.

CPI Completion January 2013 to date

Area	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
East	95%	93%	97%	100%	99%	97%	95%	91%	71%
South	100%	100%	97%	100%	99%	95%	93%	89%	88%
West	100%	99%	100%	99%	96%	97%	90%	83%	76%
LAS	**99%**	**97%**	**98%**	**99%**	**98%**	**96%**	**93%**	**87%**	**79%**

Compliance against the mental health CPI remains low, mainly due to consideration of a safeguarding referral not being documented on the PRF (57%). However, there has been a very gradual and sustained increase in compliance against the mental health CPI over the past six months.

Following the introduction of hand-portable SpO_2 monitors in June 2013, compliance against the Difficulty Breathing CPI (pre-treatment oxygen saturation recording) has increased.

CPI Compliance September 2013

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	99%	98%	97%	97%	91	97%	98%
South	98%	98%	97%	98%	90	97%	98%
West	98%	98%	97%	98%	91	98%	98%
LAS Total	**98%**	**98%**	**97%**	**97%**	**90**	**97%**	**98%**

CPI Compliance August 2013

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	96%	96%	97%	88%	97%	98%
South	98%	96%	97%	98%	92%	97%	98%
West	98%	96%	97%	98%	90%	97%	98%
LAS Total	**98%**	**96%**	**97%**	**98%**	**90%**	**97%**	**98%**

CPI Compliance July 2013

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	99%	97%	97%	90%	97%	97%
South	98%	98%	97%	97%	90%	97%	98%
West	98%	98%	96%	98%	88%	96%	98%
LAS Total	**98%**	**98%**	**96%**	**97%**	**89%**	**96%**	**97%**

The results of the National Asthma Clinical Performance Indicator Audit (Cycle 11, July 2013) have been published by the National Ambulance Clinical Quality Group.

The LAS has significantly improved in the provision of the complete asthma care bundle (assessment of respiratory rate, PEFR and SpO_2 pre-treatment and beta-2 agonist administration) from 53% (Cycle 10) to 71.3%.

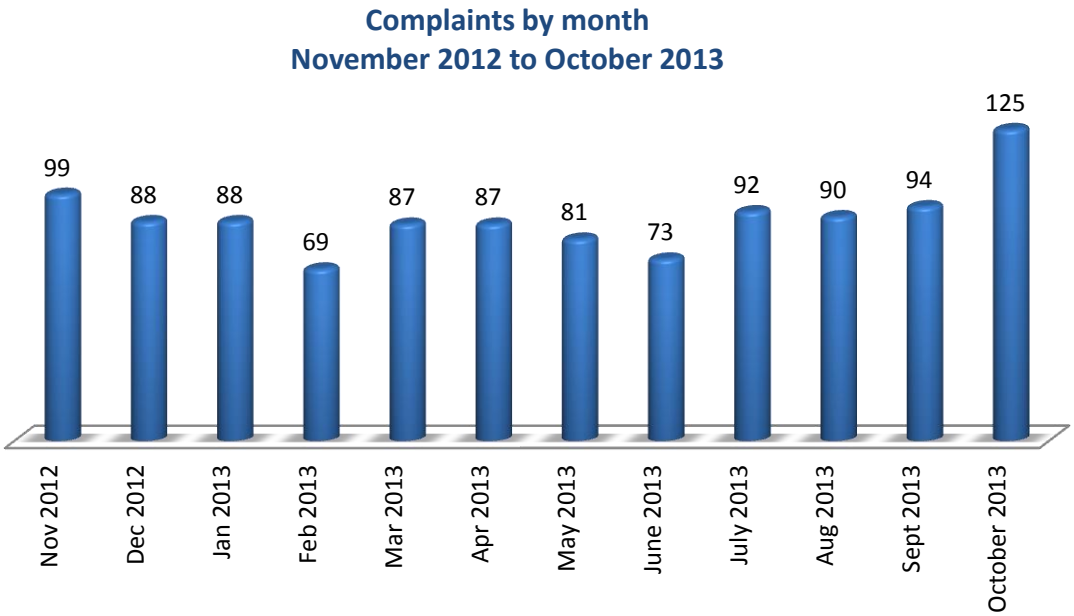
Quality Domain 4: Ensuring people have a positive experience of care

Patient Experiences

Complaint Volumes

The number of Complaints this month totalled 125, the highest number ever recorded. 42% of these were about delays.

19 complaints involved other Trusts/agencies including 9 x Acute Trusts, 2 x 111 provider, 3 x CCG, 1 x Care Home, 2 x other ambulance Trusts and 1 x dental practice. 3 complaints (C8392, C8378 and C8333) were considered SIs, one has been declared and the other two are awaiting a decision pending further information.



Complaint Themes

Complaints relating to delay and staff conduct continue to be the dominant themes.

Complaints by subject	June	July	August	September	October
Delay	29	38	30	50	53
Conduct	18	22	27	16	30
Road handling	8	15	12	9	10
Non-conveyance	6	5	5	7	8
Not our service	7	4	4	1	1
Treatment	3	4	4	5	13
Patient Injury or Damage to Property	0	3	0	1	4
High Risk Address Referral	0	1	3	1	2
Conveyance	2	0	4	2	3
Clinical Incident	0	0	1	0	1
Aggravating Factors	0	0	0	2	0
Totals:	**73**	**92**	**90**	**94**	**125**

Emerging themes

These are almost entirely the same as previously reported; with delay and poor staff attitude the major causes of complaint. The following themes were recently reported to LfEG:

1. Increased use of the recorded exit message which is frequently misunderstood by 999 callers resulting in more ETA calls.
2. Referrals unnecessarily made to CTA where the EMD already knows that a resource will be sent because the patient is situated in an outside location.
3. Triage of overdose patients at C2 and ensuing delays.
4. No EOC capacity to update a caller who is expecting CTA to call back when a decision is made that an ambulance should be arranged without the befit of further telephone assessment.
5. Examples of resources being dispatched only for it to be discovered that the patient has already left for hospital; several instances of forced entry in these circumstances.
6. Continuing cases of long delays to elderly fallers triaged at C2.
7. Ops and hospital staff allegedly questioning the delay in dispatch with patients without any corresponding incident report being filed.
8. Little evidence of a care plan approach being considered in relation to patients subject to Locality Information entries.

Performance/Quality

101 cases were closed during September and 84 cases in October. As at 11 November, 212 complaints remain open or re-opened. This represents a marked increase over September, 101/164. PED are increasingly receiving *complaints about complaints* caused by the delay in obtaining QA reports and release delays post referral to the Executive Office.

In the past 3 months PED has seen staffing numbers reduced owing to staff leaving post, retirement, maternity leave, sickness absence and study placement. Closure rates for 2013 are set out in the table below.

The following table extracts data from the above and demonstrates the number and percentage of complaints closed each month within the 35 day target:

Month	Closed within 35 days by month	Percentage of complaints closed over monthly number
2013 01	33	37
2013 02	29	42
2013 03	45	51
2013 04	42	48
2013 05	31	38
2013 06	37	50
2013 07	42	45
2013 08	31	34
2013 09	22	23
2013 10	17	13
Totals:	**302**	**381**

It should be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = 28 October 2013.

Total complaints

Month	0-25 days	0-35 days	0-40 days	0-45 days	0-60 days	0-80 days	0-100 days	Total	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	3	3	88	88
2013 04	32	10	9	14	16	5	0	86	86
2013 05	21	10	7	9	16	13	4	80	81
2013 06	30	7	4	4	14	10	4	73	73
2013 07	35	7	8	11	22	6	0	89	92
2013 08	27	4	9	20	15	0	0	75	90
2013 09	20	2	3	7	0	0	0	32	94
2013 10	17	0	0	0	0	0	0	17	125
Totals:	**262**	**67**	**56**	**100**	**136**	**57**	**19**	**697**	**886**

Benchmarking

The following analysis benchmarks complaint voulmes April - August 2013 across 9 of the UK ambulance services who responded to the request for data.

Please note ‘Mitigation’ which suggests that no 2 Trusts are actually measuring the same crtieria, rendering benchmarking effectively meaningless.

Please further note significant spikes in complaints to SECAMB following their assuming responsibility for 111 provison. No additional resourcing has been made available to manage this.

Month - Complaints 2013

Service	April	May	June	July	August	Totals
North West Ambulance	192	146	130	163	135	766
Yorkshire Ambulance	150	148	115	186	127	726
London Ambulance Service	87	81	73	92	90	423
East of England	85	62	80	61	56	344
South East Coast	79	77	43	60	44	303
West Midlands Ambulance	45	48	33	45	37	208
South Central Ambulance	29	38	26	26	24	143
North East Ambulance	24	25	19	17	20	105
East Midlands Ambulance	6	15	18	23	16	78
Totals	**697**	**640**	**537**	**673**	**549**	**3096**

PALS and Complaints

Service	April	May	June	July	August	Totals
South East Coast	526	445	290	367	346	1974
London Ambulance Service	330	296	309	355	307	1597
East of England	179	167	175	170	142	833
North West Ambulance	192	146	130	163	135	766
Yorkshire Ambulance	150	148	115	186	127	726
West Midlands Ambulance	124	134	121	144	135	658
East Midlands Ambulance	79	109	100	171	149	608
South Central Ambulance	92	97	87	115	77	468
North East Ambulance	62	59	57	65	60	303
Totals	**1734**	**1601**	**1384**	**1736**	**1478**	**7933**

Mitigation	
SECAMB	Significant spikes in April and May result from introduction of NHS111
LAS	Figures do not include specialist PALS
EEAST	No comments
NWAS	No longer records PALS but use a category of general enquiries in the case management system
YAS	Records PALS/complaints together but does not include signposting/lost property or information requests
WMAS	No comments
EMAS	No comments
SCAS	No comments
NEAS	Complaints are counted where there is a written response, others are classed as ‘concerns’

‘Comeback’ Activity

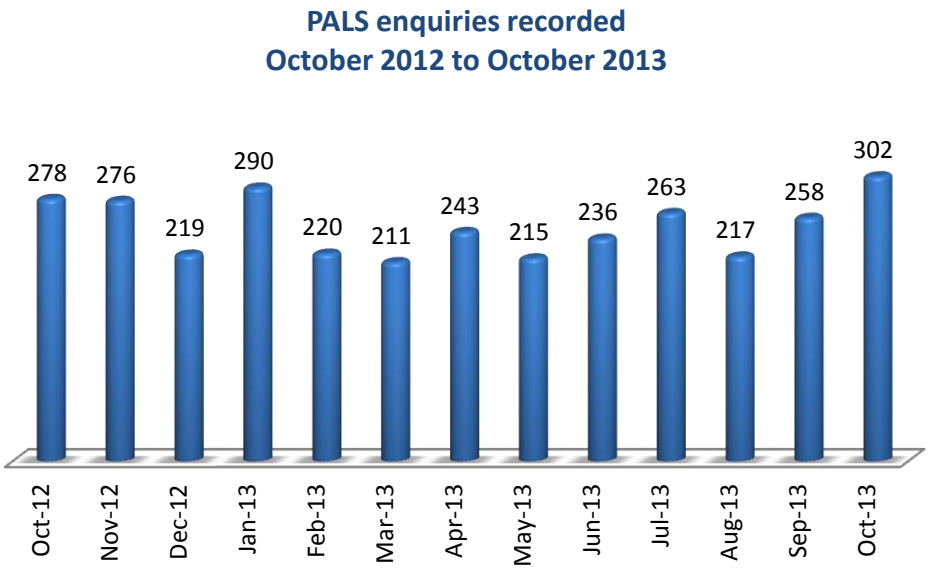
Year	Numbers of comeback responses recorded
09/10	9
10/11	4
11/12	12
12/13	37
13/14	29
Totals:	**91**

Health Service Ombudsman

There were 14 cases re-opened in September and October where the complainant was not satisfied with the initial response. PED will prepare a 6 month summary of cases that have been referred to the Ombudsman.

PALS

There was a marked increase in PALS specific enquiries during October.



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

Financial Year	Total PALS
2008/09	5606
2009/10	5674
2010/11	6031
2011/12	6264
2012/13	5714
13/14 (to 31 Oct 2013)	3394
Totals:	**32683**

PALS Themes

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

PALS by subject	Totals
Information/Enquiries	224
Lost Property	61
Appreciation	4
Patient Injury or Damage to Property	3
Delay	2
Other	8
Total	**302**

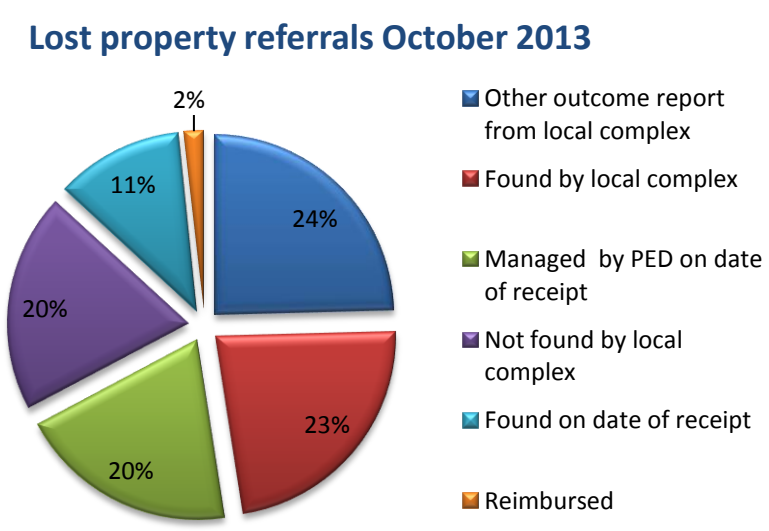
Lost property

61 lost property cases were received. 42 were managed via the shared facility.

Of the 42 local referrals, 14 items were found – representing circa 30%. Of the remaining enquiries, some items were handed to hospital staff, the police or were not taken to hospital by the crew. 12 items were not traced at all and one item resulted in a reimbursement of £25 to replace a patient's walking stick.

The spreadsheet is in the main well completed by station administrators. The system would be improved if Datixweb was shared with them and this is reflected in the department's Datixweb Business Plan.

The 6 month review of the current scheme is scheduled.



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

Serious Incidents

23 potential Serious Incidents (SIs) were considered by the Serious Incident Group (SIG) between 16th September and 15th November 2013 (DATIX). Of these, 6 incidents were declared to NHS England (London) as Sis, 13 were not declared and 4 cases are pending review.

NHS Central Alerting System (CAS)

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

There were 19 Alerts issued in September and October. All have been reviewed by Safety and Risk and two had relevance to the Trust:

1. MDA/2013/077 was a MHRA Medical Device Alert about the possibility of using incompatible Hospira/Abbott suction canister liners with the Laerdal Suction Unit (a device that is on every ambulance and fast response unit in the Trust). A programme to modify all suction units is underway, following a separate CAS Alert issued July 2013 (MDA/2013/048).

2. MDA/2013/074 was a MHRA Medical Devices Alerts about Vacutainer® blood collection tubes. An increased risk of blood exposure and a risk of under filling (which could lead to unexpected results in certain laboratory tests) has been identified. Only specific lot numbers are affected. Four complexes have been identified that use this type of blood collection device, to obtain pre-hospital blood samples for certain Acute Hospital Trusts in the West Area. Pre-Hospital blood sampling has now been stopped, following instruction from the Clinical & Quality Directorate. There have been no reported incidents within the Trust involving Vacutainer® tubes.

NHS Signals

Key risks emerging from review of serious incidents reported by the NHS to its National Reporting and Learning System (NRLS) are shared in the form of Signals. There have been no alerts in 2013.

NICE Guidance

No NICE guidance, which has relevance to the Trust, has been issued since the last Trust Board report.

Infection, Prevention and Control

A new action plan was approved by the Infection Prevention and Control Committee in November 2013.

The Advanced Practitioner for Infection Prevention and Control has identified that waste disposal procedures are not routinely adhered to with the majority of waste defined as clinical waste being of a non clinical nature. This has cost implications for the organisation and has been brought to the attention of management teams and the Director of Finance.

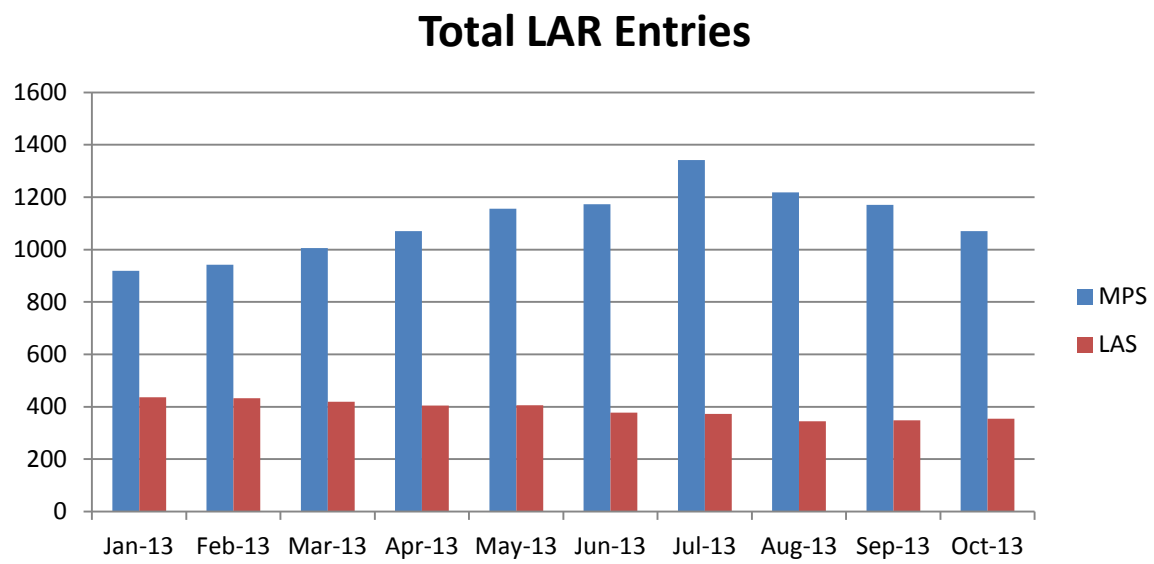
Current work themes:

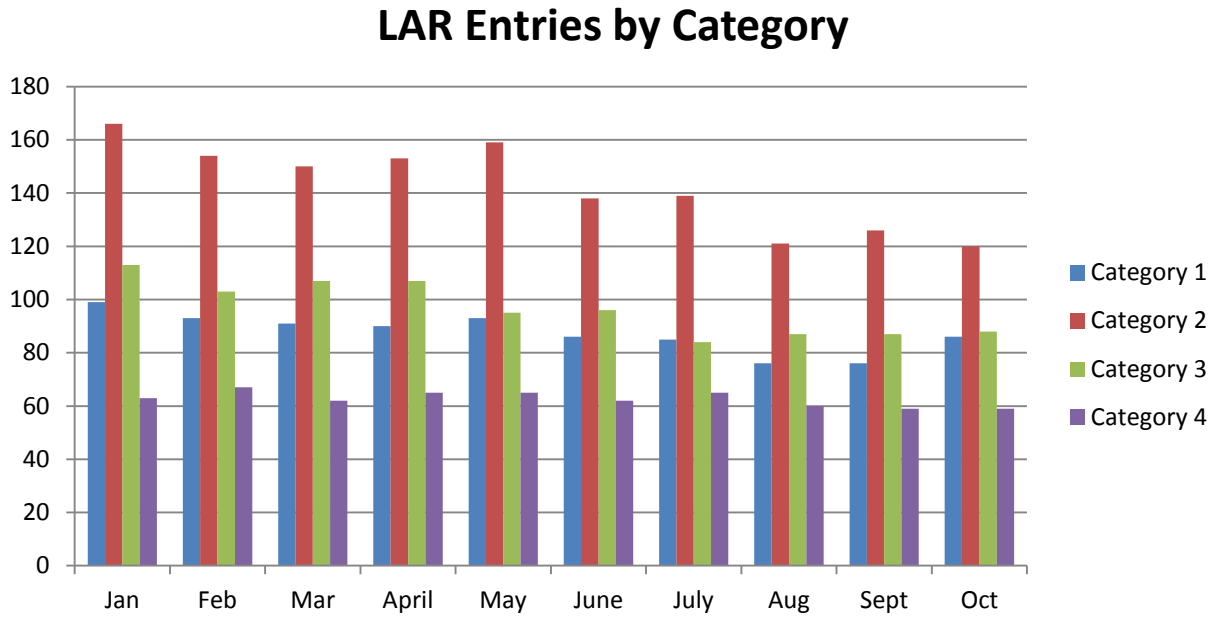
- Legionella Policy has been drafted and is currently being consulted widely. Safety and Risk will add a link to the COSSH Policy when the Legionella Policy has been ratified.
- Waste Management Policy is being enhanced by Estates Team managing the waste contracts. Gaps in management of confidential waste, WEEE waste, Out-of-date pharmacy waste, old uniforms, obsolete medical equipment will need to be addressed. Currently there is a storage problem due to unclear process of disposing of medical and patient equipment and this was confirmed by the Head of Logistics. Regular audits of different types of waste needs to be clearly identified.
- Uniform policy – awareness was raised regarding the need to clarify bare-below-the elbows requirements and a link to the waste policy for uniform disposal. Currently there is significant storage of obsolete uniforms in sites and at Deptford Logistics Support Unit, confirmed by the Head of Logistics.
- Medical Devices Policy – A decontamination Lead was identified and a policy needs to be developed to address the various aspects of medical device management from procurements, to having a register for equipment, training, planned programme of maintenance, repair, decontamination and final disposal of assets. Currently there is a lack of policy and clear procedures and governance.
- Infection control refresher training continues and 1601 clinical staff (53% of establishment) have completed CSR 2013 to-date. No IPC update figures are available for non-clinical staff. Content of training sessions have been reviewed by Infection Control.
- A Medical Bulletin on MERS-CoV was released in October. A small number of cases of people returning from Saudi Arabia with acute respiratory illnesses which caused concern have since been confirmed as influenza cases. A decision was made to use FFP2 instead of FFP3 respiratory masks, as detailed in the Medical Bulletin. Stock levels of FFP2 masks are to be increased for each vehicle. There is currently no planned programme in place for FFP3 training and this will be addressed in the 2014/15 Training Plan.

Locality Alert Register

There are currently **354** addresses on the Locality Alert Register (LAR). These are broken down as follows:

CATEGORY 1: 86
CATEGORY 2: 120
CATEGORY 3: 88
CATEGORY 4: 59





The Trust has notification of 1071 high risk addresses from the Metropolitan Police.

To ensure the Trust complies with the requirements of the Data Protection Act 1998, periodic review of records by each complex AOM must be undertaken, to confirm that the information is still relevant. The review will be undertaken every 12 months for categories 1, 2 and 4 addresses. Category 3 addresses will automatically be removed from the Register after 12 months, unless there have been further instances of verbal abuse.

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.

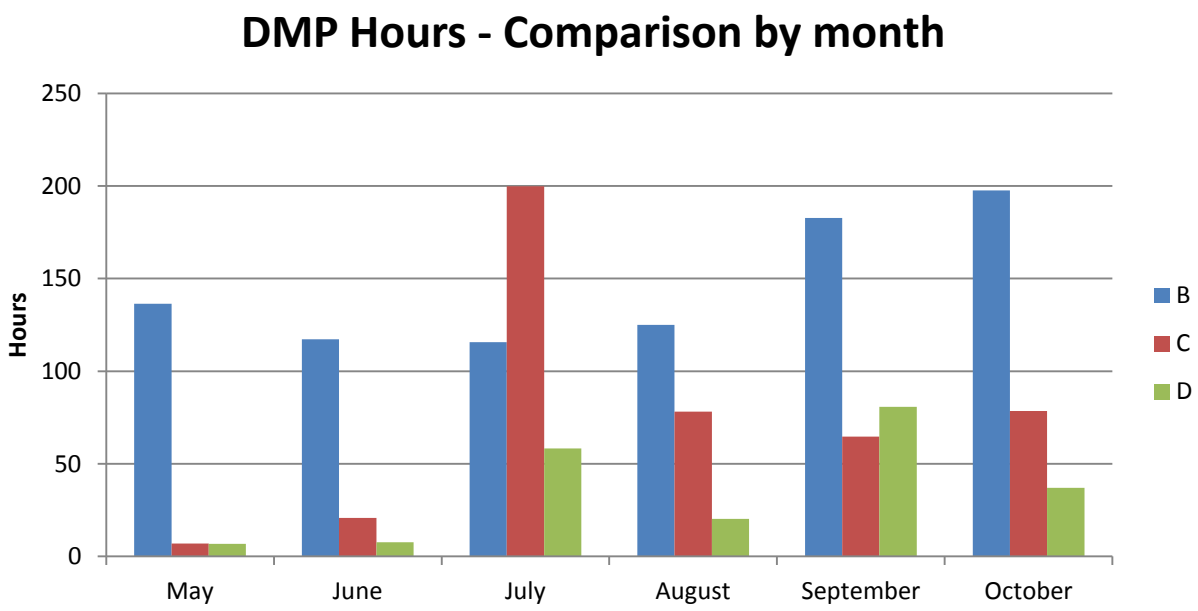
DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement 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.

There was a significant increase in the use of DMP stage D in September. There continues to be an exponential increase of DMP at stage B.

On the night of the 27th October, Hurricane St. Jude hit the UK. DMP C was in place for a continuous period of 16.75 hours from 22:30hrs.

DMP use May - October 2013

Month	Number of occasions DMP invoked	Stage B (hours)	Stage C (hours)	Stage D (hours)	Stage >D (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
July	17	115.75	199.75	58.25	0	4403	896
August	24	125	78.25	20.25	0	3771	745
September	27	182.75	64.75	80.75	0	4003	1069
October	20	197.5	78.5	37	0	3240	903



Medicines Management

There have been no mandatory reportable controlled drugs (CD) incidents since the last report to Trust Board.

There have been no Unannounced Visits by the Metropolitan Police.

The Quarter 2 mandatory report to the NHS England (London Region) Controlled Drugs Local Intelligence Network has been submitted. This was a 'nil' report. (Appendix 1)

Prevention of Future Deaths Reports; Regulation 28 of The Coroners (Investigations) Regulations 2013

The Trust has received three Prevention of Future Deaths Reports (previously Rule 43 Report) since the last Trust Board report. One Report was issued by HM Coroner for Inner North London and two other Reports were issued by HM Coroner for the Northern District of Greater London.

The first Prevention of Future Deaths Report related to the death of a patient exhibiting signs of excited delirium and acute cocaine toxicity. Police officers were on scene physically restraining the patient and requested LAS assistance. The call was categorised as C1 via SEND (Secondary Emergency Notification of Dispatch) protocol. There was a delay in dispatching an ambulance and 20 minutes after the first request for LAS assistance was sent, police officers decided to transport the patient to the Royal London Hospital. At the Royal London Hospital Emergency Department the patient continued to be violently agitated, requiring prone restraint. The patient had a cardiac arrest immediately after sedation and died.

The Report was issued to the Trust and Metropolitan Police Service (MPS). HM Coroner highlighted a number of concerns and recommendations:

1. That the term 'excited delirium' is not widely used or understood.
2. There are situations where a person exhibits extreme agitation that is not related to acute drug psychosis (for example meningitis and sepsis).

3. That the universal term ‘extreme agitation’ should be adopted and recognised as a medical emergency.
4. That the LAS amend its protocols and training to recognise extreme agitation as a medical emergency and prioritise appropriately.

Prior to the inquest, a Control Services bulletin was issued with the instruction that any MPS call where the terms ‘Acute Behavioural Disturbance (ABD)’, ‘excited delirium’ or ‘cocaine toxicity’ are used, be immediately upgraded to a RESP1. In addition, any MPS call where a patient is being physically restrained by police officers requires immediate upgrade. A formal response has been sent to HM Coroner.

The second Prevention of Future Deaths Report related to a clinical procedure undertaken to treat a tension pneumotharox (needle thoracocentesis). Evidence was provided to the inquest by an expert that the procedure should be modified by paramedics. A response was sent to the Coroner within the statutory 56 day timeframe, which provided evidence contrary to the expert’s opinion and advised that the Trust would not be adapting the clinical practice guideline for this procedure.

The third Prevention of Future Deaths Report related to the death of a patient who had taken an overdose of prescribed medication. The report highlighted concern that the Emeregncy Medical Dispatcher who received the 999 call did not ascertain that the patient was alone and did not remain on the telephone or seek advice from a supervisor, as detailed in OP/060. A formal response is being drafted by the Trust and will be sent to HM Coroner within 56 days.

Rising Tide

2013 Flu Vaccination Programme

1114 staff have been vaccinated to-date (11/11/13). 19.7% of operational staff have received the vaccine. Two adverse reactions have been noted and will be reported to Medicines and Healthcare Products Regulatory Agency (MHRA) via the ‘Yellow Card’ system.

Clinical Team Leader / Paramedic Manager Clinical Module

The first two clinical modules for existing Team Leaders and Paramedic Managers have been completed. The two week course provides a review and update of key skills and knowledge, including resuscitation, arrhythmia management, end of life care, emergency preparedness and resilience and mental health risk assessment. At the end of the course, candidates are required to undertake both written and practical assessments to pass. Initial feedback from the courses has been extremely positive.

2013 JRCALC UK Ambulance Service Clinical Practice Guidelines

Update training on the 2013 JRCALC Clinical Practice Guidelines, part of CSR 2013, continues and the Trust is on trajectory for 60% of clinical staff to have completed the update by 1 December 2013. In view of this, the Trust will formally implement the 2013 Guidelines on this date.

Fionna Moore
Medical Director

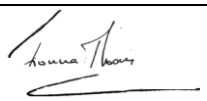
Steve Lennox
Director of Nursing & Health Promotion

Appendix 1

London Ambulance Service NHS Trust

Occurrence Report – Controlled Drugs Concerns

This form should be used by CD accountable officers to give a quarterly report to the NHS Westminster Controlled Drugs Accountable Officer of any concern that their designated body has regarding management and use of controlled drugs (clause 29).

Name of designated body	London Ambulance Service NHS Trust	
Name of accountable officer	Dr. Fionna Moore – Medical Director	
Report for three-month period	July 2013 to September 2013	
Name of local intelligence network (LIN)	**NHS North West London**	
Name of LIN lead accountable officer	William Rial	
I confirm that my designated body has **the following concerns** regarding the management or use of controlled drugs during this period		
Accountable officer signature		
Date signed	7th October 2012	
Description of concern[1]	**Date aware**[2]	**Actions taken**[3]
Nil Concern		

[1] Short description of the cause for concern, including date(s). Details may be attached in a separate document. Note regulations 25 and 26 regarding the need not to disclose information which relates to and can identify a patient.
[2] Date the accountable officer of the designated body became aware of the concern.
[3] Action already undertaken (if any) within or outside the designated body e.g. as part of internal incident investigation process, including the reference number within the internal incident investigation process (where relevant), and whether the incident is closed or still open.

Notes

The Controlled Drugs (Supervision of Management and Use) Regulations 2006 came into force in England on 1 January 2007:

http://www.opsi.gov.uk/si/si2006/20063148.htm#29

Regulation 29 concerns occurrence reports, and is shown in full below. In brief, regulation 29 requires accountable officers to give an occurrence report to the accountable officer for the PCT that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report).

> Occurrence reports
> 29. —(1) An accountable officer (other than an accountable officer nominated or appointed as accountable officer for a Primary Care Trust or Health Board) must give, on a quarterly basis, an occurrence report to the accountable officer nominated or appointed as accountable officer for the Primary Care Trust or Health Board that is leading any local intelligence network of which he or his designated body is a member.
>
> (2) The occurrence report may contain the following information—
> (a) details of any concerns that his designated body has regarding its management or use of controlled drugs; or
>
> (b) confirmation by his designated body that it has no concerns to report regarding its management or use of controlled drugs.
> (3) Nothing in this regulation requires or permits any disclosure of information which is prohibited by or under any other enactment.
>
> (4) In determining for the purposes of paragraph (3) whether disclosure is not prohibited by reason of being a disclosure of personal data which is exempt from the non-disclosure provisions of the Data Protection Act 1998 by virtue of section 35(1) of that Act (disclosure required by law or made in connection with legal proceedings etc.), it is to be assumed that the disclosure is required by this regulation.

Some designated bodies (such as ambulance trusts that cover a large area) may relate to more than one local intelligence network. They need to discuss engagement with the LIN leads and the reporting of concerns; perhaps sending a copy of their occurrence reports to all.

This document will be held securely by the LIN lead in accordance with the LIN agreed locally policies for handling information.

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NIHR Guideline B01
R&D Operational Capability Statement

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
RDOCS 001				Trust Board	Clinical Audit & Research Unit
RDOCS 002					

Contents

Organisation R&D Management Arrangements

Information on key contacts

Organisation Details	
Name of Organisation	London Ambulance Service NHS Trust
R&D Lead / Director (with responsibility for reporting on R&D to the Organisation Board)	Dr Fionna Moore, Medical Director
R&D Office details:	
Name:	Clinical Audit & Research Unit
Address:	HQ Annexe, Ground Floor, 8-20 Pocock Street, London, SE1 0BW
Contact Number:	(020) 7783 2501
Contact Email:	CARU.Administrator@lond-amb.nhs.uk
Other relevant information:	
Key Contact Details e.g. Research Governance Lead, NHS Permissions Signatory contact details	
Contact 1:	
Role:	Head of Clinical Audit & Research
Name:	Dr Rachael Fothergill
Contact Number:	020 7783 2501
Contact Email:	rachael.fothergill@lond-amb.nhs.uk
Contact 2:	
Role:	Research Manager
Name:	Dr Melanie Edwards
Contact Number:	020 7783 2588
Contact Email:	melanie.edwards@lond-amb.nhs.uk
Contact 3:	
Role:	Research & Development Co-ordinator
Name:	Sara Evans
Contact Number:	020 7783 2518
Contact Email:	sara.evans@lond-amb.nhs.uk

Contact 4:	
Role:	Research Facilitator
Name:	Julia Brown
Contact Number:	020 7783 2508
Contact Email:	julia.brown@lond-amb.nhs.uk
Contact 5:	
Role:	Assistant Head of Clinical Audit & Research
Name:	Gurkamal Virdi
Contact Number:	020 7783 2506
Contact Email:	gurkamal.virdi@lond-amb.nhs.uk
Contact 6:	
Role:	
Name:	
Contact Number:	
Contact Email:	

Add further contacts by selecting and then **copying** the five Excel **rows** (ie whole rows) above for Contact, role, name, number and email.
Then select the **blank row** under the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

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Information on staffing of the R&D Office

R&D Team		
R&D Office Roles (e.g. Governance, Contracts, etc)	Whole Time Equivalent	Comments indicate if shared/joint/week days in office etc
Head of Clinical Audit & Research	1	
Research Manager	1	
R&D Co-ordinator	1	
Research Facilitator	1	
Assistant Head of Clinical Audit & Research	1	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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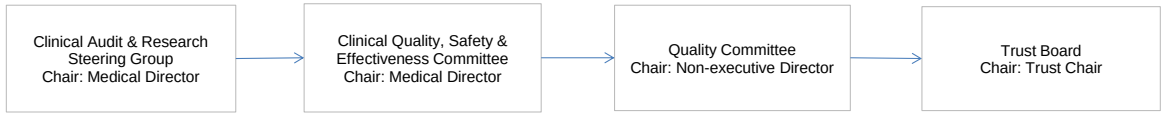
Information on reporting structure in organisation (include information on any relevant committees, for example, a Clinical Research Board / Research Committee / Steering Committee.)

Reporting Structures

The London Ambulance Service NHS Trust Clinical Audit & Research Unit reports to the Clinical Audit & Research Steering Group (CARSG). CARSG oversees all research activities taking place within the Trust. This group is chaired by the Medical Director of the Trust and includes both internal and external representatives. CARSG reports to the Clinical Quality & Safety Effectiveness Committee.

Governance Structure



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Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on Research Networks supporting/working with the Organisation.
Information on how the Organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research Networks	
Research Network (name/location)	Role/relationship of the Research Network eg host Organisation
London (NW) Comprehensive Local Research Network (CLRN)	Member Organisation
Thames Stroke Research Network	Member Organisation

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, Other NHS Organisations, Higher Education Institutes, Industry)

Current Collaborations / Partnerships				
Organisation Name	Details of Collaboration / Partnership (eg	Contact Name	Email address	Contact Number
Royal London Hospital	Collaboration for planned future research	Dr Patrick Gompertz		
University of Hertfordshire	Collaboration for planned future research	Dr Julia Williams		
Swansea University	Collaboration for planned future research	Prof Ian Russell		
Royal Brompton & Harefield	Collaboration for the DANCE study	Dr Miles Dalby		
Barts & The London	Collaboration for the PARA-SVT study	Prof. Richard Schilling		
Swansea University	Collaboration for the SAFER 2 study	Prof. Helen Snooks		
Kings College London	Collaboration for the PTSD study	Dr Jennifer Wild		
International Academies of Emergency Dispatch	Collaboration for the Identification of Stroke Symptoms in Fallers Study	Tracey Barron		
University of Warwick	Collaboration for the the OHCAO study and future planned research	Prof Gavin Perkins		
St George's, University of London	Collaboration on rAAA study	Dr Alan Karthikesalingam		
University of Edinburgh	Collaboration on ethnicity & cardiac arrest study	Dr Anoop Shah		

Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

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Organisation Study Capabilities

Information on the types of studies that can be supported by the Organisation to the relevant regulatory standards

Types of Studies Organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate Phases)	Clinical Trial of a Medical Device	Other Clinical Studies	Human Tissue: Tissue Samples Studies	Study Administering Questionnaires	Qualitative Study	OTHER
As Sponsoring Organisation	No	No	Yes	No	Yes	Yes	
As Participating Organisation	Yes	Yes	Yes	No	Yes	Yes	
As Participant Identification Centre	Yes	Yes	Yes	No	Yes	Yes	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

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Which licences does the organisation hold which may be relevant to research?

Organisation Licences			
Licence Name Example: Human Tissue Authority Licence	Licence Details	Licence Start Date (if applicable)	Licence End Date (if applicable)
Not Applicable			

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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PCT ONLY: Information on the practices which are able to conduct research

Number/notes on General Practitioner (GP) Practices
Not Applicable

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation Services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting R&D governance decisions across the organisation.

Clinical Service Departments					
Service Department	Specialist facilities that may be provided (eg number/type of scanners)	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Medical Directorate		Medical Director			
A&E Operations		Director of Operations Sector Service			
Control Services		Assistant Director of Operations Control Services			

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).

Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on key management contacts for supporting R&D governance decisions across the organisation.

Management Support e.g. Finance, Legal Services, Archiving					
Department	Specialist services that may be provided	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Legal	In house legal services	Head of Legal Services			
Management Information		Management Information Manager			

Finance	Financial Support for research based activities	Director of Finance & Business Planning			
Department Financial Analyst	Financial Support for research based activities	Financial Analyst			
Information Technology (IM&T)		Director of Information Management			
Human Resources	Support to Research Office for HR issues	Director of Human Resources			
Operations Directorate		Deputy Director of Operations			

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Interests

Information on the areas of research interest to the Organisation

Organisation R&D Areas of Interest				
Area of Interest	Details	Contact Name	Contact Email	Contact Number
Prehospital	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	
Stroke	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	
Cardiac	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	
Mental Health	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	
Trauma	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	
Fallers	Improvement of patient care	Research Manager/ R&D Co-ordinator	caru.enquiries@lond-amb.nhs.uk	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

Specialty Group Membership (Local and National)					
National / Local	Specialty Group	Specialty Area (if only specific areas within	Contact Name	Contact Email	Contact Number
National Ambulance Research Steering Group	National Research	Pre-hospital			
Thames Stroke Research Network	Stroke Research	Stroke			

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Planning and Investments

Planned Investment			
Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)	Description of Planned Investment	Value of Investment	Indicative dates
Research Conference	Annual internal conference organised to promote research within the LAS		annual
Training For Current Staff	All research staff are supported for appropriate training courses		ongoing
Training for Paramedics	All paramedics participating in research studies		ongoing

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Standard Operating Procedures Register

Standard Operating Procedures				
SOP Ref Number	SOP Title	SOP Details	Valid from	Valid to
RG1	Research Guidance Handbook	This document details the the Trust's Procedure for R&D approval, project monitoring and Final Reports.		

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on the processes used for managing Research Passports

Indicate what processes are used for managing Research Passports
The LAS is fully compliant with the NHS HR Good Practice Resource Pack. Applicants are asked to liaise with the substantive employer to complete Version 3 of the Research Passport Form. The completed form and supporting documentation are presented to the NHS organisation for validation. On validation the NHS organisation will issue an HRC or LoA as appropriate for the research. The validated research passport will then be returned to the researcher.

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process
If escalation were required this would be to the Chair of the Clinical Audit & Research Steering Group (Medical Director).

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Planned and Actual Studies Register

The Organisation should maintain or have access to a current list of planned and actual studies which its staff lead or collaborate in.

Comments
The Clinical Audit & Research Unit keep an up to date study profile for each research project the London Ambulance Service is participating in. This is stored on the Trust's network drive.

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Other Information

For example, where can information be found about the publications and other outcomes of research which key staff led or collaborated in?

Other Information (relevant to the capability of the Organisation)
The first point of contact for all research projects is the Clinical Audit and Research Unit. All enquiries should be directed to caru.enquiries@lond-amb.nhs.uk and will be forwarded to the appropriate contact within the Trust accordingly. Publications are noted in the Clinical Audit and Research Steering Group meeting minutes and can be supplied on request.

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LONDON AMBULANCE SERVICE NHS TRUST
INTEGRATED PERFORMANCE REPORT 2013/14: OCTOBER 2013 (MONTH 07)

Quality		**Delays in Cat C response time is main cause of concern. Increasing number of complaints and serious incidents**
Performance		**Activity levels remain below plan and performance below 75% for Cat A for fourth consecutive month**
Workforce		**Continued high sickness, turnover and vacancies.**
Value for Money		**On plan at month 7, however cost of recovering Cat A 75% target presents a real risk to the year end position**

Summary commentary

Category A performance remains below 75% for the fourth month in a row. Year to date performance remains below the 75% threshold. Activity remains below planned levels, overall 4.1% but with Cat A 8.2% below plan. Most CCGs are seeing lower than expected activity. To date 11 CCGs has seen performance below 72% for 3 consecutive months or more. Quality metrics have seen an increase in complaints and serious incidents in month. Cat C response times remain below expectations. This represnts a risk to patient safety due to extended response times.

Workforce measures continue to show high levels of sickness , with levels in frontline staff standing at 6.36%. Turnover remains at 10.1%. Vacancies have fallen slightly in month to 9.72% across the Trust following the intake of graduate paramedics. Workforce metrics remain a major concern for the Trust and represent a significant risk to performance, safety and finance. Increasing recruitment and addressing sickness are a key priority for EMT.

Financial performance; the income and expenditure position reports a favourable movement in the overall variance from plan, with the overall year to date variance being £30k favourable to plan. The failure to achieve 75% represents a major risk to the financial position of the Trust, given the costs that may need to be incurred if additional resources need to be engaged to deliver this target. Work is underway to scope this. Failure to secure 75% against Cat A by year end could result in penalties from commissioners. Cash remains on plan in month, although this does mask some delays in both receipts and extended payment timescales. Lower than planned capital expenditure is acting to support the cash position.

QUALITY

	Target	Current month	Previous month	Year end forecast
1 Serious Incidents	1	**4**	1	Green
2 Complaints	80	**125**	94	Green
3 Call Answering	95.0%	**99.0%**	99.0%	Green
4 Treatment CPI	95.0%	**79.0%**	87.0%	Green
5 Infection control - hand hygiene	100.0%	**98.0%**	96.0%	Green
6 Category C1 (20 mins)	90.0%	**78.9%**	72.0%	Red

PERFORMANCE

	Target	Current month	Previous month	Year end forecast
1 Category A	75.0%	**69.8%**	70.9%	Amber
2 Cat A total incidents	40,185	**39,901**	36,801	Amber
3 Cat A (red 1) incidents	1,350	**1,197**	1,081	Amber
4 Cat A (red 2) incidents	38,835	**38,704**	35,720	Amber
5 Demand Management Plan (A)		**58%**	54%	tbc
6 No send at point of contact	tbc	**903**	1,069	tbc

WORKFORCE

	Target	Current month	Previous month	Year end forecast
1 Staff retention	8.5%	**10.10%**	10.10%	Red
2 Vacancies (%)	5.0%	**9.72%**	10.80%	Red
3 Vacancies (WTE)	241	**471**	524	Red
4 Sickness all staff	5.5%	**5.82%**	5.77%	Red
5 Frontline sickness		**6.36%**	6.39%	Red

VALUE FOR MONEY

	Target	Current month	Previous month	Year end forecast
1 EBITDA (£000)	10,233	**10,099**	8,560	Amber
2 Net surplus (£000)	- 34	**5**	- 105	Amber
3 Cost Improvement Programme (£	4,425	**4,314**	3,382	Green
4 Capital expenditure (£000)	4,502	**1,490**	1,327	Green
5 Monitor FRR	3	**3**	3	Green
6 Cash balance (£000)	14,944	**16,171**	15,770	Green

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER FOR ASSURANCE

Document Title:	**Board Assurance Framework**
Report Author(s):	**Frances Field, Audit and Compliance Manager**
Lead Director:	**Sandra Adams, Director of Corporate Affairs**
Contact Details:	**Frances.field@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For review**
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 ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To review and provide feedback on the new Board Assurance Framework format.**

Key issues and risks arising from this paper

The Chief Executive is required to provide an Annual Governance Statement in order to demonstrate that the Board has been properly informed through assurances about the totality of their risks and have arrived at their conclusions based on all the evidence presented to them. In order to do this the Trust is required to provide evidence that they have systematically identified their objectives and managed the principal risks to achieving them.

Executive Summary

Following an internal audit conducted by KPMG in August 2013, recommendations were made in relation to potential changes to the Board Assurance Framework (BAF) structure. The benefits of adopting a different structure were to raise the profile of the BAF and to reduce the need for multiple sections in the BAF by aligning risks more clearly to strategic goals and objectives.

As a result of this the attached proposed BAF was compiled and reviewed by the Executive Management Team and includes amendments proposed by the Team.

The document includes:

- A one page diagram indicating where risks are linked to the Trusts strategic goals and improvement priorities. [1]
- A one page heat map depicting the movement of risks from their gross to net position. [2]
- A control sheet for each key risk highlighted outlining the effectiveness of the controls in place and the requirement for further actions. [3]

[1] A number of risks with net ratings that would not normally reach the threshold for inclusion in the BAF have been brought into the document. The reason for this is, there is evidence that these risks have been realised through Serious Incidents and will have the net rating reviewed by their

risk owners, i.e. risk 343 (PS10) relating to safeguarding referrals and risk 7 (PS9) learning from incidents and errors.

[2] The heat map currently depicts patient safety risks only and will be populated with all risks once this document has been further developed.

[3] The control sheets currently include the details from the Corporate Risk Register i.e. controls in place and action plans and risk ratings. They are to be reviewed and updated by the risk owners to populate further details around the controls stating who they are performed by, frequency and how they are monitored in order to assess the effectiveness of the controls. The inclusion of these details will ensure that we are identifying assurances and controls in order for the Trust to determine whether further actions are required to reduce the risk to a tolerable level (target rating).

The Trust Board is asked to note that this is work in progress.

Attachments:
Board Assurance Framework
Corporate Risk Register

****

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

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

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

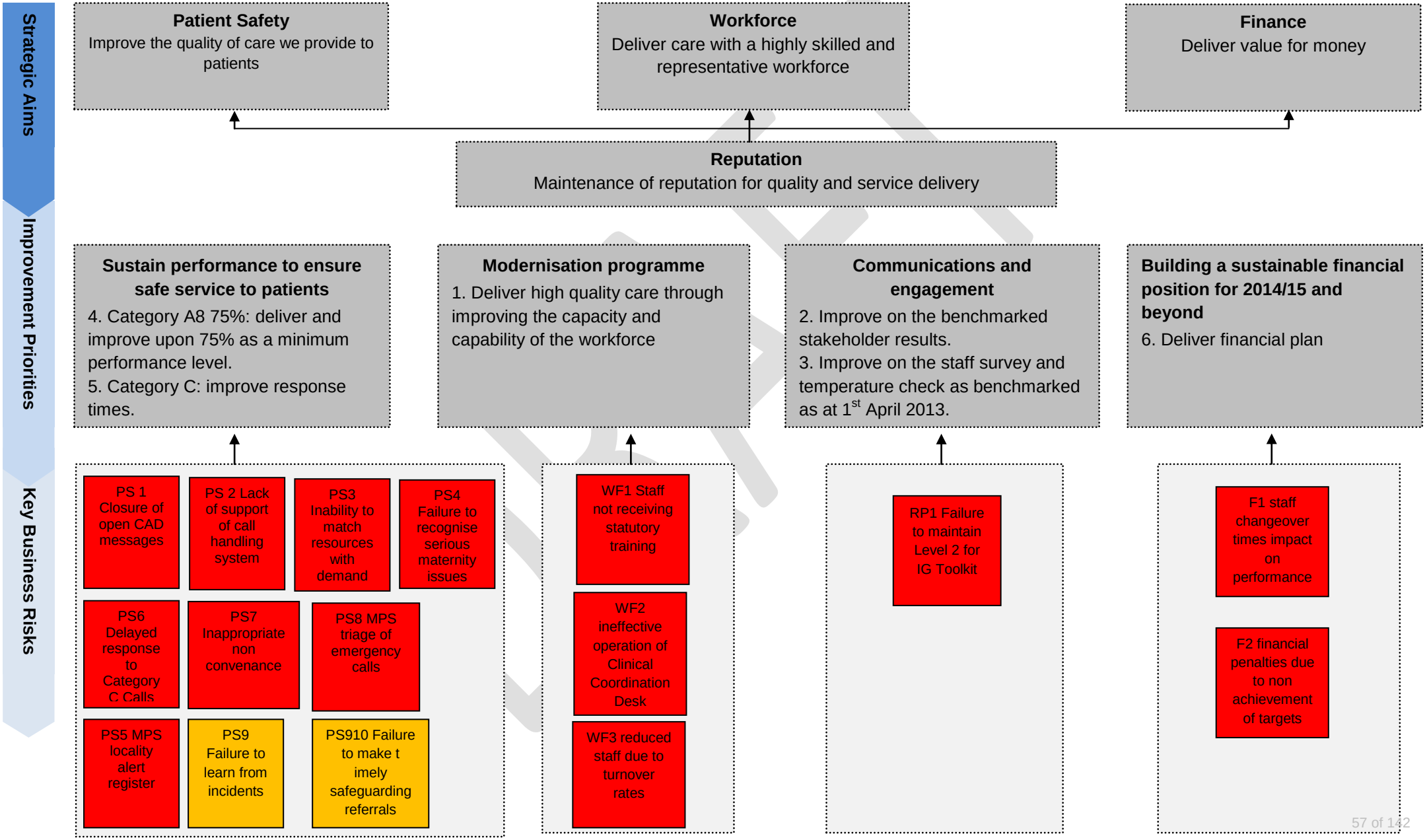
Equality Analysis

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

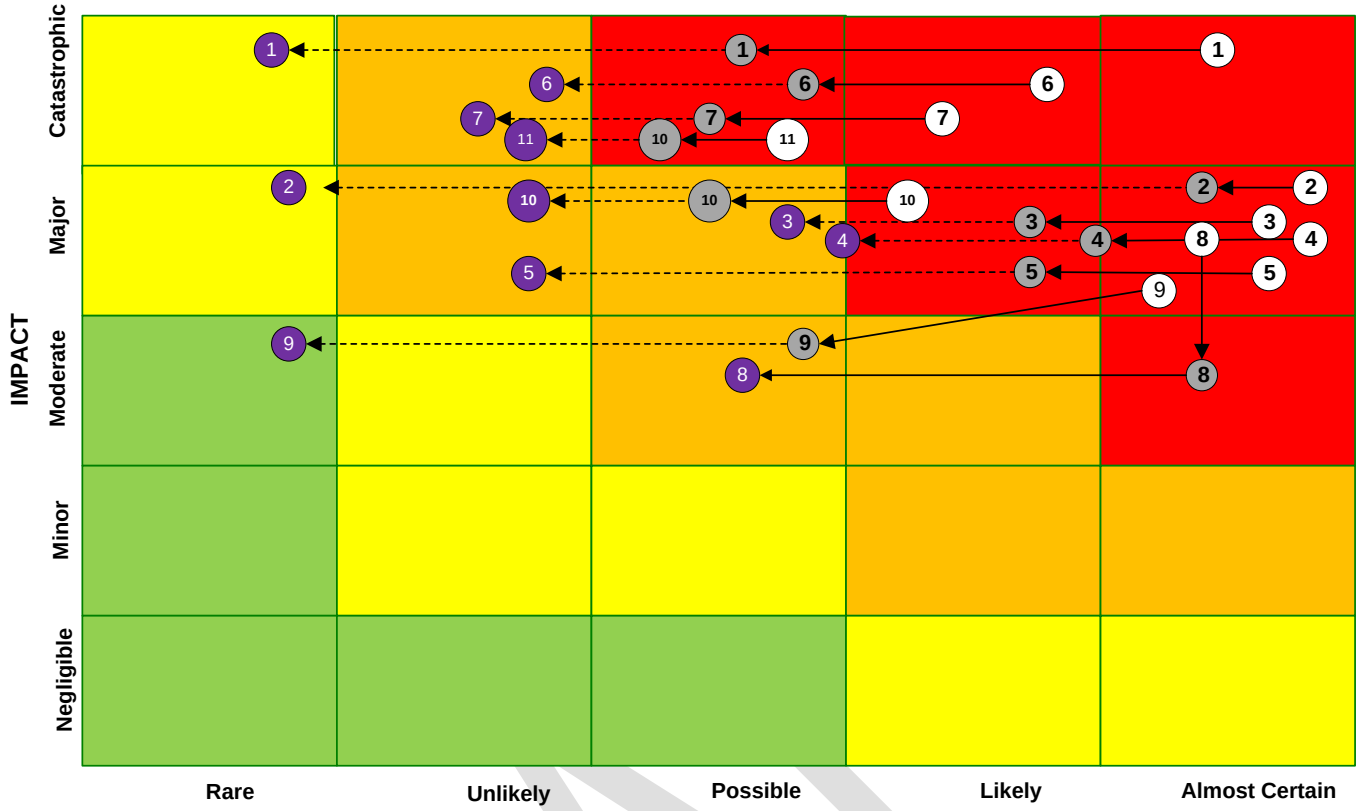
Key issues from the assessment:

Board Assurance Framework - November 2013

Key Risks to the Strategic Plan



Key Risks to the Strategic Goals and Improvement Priorities



Gross risk assessment

Net risk rating

Target risk rating

Risk 1	Messages exchanged between MDTS and CommandPoint system becoming out of sequence
Risk 2	Call handling system may be unsupported by Priority Dispatch System
Risk 3	Service Performance affected by the inability to match resources to demand
Risk 4	Failure to recognise serious maternity issues
Risk 5	Performance falls at staff changeover times
Risk 6	Insufficient information from MPS on locality alert register
Risk 7	Delay to Category C calls
Risk 8	Inappropriate non-conveyance of patients
Risk 9	Failure to capture errors and incidents and improve service provision
Risk 10	Non achievement of contractually agreed targets

Key: Low Risk | Moderate Risk | Significant Risk | High Risk

Risk 382 (PS8)	Emergency calls from Metropolitan Police Service are incorrectly triaged by the MPS					
Risk consequences	Affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.					
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
LAS METDG trial completed and evaluation reports produced. Will re-triage MPS calls via MPDS, to determine an accurate priority and facilitate more effective tasking of LAS resources. METDG will attempt to close lower priority calls by Hear & Treat. METDG only has limited times of operation at anticipated peak times of demand.					
The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated.					
EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately.					
The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.	Completed	Paul Woodrow / Fenella Wrigley		
Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS.	December 2013	Paul Woodrow		

Target rating	Likelihood	1	Impact	5	Score	5

Risk owned by: Medical Director **Signed:** **Date:** 02 Sep 2013

Risk 368 (PS1)	Messages exchanged between MDTS and CommdPoint becoming out of sequence resulting in open events being closed					
Risk consequences	This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death					
Risk owners	Director of IM&T					
Gross risk	Likelihood	5	Impact	5	Score	25

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. (Build 2.5.6).	Yes				
Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks).	Yes				
Software adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5.6).	Yes				
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes.	November 2013	John Downard	One-off	TBC
Request for Change to MDT system to provide message sequence identification and processing as above.	November 2013	John Downard	One-off	TBC
Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling.	November 2013	Kevin Canavan		TBC
Removal of ‘false positive’ messages from unexpected status change warnings generated by CAD to area controllers and dispatchers.	November 2013	Kevin Canavan		TBC

Target rating	Likelihood	1	Impact	5	Score	5

Risk owned by: Director of IM&T **Signed:** ..... **Date:** .....

Risk 265 (PS3)	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.					
Risk consequences	Patient Safety and Financial Penalties					
Risk owners	Director of Operations					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Ongoing recruitment to vacancies..					
Use of voluntary and private sector at times of peak demand..					
Use of agency Paramedics to enhance bank scheme.					
Modernisation programme.					
Targeted use of overtime.					
Use of DMP.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Modernisation programme to implement efficiencies from capacity review.				TBC
				TBC
				TBC
				TBC

Target rating	Likelihood	3	Impact	4	Score	12

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 31 (PS4)	Failure to recognise serious maternity issues					
Risk consequences	Failure to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.					
Risk owners	Medical Director					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development.					
Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012.					
Maternity care update articles in the Clinical Update when required.					
Monitoring the delivery of the CPD obstetrics module.					
The maternity pathway for use in CTA and CSD has been redesigned after audit findings. This has been implemented and reviewed. A planned reaudit will occur in 2014..					
The obstetrics section National Guidelines has been significantly updated..					
The consultant midwife arranges and oversees the training and delivery. This can also be delegated to local midwives.					
The consultant midwife designed the Maternity session for CSR3.					
EBS monitor maternity unit activity and closure with a traffic light system. This is reported to consultant midwife and deputy medical director.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents.	Quarterly Review	Andrew Stallard	Quarterly	TBC

New guidelines 2013 update.				Quarter 4 2013/14	Bill O'Neil	One-off	TBC
CSR training				Quarter 2013/14	Bill O'Neil		TBC
Target rating	Likelihood	3		Impact	4	Score	12
Risk owned by: Medical Director	**Signed:**		**Date:**				

Risk 355	There is a risk of staff not receiving clinical and non-clinical statutory training.					
Risk consequences	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills					
Risk owners	Director of HR					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
PDR / KSF Agreed rostered training days..					
Dedicated tutors..					
Paramedic registration..					
Monitoring the delivery of the CPD obstetrics module.					
Weekly Operational demand capacity meetings.					
Cluster arrangements in place from December 2011 on all complexes.					
3/5/12 The TNA was approved by TSG and published					
Overall assessment of control effectiveness					

Residual risk	Likelihood	4	Impact	4	Score	16
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
3/5/12 The TNA was approved by TSG at the April meeting and will be published imminently.			Complete	Gill Heuchen		
A workbook has been developed for Infection prevention and control it will be launched shortly.			Complete	Keith Miller		
Use of OLM for recording of CSR 1 will commence from October 2012.			Complete	Bill O'Neil		
Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.			Ongoing	Gareth Hughes		
Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: Director of HR **Signed:** ..... **Date:** .....

Risk 269	There is a risk that at staff changeover times, LAS performance falls					
Risk consequences	Fall in performance					
Risk owners	Director of Operations					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Daily monitoring of rest break allocation to resolve end of shift losses.					
Use of bridging shifts for VAS/PAS.					
Roster reviews/changes must include staggered shifts.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	4	Impact	4	Score	16
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
Implement changes to rest break arrangements.			Q3/4 12/13	Tony Crabtree		
Rota changes to be implemented as result of ORH review			Q3/4 12/13	Jason Killens		
Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 378	Insufficient information is contained within MPS Referrals for inclusion in our locality alert register					
Risk consequences	This may lead to delayed patient contact when attending MPS flagged addresses.					
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Crews carry out a dynamic risk assessment before attending the address using all available information and local knowledge					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Meet with MPS to agree changes to the police entry criteria.	End 2013	Ops Lead / Head of MI		

Target rating	Likelihood	2	Impact	5	Score	10

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 379	Delays to calls received and triaged as Category C					
Risk consequences	Category C calls sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.					
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
MPDS call triage.					
Control services staff training.					
Enhanced clinical assessment through the clinical hub.					
LAS Demand Management Plan.					
Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Recruit to Establishment minus agreed vacancy factor of 4%.		Tony Crabtree		
Deliver efficiencies in full from Capacity Review and complete Roster Implementation.		EMT		

Target rating	Likelihood	2	Impact	5	Score	10

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 371	Not achieving Level 2 for IG Toolkit requirement due to operational staff not completing online IG refresher training					
Risk consequences	The Trust will not be able to obtain FT status if it does not achieve Level 2 for IG Toolkit requirement					
Risk owners	Director of IM&T					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
ADOs have been reminded about the need for their staff to complete training.					
Training completion rates are being monitored by IGG.					
Directors have been provided with spreadsheets of staff who have completed training.					
ADG members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Produce IG training plan to ensure that as many staff as possible complete refresher training and other IG training as required by 31/03/14.	March 2014	Stephen Moore		
Our Directors, information asset owners and other managers are to be reminded to ensure that their staff complete the online IG refresher training.	March 2014	Stephen Moore		

Target rating	Likelihood	2	Impact	5	Score	10

Risk owned by: Director of IM&T **Signed:** ..... **Date:** .....

Risk 22	Failure to undertaken comprehensive clinical assessments					
Risk consequences	May result in the inappropriate non-conveyance or treatment of patient.					
Risk owners	Medical Director					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Training Strategy Group monitor the level of training delivery.					
CPIs are used to monitor the standard of assessments provided.					
LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee and the area governance committees.					
The Operational Workplace Review has been reviewed and will now include ride outs.					
A system for clinical updates is in place.					
A system of closed round table discussions is in place.					
There is continuing development of appropriate care pathways, which forms part of the 'Time for Change'.					
An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties.					
Introduction of reflective practice (as part of Module J programme).					
The updated clinical practice guidelines include some updates on clinical assessment.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
Delivery of CSR and the Guidelines Update 2013.			End of 2013	Bill O'Neil		

The Medical Directorate will continue to monitor trends. The new Datix system will assist with this.			March 2014	Stephen Moore		
The trends are formally reported to both EMT and to Trust Board.						
Target rating	Likelihood	3	Impact	3	Score	9
Risk owned by: Medical Director	**Signed:**		**Date:**			

Risk 387	LAS call handling system may be unsupported by Priority Dispatch Systems from late 2014					
Risk consequences	This will significantly impact our ability to maintain and use both systems and compromise efficient working and patient safety.					
Risk owners	Director of Operations					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Work is being undertaken by IM&T to scope the work required to integrate Paramount to facilitate identifying the costs involved.					
EOC PIM preparing a detailed paper of the options for SMT.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	5	Impact	4	Score	20

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Decision by the LAS as to the tool to be used in EOC and an implementation plan to be agreed.				

Target rating	Likelihood	1	Impact	4	Score	4

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 7	Not capturing errors and incidents and learning from them					
Risk consequences	Not improving service provision and practices as a result of errors and incidents					
Risk owners	Director of HR					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
LA52 incident reporting form.					
Risk management policy and strategy has been updated and implemented.					
Incident reporting policy is implemented.					
The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated.					
A review of incident reporting is underway and led by the PCMO.					
Weekly SI control sheet and conference call updates.					
Monthly reports to SMG.					
Implemented policy on investigating and learning from incidents, complaint, PALs and claims.					
Local risk registers have been introduced.					
Datix Coding Review has been undertaken.					
LFE group has introduced integrated reporting.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	3	Score	9

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Complete the review of incident reporting pilot and make recommendations to Corporate H&S and RCAG.	Complete	Steve Sale		

Implement the policies on investigating and learning from incidents, complaint, PALs and claims.			April 2014	Sandra Adams		
LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated.			October 2013			
Incident reporting project phase II commenced Jan 2012.			October 2013			
Target rating	Likelihood	1	Impact	3	Score	3
Risk owned by: Director of HR	**Signed:**	.....	**Date:**			

Risk 329	Non-achievement of contractually agreed targets					
Risk consequences	Financial penalties will be levied on the Trust					
Risk owners	Director of Finance					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Continue working with specific mitigation of financial risk.					
Monthly finance reports reviewed by Trust Board and SMG.					
Extra financial provisions included for contract risk in 2013/13					
Communications with commissioners.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Review by Finance and Investment Committee		Kevin Hervey		

Target rating	Likelihood	2	Impact	5	Score	10

Risk owned by: Director of Finance **Signed:** ..... **Date:** .....

Risk 349	Ineffective operation of Clinical Coordination Desk due to lack of suitably trained staff in EOC					
Risk consequences						
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12					
Overall assessment of control effectiveness					

Residual risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Increase the number of staff trained to undertake the Clinical Coordination Role.				
Ensure that, if there is no option but to split the desk between Waterloo and Bow, the CCD is co-located with the Clinical Hub at both sites.				

Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: Director of Operations **Signed:** ..... **Date:** .....

Risk 343	Staff not recognising safeguarding indicators					
Risk consequences	Failing to make a timely referral					
Risk owners	Director of Nursing and Quality					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Monitor referrals centrally.					
Safeguarding committee promotes practice guidance.					
Practice guidance issues and supported by updates.					
Training programme in place - ongoing auditing of the effectiveness of training through competency assessments.					
Monitor training uptake - monitored centrally on scorecard.					
Safeguarding Children / Adults Gap Analysis.					
Adult Action plan in operation reviewed at Safeguarding Committee. Completed Dec 2012.					
Supervision sessions underway also conference held June 2013.					
Safeguarding pocket books issued to all staff June 2013.					
Overall assessment of control effectiveness					

Residual risk	Likelihood	3	Impact	4	Score	12

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Capture safeguarding practice in bi-annual Operational Workforce review.	Completed	Peter McKenna /Kevin Brown		
Formulation of action plan based on completed safeguarding adults gap analysis.	Completed	Lysa Walder / Alan Taylor		
Provide monthly supervision sessions open to all staff.	Ongoing			

Produce and issued individual safeguarding pocket books to all frontline staff.			Completed			
Provided level one learning training for all staff.			Dec 2013			
Provide EOC staff with safeguarding level two training.			Ongoing			
Ensure Safeguarding training for all Voluntary providers.			Ongoing			
Target rating	Likelihood	2	Impact	4	Score	8
Risk owned by: Director of Nursing and Quality		**Signed:**		**Date:**		

London Ambulance Service NHS Trust
Risk Register 29th October 2013

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
368	There is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death	Following CommandPoint go live, several incidents have been reported to the CAD support team for investigation where out of sequence messages from MDTs have resulted in events showing with an incorrect status. On a number of these the event has been closed in error. The investigations have identified a number of ways that this scenario can occur. So far the identified possible causes are: • Preempt request/event updates crossing • Status change messages echoed • MDT status changes arrive out of order • Aged MDT status change messages appear • A&E resource 'cycles' through the button presses to close the job.	27-Jul-12			Clinical	Catastrophic	Almost Certain	25	1.Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. (Build 2.5.6) 2. Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks) 3. Software adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5.6) 03/07/13: As a result of an SI due to a new scenario which triggers the issue: additional control put in place	Vic Wynn	23-Oct-13	Catastrophic	Possible	15	1. Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes. 2. Request for Change to MDT system to provide message sequence identification and processing as above. 3. Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling. 4. Removal of 'false positive' messages from unexpected status change warnings generated by CAD to area controllers and dispatchers.	1. J. Downard 2. J. Downard 3. K. Canavan 4. K.Canavan	1- 4 Nov 2013	1. Technical solutions under development by tactical problem management team (led by John Downard) 2. Weekly director progress oversight in CommandPoint problem management review (led by Peter Suter) 3. Ongoing assessment of alert monitoring and identification of further incidents for CAD support team investigation by CommandPoint senior user group (led by Richard Webber) 4. Daily checks of the following Alerting systems in place: • That the software running alerts is running	Catastrophic	Rare	5	22/10/2013 - The Sept target was not achieved, however full testing has now been successfully concluded and roll out will cautiously commence 14/10 with full release (subject to no major issues reported) w/c 4/11." The MDT software rollout commenced 14/10 and will conclude during November (it takes time for all vehicles to receive the update due to their operational deployment). The corresponding NG software release (2.5.18.4) was successfully carried out Aug 13th, so by the end of November it is expected to that there will be evidence to confirm the risk is mitigated." October 13: The release of CP was successful which mitigates the risk to a degree. The Software Development for the MDT has been completed and the first two units were deployed w/c 14/10/2013. The plan indicates completion of the rollout in November 2013 which fully mitigates the risk.
387	There is a risk that the LAS could be in a position where its call handling system is unsupported by Priority Dispatch Systems (the suppliers) from late 2014 onwards. this will involve both our call taking system (ProQA) and the MPDS version we are using (12.2). This will significantly impact our ability to maintain and use both systems and compromise efficient working and patient safety.	Priority Dispatch have developed an updated and improved operating system for MPDS. This system, ProQA Paramount, repleaces the existing ProQA, Paramount is currently available for UK users and is compatible with the current version of MPDS, 12.2.. In Q3/4 2013/14 a new verison of MPDS, version 13, will be released. It is not possible to use use Version 13 without Paramount. It is likely that, following normal business practise, having released V13 and Paramount, Priority Dispatch will withdraw technical support for the existing verions of ProQAand version 12.2. This should be within a year. Loss of the technical support would cause significant impact and	23-Oct-13			Business Continuity	Major	Almost Certain	20	1. Work is being undertaken by IM&T to scope the work required to integrate Paramount to facilitate identifying the costs involved. 2. EOC PIM preparing a detialed paper of the options for SMT.	Jason Killens		Major	Almost Certain	20	1. Decision by the LAS as to the tool to be used in EOC and an implementation plan to be agreed.				Major	Rare	4	New risk added 23rd October 2013
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	reductions in frontline establishment in 1/12 and 12/13 as part of CIP Current vacancy factor against 13/14 establishment Slow recruitment	31-Jul-06	***	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Use of agency Paramedics to enhance bank scheme. Modernisation programme. Targeted use of overtime. Use of DMP.	Jason Killens	04-Nov-13	Major	Likely	16	Modernisation programme to implement efficiencies from capacity review.	1. J. Killens			Major	Possible	12	PW/KB 8/7/13 - Aggressive recruitment campaign in place. Consultations start on rosters 19/8/13. Resource levels supported by £310k per week through PAS and VAS. Modernisation programme at implementation phase.

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31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	***	4	Clinical	Major	Almost Certain	20	1. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 2. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 3. Maternity care update articles in the Clinical Update when required 4. Monitoring the delivery of the CPD obstetrics module. 5. The maternity pathway for use in CTA and CSD has been redesigned after audit findings. This has been implemented and reviewed. A planned reaudit will occur in 2014. 6. The obstetrics section National Guidelines has been significantly updated. 7. The consultant midwife arranges and oversees the training and delivery. This can also be delegated to local midwives 8. The consultant midwife designed the Maternity session for CSR3. 9. EBS monitor maternity unit activity and closure with a traffic light system. This is reported to consultant midwife and deputy medical director.	Fionna Moore	21-Oct-13	Major	Likely	16	1. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents. 2. New guidelines 2013 update 3. CSR training	1. A.Stallard 2. B. O'Neil 3. B. O'Neil	1. Review during each quarter and any serious or recurrent themes highlighted through updates to operational and/or control staff and CQSEC. 2. End of 2013/14 financial year 3. End of 2014/15 financial year	1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services. 2. Incident reporting. 3. Reports to CQSEC, SI group, Learning from Experiences	Major	Possible	12	21/10/13 Risk rating to remain unchanged.
355	There is a risk of staff not receiving clinical and non-clinical statutory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills	23-Nov-11		5	Human Resources	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes. 6. 3/5/12 The TNA was approved by TSG and published	Tony Crabtree	20-Aug-13	Major	Likely	16	l. 3/5/12 The TNA was approved by TSG at the April meeting and will be published imminently. 2. A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commence from October 2012. 4. Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.	1. G.Heuchan 2. K.Miller 3. B.O'Neill 4. G. Hughes	1. Complete 2. Complete 3. Complete 4. Ongoing	1. Reporting to TSG 2. Monitoring by Modernisation programme recruitment and Training working group 3. TNA Policy	Major	Unlikely	8	Risk Links, 371, 31 and 22 8/07/13 - BO'N proposes change of net rating to Major x Possible = 12. SMT 13/11/13 - Risk wording amended to replace the word mandatory training to statutory training. The group did not agree with downgrading the net rating until progress has been made with implementing the training programme.
269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	***	17	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts.	Jason Killens	08-Jul-13	Major	Likely	16	1. Implement changes to rest break arrangements 2. Rota changes to be implemented as result of ORH review	1. T. Crabtree 2. J. Killens 3. G.Hughes	1. Q3/4 12/13 2. Q3/4 12/13 3. Q3/4 12/13		Major	Unlikely	8	PW/KB 8/7/13 - Modernisation agenda will address this area.
378	There is a risk that insufficient information is contained within MPS referrals for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses.	Police fail to set an appropriate criteria for inclusion on the LAS register	14-Jan-13			Operational	Catastrophic	Likely	20	1. Crews carry out a dynamic risk assessment before attending the address using all available information and local knowledge	Paul Woodrow	08-Jul-13	Catastrophic	Possible	15	1. Meet with MPS to agree changes to the police entry criteria	1. Ops Lead/Head of MI	End 2013		Catastrophic	Unlikely	10	PW/KB 8/7/13 - Local Alert Register in place. OP.010 published. Aide Memoire for front line staff. MPS informed us that their new form went live w/c 24/6/13
379	There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.	The Learning from Experience Group requested an analysis of delays to category C patients which resulted in Serious Incident reviews. During the period April 2011 - March 2012 the Trust reviewed 92 serious incidents 10 involved Category C calls. 4 incidents were declared	11-Mar-13			Operational	Catastrophic	Likely	20	1. MPDS call triage 2. Control services staff training 3. Enhanced clinical assessment through the clinical hub 4. LAS Demand Management Plan 5. Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime	Jason Killens	03-Jul-13	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 4% 2. Deliver efficiencies in full from Capacity Review and complete Roster Implementation	1. T. Crabtree 2. EMT		1. Operational Demand and Capacity Review Group 2. Risk Compliance and Assurance Group 3. Medical Directorate senior clinical advice; Clinical risk and Patient safety	Catastrophic	Unlikely	10	

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371	There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2014.	Service pressures during the year have meant that Operational training has had to be deferred in many cases and winter pressures may make this situation worse.	14-Jan-13			Governance	Major	Almost Certain	20	1. ADOs have been reminded about the need for their staff to complete training 2. Training completion rates are being monitored by IGG 3. Directors have been provided with spreadsheets of staff who have completed training 4. ADG members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.	Vic Wynn	29-Oct-13	Catastrophic	Possible	15	1. Produce IG training plan to ensure that as many staff as possible complete refresher training and other IG training as required by 31/03/14. 2. Our Directors, information asset owners and other managers are to be reminded to ensure that their staff complete the online IG refresher training.	1. S. Moore 2. S. Moore	1. March 2014 2. March 2014	1. Compliance with completion of IG refresher training is checked monthly by the Information Governance Manager. 2. Progress is checked at the Information Governance Group Meeting monthly.	Catastrophic	Unlikely	10	
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	***	5	Clinical	Major	Almost Certain	20	1. Training Strategy Group monitor the level of training delivery. 2. CPIs are used to monitor the standard of assessments provided. 3. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee and the area governance committees. 4. The Operational Workplace Review has been reviewed and will now include ride outs. 5. A system for clinical updates is in place. 6. A system of closed round table discussions is in place. 7. There is continuing development of appropriate care pathways, which forms part of the 'Time for Change'. 8. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 9. Introduction of reflective practice (as part of Module J programme). 10. The updated clinical practice guidelines include some updates on clinical assessment	Fionna Moore	21-Oct-13	Moderate	Certain	15	1. Delivery of CSR and the Guidelines Update 2013 2. The Medical Directorate will continue to monitor trends. The new Datix system will assist with this. 3. The trends are formally reported to both EMT and to Trust Board	1. Bill O'Neil 2. Joanne Nevett 3. Fionna Moore/Steve Lennox (EMT/TB)	1. End of 2013/2014 Finance Year 2+3. Review during each quarter and any serious or recurrent themes highlighted through updates to operational and/or control staff and CQSEC	CPI reports OWRs CQSEC EMT/TB reports Learning from Experience	Moderate	Possible	9	
382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	In 2001 CAD link was developed, which enabled the MPS and LAS to exchange emergency calls and other messages directly via each organisation's CAD system. This process bypasses the standard triage system that all other 999 calls are subject to. To request the LAS, the MPS complete a basic triage of the call, known as the SEND protocol (Secondary Notification of Dispatch). SEND requires the MPS to answer five key questions to determine the medical priority of the call.	07-May-13			Clinical	Catastrophic	Likely	20	1. LAS METDG trial compleed and evaluation reportss produced. will re-triage MPS calls via MPDS, to determine an accurate priority and facilitate more effective tasking of LAS resources. METDG will attempt to close lower priority calls by Hear & Treat. METDG only has limited times of operation at anticipated peak times of demand. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated. 3. EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately. 4. The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning.	Jason Killens	04-Nov-13	Catastrophic	Possible	15	1. A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads. 2. Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. April 2013 2. Dec 2013		Catastrophic	Rare	5	METDG trial completed and evaluation reports produced . EMT options paper discussed in June 13. Approved further work to improve clinical safety of CAD MPS involvement
7	There is a risk that we do not capture errors and incidents, and do not therefore learn from these and improve service provision and working practices.	Insufficient recorded evidence of reported incidents	13-Nov-02	***	4	Health & Safety	Major	Almost Certain	20	1. LA52 incident reporting form 2. Risk management policy and strategy has been updated and implemented 3. Incident reporting policy is implemented 4. The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated. 5. A review of incident reporting is underway and led by the PCMO. 6. Weekly SI control sheet and conference call updates. 7. Monthly reports to SMG. 8. Implemented policy on investigating and learning from incidents, complaint, PALs and claims. 9. Local risk registers have been introduced 10. Datix Coding Review has been undertaken 11. LFE group has introduced integrated reporting	Tony Crabtree	23-Oct-13	Moderate	Possible	9	1. Complete the review of incident reporting pilot and make recommendations to Corporate H&S and RCAG. - (Phase 2 of this project has commenced and is being led by CDB) 2. Implement the policies on investigating and learning from incidents, complaint, PALs and claims. 3. LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated. 4. Incident reporting project phase II commenced Jan 2012.	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. C.Dodson-Brown	1. Complete 2. April 2014 3. Oct 2013 4. Oct 2013	1. Completion of the review and recommendations to RCAG and SMG for implementation. 2. Reports and minutes from Learning from Experience, RCAG, SMG and Quality Committee. Consistent coding and reporting across the risk indicators. 3. Compliance with Incident Reporting Procedure	Moderate	Rare	3	

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343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		4	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Safeguarding committee promotes practice guidance. 3. Practice guidance issues and supported by updates. 4. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments. 5. Monitor training uptake - monitored centrally on scorecard. 6. Safeguarding Children / Adults Gap Analysis. 7. Adult Action plan in operation reviewed at Safeguarding Committee. Completed Dec 2012 8. Supervision sessions underway also conference held June 2013. 9. Safeguarding pocket books issued to all staff June 2013.	Steve Lennox	15-Aug-13	Major	Possible	12	1. Capture safeguarding practice in bi-annual Operational Workforce review 2. Formulation of action plan based on completed safeguarding adults gap analysis 3. Provide monthly supervision sessions open to all staff. 4. Produce and issued individual safeguarding pocket books to all frontline staff. 5. Provided level one learning training for all staff. 6.Provide EOC staff with safeguarding level two training. 7.Ensure Safeguarding training for all Voluntary providers.	1. P.McKenna, K.Millard,K Brown 2. Lysa Walder & Alan Taylor	1. Completed 2. Completed 3. Ongoing 4. Completed June 2013 5.On line package in development Dec 2013 6. Ongoing 7. Voluntary providers have ensured that safeguarding is delivered to all staff - these packages have been seen and assistance given to train the trainers - completed	1. Monitored at Safeguarding Committee- see minutes of meeting. Action plan discussed at 1 to 1 with director and at Safeguarding Committee	Major	Unlikely	8	LW 25/06/2013 - Propose to regrade current rating to 12 (major x possible) further actions required - 1) Ongoing and regular audits on safeguarding practice 2) Continue to deliver Level 2 and 3 safeguarding training 3) Introduce Level 1 by e-learning SMT 13/11/13 - Agreed to amend net rating to major x possible 12
349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	***	4	Operational	Major	Likely	16	1. CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12	Jason Killens	04-Nov-13	Major	Likely	16	1. Increase the number of staff trained to undertake the Clinical Coordination Role 2. Ensure that, if there is no option but to split the desk between Waterloo and Bow, the CCD is co-located with the Clinical Hub at both sites				Major	Unlikely	8	28/04/13 FW - The risk of insufficient staff trained to undertake the role persists and the risk is slightly increased now we are in two control rooms as the pool of staff who are trained may not be on the Waterloo Site which is where the desk is run from in order to be co-located with the HEMS paramedic and the Clinical Hub. . MPS involvement
388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care.	1. Competitive recruitment market for Paramedics 2. Increasingly mobile workforce with a multitude of recruitment possibilities 3. Cost of living pressures in London coupled with increasing travel costs for commuting 4. Opportunities for clinical career progression in other organisations, which do not exist within the LAS, such as 111 and other public, private and voluntary healthcare providers 5. Staff morale 6. Perceptions of access to funding for personal development and study leave 7. Concerns about job security	13-Nov-13			Clinical	Major	Likely	16	1. NHS staff benefits 2. Listening into Action - to understand staff improvements. 3. Developing the modernisation programme – including rota reviews and development of a clinical career structure. 4. Actively recruiting university and registered paramedics and A&E support. 5. Monitoring and developing plans to address trends in turnover. 6. The use of overtime, private and voluntary ambulance services to increase the number of available resources.	Tony Crabtree		Major	Likely	16	1. Development of Clinical Career Structure. 2. Skill mix review. 3. Review exit interview process and data capture. 4. Review and update rewards and retention strategy. 5. Promote learning and development opportunities. 6. Recruitment drive to fill vacant established posts. 7. Implementing the modernization programme.	1. JC/PW 2. JC/PW 3. LK 4. JC 5. BO'N 6. CM 7. JC/PW	1. 2014/15 2. 2014/15 3. Completed 4. Nov 13 5. Nov 13 6. Dec 15 7. Dec 15	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for ongoing cohorts of A&E support and Paramedic staff. 5. Development of reward strategy. 6. Development of	Major	Unlikely	8	The Trust continues to investigate funding streams to support professional development with the aim to positively influence turnover. New Risk added 13/11/13.

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138	There is a risk that failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.		12-Nov-03	***	5	Clinical	Major	Likely	16	1. The new 'Mental Health' module has been designed and has been included in the training plan for 2009/10. 2. An e-Learning Manager has been appointed and will start work with the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	29-Oct-13	Major	Possible	12	1. Development of mental health risk assessment tool: 2. Roll-out of mental health e-learning training 3. Mental Health Committee to consider alternatives to e-learning 4. Mental health audit 5. CSR3 Training	1. S.Lennox 2. S.Lennox 3. S.Lennox 4. S.Lennox 5. K.Miller	1. Nov 2013 2. Complete 3. Nov 2013 4. Complete 5. Complete	1. CPD completion records 2. Monitor processes at CQSE 3. Monitor package completion data on e-learning site	Major	Unlikely	8	Action: 1. The Hillingdon pilot evaluation is now complete, report discussed in the Mental Health Committee meeting on the 24th October 2013. Further meeting to be held on the 7th November 2013 to discuss next steps and how we take forward the recommendations from the project. 2. Complete mental health e-learning available for all staff, Mental health leads will continue to monitor completion rates on the e learning site with the help of the education & training department. 3. As part of the clinical career structure, a 2 week clinical update for Team Leaders and Clinical Managers has been rolled out and Mental health is included. 2sessions have been delivered so far with some good feedback, further sessions to be delivered on 24th November and dates to be confirmed for 2014.
205	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system.	Capacity of Fulham Archive Store (for hard copy training records) is exhausted.	01-Jun-05	***	7	HR	Major	Likely	16	1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc. 2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system	Tony Crabtree	25-Oct-13	Major	Possible	12	1. Develop plans to move to the electronic storage of all operational training records generated within the LAS 2. Further develop the plans to create a central management hub (currently Fulham) to support and underpin the provision and quality of all Education & Development activity throughout the Trust. This will include the review of Fulham E&D administrative staff levels, so as to ensure that sufficient capacity exists to fulfil the requirements of the new training record management system. 3. Scope the potential and options for the back scanning of existing training record documentation.	1. P.Billups 2.B.O'Neill/P.Billups 3. P.Billups	1. Dec 2013	1. Annual reaccreditation visits by IHCD external verifier 2. Monitoring by Clinical Education Steering Group with subsequent reporting to the Training Strategy Group	Major	Unlikely	8	Proposals for the electronic capture and storage of training records are currently being developed with Management Information and an external supplier. It is intended that these will integrate with the storage systems already in use within the LAS.
211	There is a risk that drug errors and adverse events may not be reported.	Concerns that drug errors may not be reported	08-May-06	***	4	Clinical	Major	Likely	16	1. No evidence of any issue of significance from service users or stake holder feedback. 2. Safety and Risk to track back complaints to see how many have LA52's associated with drug errors and adverse events not being reported 3. Medical Directors Bulletin to remind staff of importance of reporting drug errors and adverse events. 4. Article included in the Clinical Update highlighting the importance of incident reporting. 5. Importance of clinical incident reporting highlighted in the Team Leader Clinical Update Course and Team Leader Conference. 6. OP02 (use of drugs) and OP30 (controlled drugs) recently been reviewed 7. Updated guidelines and new pocket books 8. Medicines management group reports to EMT, Trust Board and CQSEC	Fionna Moore	21-Oct-13	Major	Possible	12	1. Continue to encourage reporting of all clinical incidents using LA52's. 2. Continue to reinforce that the LAS has a fair blame culture by providing feedback from outcomes of complaints to staff involved in incidents. 3. CSR 2013 training delivery 4. CSR 3 training delivery 5. Concept of 'check and challenge' process is under development by the Medical Directorate. It is planned that a simple check-list will be produced for use by clinicians. 6. Emphasis on checking drugs and reporting errors is included on the Team Leader/Paramedic Manager update module 2013/14.	1. John Selby 2. D Whitmore / Tony Crabtree 3. Bill O'Neil 4. Bill O'Neil	1. Ongoing 2. Ongoing 3.End of 2013 Financial Year 4. End of 2014 Financial Year 5 December 2013	1. CPI checks 2. Incident Reporting 3. CQC inspections 4. Clinical opinions provided on incidents 5. Learning from Experience Group review incident activity 6. Review of closed cases and claims. 7. Learner outcomes and achievement records documenting discussions on incident reporting. 8. Medicines Management Group meetings/reports	Major	Unlikely	8	Risk updated 21/10/2013 - Actions updated

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305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	Controlled Drugs Incidents arising from poor adherence to policy	21-Oct-08	***	4	Clinical	Major	Likely	16	1. Policy reminder to be reinforced by bulletins from Director of Operations/Medical Director. 2. Independent audits to be carried out throughout the Trust. 3. Initial peer review pilot audit carried out in the south area with results and process amendments discussed at a morphine audit group quarterly meetings. The south area peer review is now standard Trust wide. 4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 5. Daily audit checks 6. The policy itself defines individual responsibility 7. Area governance reports to CQSEC 8. Mandatory LIN reports to CCG 9. Unannounced visits by MPS 10. Annual attendance by MMG to AO update days 11. MMG reports to EMT and Trust Board	Fionna Moore	21-Oct-13	Major	Possible	12	1. Continue to highlight practice from the peer review audits. 2. Continue to review feedback from spot checks made by the MPS. 3. Peer review	1. D.Whitmore 2. D.Whitmore	1. Ongoing 2. Ongoing 3. Ongoing	1. Internal Audit 2. Independent Audit 3. LIN oversight of system 4. MMG to CQSEC, EMT and Trust Board	Major	Unlikely	8	TO CONSIDER REGRADE Medicines Management Committee 24/07/2013 - Audits carried out on controlled drugs registers indicate non compliance with witness signatures for signing out drugs. Untill compliance with this can be demonstrated proposed not to downgrade net rating. 21/10/2013 - Q2 LIN report was a nil report. South Area CD audit system is now ready for roll-out across the Trust and will be actioned in Q4.
390	There is a risk that the demand from patients in South-East London for 111 service exceed the capacity of the resources at Beckenham, leading to extended periods of call handling delays and an adverse impact on Patient Safety.	This could be caused by unexpectedly high increases in call demand from winter pressures, advertising campaigns for the service, or any unusual short term demand spikes. It could also be caused by higher than expected staff	13-Nov-13			Clinical	Major	Likely	16	1. Short term resilience from super-numery staff. 2. Formalise surge plan agreement with other Ambulance Service Trusts, invocation documented. 3. Gather actions from letter to SEL commissioners from 25/10/13.	Jason Killens		Major	Possible	12	1. Recruitment of more clinical staff at Beckenham. 2. Arrangement in place to forecast book and call of contractor clinical resources.	1. N. Daw 2. N. Daw	1. Nov 13 2. Nov 13	1. 111 Service Winter Pressures Plan. 2. 111 Service Surge and Capacity Plan.	Major	Unlikely	8	New risk added 13/11/13.
326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	***	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Improved decontamination processes in operation.	Steve Lennox	23-Oct-13	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process 2. Decontamination Policy to be agreed by SMT	1. K.Merritt 2. E. Potter	1. 2.	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	Reviewed by Fleet and Logistics Team 21/10/13. Sean Westrope to meet with Jason Killens to discuss who should be the action owner.
352	There is a risk that operational staff sustain a manual handling type injury whilst undertaking patient care. The consequence of injuries being:- -Increased staff absence through industrial injury. -Impact on service delivery. -Impact on patient care.	Staff injured whilst manual handling patients	23-Nov-11		7	Health & Safety	Major	Likely	16	1. Manual Handling Implementation Group and Manual handling policy 2. Manual handling awareness is provided at corporate Induction; refresher training through e-learning is available through L&OD; Education and Training dept provide training to all operational staff during initial and subsequent core refresher training; all operational ambulance vehicles are fitted with tail lifts 3. Core Skills Refresher training is monitored via the quality dash board. 4. The Corporate Health and Safety Group monitor manual handling incidents and training activity, 5. Small handling kits on all vehicles 6. BTech trained Manual Handling assessors 7. Specialist MH equipment e.g. Manager Elk 8. All A+E and PTS operational vehicles have either tail lift of ramp access 9. All A+E and PTS operational vehicles are fitted with hydraulic trolley bed 10. Generic Risk Assessments 11.All A+E Operational vehicles have access to Manager Elks 12. 3x PTS Bariatric vehicles are available by request to A+E	Paul Woodrow	29-Oct-13	Major	Possible	12	1. Implementation of LAS/HSE Manual Handling Improvement Programme Action Plan 2. Develop structured bariatric capability 3. Ongoing review of marketplace to identify new lifting aids 4) Complete Operational Workforce Review 5) ISON for chair transporter being raised by Logistics. Funding for chair replacement in Draft Capital Plan. 6) MEG are reviewing maximum weight allowance for medical response bags (group to review bag contents in conjunction with medical directorate June 11th 2012). Prototype bag with MEG for review - expected decision September 2013.	1. J.Selby 2. J. Killens 3. J.Selby 4. S.Sale 5. J.Selby 6. M. Faulkner	1. Q3 12/13 2. 2013/14 3. Ongoing 4. Sept 2013 5. Dec 2013 6.On going	1. Manual Handling Implementation Group 2. Manual Handling Policy 3. Central Health and Safety Group Incident Statistics Monitor and Audit Reviews	Minor	Unlikely	4	KB/PW 08/07/2013 - £578k funding for new chairs included in final draft of capital plan. Final approval with EMT for 24/7 EMT approved buisness case 23rd Oct. LA 95 request for single tender approval drafted 30th Oct
385	There is a risk that the total level of financial loss due to theft and criminal damage to the organisation is anaccurately reported.	Incidents of theft and criminal damage are not reported through a single route and a result of this is that there is no central receiving department which can confidently put a total value to the financial loss suffered by the organisation.	07-Oct-13			Finance	Major	Likely	16	LA 52 (Accident/ Incident Report), LA 154 (Report of Loss / Burglary / Theft), LA 41 (Digital Radio Hand Portable Terminal Theft/ Loss/ Damage Report) Logistics Asset Tracking System Annual Fixed Assets verification process	Andrew Grimshaw	21-Oct-13	Major	Possible	12	1. Production of Security of Assets Policy detailing responsibilities and reporting routes. 2. Notice in RIB instructing staff how to report theft, burglary and criminal damage.	1. M. Nicholas 2. M. Nicholas	1. 31/08/13 2. 18/06/13	1. LA 52 Data reviewed / monitored by Corporate Health and Safety Group. 2. LSMS reviews LA 52 reported data. 3. Security Management Policy.	Major	Rare	4	New Risk
153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	Increasing fuel prices	06-Jan-04	***	8	Finance	Major	Likely	16	1. Monthly review as part of month end reporting process. 2. Prices will continue to be closely monitored by the Finance Department for 2012/13. The move to an all diesel fleet will further mitigate against fuel costs.	Andrew Grimshaw	23-Oct-13	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance. Further investigation of vehicle telemetry technology to manage fuel spend.	1. A.Grimshaw	1. Ongoing	Monitored at SMG and Trust Board	Moderate	Possible	9	Risk at target rating but to remain visible on Risk Register

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322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	***	1,2,4, 5	Infection Control	Major	Likely	16	April 2013 update: infection prevention and control training remains in new entrant courses and CSR 1.13, including hand hygiene tuition. Staff will be issued the IPC training workbook as a CPD activity as well as receiving their core tuition. In addition, they receive ANTT, norovirus and sharps injury aide memoires for their PRF folders. Core subject areas (including IPC) will also undergo a quality assurance this year, to ensure they contain best practice information. IPC including hand hygiene is also included in all in one and induction sessions.	Steve Lennox	23-Oct-13	Moderate	Possible	9	To be fully compliant with CQC expectations and all staff to have up to date infection control training: 1. Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) 2. Monitor and implement hand hygiene training. 3. Need to capture the training of contracted staff on the scorecard.	1. C. Dodson-Brown / B.O'Neil 2. S.Lennox 3. S. Hines	1. Ongoing 2. Completed 3. TBA	Reports from the central training register	Minor	Unlikely	4	Reviewed by the IPCC 08/08/2013 - CSR 2013 commenced in June, containing a short IPC session and focussing on disseminating the IPC workbook. As at the beginning of August 690 places had been offered with 654 staff attending, in addition 144 staff had attended an earlier draft of CSR, this equates to 798 staff in total received CSR training since June, although there are no planed courses for Aug-Sept. CSR 2013 will continue until 65% of staff are trained Links to risk 355
389	There is a risk that… Unexpected cost liabilities arise from operating 111 Services from Beckenham that are either hidden, not directly attributable or outside of any contract terms with the commissioners.	Costs of providing support services (HR, Finance, PALS, procurement, IM&T) are unclear. the 111 service itself is quite immature and costs may not have fully emerged. If the site	13-Nov-13			Finance	Major	Likely	16	1. Due diligence process with NHS Direct to identify liabilities as far as possible. 2. Open book contract terms formally agreed commissioners. 3. KPMG & Deloitte reviews.	Jason Killens		Negligible	Possible	3	1. Site administration costed and provisioned. 2. Process for agreeing additional capacity costs over and above plan.	1. N. Daw / Commissioners 2. N. Daw / Commissioners	1. Nov 13 2. Nov 13	Highlighted risks are discussed and updated in regular project checkpoint meetings and project boards. Records of meetings and	Negligible	Unlikely	2	* NB open book funding essentially negates the risk, but it was agreed by the 111 transition project group to document New Risk added 13/11/13.
329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10		3,4,8	Finance	Catastrophic	Possible	15	1. 2012/13 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMG. 3. Extra financial provisions included for contract risk in 2012/13. 4. Communications with commissioners.	Andrew Grimshaw	21-Oct-13	Catastrophic	Possible	15	1. Review by Finance Investment Committee	1. K.Hervey		1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board. Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed. 3. Monthly meetings with PCT commissioners were performance is reviewed against targets and agreement is reached and findings are documented. 4. Performance is reported to the SHA monthly. 5. The Finance and Investment Committee will	Catastrophic	Unlikely	10	
373	There is a risk that crews will not carry out a comprehensive dynamic risk assessment when attending high risk addresses resulting in a delay in attending the patient	Custom and practice that crews do not do this as a matter of course	14-Jan-13			Clinical	Catastrophic	Possible	15	1. Recent new guidelines issued 2. Discussions taken place with ops, EOC and all interested parties including staffside reps 3. Policy reviewed and signed off by SMG 4. AOMs reviewing LAR yearly and scrutinise each new LA277. Also the Area Governance Reports are to be fed back to CQSE at alternate meetings reporting on the updating / removal or otherwise of patients in all groups, with particular attention to care plans / action plans as appropriate. 5. Education about the LAR and need to undertake dynamic risk assessments is included on the newly introduced Intern Programme.	Fionna Moore	21-Oct-13	Catastrophic	Possible	15	1. Emphasied through Ed & Dev to new staff / Internship programme. Needs to be cascaded to all staff via Team Leaders / DSOs and AOMs. This will be achieved Med Directorate input to Team LEader Conferences and Internship programmes. 2. Monitor incidents as a result of staff applying a dynamic risk assessment and not entering a call as a result 3. Monitor delays from attendance at known high risk addresses	1.Ops / Medical Directorate 2. John Selby 3. Patient Experiences/EOC/ Legal/Medical Directorate	1-3 Team Leader Updates delivered in March 2013. Internship Programmes delivered in Oct -12; Aug-13 and Nov-13. Team Leader Update courses September-13 & therefter monthly until Apr-14	Monitoring through CQSE (3x/year) SI Group PED Legal	Catastrophic	Unlikely	10	21/10/13 - No SIs or problematic inquests identified where a delay due to a high risk notification has occured.

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362	There is a risk that the absence of a medical devices tracking system may result in the Trust being unable to maintain and track equipment which could result in equipment not being available for patient use.	Impact on Complexes not being able to manage allocation of medical equipment to vehicles. Impact on patient safety if medical equipment is not available possibly resulting in a serious incident. Equipment is not serviced at the correct intervals and there are no indicators, if an item of equipment has not been maintained. Impact on patient safety if faulty equipment remains in use. Financial impact on the organisation through the increased likelihood of loss or theft of medical devices.	17-Apr-12			Clinical	Catastrophic	Possible	15	1. Occasional audits of equipment by complexes and logistics department. 2. Equipment lists are available from the company which maintains the medical devices, which includes services and non serviced items.	Paul Woodrow	23-Oct-13	Catastrophic	Possible	15	The Trust will ensure that appropriate equipment is provided on all front-line vehicles essential equipment = vehicle-based, portable, and personal-issue) 1. Implementation of asset tracking project 2. Monitor contractor's compliance with asset tracking process and vehicle inventory management 3. Review portable equipment supply	1. 2. Anne Fulcher 3. Anne Fulcher	1. Closed 2. Daily Monitoring 3. Daily Monitoring		Catastrophic	Rare	5	TO CONSIDER REGRADE KB/PW 08/07/2013 - Asset tracking is now routine business through the vehicle preparation team An equipment maintenance database is now in place which shows repairs and servicing of equipment. Personal issue BM kits have been rolled out for all staff, a proposal has been put in place to provide personal issue thermometers. This will improve the availability of small items of diagnostic equipment. New equipment is purchased with every new vehicle which should ensure sufficient equipment for all vehicles. As part of the Logistics Review a proposal has been put forward to centralise the budget for equipment repairs which will speed up repairs and improve availibility.
381	There is a risk that the service does not comply with DH guidance on the re-use of linen for patients and the quality of care delivered to patients may be affected which may have an adverse reputational risk to the Trust.	There is no service wide agreement for the provision and use of a sheet as a mattress protector. Blankets are re-used on patients and there is no consistent process for the swapping of blankets or sheets at hospitals. This has an impact on the quality of care delivered to patients.	07-May-13			Infection Control	Moderate	Almost Certain	15	1. Laundry contract in place for blankets. 2. Some local arrangements in place for swapping of sheets at hospitals. 3. Additional capacity for re-usable blankets in stores. 4. Disposable blankets available. 5. Swapping of mattresses by workshops to reduce risk from tears and damaged items. Elimination of repairs undertaken with tape.	Steve Lennox	23-Oct-13	Moderate	Likely	12	1. Negotiation to increase return of sheets and blankets from laundry provider. A proposal to supply trolley covers has been put forward by the Infection Control lead and will be discussed at the next IPCC meeting in November to remove the need to take sheets from hospitals for which there are no formal arrangements in place to launder or return to hospitals. 2. Options paper to be written and then discussed by working group.Favoured option was for a managed service which will be very expensive. This will next IPCC in November. 3. As part of the Logistics Review visits to hospitals in the south are being undertaken to build relationships with the hospitals and agree processes to retrieve LAS blankets that are left here. This will then be spread to all hospitals.	1. C.Vale 2. C.Vale 3. C.Vale / K.Merritt	1. 2. 3. Nov 2013	Return of sheets, monitoring process in place. Indication of blanket collection.	Minor	Unlikely	4	Reviewed by the IPCC 08/08/13 update: The committee agreed the directive is, that ripped mattress can be used as long as there is evidence that the mattress has been documented and a replacement arranged. The committee suggested that it would be helpful for an audit of ripped mattresses be undertaken and a report prepared on the processes around replacement. Steve agreed to ask Fleet for this information and to invite Ed Potter along to the next meeting for further discussion.
380	The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls will not be recorded. This could then impede investigations and clarification related to decisions made by control room staff and communication with patients and other agencies.	This relates to historic investigations in retrospect and clarification sought within the control room concerning the actual details of the conversation. Both Waterloo and Bow control rooms have recorders that integrate digitally with the main control room telephone system. These are set up to record the extensions within the Control rooms at each site. Currently the Bow Control room is a fall-back control room, however by April 2013 it is intended that this room will house the East Area Dispatch function and a proportion of overall call-takers. Later in 2013 it is expected that the West Area and a further proportion of call-takers will move to Bow so that the sites	05-Feb-13			IM&T	Moderate	Almost Certain	15	1. Detailed investigation by technology supplier. 2. Upgrade of Bow system to same software release as HQ (where we do not currently have the same issue) 3. Live monitoring during any event by technical staff. 4. Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2013/14.	Vic Wynn	29-Oct-13	Moderate	Likely	12	1. Non service affecting testing of FBC infrastructure to be undertaken to either prove cause of failure or confirm resolution. 2. Live testing of FBC infrastructure under load in combination with a live run for the East at Bow to prove that the fault has been resolved. 3. Introduction of alerts for the condition known to occur so that services can be restarted. 4. Validated explanation from supplier as to previous problems. 5. Consideration of implementation an alternative recording solution in parallel at Bow - but only if cost effective. 6. As part of the capital plan for 13/14 proposal to procure a new solution to encompass all recording across the Trust, as current system is end of life.	1. V.Wynn 2. V.Wynn 3. V.Wynn 4. V.Wynn 5. V.Wynn 6. V.Wynn	1. Feb 2013 2. 19 Feb 2013 Go live Upgrade completed for Go-live covers 1, 2 , 4 Unsighted on 3 - may not be possible 5 discounted. 6 Q2 2014	This has been identified as the highest risk to allowing bow to going live on 27 Feb as planned, as go live cannot take place without a reliable recording system. It is under close scrutiny from the Senior Supplier & User, Project Manager and Project executive. Progress is reviewed at each Monday review meeting.	Moderate	Rare	3	13/08/2013: In light of no further failures since the upgrade was applied, it is recommended this risk is now considered Moderate X Unlikely i.e. a risk score of 6. The target score can not be achieved while we are using end of life equipment that is unsupportable. 22/10/2013: No update required, risk is accepted until a new solution can be purchased.
345	The Trust currently receives a sum of £7.7m non recurring funding to maintain a CBRN (Decontamination) Response. There is a risk that the funding may not continue. The funding is used to fund 143 WTE and the hours required for annual CBRN training	Public sector funding constraints. No formal service level agreement in place	16-May-11		1,2,3, 4,8	Finance	Catastrophic	Possible	15	A draft CBRN SLA for 2013/14 in the amount of £7.7m (no change from 12/13) has been sent by Peter McKenna to NHS England for consideration. Awaiting response from NHSE.	Jason Killens	21-Oct-13	Catastrophic	Unlikely	10	1. Trust to attempt to gain assurances from DH that this funding will continue. 2. Reviewed by Finance Investment Committee.	1-2 A. Grimshaw	1. Feb 2013	1. Service Line Reporting	Catastrophic	Unlikely	10	

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315	There is a risk of service failure during relocation to the FBC because effective arrangements for continuity have not been made between LAS and the Metropolitan Police.	Lack of robust BC arrangements in event of full scale evacuation of EOC HQ	17-Aug-09	***	17	Business Continuity	Catastrophic	Possible	15	1. New arrangements agreed with surrounding Trusts to take LAS 999 calls in event of total loss of HQ during Olympic period which need formally agreeing via NDOG as a permanent solution. 2. 2nd Control room went live at located at Bow 27-2-13 2. Smart numbers implemented 20-2-13 which allow for a rapid transfer of calls in a case of total loss of a site	Jason Killens	04-Mar-13	Catastrophic	Unlikely	10	Status Quo				Catastrophic	Rare	5	KB/PW 08/07/2013 - Formal MOU has been signed with surrounding ambulance services to take LAS999 calls if there is a catastrophic failure. Two control rooms now running live
353	There is risk that Operational ambulance staff and Emergency Operations Centre Staff are unsure of the safe systems of working/procedures in relation to railway trackside working, due to the rare occurrence of such incidents.	Lack of regular exposure to this risky environment	23-Nov-11		5,7	Operational	Catastrophic	Possible	15	1. Emergency Medical Dispatchers (EMD) receive familiarization and procedural awareness during initial training and during their dispatch training course. 2. Work Based Trainers oversee adherence to procedure during placements Student Paramedics receive trackside awareness training during initial training. 3. "Trains Can Kill" card included in Major Incident Action Cards as point of reference. 4. Contingency Plans in place for calls on Network Rail, LUL, DLR and Croydon Tramlink calls including safety awareness information. 5. Operational bulletins available via The Pulse. 6. Trackside Awareness Training provided for all student paramedics and trainee emergency medical dispatchers including demonstrations of short circuit devices 7. Revised policy and procedure in place setting out requirements when attending railway incidents	Jason Killens	03-Jul-13	Catastrophic	Unlikely	10	1. Develop e-learning package for operational managers to enhance safety. 2. Inclusion of railway incidents session in Q3/4 12/13 ops managers EP updates. 3. LAS has engaged with other multi-agency partners since 2012 regarding best practice. 4. Monthly multi-agency trackside training using three live scenarios.	1. W.Kearns 2. L.Lehane 3. W.Kearns		1. Manager briefings Undertaken 2. EOC briefings undertaken 3. Publications in RIB / LAS News / Pulse	Catastrophic	Rare	5	Monthly exercises now superseding e-learning where appropriate.
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	***	1,2,4, 5	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from data cards. 5.LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units. 6. New Malden pilot has trialled the transmission of data from the LP15	Fionna Moore	21-Oct-13	Moderate	Possible	9	1. To highlight the importance of clinical incident reporting in the Team Leader Clinical Update Course. 2. Audit of FR2 data cards and card readers. 3. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 4. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 5. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area. 6. Consider roll out of transmittable data from LP15 once vehicle on station	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread 6. M.Whitbread	1. Complete 2. Ongoing 3. Ongoing 4. Ongoing 5. Ongoing 6. Ongoing post N/Malden pilot evaluation	2. EOC briefings undertaken	Moderate	Unlikely	6	21/10/2013 No update on previous position.
200	There is a risk of loss of physical assets due to the risk of fire.		01-Jan-02	***	1,2,3, 4,7	Health & Safety	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2.Annual Fire Risk Assessments are undertaken by the Estates Department. 3. Fire Fighting equipment is sited at all strategic locations. 4. Premises Inspection Procedures require all premises to be inspected on a three monthly basis. 5. Local Induction Training requires managers to identify fire precaution to all new staff. 6. Updates of health and safety issues are provided at the Estates Meeting monthly. 7. Estates department annual assurance of Trusts fire safety compliance. 8. Fire Marshals are appointed by Line Manager 9. Fire & Bomb evacuation Policy 10. Update on premises inspection reported to Corporate Health and Safety Group Quarterly 11. Core skills refresher 2 includes vehicle fire precaution awareness training. 12. All operational vehicles are fitted with appropriate extinguishers and crew staff fire awareness is included in CSR 13. Local induction includes fire safety awareness. 14. Local testing of fire alarm systems occurs on a weekly basis 15. Local fire drills are taken on a 6-monthly basis	Tony Crabtree	25-Oct-12	Major	Unlikely	8	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training. 2. Estates department in process of undertaking annual fire risk assessments of all LAS premises	1. J.Selby 2. Estates Department	1. Ongoing 2. Ongoing	- Corporate Health and Safety Group - Emergency Evacuation policy. - Annual assessment undertaken by Estates. -	Minor	Rare	2	25/10/13 JS - Estates Department confirmed the commencement of 2013/14 assessments.
354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.	There could be an impact on service delivery, patient care and the Trust's reputation.	23-Nov-11		1,2,3, 4,7,8	Human Resources	Major	Possible	12	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff.	Tony Crabtree	25-Oct-13	Major	Possible	12	1. Implement recommendations from N30 review. Note - Actions from N30 internal review are all complete, and actions from the NHSL integrated action plan are on track -	1. Tony Crabtree	1. 2012/13		Major	Possible	12	25/10/13 A. Buchanan confirmed net assessment remains at Major x Possible = 12.

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282	There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.		03-Jul-07	***	1,2,5,	Business Continuity	Major	Possible	12	1. The move of business information from hard drives to network drives. 2. Part of the 2010/11 audit programme will test this facility and give assurances. 3. IM&T Infrastructure Team to review and take actions as appropriate.	Vic Wynn	23-Oct-13	Major	Possible	12	1. Audit to be carried out on the status of the move to network drives. 2. Ensure central data servers are backed up. 3. Fundamentally review how data is stored on local drives and potentially not backed up.	1 - 3 Paul Sulja	2. Complete 3. Feb 2014	Action 2 has been completed, this has been tested by recovering lost data, this is moving to BAU	Major	Unlikely	8	13/08/13: An Electronic Document Record Management (EDRM) project has been tasked with ensuring locally saved data is moved to servers. Work with the Information Asset Owners (IAOs) has commenced in August (13) and it is envisaged data migration will commence by October. 22/10/2013: There have been delays to commencing this project. Target date revised to February 2014.
386	There is a risk that tail lift failures on operational ambulances will impact on patient care.	Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07-Oct-13			Operational	Major	Possible	12	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis. 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with Lola compliance. Additionally independent inspections by the Freight Transport Association are undertaken. These are on a 10% inspection basis.	Andrew Grimshaw		Major	Possible	12	1. A review of operational tail lift design is being undertaken. 2. A review of an alternative tail lift provider is being undertaken. 3. A training program for workshop staff is to be rolled out covering fault finding awareness. 4. The maintenance of the tail lift will be increased to operate on a 12 week cycle rather than a 16 week cycle as specified by the manufacturers. 5. Signage will be placed within the AMB to indicate the type and correct operation of the tail lift in question.	1. P. Mann 2. P. Mann 3. P. Mann S. Westrope 4. P. Mann 5. P. Mann	1. Mar 2014 2. Mar 2014 3. Mar 2014 4. Dec 2013 5. Mar 2014	1. Motor risk management group review identified incident related to operational vehicles. 2. Corporate Health and Safety Group review all incident statistic trends. 3. Fleet management meet on a weekly basis and also review vehicle incident rate trends.	Major	Unlikely	8	New Risk October 2013
293	There is risk that that Patient Specific Protocols (PSP) and palliative care, out of hours forms, etc. may not be triggered by the call taker when the patient's address is identified during 999 call.	Incident where call taker had not picked up patient specific protocol	18-Feb-08	***	1,2,4, 5	Clinical	Major	Possible	12	1. The Senior Clinical Adviser has lead responsibility to PSPs. 2.The Clinical Hub Administrator has responsibility for PSP and CMC data 3. Input and maintenance are performed by Management Information who have introduced a range of control measures. 4. The Senior Clinical Advisor liaises with Management Information for the appropriate access to be provided to Clinical Support. 5. All relevant staff are periodically reminded of the requirement to correctly trigger PSPs, in particular call takers	Fionna Moore	21-Oct-12	Major	Possible	12	1. Increase in use and functionality of the Coordinate my Care (CmC) system across all London in conjunction with the Royal Marsden (owner of CMC) 2. Introduction of auto flagging of addresses in a data pull from CMC as well as interface with other stakeholders	1. D.Whitmore 2. David Whitmore/Sue Meehan/Vic Wynn	1. Sep 2013	1. Incident reporting. 2. Complaints monitoring. 3. Protocols and transfer procedure	Major	Unlikely	8	21/10/2013 We recomend that this specific risk is archived. However we recomend that a new risk is substituted. This new risk is that there are currently in excess of 1,000 addresses waiting to be flagged. This requires urgent action and possibly the employment of a temp to undertake the work, in the absence of any suitable "light duties" members being identified. SMT 13/11/13 - Did not agree to archive this risk until the new risk is put in place.
369	There is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level.	a) Changes to NED appointments and b) substantive/temporary (i.e. maternity leave) changes to the executive team.	08-Oct-12			Governance	Major	Possible	12	1. Executive structure confirmed and 5 appointments in place plus interim arrangements whilst recruitment underway. 2. Refresh of BGAF confirms progress being made and does not highlight any new areas of concern. 3. Appointments process for NEDs confirmed with TDA	Sandra Adams	29/10/2013	Major	Possible	12	1. Recruitment to Executive structure from August to October 2013. 2. Succession planning for NEDs being implemented with recruitment underway from September 2013.	1. Ann Radmore 2. Richard Hunt/Sandra Adams	1. Oct 2013 2. Dec 2013	1. Board effectiveness review and actions 2. BGAF report April 13 3. Recruitment underway for board posts and interim/designate arrangements provide additional assurance	Major	Unlikely	8	29/10/13 Exec recruitment underway with all but one post appointed to or with arrangements in place. EMT could be at full strength before end 13/14. Non-executive recruitment completes on 29/10/13. Clinical NED appointed and 2 further appointments to be made. Unclear as yet on TDA approval timescale.
370	There is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles.	The board of directors leads the strategic direction of the organisation and need to be able to articulate and support this both internally and externally to the Trust. New appointments to key roles such as the chief executive may lead to a change of strategic direction. This may impact on the FT application and destabilise progress against plans.	08-Oct-12			Governance	Major	Possible	12	1. Trust Board had agreed the strategic direction to 2017/18 and this is due for review in Autumn 13. 2. Changes to the structure of the executive team are now being implemented.	Sandra Adams	29-Oct-13	Major	Possible	12	1. Review of Trust strategy to 2020 is being developed with a programme of engagement through the Autumn 13 leading to final strategy being agreed in January 14. 2. Board appointments to be made in Autumn 13 for ED and NED with full Board in place from March 14.	1. Jane Chalmers	1. October 14	1. Successful recruitment to ED and NED positions with interim and designate arrangements in place for the next 6 months. 2. Final strategy signed off in January 2014. 3. Board development programme in place.	Major	Unlikely	8	SA 29/10/13 - On track

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360	There is a risk that the Trust will not achieve level 2 NHSLA compliance where there is a significant gap between policy/procedure and practice.	- some evidence which can be provided is not consistent with the processes outlined within the documents - non compliance with the related NHSLA standards may contribute towards overall non compliance with the NHSLA standards at a Level 2 assessment as the trust will not be able to provide evidence	09-Jan-12		1,2,4	Corporate	Major	Possible	12	1. NHSLA Level 1 compliance with 50/50 standards. 2. Established meetings with leads for NHSLA and CQC standards where gaps in compliance are monitored and actions agreed. 3. Audits conducted by Governance and Compliance Team on current CQC and NHSLA to identify non compliant areas.	Sandra Adams	290/2013	Major	Possible	12	1. Quality Performance Improvement Managers to be invited to attend compliance standards meeting on a regular basis. 2. Disseminate current compliance status with NHSLA and CQC standards at Directorate and Area meetings with actions required. 3. Level 2 gap analysis to be updated in conjunction with standard leads, including refresher training on PA and user guides circulated. 4. The first quarterly update provided by users, including uploading of all required evidence, as specified in the gap analysis. 5. The first of the quarterly governance audits, reviewing evidence and compliance ratings, providing feedback via user group and escalation of concerns via Compliance Assessment Group. 6. Informal visit/mock level 2 assessment with NHSLA assessor to review evidence of compliance and agree date for assessment. 7. Implementation of datix web to manage CQC . Evidence for NHSLA standards to be managed in folders.	1. GCT 2. GCT 3. Standard Leads 4. GCT and Standard Leads 5. GCT 6. GCT and Standard Leads 7. GCT & Standard leads	"1. From Oct 2012 2. From Oct 2012 3. Completed 4. Dec 2012 5. Jan 2013 6. May 2014 7. 13/14	Evidence and Compliance Group meeting minutes. Evidence folders 1:1 meetings with Standard leads	Major	Unlikely	8	29/10/13 JD - we still have not heard from NHSLA regarding the new assessment process and whether the existing one remains in terms of assessment next year
63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	***	1,2,4,5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	23-Oct-13	Major	Possible	12				1. Incident reporting. 2. Complaints/ claims monitoring. 3. Audit of single use policy	Moderate	Rare	3	Actions and owners are to be identified. S.Lennox and Sean Westrope to discuss.
272	There is a risk that the LAS may not achieve the full CIP due to new/unforeseen cost pressures.		03-Jul-07	***	8,10	Finance	Major	Possible	12	1. CIP has been agreed with SMG/ Trust Board. SMG/Trust Board review report monthly. 2. Monthly monitoring via Performance Accelerator. Monthly Finance Review includes detailed forecast. 3. 37 CIP related projects are integrated with the standard programme management arrangements through the Integrated Business Plan. 4. Continue to Identify further savings - monthly CIP reporting. 5. Continued collaboration with wider health care services.	Andrew Grimshaw	21-Oct-13	Moderate	Possible	9	1. Review as part of CIP monitoring 2. Review by Finance Investment Committee		1. Ongoing 2. Ongoing	1. CIP reported monthly to SMG and the Trust Board. 2. Programme Governance Structure 3. Finance Investment Committee	Moderate	Possible	9	No revisions made to risk
309	There is a risk of fraudulent activity from staff, patients and contractors.		16-Feb-09	***	4,5	Finance	Major	Possible	12	1. An annual Counter Fraud work-plan is agreed with the Director of Finance and is approved by the Audit Committee. The work-plan ensures that time is allocated to the Local Counter Fraud Specialist to undertake work in the areas of the Counter Fraud Strategy, inclusive of Creating an Anti-Fraud Culture; Deterring Fraud; - Preventing Fraud; Detecting Fraud, - Investigating any allegations of fraud that are received against the Trust; - Applying Sanctions that can involve disciplinary, civil and/or criminal hearings; - Seeking redress - seeking to recoup money that has been obtained from the Trust by fraudulent means. 2. RSM Tenon - audit function	Andrew Grimshaw	23-Oct-13	Moderate	Possible	9	1. Promoting an anti-fraud culture amongst Trust staff by giving presentations, distributing Counter Fraud literature, holding fraud awareness events. 2. Creating deterrence by promoting successfully locally and nationally investigated fraud cases. 3. Preventing fraud by reviewing Trust policies and procedures. 4. Detecting fraud by undertaking Local Proactive Exercises into areas of concern. 5. Undertaking of a Fraud Risk Assessment.	1-5. A. Grimshaw (via Trust Counter Fraud Group)	1-5. As scheduled in the Local Counter Fraud Specialist Annual Work Plan for 2012 / 2013	1. Reported incidents. 2. Trust Counter Fraud Group	Moderate	Unlikely	6	No revisions made to risk
308	There is a risk that LAS staff may suffer emotional or physical injury as a result of being subject to physical or verbal assault, and this may adversely affect the delivery of the service that the LAS provides and/or the reputation of the LAS.	Injury and Sickness Absence	01-Apr-11	***	1,2,5,7	Health & Safety	Moderate	Likely	12	1. The Local Security Management Specialist (LSMS) has developed a draft Trust Security Management Plan in accordance with Counter Fraud and Security Management guidance. 2. Serious Incident Reporting system will ensure information is regularly reported to NHS Protect. 3. Local management support, LINC and counselling services are available to staff	Tony Crabtree	25-Oct-13	Moderate	Possible	9	1. Conflict Resolution Training update is included in CSR 3 of core learning skills. 2. Review post-violence support procedure 3. Accreditation of 2 master trainers, and LAS with the Institute of Conflict Management, is progressing and should be complete by 30/09/2013	1. M. Nicholas 2. M.Nicholas 3. M.Nicholas	1. Core Skills refresher 3 will include CRT 2013/14. 2. Ongoing 3. Approval of funding Dec 2012.	1. Monitoring of Incident reports by CHSG. 2. Periodic of High Risk addresses.	Moderate	Unlikely	6	
223	There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process.	Unable to produce sufficient capacity to meet current and ongoing demand levels	12-Jun-06	***	4,5	Operational	Moderate	Likely	12	1. Demand management strategies deployed to reduce overall activity. 2. Use of third party capacity at times of peak demand.	Jason Killens	08-Jul-13	Moderate	Possible	9	Recruitment to establishment	1. Tony Crabtree	1. Q3/4 2012/13		Moderate	Unlikely	6	

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164	There is a risk that Policies and Procedures are not adhered to due to lack of staff awareness and robust implementation plans.	Serious incidents often show that non-compliance with policy is often the root cause of an incident	04-Jan-05	***	1,2,5, 8	Corporate	Moderate	Likely	12	1. NHSLA level one achieved in October 2012 2. Incidents and serious incidents where policy has not been followed and action is required is monitored by the SMT. 3. All new policies and procedures and significant amendments are announced in the RIB.	Sandra Adams	23-Oct-13	Moderate	Possible	9	1. Where there has been a breach of policy, Owners/E&D to be requested to arrange appropriate training and awareness for staff.	1. S. Moore	1. When required	NHSLA level 1 Review of incidents and complaints to ascertain any breach of policy. The SI action plan is reviewed and updated by the SMT.	Moderate	Rare	3	Proposal to close this risk and replace with a risk that brings the issue back to Patient Safety with the ownership placed on operations to monitor compliance and take remedial action where required. SMT 13/11/13 - Did not agree to archive this risk until the new risk replaces it.
356	There is a risk arising from no provision for protected training time for clinical and paramedic tutors. This may as a consequence cause:- ● Dilution of training skill levels ● Credibility and reputation concerns of trainers ● Impact on the validity of clinical training	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	23-Nov-11		1,2,4, 5	Human Resources	Moderate	Likely	12	1. All tutors have received a clinical update package. 2. All tutors have received major incident update training. 3. A clinical update training day has been provided to all clinical training staff. Additional clinical skills programmes have been run based on identified need in preparation for pre-winter 2013 Operational Support.	Tony Crabtree	25-Oct-13	Moderate	Possible	9	1. Inconjunction with the Medical Directorate plan sufficient places in an amended format to facilitate all of the training officers / clinical tutors to attend the clinical module which is being delivered for team leaders. 2. Propose specific monitoring report CESG.	1. B O'Neil 2.	1. April 2014	Course review and feedback by Education Governance Manager	Moderate	Rare	3	This is dependant on the demands of the modernisation programme and cluster activity on the department being mitigated in some way to allow for the development of training officers and clinical tutors.
222	There is a risk that lack of frontline management at weekends may reduce the level of support/advice available to staff		13-Jun-06	***	1,2,4, 8	Operational	Major	Possible	12	1. DSO annual leave is restricted to ensure 5 are always available pan-London. 2. Team Leaders are also available to respond to incidents in support of crew members. 3. This risk is reduced by safety training for crew staff and the advice to await the arrival of police in high risk situations. 4. A requirement for on duty Silver officer to respond where appropriate, for this reason the Trust has a duty AOM and a on-call AOM available at all times. 5. General broadcast to other vehicles where requirement for a manager is due to crew safety. 6. Clinical Support Desk is now in place and provides a route for staff to gain support and advice on a range of matters	Jason Killens	04-Nov-13	Major	Unlikely	8	1. Review new leave rules for DSOs. 2. Develop changes to ops management structure in the light of capacity review. 3. Operational management restructure to be prepared for consultation for Q4 post ORH review 4. Recruitment to vacant CTL posts in Q4 13/14.	1. J.Killens	1. Q3 2012/13 2. Q4 2012/13	1. Analysis of incident reporting	Major	Unlikely	8	
383	There is a risk that the processes and enabling technology for operating on paper across two sites are not sufficiently robust and resilient resulting in a delayed LAS response.	The CAD system logger software does not optimally support two site fall back to paper operations in its current configuration. This means that in the event of fallback to paper, there is a risk that any lost patient details could take longer to identify than if an enhanced configuration was adopted. The current logger issues and enhancements will affect patients for a single site fallback anyway, but it is considered the impact and possibility for confusion could be greater across two sites. The risk is considered much less in impact, however, than that of infrastructure failures leading to a failure at Waterloo without live backup at Bow and this is not therefore a risk for	07-May-13			Operational	Major	Possible	12	1. PC Logger with current configuration now enhanced to more directly support fall back to paper by substantially increasing print speed. 2.OP/66 operational procedure updated for two site paper operations.	Paul Woodrow	23-Oct-13	Major	Unlikely	8	1. Further Enhancements to PC Logger - RFC29 2. Dry run exercises of paper operations on two sites. Table top exercises and rehearsals - OP66 checks. 3. Audit check of SMG recommendations from CommandPoint SI relating to paper operations.	1. J. Downard 2. S. Goodwin 3. Medical and CS	1. TBC 2. April 2013 3. April 2013		Moderate	Unlikely	6	GF 23/10/13 No progress made. Operations propose change of ownership of risk to Vic Wynn
365	There is a risk that Board Members are unable to commit time required to prepare for becoming an FT Board of Directors.	Unplanned changes to FT related meetings, particularly with external stakeholders, may not be accommodated by NEDs who have other time commitments outside the LAS	03-May-12			Governance	Major	Possible	12	1. Schedule of committees includes SRP for strategic focus. 2. NEDs have a time commitment to LAS of 2.5 days. EDs are clear on their board and committee commitments. 3. Trust Board and SRP sessions extended to full day to incorporate development time	Richard Hunt	29-Oct-13	Major	Unlikely	8	1. Programme of Board development that focuses on becoming a well governed organisation. 2. All Board members have agreed PDPs in place. 3. Board effectiveness and committee review provides assurance on commmitment	1. Sandra Adams 2. Richard Hunt/Ann Radmore 3. Francesca Guy	1. March 2014 2. March 2014	1. Attendance schedule for Board development. 2. PDPs in place for all Board members.	Major	Rare	4	SA 29/10/13 On track
376	There is a risk that the Trust Board fails to fulfil all its statutory duties.	NHS Trust Boards have many requirements placed on them by external organisations such as CQC, NHSLA, Department of Health and Monitor, following authorisation as a Foundation Trust.	14-Jan-13			Governance	Major	Possible	12	1. Trust Board forward planner 2. Board assurance framework and corporate risk register 3. Full understanding of regulatory requirements 4. Annual Reporting and external annual audit opinion 5. Monthly board compliance statements submitted to the TDA.	Sandra Adams	29-Oct-13	Major	Unlikely	8	1. On becoming a Foundation Trust, adherence to Monitor's compliance framework 2. Quarterly governance submissions to Monitor 3. Independent assessment of quality governance framework 4. Self Assessment for FT Board Statements and Memorandum	1. S.Adams 2. S.Adams 3. S.Adams 4. S.Adams	2. Ongoing	Board sign off monthly statements of compliance	Major	Rare	4	22/05/13 SA amended target rating to major x unlikely = 8. 29/10/13 CQC compliance inspection positive.

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384	There is a risk that unsecured LAS equipment taken onto a third party Ambulance causing injury following an RTC	Injury to ambulance staff, patients or third parties	07-May-13			Operational	Major	Possible	12	1. PAS/VAS vehicles should comply with the construction in use and CEN regulations in respect to providing suitable and sufficient securing for equipment. 2. LAS operational staff when attending a patient in a third party ambulance, are required on occasions to dynamically assess the risk of transferring a critically ill patient using unsecured LAS medical equipment, against the foreseeable clinical risk to the patient. 3. LAS operational staff should use, where practicable, the third parties secured on board medical equipment	Jason Killens		Major	Unlikely	8	1. LAS operational staff should ,where reasonably practical, ensure that LAS medical equipment is secured on third party vehicles. 2. Operational bulletin reminder about securing, where possible, of LAS medical equipment on a third parties ambulance. 3. Purchasing have reviewed the existing PAS/VAS contract , with the aim to include the provision in future contract specification for stowage of a attending services equipment.	1. Operations 2. Operations 3. Purchasing	1. 2. ASAP 3.		Major	Rare	4	KB/PW 08/07/2013 - Risk assessment completed betweens safety and risk and ops. Bulletin delayed, not in final draft and to publish mid July
358	There is a risk that the joiners and leavers process is not established, leavers still have access to LAS information or have assets belonging to LAS.	There is a disconnect between HR processes and IM&T to ensure that leavers return all assets and accounts are disabled when the staff member leaves.	09-Jan-12		4	IM&T	Minor	Almost Certain	10	1. Removal of duplicate Employee IDs	Vic Wynn	23-Oct-13	Minor	Unlikely	4	1. Starters and leavers process documentation being created. 2. Complete and distribute 'Managers Guide to Administration' to Managers. 3. Ensure that assets held by the leaving member of staff are identified and returned on the last day of work; New leavers process starts 31/05/13. 4. Ensure that logical access to LAS systems is disabled when the staff member leaves. This is to include, as much as possible, this is to include all remote access and NHSmail accounts. Complete. New technology automatically removes access to LAS networks upon termination in the Electronic Staff Record (ESR).	1. A.Honour 2. G.Masters 3. A.Honour 4. A.Honour /G.Farquhar	1. Complete 2. Complete 3. May 2014 4. Complete	1, Starters and leavers meeting held every 2 weeks The new leavers process will ensure that line managers confirm they have collected any sensitive or valuable assets and compliance can be audited	Minor	Unlikely	4	22/10/2013: Only Action 3 remains, this is being mitigated through a new module in our ITSM tool. The current estimate may even be as late as this time next year, although the intention is for it to be in place by May 2014. The requirement is to put in place a CMDB to keep records of the introduction, change history and decommissioning of IT assets.
331	There is a risk that the Trust will not achieve the target of reducing its carbon footprint by 10% by 2015 (based on 2007 carbon footprint)	Underlying cause is the legal requirement on the Trust (in line with the rest of the NHS) to deliver on the commitment to reduce carbon footprint by 10% by 2015 (based on 2007/08 carbon footprint Scope 1&2).	06-May-10	***	4	Finance	Moderate	Possible	9	The Trust's five year carbon management plan has been endorsed by the Carbon Trust. The Plan outlines how the Trust will achieve reduction in carbon footprint primarily based on changes in response model - increased use of CTA, reduction in non-conveyance and Multiple Sends	Sandra Adams	08-Jan-12	Moderate	Possible	9	1. CMc 27/09/12: the Trust is exploring possibility of working external contractor re. Energy Services to continue to modernise our infrastructure and reduce our consumption by 15%. The Trust's Energy Manager is investigating joining the ReFIT programme which is a GLA sponsored initiative with the objective of improving energy conservation in London. 08/01/13: this is work in progress. 2. Management action plan will be overseen by Carbon Reduction Project Board (chaired by Mike Dinan). 3. 6 monthly progress reports will be submitted to the Finance & Investment Committee. 08/01/13: This was done in November 2012, available data suggests Trust is on track with carbon reduction measures. 2012/13 will be submitted to the FIC in May 2013. 4. Pilot projects to be undertaken in the buildings that have half hour meters measuring electricity usage. 5.Travel plan and supporting survey to be undertaken 6. Recruitment of green champions.	1.C.McMahon 2.C.McMahon 3.C.McMahon 4.C.McMahon 5.C.McMahon 6.C.McMahon	1. March 2013 2.quarterly 3. May 2013 4. March 2013 5. March 2013 6. March 2013	1. Regular reports to Carbon Mgt Project Board & 6 monthly progress report to the Finance & Investment Committee	Moderate	Unlikely	6	Data is being gathered for both Scope 1 & 2 on a routine basis and the indications are that the downward trend is continuing.
350	There is a risk that the establishment of a Clinical Commissioning Group and reconfiguration of the SHA and PCT's may result in a temporary reduction in stakeholder engagement and partnership working and subsequent delivery of improvements in the urgent and emergency care system.	Since the implementation of the Health Bill the following issues have been highlighted. 1) Impact on providing appropriate clinical care to patients. 2) Staff clinical decision making could be affected. 3) Impact on finance due to not achieving financial targets such as CQIN and Quality, Innovation , Productivity and Prevention. 4) Impact on performance due to increased turnaround times. 5) Reputation risk for the LAS through inefficient use of the health economy. 6. Ensuring ongoing support from CCGs for our FT application.	11-Jul-11	***	1,2,4, 10	Clinical	Moderate	Possible	9	1. Monthly monitoring of current care pathway usage. 2. Feedback mechanism in place of care pathways with commissioners. 3. Creating an evidence base and continuing a dialogue with commissioners to maintain clinically appropriate pathways and reported bi monthly to Clinical Quality Group. 4. A Clinical Quality Group to engage senior GPs from clusters in strategy and quality issues meets bi-monthly. 5. Membership and attendance at NHS London and cluster level unscheduled care boards and attended by CCG clinical commissioners provides further opportunity for engagement.	Jason Killens	18-Mar-13	Moderate	Possible	9	1. Attendance at cluster level clinical cabinets to gain support for LAS strategy and FT application.	1. J. Killens	1. April 2013	1. Established relationships with Senior Leads. 2. Commissioners and LAS CQG quarterly providing direct engagement with clinical commissioners 3. Strategic commissioning board meeting quarterly and attended by CCG clinical commissioners provides further opportunity for engagement.	Moderate	Unlikely	6	

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199	There is a risk to staff safety / vandalism/theft due to inability to adequately secure premises.	There is no overarching Security Risk Policy to coordinate and bolster existing security measures within the Trust and there is no identified specific group who oversee security issues.	01-Jan-03	***	7,8	Finance	Moderate	Possible	9	1. Operational managers in conjunction with H&S representatives carry out quarterly health and safety premises inspections. If there is a perceived security issue it will be reported to Estates who will investigate and take appropriate action. 2. OP/018 Procedure On Station Duties. 3. Bulletin reminding staff to secure premises when leaving unattended. 4. Security Management Policy has been developed and has been ratified by the EMT.	Sandra Adams	25-Apr-13	Moderate	Possible	9	1. Audit of security at stations has been undertaken and a schedule of full security audits has been drawn up and is being carried out. 2. To establish an internal security review group to monitor recommendations made following the outcomes of security audits. 3. Specific Security Section had been added to the Premises Quarterly Inspection schedule and is being rolled out during the first quarter of 2013/14.	1. M. Nicholas / John Selby 2. M. Nicholas 3. to be agreed 4. M. Nicholas	1. May 2014 2. June 2013 3. 2013/14	The controls will be monitored by the Safety & Risk Dept, reporting to the Corporate Health & Safety Group and also the Trust Internal Security Review Group, reporting to the ADG.	Moderate	Unlikely	6	
303	There is a risk of unavailability of critical patient care equipment on vehicles.	Equipment moved to satisfy operational needs for patient care	21-Oct-08	***	1,2,4, 8	Logistics	Moderate	Possible	9	1. New vehicle preparation contracts in place with new contract that will introduce electronic asset tracking in Q3/4 2012/13. 2. Regular equipment amnesty. 3. New capital equipment (defibs) purchased.	Paul Woodrow	24-Oct-13	Moderate	Possible	9	1. Trial of new LA1 forms to include equipment and VDI checks being carried in the West Area for 3 months commencing June 2011. 2. Following West area review, begin roll-out to East and South areas 3. New LA4 forms and Red Bags in place across trust 4. Surplus equipment held by make ready 5. Area based equipment stores to be established by logistics Q3/Q4 working with asset tracking				Moderate	Unlikely	6	PM 23/10/13. Personal Issue policy approved by EMT and roll out commenced at Pinner complex 5/8/13. roll out accross the service commence on 21/8/13 to all complexes for BM machine
364	There is a risk that changes to the external commissioning and provider support environment cause uncertainty and delay in progressing the FT application	Transitional arrangements commence in 12/13 within the SHA provider/FT application support team and within commissioning. If there are changes within those teams this may create delay to the FT application whilst there are gaps or handover arrangements taking place	19-Apr-12			Corporate	Moderate	Possible	9	1. Engagement of lead commissioner in FT development 2. Strategic Commissioning Board provides the opportunity to reinforce the LTFM requirements 3. Cluster letter of support – October 13	Sandra Adams	29-Oct-13	Moderate	Possible	9	1. Strengthen the commissioner engagement in reviewing and developing the 5-year strategy through the IBP and LTFM 2. Engage commissioners in the development and sign off of the downside scenarios 3. Letter of convergence is clean and unambiguous	1. J.Killens / S.Adams / A.Grimshaw 2. A.Grimshaw / A.Cant 3. A.Grimshaw/ S.Adams	1. Dec 13 2. Dec 13 3. Dec 13	1. Commissioner letter of convergence fully supports the LAS application and strategy 2. IBP and LTFM fully supported and signed off by commissioners 3. Downside scenarios updated and supported by the commissioners	Moderate	Unlikely	6	29/10/13 No further action on FT timeline or application at this stage whilst TDA, CQC and Monitor review the process.
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	***	4,7	Infection Control	Moderate	Possible	9	1) Safer cannula in place since 2009 2) Retractable capillary lance in place since 2013 3) Retractable IM/Sub Cut syringe training be rolled out as part of CSR 1.13 device to be introduced Q3 2013 once training has been embedded 4) New razor procured with cover which is securely attached 5) New sharps box procured with larger aperture to accommodate near patient disposal of razor 6) IO needles supplied with near patient "make safe" device 7) OH guidance in place for actions post sharps injury	Steve Lennox	23-Oct-13	Moderate	Possible	9	Minimise the risk of sharps injury: 1. Audit the cause of sharps injuries. 2. Place an article in LAS news.	1. H. Day 2. H. Day	1. Nov 2013 2. Completed	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	Reviewed by the IPCC 08/08/2013 - Eng-Choo Hitchcock to review how quickly staff are seen following a sharps incident with Gill Heuchen. There is currently no KPI for time form referral to appointment at the moment but as I said at the IPCC meeting and yesterday we are re-tendering/redesigning the service specification so this is an opportunity to create the thresholds and reporting we want for the future.
366	There is a risk that frontline staff may not be able to measure oxygen saturations on some paediatric patients, in particular infants due to an inconsistency in availability of paediatric pulse oximetry across the Service.	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured.	09-Jul-12			Clinical	Moderate	Possible	9	1. Article published in Clinical update Sept 2011 reminding crews not to withhold oxygen if pulse oximetry not immediately available and patient unwell. 2. Adult and paediatric pulse oximetry available on Lifepak 12/15s available on all frontline vehicles (probes ordered on eseries) 3. Portable Adult, paediatric and infant pulse oximetry probes are now ordered and awaiting dissemination to complexes for distribution	Fionna Moore	21-Oct-13	Moderate	Unlikely	6	1. June 2012 audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 2. Discussion ongoing as to optimum way to overcome problem of lack of paed probes 3. Discussion surrounding best way to distribute and track the new portable sats probes 4. Monitor CPI for difficulty in breathing CPI until end december 2013 for improvement.	1. Mark Faulkner 2. Mark Faulkner 3. Mark Faulkner / ADOs	1. 2. Complete 3. Complete 4. End December 2013	1. Adult, child and infant probes (LP15) are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes. 3. the new portable devices with paediatric probes have been been ordered and distributed to all complexes with a scale of issue of one / ambulance. 4. Monitors placed on vehicles since June 2013 with CARU monitoring CPI compliance.	Moderate	Rare	3	CONSIDER REGRADE CONSIDER WHY 366 and 367 ARE NOT AMALGAMATED (Should be patient not separate for Adults / paeds) Discussed at CQSEC 17/07/2013 who supported this action. 21/10/2013 Assurances to be obtained via the difficulty in breathing CPI for pre-treatment SPO2 measurements. (Initial indications for the three month period post implementation is an increase in te documented SPO2 measurements).

London Ambulance Service NHS Trust
Risk Register 29th October 2013

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
367	There is a risk that oxygen saturations may not be able to be measured immediately after arrival of the crew (at present oxygen saturations can only be measured using a Lifepak 12/15 which can be removed from the vehicle but, being a large piece of equipment is not usually taken in initially with the primary response bag, AED and oxygen bag).	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured. In addition, oxygen may be administered to COPD patients who do not require it (or higher levels than necessary may be administered).	09-Jul-12			Clinical	Moderate	Possible	9	1. Article published in Clinical update Sept 2011 reminding crews not to withhold oxygen if pulse oximetry not immediately available and patient unwell. 2. Adult and paediatric pulse oximetry available on Lifepak 12/15s available on all frontline vehicles (probes ordered on eseries) 3. Portable Adult, paediatric and infant pulse oximetry probes are now ordered and awaiting dissemination to complexes for distribution	Fionna Moore	21-Oct-13	Moderate	Unlikely	6	1. June 2012 audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 2. Discussion ongoing as to optimum way to overcome problem of lack of paed probes 3. Discussion surrounding best way to distribute and track the new portable sats probes 4. Monitor CPI for difficulty in breathing CPI until end december 2013 for improvement.	1. Mark Faulkner 2. Mark Faulkner 3. Mark Faulkner / ADOs	1. 2. Complete 3. Complete 4. End December 2013	"1. Adult, child and infant probes (LP15) are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes. 3. the new portable devices with paediatric probes have been been ordered and distributed to all complexes with a scale of issue of one / ambulance." 4. Monitors placed on vehicles since June 2013 with CARU monitoring CPI compliance.	Moderate	Rare	3	CONSIDER REGRADE CONSIDER WHY 366 and 367 ARE NOT AMALGAMATED (Should be patient not separate for Adults / paeds) Discussed at CQSEC 17/07/2013 who supported this action 21/10/2013 Assurances to be obtained via the difficulty in breathing CPI for pre-treatment SPO2 measurements. (Initial indications for the three month period post implementation is an increase in te documented SPO2 measurements).
271	All staff may not be in possession of a valid driving licence for the category of vehicle they are required to drive.	Driver of vehicle does not hold valid licence	14-Mar-07	***	4,5,8	Operational	Moderate	Possible	9	1. All staff have their driving license checked upon recruitment. 2. Driving licence checks should be undertaken for all service drivers on a 6-monthly basis (TP023a/TP065). 3. All staff claiming mileage must declare whether they have a valid driving licence.	Jason Killens	00411/2013	Moderate	Unlikely	6	1. The Trust is exploring an automated system to check licences directly with the DVLA.		1. & 2. TBA (following review)	1. Internal Audit	Moderate	Rare	3	KB/PW 08/07/2013 - A proposal for a driving standards unit will go to EMT. Some automation of reports being looked at. Paul Newman investigating some automatic checks with DVLA. Covered in PDRs and area governance meetings

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London Ambulance Service NHS Trust
Finance Report 2013/14
Month 7: October

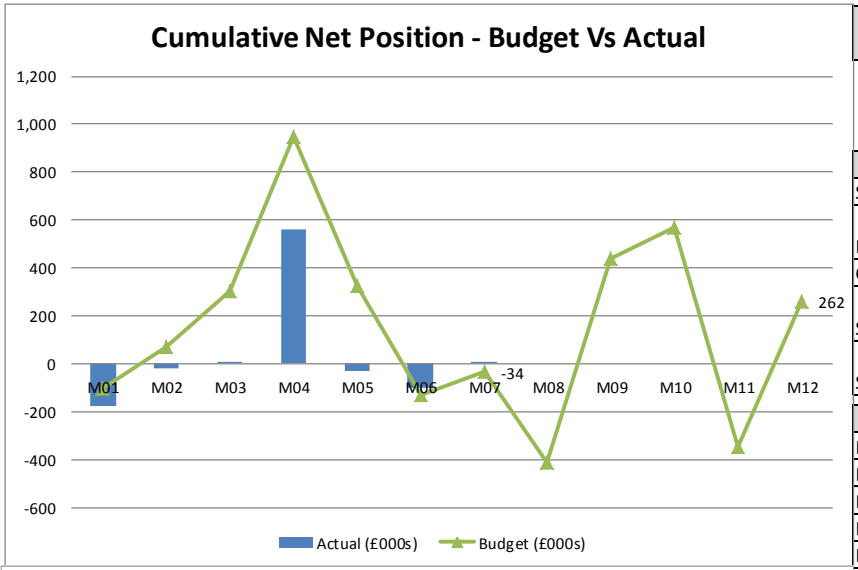
Trust Board PART 1 – 26th November 2013

Andrew Grimshaw
Finance Director

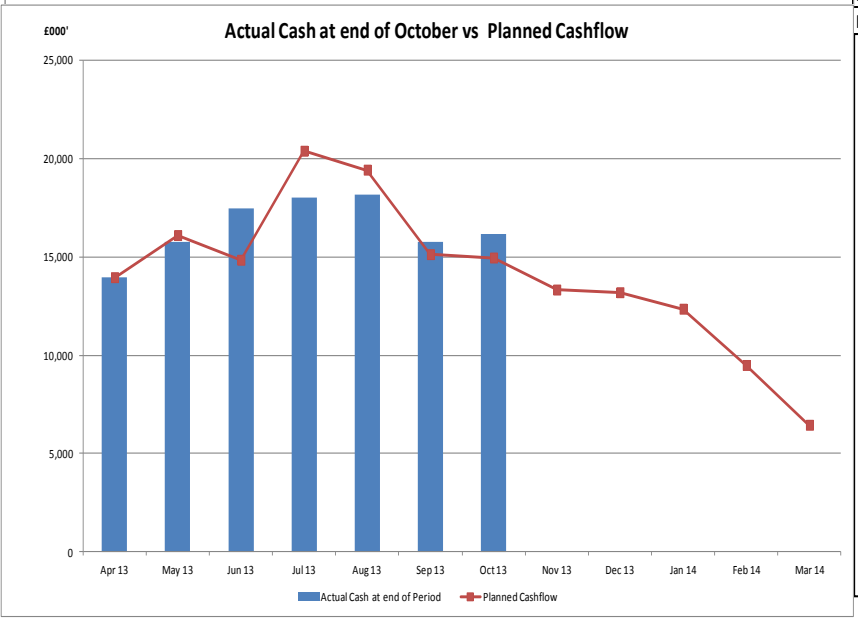
Executive Summary

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the trust reported an on plan. YTD the trust is on plan. The trust still expects to deliver its £0.3m year end surplus position. However, the continued failure to deliver 75% must be seen as a risk to this. The risk to maintaining the YTD plan position is driven by a number of factors including excess relief costs in operational staff groups. This has meant additional usage of premium resource such as overtime and private ambulance services.	**AMBER**	**AMBER**
Income	Income is £0.1m favourable in month and £1.3m adverse YTD. Risks to the full year position include shortfall in core income (currently managed through reserves), and Hospital Turnaround Penalties (YTD £0.08m impact adverse). Mitigation has been seen in the form of better than expected PTS performance (£0.2m), Additional A&E Journeys (£0.4m) and 111 income (£0.3m).	**GREEN**	**GREEN**
Expenditure	In month spend is £0.1m adverse, YTD there is a favourable variance of £1.3m; this is driven by ongoing vacancies in substantive pay (e.g. admin and clerical and frontline). Operational Pay is currently £1.0m adverse YTD when 3rd Party is included and this is not sustainable in the longer term. The modernisation programme will look to address the current inefficiencies in front line delivery.	**AMBER**	**AMBER**
CIPs	Currently reporting behind schedule YTD by £0.1m 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 on 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 £1.2m above plan. This is mainly due to a increase in trade creditors, increase in debtors and decrease in borrowings. 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	2013/14 - Month 7			Year to Date			FY 2013/14
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus	98	110	12	(34)	5	39	262
EFL	227	(450)	(677)	(10,065)	(11,650)	(1,585)	(2,288)
CRL	1,317	162	(1,155)	4,502	1,490	(3,012)	10,250
Suppliers paid within 30 days - NHS	95%	61%	-34.0%	95%	58%	-37.0%	95%
Suppliers paid within 30 days - Non NHS	95%	84%	-11.0%	95%	82%	-13.0%	95%
Monitor							
EBITDA %	6.8%	6.2%	-0.6%	6.0%	5.9%	0.0%	6.3%
EBITDA on plan	1,705	1,539	(166)	10,223	10,099	(124)	0
Net Surplus	98	110	12	(34)	5	39	262
Return on Assets	2.02%	1.87%	-0.1%	0	0	-0.1%	3.56%
Liquidity Days	(8.64)	(8.72)	-0.1	(9)	(9)	-0.1	(8.63)
Monitor FRR net rating		3			3		



- In month on plan.
- Year to date on plan; Ongoing pressures:
  - Management of operational staff – especially relief factor
  - CIP delivery
- EFL variance due to higher than planned cash balance and higher repayment of borrowings.
- Cash is £1.2m above planned. This is mainly due to a increase in trade creditors and borrowings, increase in debtors and lower than planned capital expenditure.
- The Trust would expect to score an FRR of 3 against the current Monitor metrics.
- CRL position – The Capital plan is currently £3.0m behind plan due to programme delays but the full Capital allocation of £10.3m is still expected to be spent

Statement of Comprehensive Income

2013/14 - Month 7			Description	Year to Date			FY 2013/14	
Budg	Act	Var		Budg	Act	Var	Budg	Fcast
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000	£000
			Income					
22,264	22,248	(16)	Income from Activities	152,228	152,128	(100)	262,415	
2,738	2,683	(55)	Other Operating Income	18,959	17,753	(1,206)	32,417	
25,002	**24,931**	**(71)**	**Subtotal**	**171,187**	**169,881**	**(1,306)**	**294,833**	
			Operating Expense					
17,840	16,879	961	Pay	125,515	120,174	5,341	215,797	
5,457	6,513	(1,056)	Non Pay	35,449	39,608	(4,159)	60,327	
23,297	**23,392**	**(95)**	**Subtotal**	**160,964**	**159,782**	**1,182**	**276,125**	
1,705	**1,539**	**(166)**	**EBITDA**	**10,223**	**10,099**	**(124)**	**18,708**	
6.8%	6.2%	0.6%	**EBITDA margin**	6.0%	5.9%	0.0%	6.3%	
			Depreciation & Financial					
1,236	1,112	123	Depreciation	7,657	7,657	(0)	13,990	
326	296	30	PDC Dividend	2,284	2,260	23	3,915	
45	20	25	Interest	317	177	140	540	
1,607	**1,429**	**178**	**Subtotal**	**10,257**	**10,094**	**163**	**18,446**	
98	**110**	**12**	**Net Surplus/(Deficit)**	**(34)**	**5**	**39**	**262**	
0.4%	0.4%	0.0%	**Net margin**	0.0%	0.0%	0.0%	0.1%	

- The Year end forecast is for a surplus of £0.3m
- The YTD trend has improved and is on plan
- Income is adverse due to lower than planned central income (£2.6m) offset by improved PTS performance (£0.2m), A&E journey (£0.4m) and 111 related income (offset by cost)
- Pay is showing a favourable position overall (£5.3m) due to vacancies across the trust. However, frontline pay (including PAS usage) is showing £0.9m 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 on £0.6m adverse 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. This is excluded from the Trust 13/14 financial performance total reported to the NTDA and therefore it is also excluded here.*

Statement of Position: YTD

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Oct-13		
	Act	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000	£000			
Non Current Assets											
Property, Plant & Equip	119,021	118,240	117,414	119,201	118,434	117,675	117,021	116,362	116,549	(187)	-0.16%
Intangible Assets	13,628	13,478	13,328	13,061	12,869	12,690	12,864	12,663	12,945	(282)	-2.18%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	0	
Subtotal	132,649	131,718	130,742	132,262	131,303	130,365	129,885	129,025	129,494	(469)	-2.34%
Current Assets											
Inventories	3,264	3,176	3,310	3,217	3,248	3,280	3,311	3,247	3,264	(17)	-0.52%
Trade & Other Receivables	16,075	18,604	15,797	14,875	15,267	15,972	16,670	18,602	14,055	4,547	32.35%
Cash & cash equivalents	5,500	13,968	15,747	17,486	18,028	18,164	15,770	16,171	14,944	1,227	8.21%
Total Current Assets	24,839	35,748	34,854	35,578	36,543	37,416	35,751	38,020	32,263	5,757	40.04%
Total Assets	157,488	167,466	165,596	167,840	167,846	167,781	165,636	167,045	161,757	5,288	3.27%
Current Liabilities											
Trade and Other Payables	(24,546)	(34,792)	(32,694)	(33,091)	(32,613)	(32,861)	(31,553)	(33,021)	(30,169)	(2,852)	9.45%
Provisions	(2,098)	(1,000)	(1,000)	(2,098)	(2,098)	(2,098)	(1,908)	(1,908)	(1,281)	(627)	48.95%
Borrowings	(309)	(263)	(263)	(263)	(263)	(263)	(263)	(263)	(247)	(16)	6.48%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,197)	(37,299)	(35,201)	(36,696)	(36,218)	(36,466)	(34,968)	(36,436)	(32,941)	(3,495)	9.45%
Non Current Assets plus/less net current assets/Liabilities	129,291	130,167	130,395	131,144	131,628	131,315	130,668	130,609	128,816	1,793	49.49%
Non Current Liabilities											
Trade and Other Payables	0	0	0	0	0	0	0	0	0	0	
Provisions	(8,731)	(9,766)	(9,853)	(8,839)	(8,816)	(8,862)	(9,144)	(9,021)	(8,848)	(173)	1.96%
Borrowings	(641)	(661)	(641)	(427)	(377)	(380)	(379)	(330)	(641)	311	-48.52%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(4,343)	(4,343)	(4,343)	(4,343)	(4,343)	(4,343)	(3,721)	(3,721)	(3,721)	0	0.00%
Total Non Current Liabilities	(13,715)	(14,770)	(14,837)	(13,609)	(13,536)	(13,585)	(13,244)	(13,072)	(13,210)	138	0.00%
Total Assets Employed	115,576	115,397	115,558	117,535	118,092	117,730	117,424	117,537	115,606	1,931	47.16%
Financed by Taxpayers Equity											
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	0	0.00%
Retained Earnings	20,053	19,874	20,035	20,395	20,952	20,590	20,284	20,397	20,083	314	1.56%
Revaluation Reserve	33,426	33,426	33,426	35,043	35,043	35,043	35,043	35,043	33,426	1,617	4.84%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	115,576	115,397	115,558	117,535	118,092	117,730	117,424	117,537	115,606	1,931	6.40%

> Non current assets stand at £129.0m.

Variance on non current assets
The land & buildings have been revalued as at 1st April 2013, by the district valuer this resulted in an overall increase on land and buildings of £1.9m. The capital programme is £3.0m behind plan.

Current assets are £38.0m

Variance on current assets

> Cash position as at October is 16.2m, this is £1.2m above planned. This is due to a higher than planned creditor balances being offset by a higher than planned debtor balances

> Receivables (debtors) are £4.8m below plan , Accrued Income £6.9m higher than planned and prepayments are £2.5m above plan .

> Receivables (Debtors) comprise principally trade debtors £5.9m, prepayments £5.8m and accrued income £6.9m.

Current Liabilities are £36.4m

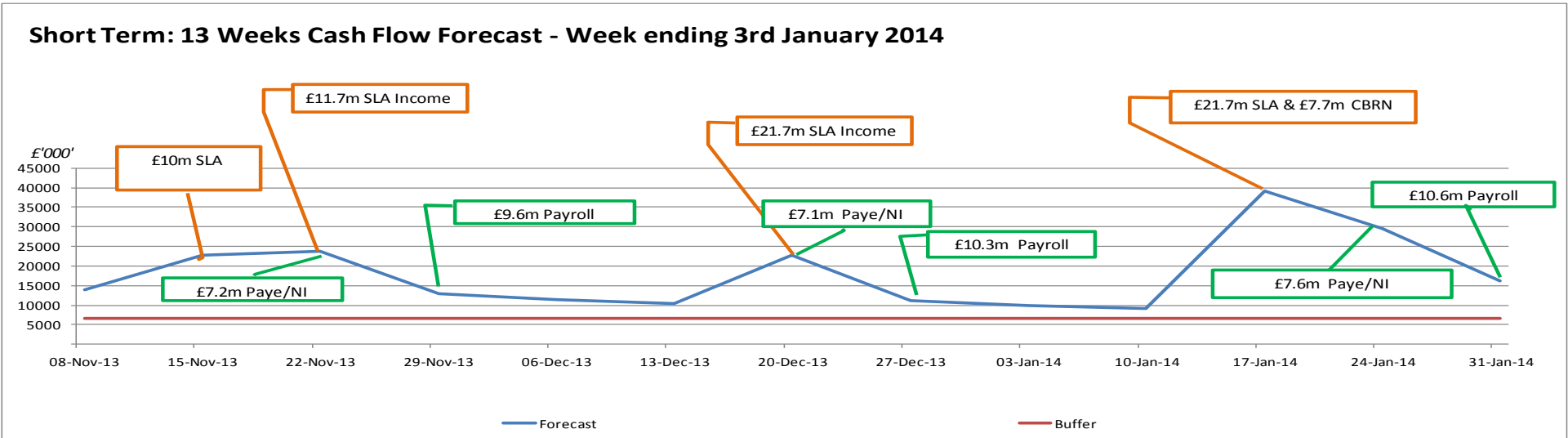
> Current Liabilities comprise principally trade payables (creditors) £8.9m, Accruals £5.3m, Deferred Income £3.2m, Other Creditors £11.5m, HMRC £4.1m, Borrowings £1.5m and provisions £1.9m.

Variance on current liabilities
Current liabilities variance was higher than planned due to higher trade & other creditors £7.8m, provisions £0.6m and lower than planned accrual £0.9m balances. The trust has a high volume of unapproved invoices and is accruing for the ORH transitional costs. Deferred Income is £4.0m lower than planned due to CBRN invoice being deferred while NHS England sorts out the contracting arrangements.

> Borrowings - No new loans were taken out during the year. In June the 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.

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

13 week Cashflow Forecast



Short Term: 13 Weeks Cash Flow Forecast - Week ending 31st January 2014

Week Ending	08-Nov-13 Forecast £'000	15-Nov-13 Forecast £'000	22-Nov-13 Forecast £'000	29-Nov-13 Forecast £'000	06-Dec-13 Forecast £'000	13-Dec-13 Forecast £'000	20-Dec-13 Forecast £'000	27-Dec-13 Forecast £'000	03-Jan-14 Forecast £'000	10-Jan-14 Forecast £'000	17-Jan-14 Forecast £'000	24-Jan-14 Forecast £'000	31-Jan-14 Forecast £'000
Bank Balance b/f	**14807**	**13997**	**22674**	**23799**	**12910**	**11406**	**10404**	**22868**	**11272**	**9790**	**9043**	**39217**	**29585**
Receipts													
CCG SLA Income		10000	11656				21656				21656		
Other NHS Related Income	37	30	391	40	42	35	1176	34		28	8130	511	27
111 Income							750				750		
Winter Pressures											900		
Other Receipts	216	91	90	341	62	188	194	311	48	139	63	62	311
Total Receipts:	**253**	**10121**	**12137**	**381**	**104**	**223**	**23776**	**345**	**48**	**167**	**31499**	**573**	**338**
Payments:													
Payroll Costs			(7211)	(9605)			(7135)	(10334)				(7566)	(10588)
Supplier Payments	(1042)	(1129)	(2792)	(1380)	(1243)	(1212)	(3066)	(1603)	(878)	(893)	(985)	(1771)	(1111)
DD's and SO's	(21)	(315)	(35)	(286)	(364)	(13)	(347)	(4)	(652)	(21)	(340)	(434)	(305)
Capital Payments			(974)				(414)					(434)	
NHS Suppliers													
PDC Dividend, Loan Repayments and Interest													
111 Pay & Non-Pay Costs							(350)						(750)
Winter Pressures													(900)
Other Payments													
Total Payments:	**(1063)**	**(1444)**	**(11012)**	**(11271)**	**(1607)**	**(1225)**	**(11312)**	**(11941)**	**(1530)**	**(914)**	**(1325)**	**(10205)**	**(13654)**
Net Receipts / (Payments)	**(810)**	**8677**	**1125**	**(10890)**	**(1503)**	**(1002)**	**12464**	**(11596)**	**(1482)**	**(747)**	**30174**	**(9632)**	**(13316)**
Bank Balance c/f	**13997**	**22674**	**23799**	**12910**	**11406**	**10404**	**22868**	**11272**	**9790**	**9043**	**39217**	**29585**	**16269**

Note - The £7.7 million expected from the Department of Health in July 2013 for CBRN has been delayed due to organisational changes at the Department. NHS England is currently putting into place the monitoring arrangements and payment mechanism. The estimated payment date is January 2014. This does not pose an immediate risk to the trust as we have sufficient cash to manage in the short term. The Impact of LAS action plan to improve operational performance over the winter period is not included in the above as it is still being developed.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER FOR ASSURANCE

Document Title:	**Report from Quality Committee**
Report Author(s):	**Roy Griffins, Non-Executive Director**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To ensure appropriate reporting between the committees and up to the Trust Board**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☒ Audit Committee (verbal update) ☐ 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:	**The recommendation to the Trust Board is to note the report**

Key issues and risks arising from this paper

- Quality oversight
- Governance structure
- Cost Improvement Programme monitoring
- 111 quality

Executive Summary

The attached paper provides an update from the Quality Committee meeting on 23rd October 2013. An oral update was also provided to the Audit Committee at its meeting on 4th November 2013.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

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:

Quality Committee 23 October 2013

Chair's summary report to the Trust Board

(this reflects the report given orally to the Audit Committee on 4 November)

1. Concerns were expressed by the Chair and others about attendance at the Quality Committee – formally quorate on this occasion only because one of the official members joined by telephone.
2. The hope and expectation was that the new enlarged membership of the Committee and its revised Terms of Reference within the Trust's new governance structure – which were endorsed by the Quality Committee at this meeting – would lead to the Committee's making a full and effective contribution to the Board's oversight of quality.
3. The Committee also:
   - reviewed the latest Quality Report;
   - received a progress report on progress with Clinical Audit recommendations, and were satisfied;
   - received a report from CQSEC.
4. The Committee was glad to note the results of the recent CQC inspection of the LAS: essentially a clean bill of health.
5. The Committee reviewed the implementation of the Cost Improvement Programme and had no concerns as to the impact on quality.
6. The Committee received a presentation about the governance of the NHS 111 services which was to be provided by the LAS in South East London. Members were sufficiently assured to lift the condition placed on the Trust Board's approval (of the previous day) of the 111 strategy and business case.
7. The Committee's new composition and Terms of Reference were agreed and endorsed, the Terms of Reference subject to minor changes which were subsequently effected and then endorsed by the Audit Committee.
8. The chairmanship of the Committee passed to Bob McFarland.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

Document Title:	**Audit Committee Assurance Report**
Report Author(s):	**Caroline Silver, Chair of the Audit Committee**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To receive an update on the key items of discussion at the Audit Committee meeting on 4th November 2013 and to receive assurance from the Committee.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ 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:	**To note the report**

Key issues and risks arising from this paper

None.

Executive Summary

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance.

Attachments

- Report from the Audit Committee meeting on 4th November 2013.

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

☐ Preventing people from dying prematurely
☐ Enhancing quality of life for people with long-term conditions
☐ Helping people to recover from episodes of ill health or following injury
☐ Ensuring people have a positive experience of care
☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
☐ Caring for the workforce

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper supports the mitigation of 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:

Report from the Audit Committee on 4th November 2013

STRATEGIC RISKS

1. There is a risk that we fail to effectively fulfil responsibilities to deliver high quality and safe care
2. There is a risk that we cannot maintain and deliver the core service along with the performance expected.
3. There is a risk that we are unable to match financial resources with priorities.
4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised.

ASSURANCES AND CONTROLS

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

The following controls are in place to support the management and mitigation of our strategic risks and these are referenced against each control as appropriate (eg SR 1.2.3.4).

RISK MANAGEMENT AND GOVERNANCE

Governance Structure – Audit Committee Terms of Reference (SR 1.2.3.4)

The Audit Committee agreed its terms of reference which had been updated to reflect the decision, following the governance review, for the Audit Committee to take on the board's oversight of risk.

Board Assurance Framework and Corporate Risk Register (SR 1.2.3.4)

The Audit Committee agreed the new format Board Assurance Framework which has been developed with input from the internal auditors and which is presented to the Trust Board today. The Audit Committee noted that the business risks relating to operations, workforce and non-delivery of the modernisation programme are yet to be fully articulated and will be presented to the next meeting of the Audit Committee in February 2014.

At each meeting, the Audit Committee will conduct an in depth review of a specific risk on the BAF. Sandra Adams and Andrew Grimshaw were asked to identify which risk should be subject to an in depth review at the next meeting.

The Audit Committee expressed some concern about the completeness of the risk register and asked Sandra and Andrew to conduct a scoping exercise to understand whether there are any risks which have not been articulated on the risk register. Internal Auditors were also asked to identify any examples of best practice.

Internal Audit Progress Report (SR 1.2.3.4)

The Audit Committee received an update from the internal auditors on recent internal audit activity. The Audit Committee was updated on the actions which are train to improve the management of serious incidents and asked for a further update to be provided at the next meeting of the Audit Committee.

Local Counter Fraud Specialist (SR 3)

The Audit Committee received an update on local counter fraud activity.

Report from Trust Board Sub-Committees (SR1.2.3)

The Audit Committee received updates from the Quality Committee and the Finance and Investment Committee, which are reported separately to the Trust Board.

COMPLIANCE

Fit and Proper Person Test (SR 1)

The Audit Committee agreed the proposal, which was made on the basis of legal advice, to apply the minimum background checks to existing and newly-appointed directors during 2013/14. These are DBS, interview and formal selection procedure, proof of qualifications and bankruptcy search. The Audit Committee is assured that the Trust already has good governance practice in place to support this, such as reviewing the skill set of existing NEDs, undertaking a skills assessment of executive directors, holding regular appraisals with directors and requiring all board members to declare any material interests at each board meeting and on an annual basis.

FINANCIAL REPORTING

Standing Orders

The Audit Committee noted that the Standing Orders and Standing Financial Instructions were under review. The Audit Committee endorsed the proposal to continue using the existing Standing Orders and Standing Financial Instructions until a revised version is presented to the next meeting on 3rd February 2014.

Accounting Policies

The Audit Committee approved an update to the accounting policies relating to the useful life of three cleaning machines which had recently been purchased.

Draft Year End Timetable 2013/14

The Audit Committee agreed the year end timetable for 2013/14.

Charitable Funds Benchmarking

The Audit Committee received a report which benchmarked LAS charitable funds with that of other ambulance service. This report demonstrated that the LAS was not a significant outlier. None of the other ambulance services conduct any specific fundraising activity and five ambulance trusts had voluntary responder groups in place.

Date of next meeting

The next meeting of the Audit Committee is on Monday 3rd February 2014.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 NOVEMBER 2013

PAPER FOR ASSURANCE

Document Title:	**Mental Health Annual Report 2012/13**
Report Author(s):	**Kudakwashe Dimbi & Steve Lennox**
Lead Director:	**Steve Lennox, Director of Nursing 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:	**To note the assurance offered within the report.**

Key issues and risks arising from this paper

The work pulls together the evidence regarding mental health care and draws the conclusion that the care provided to mental health patients is of a reasonable quality.

The greatest risk is to patients who have self harmed and ingested poison or toxic substances and this risk has been audited in the current year.

Executive Summary

The report describes the patient experience of our mental health care provision and concludes that overall a reasonable level of care is being maintained. There are three areas of work for concentration in the current year:

1. Management of patients who have self harmed through ingestion of toxic substances or poisons;
2. Safeguarding and mental health;
3. Education and training of our staff.

A mental health action plan is being progressed and a progress update was given within the annual safeguarding report.

Attachments

Mental Health Annual Report 2012/13

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☒ Preventing people from dying prematurely
- ☒ Enhancing quality of life for people with long-term conditions
- ☐ Helping people to recover from episodes of ill health or following injury
- ☒ Ensuring people have a positive experience of care
- ☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
- ☐ Caring for the workforce

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:

MENTAL HEALTH CARE

ANNUAL REPORT 2012/13

INTRODUCTION

1. In follow up to last year the team have developed a short report on Mental Health that pulls together the improvement work into a single record.

2. London Ambulance Service has continued to work to improve mental health care provision for the service in 2012-2013. Although not a part of our CQUIN scheme in 2012-2013 it has remained a priority within the service.

3. Poor mental health is the largest cause of disability in the United Kingdom. It is also closely associated with other problems, including poor physical health and problems in other areas like relationships, education and work prospects. The London Ambulance Service received 1,713,958 total 999 and cad-link calls in 2012-13. Of these, 19,433 were purely mental health calls accounting for 1.80% of all calls during this financial year (this does not include mental health factors encountered through attending non mental health causes). This was a slight rise from last year's figures. The London Ambulance Service acknowledges that for us to improve the way we respond to our mental health callers it is essential for the Trust to highlight the importance of mental health in their planning, putting it on a par with physical health with shorter waiting times.

4. Improvements in the area of mental health continue to draw wide spread support from patients. Although these callers make up only a small percentage of our work, mental health calls can be time consuming for responding call takers and assessing and deciding on the disposition of calls is not always straight forward.

5. Mental health remains a public health issue, with numerous reports published in 2013 focusing the spotlight firmly on mental health provision across the NHS including ambulance services. High profile reports have included the Winterbourne View Report which revealed abuse against vulnerable people with mental health problems and learning disabilities in a private care home and the Trust has previously responded to this report.

6. Another report was the Independent Commission on Policing and Mental Health Report by Turning Point Chief Executive, Lord Victor Adebowale. The review was launched in 2012 at the request of the Metropolitan police after a series of deaths in custody involving people with mental health issues. The report concluded that the failure of ambulances to attend a number of mental health crisis situations had left police with "no option" but to transport people in mental distress in police vans. Following the publication of this report another piece of work commissioned by the CEO group for the nine mental health trusts in London commenced looking at the difficulties associated with patients at places of safety detained under section 136 of the mental health act and surrounding issues.

7. One difficulty revealed through this work was that whilst the code of practice of the Mental Health Act expects ambulances to transport people detained by the police under section 136 to a place of safety, in practice the task frequently fell to the police because an ambulance was not always available. This piece of work was to carry out an in depth analysis of this to assess just how accurate this claim was. As a result of the report from

this piece of work which was led by Mike Partridge, a section 136 action plan is currently being implemented across London by the Mental Health Trusts and the police.

8. In September 2012, The Department of Health published a paper titled *Preventing Suicide in England: A cross-government outcomes strategy to save lives.* This is a new strategy intended to reduce the suicide rate and improve support for those affected by suicide. Recommendations from this report include that appropriate training on suicide and self harm should be available for staff working in emergency departments and that a case for enhanced training should be developed.

9. The Prime Minister has also launched a programme which aims to deliver major improvements in dementia care and research by 2015. The Prime Minister's challenge on dementia builds on the achievements of the existing National Dementia Strategy in which the government will focus on improving the areas that matter most for dementia namely, awareness, quality care and research.

PATIENT SAFETY AND QUALITY

10. Patient safety remains the cornerstone of high-quality health care. London Ambulance Service continues to undertake a number of initiatives to improve the quality of care provided to mental health patients. These include incident and near miss reporting, use of information, patient feedback & involvement, complaints, concerns and compliments, clinical audit, good leadership and management systems.

11. A robust approach to organisational development and our performance management framework have also been included in the improvement of patient safety and quality. A vast amount of work has been undertaken to improve care provided to mental health patients even though there remains two measurements in the mental health clinical practice indicator (MH CPI) against which the Trust has not been performing well mainly around safeguarding referrals. The Mental Health Clinical Adviser, is now working closely with the Clinical Audit Research Unit (CARU) to help raise awareness of this aspect of care by addressing it complex by complex starting with the worst performing complexes. Actions include producing posters, aide memoirs, or simply highlighting specific aspects of care as an area of improvement on traffic light posters and meeting up and engaging with team leaders and Ambulance Operation Managers (AOM).

12. The London Ambulance Service focuses on the full range of enquiries from patients, the public and our partners and incidents reports from other health and social care agencies to help inform patient safety and self harm prevention strategies. The service has systems and processes in place to provide assurance that services they are commissioned and contracted to provide are safe and of a high standard. Many of these systems are already in place within the trust and will continue to be monitored throughout the year.

SERIOUS INCIDENTS

13. The Trust's Serious Incident process asks for all potentially serious incidents to be referred to the Serious Incident group for consideration. In 2012/13 the group considered four potentially serious incidents regarding mental health care and decided two of these met the SI definition and were declared.

CONSIDERED SERIOUS INCIDENT 1 (not declared)

14. The first considered serious incident was concerning a young female who had taken an intentional overdose. The call origin was at 23:53, category C2, to a female aged 32, taken an intentional overdose, conscious and breathing. This was reported by a mental health worker who was the origin. The call was dispatched at 01:18 who arrived on scene at 01:26. On arrival, the crew reported no reply at the address and the Metropolitan Police were asked to attend and assist. The patient report form (PRF) states MPS called by crew at 01:26 and arrived at 01:39 but states entry not gained until 02:10 (delay not explained). At 02:24 hours, the log shows a blue call placed to Charing Cross Hospital as the patient had a serious coma score of GCS3.

15. A similar situation occurred on 17 Sept 2007, where we received a 999 call from the Community Psychiatric Nurse to this same patient who had taken an overdose, logged in CAD as ?collapsed behind closed doors. The case raised in 2007 was an enquiry from the CPN on where the patient had been conveyed to. At the time the Serious Incident group decided that this was not a declarable incident. The patient had been intubated and admitted to ITU and had survived. The Group recommended that the LAS should contact West London MH Trust to discuss how they/we managed this patient in the future**.**

CONSIDERED SERIOUS INCIDENT 2 (not declared).

16. A second considered serious incident related to the Trusts attendance to a mental health patient who had murdered his neighbour. LAS had initially been called to the patient's residence on the 10th August but the ambulance was cancelled by the patient as not needed. On the 14th August, LAS were again called in the early hours of the morning to a patient at the same address, which appears to have been the man who committed the murder the following day. The CAD stated "rambling about having killed demons" and "everything now being clean". The crew had requested police to attend with them. Over the course of an hour they requested updates from EOC regarding police attendance but were told no estimated time of arrival had been given. The first crew were diverted to a nearby stabbing as there was no police resource available at the time. A second crew eventually attended 1.5 hours after the original crew left the scene and reported that the male was wandering outside and calm, he had allowed them into his property and the police were in attendance the whole time they were there. The police did most of the talking and although the crew believed him to be a mental health patient, he did not give them cause for concern so there was no reason to remove him from the property or convey him.

17. On the 15th August 2012, we were called to the neighbouring address where a woman had been murdered. A patient with what appeared to be psychiatric issues was arrested at the scene. It turned out that the assailant had been the man we had attended to the previous day. He had been under the care of St Anne's personality disorder services since 2008 with a diagnosis of a personality disorder until the 24th July 2012 when he was discharged back into primary care. He was known to all local agencies and a frequent caller of the metropolitan police. He had also numerous calls to the LAS in the previous five years but had not reached the frequent caller thresh hold. It was decided that this would not be a serious incident for LAS but that LAS would assist Metropolitan police and Barnet Enfield & Haringey Mental health trust who declared this a serious incident for their trust.

DECLARED SERIOUS INCIDENT 1

18. This related to a response time of 3 hours 30 minutes to a patient who had taken an intentional overdose. A 999 call was made by the patient at 08.27hrs on the day in question. The patient reported that he had taken an overdose of prescribed medication, and that he had been drinking. The call was processed through MPDS and given the determinant 23C2I – intentional overdose with abnormal breathing. This attracts a Category C2 30 minute ambulance response.

19. The Clinical Hub assessed the call at 08:33 and noted on the log that this was not suitable for an A&E Support crew. The call was held on the Sector Dispatch Desk due to high demand and lack of suitably skilled available resources, and an ambulance resource dispatched at 09:27, but this was cancelled for a higher priority call at 09:32.An attempt was made by the Clinical Support Desk (CSD) to call the patient back at 09:44, but there was no answer and the services of the Metropolitan Police were not sought. CSD upgraded the call to a Category C1 at this point, but there were no resources available to send. A further call back was made at 10:26 by the Sector Dispatch Desk to advise of the delay, but there was no answer, so a message was left, and again the request for police assistance was not considered.

20. The first ambulance resource, a Paramedic Team Leader arrived on scene at 11.18hrs and was unable to gain access to the premises. Police assistance was sought and access gained. The patient was found deceased. Resuscitation was not attempted and the patient was formally recognised as life extinct at 11.55 and a Verification of Fact of Death was completed.

21. It was concluded that due to the MPDS system triaging intentional overdose calls as a 30 minute response, there is limited time to attend the patient and convey to Emergency Departments for helpful intervention, such as administration of charcoal which can currently only be performed by clinical staff at the Emergency Department. During periods of high demand, the Trust cannot guarantee that a resource will attend the patient within the category C2 30 minute response time.

DECLARED SERIOUS INCIDENT 2

22. The second declared serious incident related to a call which originated from West London Mental Health Trust at St Bernard's hospital and the chief complaint was overdose at 21.42hrs. It was made clear that the caller was not with the patient and that the patient had called St Bernard's Hospital staff and disclosed that she had cut her wrists with a razor blade, taken an overdose and consumed alcohol. According to the PRF, she was intoxicated.

23. The patient had taken an overdose of an unknown quantity of an unknown substance. No one knew what condition the patient was in physically (i.e. changing colour, alert, breathing normally etc). It was not known when the patient had taken the overdose. There was no mention of a threat to staff or anyone else and it appears she was not known to be violent but a conclusion was made that she maybe potentially violent based on the fact that she was "armed" with a razor blade which she had been using to cut her wrists.

24. There was a delay in crews providing assistance due to the assumption that the patient was potentially violent and the police needed to be involved. By the time the police managed to gain entry, the patient was in cardiac arrest. She was eventually conveyed to hospital but did not survive.

COMPLAINTS

25. Complaints are in important part of the patient feedback process within London Ambulance Service. It has not been possible to quantify the number of mental health related complaints over the year as this is not coded in the Datix web system. However, The Patient Experiences Department continues to regularly seek assistance from the Trust's Clinical Adviser for Mental Health, in relation to clinical advice pertaining to complains with a mental health component. This may be to respond to an LA52 referral from a member of staff, an external agency referral, PALS enquiries or complaints. Our clinical adviser has responded to 20 such request this financial year. We have also continued to assist Acute and Mental Health Trusts with reports when an external Serious Incident has been declared with NHS London.

26. One such incident where advise and a clinical opinion was sought from the Clinical advisor for mental health related to ongoing difficulties the London Ambulance Service were facing with regards to the conveyance of mental health patients involving Barnet Enfield and Haringey Mental Health Trust, in particular St Anne's Hospital. A number of incidents had been brought to the attention of the Clinical Adviser through LA52s in a short space of time which included 5th September 2012 when LAS was called to Edgware community hospital to transfer a patient to the Mental Health Access Service in Silver Street. The Trust had been informed that the patient had been discussed and accepted by a psychiatrist on Silver Street. However, on arrival to Silver Street, the doctor had refused to accept the patient stating that the patient should be taken to Chase Farm Hospital. There seemed to be some confusion with regards to who would accept the patient at Chase farm. Reports from Edgware Rd team suggested that Chase farm had accepted the initial call and agreed that Silver Street would be an acceptable location. There however did not appear to have been any communication between Chase Farm Hospital and Silver Street. Silver Street staff claimed that they would not accept the patient as there was a possibility of the patient going into acute alcohol withdrawal even though the patient had been medically cleared and had not had a drink for 3 days and that they did not have the money in their budget to accept a transfer. 3 hours later it was agreed that the patient should be transferred to Chase Farm. Clearly this was not in the best interest of the patient.

27. A further incident related to a torrent of abuse received by LAS clinicians and police officers by a member of staff at St Ann's Hospital and there was no focus on the patient or the patient's needs. The Trust's clinicians were attempting to convey an informal patient to St Anne's Hospital for an assessment but were met by an angry member of staff who did not want the patient conveyed to St Ann's. Our mental health Clinical Adviser decided that in light of the frequency of incidents and LAS's commitment to successful partnership working it would be a good idea to arrange a meeting with BEH-MH Trusts to discuss these difficulties and work on improving our working relationship. A meeting was arranged with the local complex ambulance operation managers, the mental health advisor and representatives of the Mental Health Trust which helped to resolve some of the difficulties.

28. Another incident related to a patient's relative who was unhappy with the overall quality of care her sister had been given by the NHS. She felt that the services were disjointed and "not fit for purpose" The complainant's sister was a known patient to Oxleas Mental Health Trust who had a diagnosis and was under the care of a local community mental health team. According to the complainant, she had initially made contact with the patient's mental health team in an attempt to speak to her care co-ordinator to inform them of the crisis on 6 separate occasions between 12:48 and 14.15hrs without making any progress. She was eventually advised by the mental health team to dial 999 and take her sister to the emergency department where a psychiatrist from Oxleas would then come and see them.

29. The ambulance arrived within 20minutes of the 999 call. The patient was conveyed directly to the mental health unit but on arrival the staff declined to accept the patient as she was not under a section of the mental health act and they had not been pre-warned. They were advised to take the patient to the emergency department directly adjacent to the mental health unit to be seen by the mental health liaison team. Following conveyance to the emergency department at 17.15hrs, they decided to leave the department without being seen at 22.30hrs. Understandably, the patient was unhappy with the service she had received. It was explained to the patient and her sister that that Oxleas NHS Trust would lead on this complaint as essentially the problem lay with Oxleas who failed to provide an appropriate crisis service to a patient who was well known to them and explaining to the patient that LAS had no other alternatives but to convey her to the ED.

30. It was highlighted to the attending clinicians that mental health ACPs are not conveyance ACPs but rather to facilitate a conversation between the crews on scene and the Mental Health Trust and to come up with a recommendation/decision which could include conveyance direct to the Mental Health Trust. As no one from LAS had spoken to the mental health unit prior to conveying the patient to the mental health unit, the unit were unaware that the patient was coming and as per their protocol they could not admit them directly without a psychiatric assessment unless they had been under a section of the MH Act.

PATIENT EXPERIENCE

31. Patient Experience is one of the three domains of quality and provides feedback from patients and the public on their experience with the Trust. Patient feedback remains an important part of our learning from experience and this helps us to improve on the quality of service we provide to our patients. We continue to engage with our patients with regular attendances at the patients' forum as well as keeping close links with patient representatives who form part of our mental health committee meetings.

32. The London Ambulance service continues to receive valuable feedback from health professionals and other partners with the main theme remaining frustration at delays in dispatching resources or delays in conveyance of mental health patients. The London Ambulance Service remains committed to engaging widely with service users and the general public. Some future initiatives and ideas are under development and the Board will be kept appraised of these and will in due course receive feedback from these and other relevant events

ACTIONS TAKEN TO IMPROVE MENTAL HEALTH CARE

33. The initiatives below encapsulate the actions that the LAS are taking which lead to good results and improve the quality of care provided to our mental health callers.

34. The Mental Health Committee continues to run bi-monthly. It is now chaired by our Mental Health Clinical Adviser, with support of the Director of Nursing and Quality, both of whom are mental health trained nurses. The committee remains responsible for driving the trust's Mental Health Action plan which has been updated.

35. As a result of the Independent Police Commissioning Report, Work has been undertaken to draw up a Pan-London section 136 Action Plan. Members include The CEO group for the 9 Mental Health trusts with territorial responsibility for London, the Metropolitan Police, and London Ambulance Service. The Action plan sets out recommendations for each service in order to improve the patient experience of someone detained under section 136.

36. The Trust continues to progress with its mental health action plan. Following launch of the Mental Health ACPs in May 2013 action plans include monitoring the usage of the new mental health pathways, and identifying any issues that our crews face when trying to use them and reviewing them in 1year time.

37. Our clinical Advisor for Mental health has started to deliver teaching sessions for Clinical Paramedic Managers and Team Leaders as part of the "a time for change programme". Sessions include the Mental Health Act and clinical risk assessment in mental health.

38. Ongoing work to develop the skill set of the Clinical Hub staff continues. These staff have access to the Mental Health Clinical Advisor via email, phone or in person to assist with queries, complaints and general advice.

39. Joint working and collaboration remains good with LAS attending regular meetings with our partners. External meetings include the Mental Health Partnership Board, Mental Health Trust /MPS meetings which are attended locally by complex AOMs; London AMHP leads network meetings and most recently attendance at a National Mental Health Lead meeting which will be held bi-monthly allowing LAS to share good practice and network at a national level.

40. The new protocol for LAS response to calls from Approved Mental Health Professionals (AMHPS) or doctors to attend Mental Health Act assessments in the community which was launched last year continues to receive good reviews/feedback with the general consensus being that the overall responsiveness of the service as a result of the move to "real time" bookings has improved significantly,

41. In terms of education, The trust delivers a comprehensive suite of bespoke mental health e-learning modules as listed below:

    - Introduction to mental health
    - Approaching people with Mental Health
    - Patient consent
    - Depression

- Post Traumatic Stress Disorder
- Self Harm
- Common Drug problems,

42. In addition to the in-house material developed, we also provide staff access to e-learning material developed by the Social Care Institute for Excellence which includes an introduction to mental health and older people, risks and protective factors in older people's mental health, common mental health problems amongst older people, understanding depression in later life and services for older people with mental health problems. As the Trust was unable to deliver the Core Skills Refresher (CSR3) as planned, a decision was made to extend the current CSR by 1 ½ hrs. This will include sessions on the Mental Capacity, Adults at risk and children's Safeguarding and the Mental Health CPI.

43. One of our Clinical Involvement Officers, has continued to work very closely with Oxleas Mental Health Trust in Bexley. Part of his work has meant that the LAS have also been engaged with MH training in Bromley. There have been three multi-agency training sessions at the Princess Royal Hospital Education Centre and Community House, Bromley with over 100 participants, including police officers (MPS and BTP), community mental health teams, emergency duty teams, A&E psychiatric liaison, Green Parks House staff and LAS staff. The training involved each agency explaining their role and outlining some of the pressures they work under. We then looked at several scenarios around the correct and incorrect procedures for detention under the Mental Health Act. It is a very complex area and the training highlighted the difficulties each agency faces in terms of resourcing and the law.

44. Additionally the London Ambulance Service took part in a training video for the Metropolitan Police around the correct application of legislation for conducting Section 136 (removal from a public place). The STeLI (Simulation and Technology-enhanced Learning Initiative) section 136 Training DVD puts the views of service users at the centre of practice, and presents a very realistic set of behaviour by the professionals involved with their care. The DVD is very watchable and shows clear examples of good and bad practice. The DVD has now been made available to LAS staff at no cost. The film is on the x drive but is only viewable if a computer supports VLC; we are therefore currently exploring ways of distributing the DVD to all staff including uploading it onto the pulse and including it in our e-learning package in the long term.

DEMENTIA

45. In recent times, London Ambulance Service has been invited and continues to work with The Alzheimer's Society and have become a founder member of the Dementia Action Alliance. By joining the Pan-London Dementia Action Alliance and developing a short Action Plan, London Ambulance Service has become part of the national movement to improve the lives of people living with dementia.

46. Appendix I contains an explanation of the work of the Dementia Action Alliance Programme.

ALCOHOL

47. London Ambulance Service will be working with Alcohol concern to produce a report on the impact of alcohol on the ambulance service. This will be a collaborative project where all aspects of the project will be agreed by both parties. Alcohol concern will design the survey and write up the report with LAS sign-off and agreement. LAS will also help in distributing the survey to front-line staff. This will ensure that alcohol remains a priority for London Ambulance

CONCLUSION

48. Overall, we continue to make steady progress in the quality of care we provide to mental health patients with the majority of mental health related calls having a good outcome. There still remain some areas for improvement however, these have been identified as the Mental Health CPI and the way we triage and prioritise overdose calls. There is currently a piece of work ongoing with CARU undertaking a clinical audit assessing the management of overdose patients. A protocol for the audit has already been developed and a list of some draft standards against which we will assess the care given by crews. There are two sample groups, one which will look at the calls made to the LAS, the response times and categorization of the call and the second group will look at the PRFs and outcome data for patients seen by crews. The data source will be from November to January 2012, so the standards relate to the 2006 JRCALC guidelines. It is hoped that this work will give us some insight into the care we are providing to this group of patients.

49. The Mental Health CPI and the risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral for vulnerable patients and safeguarding children referrals within this patient group remains a concern within the service an there is ongoing work to improve this aspect of care.

50. The pre-hospital care of mental patients remains extremely challenging especially out of hours with other service provisions not providing as much support as we would like. In conclusion, the presentations will vary greatly in each case and care provisions will vary from one provider to the next but the more training we provide to our staff the more they are better able to negotiate and asset themselves in a confident manner with our partners. Although some training is being provided to staff, many feel that they are not getting adequate mental health training. The importance of getting the patient the help they require quickly and safely can not be overstated. This will reduce potential risks to both the patient and our staff.

51. Training remains the overarching principle and concern for our staff to allow them to feel confident and safe in their mental health practice.

SUBSEQUENT ACTIONS

52. Much has been achieved to raise the profile of Mental Health across the Trust and the improvement action plan is progressing. The main areas of concern 1) the management of overdose, 2) safeguarding and 3) training are incorporated into the action plan and progress is monitored at the Trust's Mental Health Committee.

53. An audit on the management of overdose has been completed and the recommendations are being considered by Operations and the Clinical and Quality Directorate.

APPENDIX I –Dementia Action Alliance

Dementia

In March 2012 the Prime Minister's made a number of challenges on dementia including a specific call that by 2015, up to 20 cities, towns and villages will have signed up to become dementia friendly. The Alzheimers society took the initiative to help London to become a dementia friendly city through both a top-down approach, via the Pan London Dementia Action Alliance, and locally, through local Dementia Action Alliances[1] at borough level.

A number of organisations have committed to a National Dementia Declaration; which is a set of seven outcomes informed by people with dementia and their family carers as below:

- I have personal choice and control or influence over decision about me
- I know that services are designed around me and my needs
- I have support that helps me live my life
- I have knowledge and know-how to get what I need
- I live in an enabling and supportive environment where I feel valued and understood
- I have a sense of belonging and of being a valued part of my family, community &civic life
- I know there is research going on which delivers a better life for me now and hope for future

By joining the commitment the LAS will work towards delivering this vision by taking action within our organisation and undertaking joint programmes of work. The Pan-London Dementia Action Alliance asks organisations to sign up to the National Dementia Declaration and come up with three actions they will take to make life better for people with dementia. The Pan London Dementia Action Alliance was launched on the 16th September 2013 at City Hall

The actions that the London Ambulance Service is considering are;

- Training and awareness campaign (some already being done via our e learning package)
- Encourage LAS staff to join Dementia Friends
- Raise Dementia awareness within LAS and find some Dementia champions across the trust

Dementia remains everyone's responsibility. At present, it is difficult to measure the number of people LAS respond to who have dementia as we do not generally receive a call for "dementia" but rather for falls, distressed carers, or other medical emergencies. It is felt that by joining the Pan-London Dementia Action Alliance, the Trust can have regular contact with likeminded organisations who are undertaking similar actions to improve the lives of people living with dementia.

Other benefits would include networking with members who they may not regularly come into contact with; e.g. sheltered housing and to showcase our achievements on the national DAA website and an opportunity to gain dementia friendly accreditation (through Dementia Friendly Community accreditation)

[1] A Dementia Action Alliance (DAA) is a membership of organisations wanting to improve their approaches to people living with dementia.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 NOVEMBER 2013

PAPER FOR APPROVAL

Document Title:	**Winter Sustainability Plan**
Report Author(s):	**Jane Chalmers**
Lead Director:	**Ann Radmore**
Contact Details:	**jane.chalmers@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide the Board with details of the plans and activities which are being put in place to sustain services through winter**
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 plan**
Key issues and risks arising from this paper To be advised at the Trust board meeting.	
Executive Summary The 2013/14 Winter Sustainability Plan will be circulated prior to the Trust Board meeting. The Trust Board will be asked to approve the plan.	
Attachments None. To follow.	

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Preventing people from dying prematurely
☐ Enhancing quality of life for people with long-term conditions
☐ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

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

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER FOR INFORMATION

Document Title:	**Chief Executive's Report**
Report Author(s):	**Ann Radmore, Chief Executive**
Lead Director:	
Contact Details:	
Why is this coming to the Trust Board?	**To provide an update**
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

None.

Executive Summary

This report covers the following items:

- The Keogh Report
- NHS England's five year strategy for specialised health services
- London Assembly Health Committee Report
- Government's Response to the Francis Report
- London Healthwatch Network at NHS England
- PRO QA (MPDS)/NHS Pathways
- Meeting with David Flory
- Executive Management Team interaction with Clinical Commissioning Groups
- 111 Step In
- Executive Director appointments

Attachments

Report from Chief Executive

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Quality Strategy

This paper supports the following domains of the quality strategy

☐ Preventing people from dying prematurely
☐ Enhancing quality of life for people with long-term conditions
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☒ 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:

CHIEF EXECUTIVE REPORT FOR THE LONDON AMBULANCE SERVICE TRUST BOARD MEETING HELD ON 26 NOVEMBER 2013

1. The Keogh Report

On 13 November Sir Bruce Keogh published Phase 1 of his report 'Transforming urgent and emergency care services in England'. The report contains five key headlines:

(1) We must provide better support for self-care to reduce avoidable attendances & admissions
(2) We must help people with urgent care needs to get the right advice first time
(3) We must provide a more responsive out of hospital service to prevent A&E being the default choice for urgent care
(4) We must ensure that medical emergencies are treated in the right facilities with the right expertise
(5) We must connect the whole urgent & emergency care system together through networks

The full report can be accessed here: www.nhs.uk/NHSEngland/bruce-keogh

2. NHS England launches major exercise to shape the future of specialised services

Patients, clinicians and other key stakeholders are being encouraged to get involved in the development of NHS England's five-year strategy for specialised health services. NHS England, in partnership with the Specialised Healthcare Alliance, and others, is organising a major scoping event on 9 December as part of the first phase of the development of the strategy. The event will be attended by representatives from the trust.

3. London Assembly Health Committee Report: Risks to Accident & Emergency (A & E) Services this Winter

On 12 November 2013, the London Assembly Health Committee published its report on the risks to A and E Services this winter. The key conclusions are as follows:

- The report highlights how attendances at the capital's A&E departments have risen by a third over a decade to 3.6 million each year and it warns A&E services, as they currently stand, are unsustainable in the long term.
- It says radical change is needed to cope with increasing demand in coming years and a clear London-wide plan will be needed for this is to happen. It will also be required to address the inevitable tension between those wanting rationalise services and local people's concerns about access to care.
- The Committee notes the Kings Fund's view that there is a vacuum in strategic leadership in London and is concerned that there is no clear London-wide plan for A&E services.
- It also calls on NHS England (London) to publish immediately proposals for how hospitals will deal with pressures this winter and wants more information on the Urgent Care Boards, which have drawn up the plans.

The full report can be accessed here:
http://www.london.gov.uk/mayor-assembly/london-assembly/publications/risks-to-london-a-e-services-this-winter

4. Government's Response to the Francis Report

The February 2013 Francis Report called for a 'fundamental culture change' across the health and social care system to put patients first at all times. It looked at six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour.

The Government calls for a cultural shift, built on candour and continuous improvement, which recognises and addresses variations in quality: *"Being honest and open about this and creating an environment in which problems are prevented, detected quickly and addressed firmly and in the interests of patients is the basis for re-establishing public trust"*. The Government sees the Francis recommendations as resonating across health and social care, and is explicit that its response applies equally to mental health and physical health services. Developments in this report include:

- The expectation of monthly reporting of ward-by-ward staffing levels
- Hospitals to set out clear routes for patients to raise complaints and concerns, with trusts reporting complaints data and lessons learned on a quarterly basis
- A statutory duty of candour on providers, and a professional duty of candour on individuals through changes to professional guidance and codes
- Consultation on whether trusts should contribute to the NHS Litigation Authority's compensation costs when they have not been open about a safety incident
- Legislation to hold accountable those responsible for wilful neglect
- A fit and proper person's test which will act as a barring scheme
- A protocol to minimise bureaucratic burdens on Trusts signed by all arm's length bodies and the Department of Health
- A Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills
- A new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading

The full report can be viewed here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259650/34661_Cm_8755_Accessible.pdf

5. London Healthwatch Network at NHS England

The interim Director of Strategy, Barbara Green attended the above event earlier this month and presented on the areas the Trust is exploring for the LAS 2020 strategy. Following a positive discussion the following actions were identified

a. Provide the opportunity for Health watch members to comment on key questions re our strategic direction and plans via their network web-site.
b. Publish Borough level data on our public web-site.
c. Healthwatch groups would like the Trust to speak to their groups about future service plans.

6. PRO QA (MPDS)/NHS Pathways

There are currently two triage systems in use in the UK for the receiving of 999 calls that are approved and licensed by the Department of Health (DH) for use in an Ambulance Trust Control room setting. These are PRO QA (MPDS) and NHS Pathways.

PRO QA (MPDS) is currently in use by the LAS (version 12.2). Five other ambulance Trusts also use MPDS. The forthcoming version 13 to MPDS (called Paramount) will require a fundamental change to the communication protocol and will result in a CAD System upgrade that will require considerable development by the current CAD provider (Northrop Grunman).

NHS Pathways, currently used by 4 ambulance trusts, has evolved since June 2011, and is used also by a number of 111 providers. Using Pathways will also require considerable development work to be undertaken by Northrup Grunman.

A task and finish group has been established to review a range of factors including the clinical quality of each system, clinical and operational risks, resilience, and costs, which will provide a full report to EMT in the week prior to Christmas.

The Board is asked to note this and that either option carries significant costs, training requirements and an element of risk, as yet unquantified. A decision must be made by early 2014 in order to allow sufficient time for either option to be in place within the timeline of 12-18 months.

7. Meeting with David Flory (Department of Health Director General of NHS Finance, Performance and Operations).

The Chief Executive met with David Flory and other London CE's on 6 November 2013. The following areas were discussed;

- In year performance and the upcoming winter specifically the increased level of government focus on this
- Finance and the challenges facing the NHS in 2013/14 and beyond as austerity continues to be a reality
- Quality specifically the scale of improvement which is needed in some Trusts and how workforce is ofter the key to unlocking that improvment.
- Nature of Monitor and its role going forward
- Impact of integrated system plans
- Impact of changing CCG allocations

8. Executive Management Team (EMT) Interaction with Clincal Commissioning Groups (CCGs)

Members of the EMT have each been allocated a group of CCGs in London. The purpose of this is to ensure that the Trust has an executive director who has a direct relationship with each CCG Chief Officer and if possible Chair. The intention is that these relationships will promote improved information sharing and highlight any issues relating to the 13/14 contract. Additionally views will be sought on what CCGs wish to commission from the Trust as part of the 14/15 contract round Executive directors will also work closely with the local operational management team to managing this crucial relationship. A feedback process will be in place to allow for feedback to the EMT and the Board.

9. 111 Step In

On 19 November 2013 the Trust officially 'stepped in' as the provider of the 111 service in South East London.

10. Executive Director Appointments

Following a national recruitment process, the final three executive director posts have been appointed to:

- Mark Whitbread has been offered and accepted the role of Director of Paramedic Education and Development. Mark, who is currently a consultant paramedic with the Service, will take up his new position in early 2104.
- David Prince has been appointed as Director of Support Services. David is currently Group HR Director at CareTech Community Services and has previously worked with the National Autistic Society and Royal Mail in HR director roles. David will be responsible for IM&T, HR, fleet and logistics, and estates. A start date has yet to be confirmed but it is anticpated that David will join in early 2014
- Mike Evans has joined as the Trust as Director of Business Development. Mike has sales and business development experience gained within the healthcare industry and will be with the Trust for the next nine months. His role is to build on existing business and to seek out new opportunities within the NHS and the wider healthcare community

Ann Radmore
Chief Executive

November 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
Report Author(s):	**Sandra Adams**
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 November 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 are making good progress to achieve full compliance before the end of 2013/14.

1. Monitor Compliance

The Monitor Compliance 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. A minimum set of background checks will be implemented for current and newly appointed directors by the end of November 2013.

C2 – competition oversight: the Trust Board will receive a training session from Capsticks – NHS Context – Competition Law – on 26th November 2013.

Attachments

Progress report on Board Statements and Monitor Compliance.

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

☐ Preventing people from dying prematurely
☐ Enhancing quality of life for people with long-term conditions
☐ Helping people to recover from episodes of ill health or following injury
☐ Ensuring people have a positive experience of care
☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
☐ Caring for the workforce

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

LAS Strategic Goals
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☒ 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:

Progress report on Board statements and declarations

Since reporting commenced on the two required submissions - Board Statements and Monitor Compliance – the Trust has reported non-compliance against 3 conditions. These are listed below with a progress report on moving towards compliance:

Condition G4: Fit and Proper persons as Governors and Directors

The Audit Committee considered and approved a recommendation for a minimum set of background checks to be applied to all current and newly appointed directors as follows:

- Disclosure and barring service checks (DBS)
- Interview and formal selection procedure
- Proof of qualifications
- Bankruptcy search.

These will be implemented before the end of November 2013.

Condition C2: Competition oversight

Capsticks are running a session on Competition Law and the NHS Context for the Trust Board on 26th November 2013. A further, more detailed, session is being provided for the Executive team in January 2014.

Board statement 2: Clinical quality – ongoing compliance with the Care Quality Commission registration requirements.

Ongoing compliance confirmed by the Care Quality Commission following the inspection visit in August 2013.

Summary

Progress is being made to achieve full compliance with the Board Statements and Monitor's Licence Conditions (Compliance Monitor) during 2013/14.

Sandra Adams

Director of Corporate Affairs/Trust Secretary

November 2013

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 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 ☐ 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 be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 24th September 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 new tender has been received since 24th September 2013:
Installation of bunded diesel oil tank, forecourt separators and associated drainage and other works. Tenders received and opened on 24th October 2013:

- Southern Tank Services Ltd
- Adler and Allan Group
- Aquasentry Environmental Services Ltd.

There has been one new entry to the register for the use of the Trust Seal since 24th September 2013:
The Trust Seal was used on 27th September 2013 for the lease for the first floor, 18-21 Morley Street, London SE1 7QZ.
This accommodation is now occupied by the Finance team enabling the Trust to fully vacate Loman Street.

Attachments
None.

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☐ Preventing people from dying prematurely
- ☐ Enhancing quality of life for people with long-term conditions
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- ☐ 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

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH NOVEMBER 2013

PAPER FOR APPROVAL

Document Title:	**21 Century Network Approval**
Report Author(s):	**Vic Wynn**
Lead Director:	**Vic Wynn**
Contact Details:	**vic.wynn@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For the Trust Board to approve LAS enter in to Contract(s) over £1M**
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: SMT and CIP Board
Recommendation for the Trust Board:	**To provide approval**

Key issues and risks arising from this paper

This initiative is required as without a replacement service, the existing LAS wide area data services will become unmaintained.
It also provides a significant cost improvement over the current services.

Executive Summary

The 2013/4 Financial Plan approved by the Trust Board in March 2013 included a planned CIP based on introducing a new network, known as the 21 Century Network or 21CN, to replace the current LAS wide area network.

Work has continued in 2013/14 to provide this scheme. The scheme consists of

- Initial Investment £444K (spread over two FY)
- Revenue of between £394K and £430K (dependant on level of backup implemented)

This will provide an annual revenue saving of circa £0.5M on the existing services.

Funding has been allocated accordingly. The detailed case has been reviewed and approved by

- SMT: 28th August 2013 ISON Approved as per minutes
- CIP Project Board: 9th September 2013 for Noting
- EMT: 11th September 2013 – EMT requested SMT identify funding before approval. Andrew Grimshaw and Fenella Wrigley proposed to fund from Service Developments over two years
- EMT: 19th November 2013 –Approved to take forward to FIC and the Trust Board
- FIC: 22nd November 2013 –Approved to take forward to Trust Board

In order to progress the Project new Contracts need to be put in place for the new services

As these are above £1M Trust Board Approval is required.

The Contracts central to the supply of the services are:

1) "Wires Only" service to all LAS sites, Supplier BT, Framework Contract.

Set up Charges	Monthly Rental	Total over 5 Years
£ 232,382.00	£ 31,912.00	£ 2,147,101.00

2) N3 connection LAS central sites, Supplier BT, Framework Contract.

Set up Charges	Monthly Rental	Total over 5 Years
£ 31,145.45	£ 940.02	£ 87,547.00

3) There will be separate lower cost Contracts for router hardware (27K) and some backup circuits as indicated above. These will be within the envelope of the business case but will be ordered separately once design and costs are confirmed.

Trust Board: 26th November 2013 – Trust Board are requested to approve Contract signing.

Attachments

See gating template attached

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☐ Preventing people from dying prematurely
- ☒ Enhancing quality of life for people with long-term conditions
- ☐ Helping people to recover from episodes of ill health or following injury
- ☒ Ensuring people have a positive experience of care
- ☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
- ☒ Caring for the workforce

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:

Clinical Quality assessments have been carried out as part of the CIP activity.

London Ambulance Service NHS Trust
Service Development Gating Template

Name of Case	21CN NETWORK REFRESH

Department/Specialty	IM&T	**Is the proposed project: (please tick one)**	
Departmental lead	Mick Theobald	A new development?	No
Clinical Director Sponsor	?	A replacement of existing kit?	replaces a service
Director in charge	Vic Wynn	An enhancement to an existing service?	Yes

What is the aim of the proposal? (No more than 50 words)

This initiative aims to make significant savings and improve the service provided by the Trust's wide area data network. It will

- Save the Trust over £ 0.5 M in network costs p.a. after the initial revenue payback period of approx 18 months
- Provide more flexibility and capacity in the Trust's wide area data network to 80 sites and to N3 based Applications.

Why is this development needed? (include risk of not doing)

1) To reduce the cost of the Trust's wide area data network as part of the Trust's CIP.
2) For the last 9 years, the LAS have operated a wide area data network to 80 sites based on traditional network technology (i.e. copper-based circuit as opposed to fibre-based circuits). The technology currently used is being refreshed nationally and will be out of full support within a year.
3) Given the estate and organisational changes identified in the Estates Strategy and the increasing use of N3 hosted services, the Trust has a requirement for a more flexible delivery with additional capacity capability.
4 The current backup service does not provide voice backup and has limited capacity. This is ineffective for medium/large

Alternatives and Mitigations (Max 50 words)

The following options were considered as part of the GEM.
Do nothing continue with current setup
Option 1 Current technology on 3 year contract
Option 2 Current technology on 5 year contract
Option 3 use 21CN technology

Will the development affect any other areas of the Trust?

Operations	Y	HR		Quality	
EOC		Recruitment	Y	Patient safety	
Fleet	Y	Training	Y	Medical Director	
IMT	Y	Finance	Y	Governance	
Estates	Y	Corporate Affairs	Y		
Logistics	Y	Service Development			
Communications	Y	Chief Executives Office			

Link To Trust Objectives

Objective	Y/N	Brief explanation
Improve Quality of Care	Y	Provide improved access to N3 based applications inc clinical e.g ESR, computer based training accounts, the spine
High-skilled and representative workforce	Y	Provide improved access to n3 based application and LAS Centralised applications including computer based training accounts.
Value for Money	Y	Save the Trust over £ 0.5 M in network costs p.a. after the initial revenue payback period of approx 18 months

One-off Project or Recurrent	One-off Project
Does the Project deliver a CIP?	Y
If Yes, which CIP Scheme?	IM&T
IF Yes, how much is the saving?	£ 0.5 M in network costs p

Financial Impact Assessment (incremental costs)

Revenue Impact	£K
Change In Income	0
Change In Expenditure	-541.173
One off Costs	444.667

Capital impact	£K
Equipment costs	
Building costs	
IT costs	27
Fleet costs	

Sign Off	
Service Lead	Mick Theobald
Director	Vic Wynn
Medical Director	
Director of Finance	

OUTCOME	✓
Approved to proceed Immediately	✓
Proceed to develop detailed case	
Resubmit with more Info	
Not Approved	

Date of Senior Management Team (SMT) meeting: 28/08/13
To be completed by Management Board

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TRUST BOARD FORWARD PLANNER 2013

17th December 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard** **Integrated Board Performance Report** **Clinical Quality and Patient Safety Report, including serious incident update** **Finance Report (Month 8)** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents**	Presentation on AACE Draft Strategy (Part II) Report from Chief Executive Modernisation Programme	Board declarations 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**	**29**		**30**		**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									**30**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													TBC
Remuneration Committee	Trust Chair						**3**							14.00 - 15.00
Audit Committee	Caroline Silver (NED)			**3**		**22**	**2**			**8**		**10**		14.00 – 17.00 (except 2nd June which is at 13.00 – 14.30)
Finance and Investment Committee	Nick Martin (NED)	**16**		**20**		**15**		**17**		**18**		**20**		
Quality Committee	Bob McFarland (NED)		**x**		**x**		**x**		**x**		**x**		**x**	TBC (usually third Wednesday of the month)
Clinical Quality Safety and Effectiveness Committee	Medical Director	**23**		**24**		**19**		**21**		**29**		**24**		
Learning From Experience Group	Director of Nursing and Quality	**13**			**28**			**14**			**13**			14.00 – 17.00
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00 – except last Wednesday in the month**												9.00 - 11.00