London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 03 OCTOBER 2017 AT 09:00-12:00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.00	**1.**	**TB/17/64** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
09.05	**2.**	**TB/17/65** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	3.	**TB/17/66** Attachment	**Minutes of the meeting held in public on 01 August 2017** To approve the minutes of the meeting held on 01 August 2017.	HL	Decision
	4.	**TB/17/67** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
09.15	**5.**	**TB/17/68** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
09.20	**6.**	**TB/17/69** Attachment	**Report from Chief Executive Officer (CEO)** To receive a report from the CEO.	GE	Information
PERFORMANCE AND ASSURANCE					
09.25	**7.**	**TB/17/70** Attachment	**Performance Report – August 2017** To receive the integrated performance report.	LB	Discussion
09.40	**8.**	**TB/17/71** Attachment	**Board Assurance Framework and Risk Management** To receive the Board Assurance Framework and risk register.	PH	Discussion
09.45	**9.**	**TB/17/72** Attachment	**Audit Committee Assurance Report** To receive the report of the Audit Committee meeting on 4 September 2017.	JJ	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.50	**10.**	**TB/17/73** Attachment	**People and Organisational Development Committee Assurance Report** To receive the report for the People and Organisational Development Committee meeting on 7 September 2017.	JM, PG	Assurance
09.55	**11.**	**TB/17/74** Attachment	**Finance and Investment Committee Assurance Report** To receive the report from the Finance and Investment Committee meeting on 21 September 2017.	FC, LB	Assurance
10.00	**12.**	**TB/17/75** Attachment	**Quality Assurance Committee Assurance Report** To receive the report from the Quality Assurance Committee meeting on 26 September 2017.	RM, TB	Assurance
10.05	**13.**	**TB/17/76** Attachment	**Serious Incident (SI) Reporting** To note declared and closed SIs and receive assurance in relation to overdue actions.	TB, FW	Discussion
10.10	**14.**	**TB/17/77** Attachment	**Lessons Learned from Major Incidents** To note learning from recent major incidents.	PW	Discussion
STRATEGY & PLANNING					
10.25	**15.**	**TB/17/78** Attachment	**Strategy Development Update** To approve the proposed approach to finalising the Trust's strategy and how stakeholders should be engaged on it.	GE, AF	Decision
10.40	**16.**	**TB/17/79** Attachment	**Review of 2017/18 Business Plan** To receive the 20107/18 Business Plan.	LB	Discussion
10.50	**17.**	**TB/17/80** Attachment	**People and Organisational Development Strategy 2017-2020** To approve the People and Organisational Development Strategy.	PG	Decision
11.05	**18.**	**TB/17/81** Attachment	**Winter Plan 2017/18** To approve the Winter Plan 2017/18**.**	PW	Decision
11.15	**19.**	**TB/17/82** Attachment	**Quality Improvement Plan and CQC preparation** To approve the Quality Improvement Plan.	TB	Decision
GOVERNANCE					
11.30	**20.**	**TB/17/83** Attachment	**Computer Aided Dispatch (CAD) – Action Plan update**	RF	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
			To provide assurance with regard to progress made against the CAD Action Plan**.**		
11.35	**21.**	**TB/17/84** Attachment	**Scheme of Delegation Adjustments** To approve changes to the Scheme of Delegation.	LB	Decision
11:40	**22.**	**TB/17/85** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
11.45	**23.**	**TB/17/86** Oral	**Questions from members of the public**	HL	Information
11.50	**24.**	**TB/17/87** Oral	**Any other business**	HL	Information
11.55	**25.**	**TB/17/88** Oral	**Review of the meeting** To consider: - Behaviours at the meeting - Standard of papers submitted for Board consideration - Standard of debate	HL	Information
12.00	**26.**		**Meeting close** The meeting of the Trust Board in public closes.	HL	
	Date and time of next meeting: The date of the next Trust Board meeting in public is on Tuesday 31 October 2017 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.				

Additional reports, circulated for information only:

TB/17/89: Quality Report (August 2017)

TB/17/90: Well Led CQC Key Lines of Enquiry (KLOE) Analysis

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 01 August 2017 at 9:00 am

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

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Lorraine Bewes	LB	Director of Finance
Fergus Cass	FC	Non-executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Robert McFarland	RM	Non-executive Director
Jayne Mee	JM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
Maeve Stevenson	MS	Administrator (Minutes)
Patricia Grealish	PG	Director of Workforce & Organisational Development
Philippa Harding	PH	Governance Improvement Director
Apologies		
Jessica Cecil	JC	Associate Non-Executive Director
Karen Broughton	KB	Director of Transformation and Strategy
Trisha Bain	TB	Chief Quality Officer

1. TB/17/45 – Welcome and apologies

- The Chair welcomed all to the meeting and noted the apologies that had been received.
- Three members of the public were in attendance.
- The CEO offered his apologies for the late issuing of the Board papers, advising there will be a revision of the internal process to ensure timely distribution for all Board and committee meetings in future.

2. TB/17/46 – Declarations of Interest

- There were no declarations of interest in matters on the agenda.

3. TB/17/47 – Minutes of and matters arising from the previous meeting held on 27 June 2017

- The minutes of the Trust Board meeting held on 27 June 2017 were approved as a true and fair record, subject to the following amendment:

    - (TB/17/37) to reflect the fact that meetings had been held with the Mayor of London, the Greater London Authority and Transport for London.

4. TB/17/48 – Matters arising

- The Board reviewed the action log and noted the following:

    - Action reference 8 – to be closed as this would be incorporated into broader strategy work.
    - Action reference 35.2 – a resourcing co-ordinator had been recruited and work was underway to establish the number of Bank Staff who were currently working for the Trust, in order to track appropriate compliance with statutory and mandatory training requirements.

5. TB/17/49 – Report from the Chair

- In addition to the information set out in her report the Chair advised Board members that the Trust's action plan for responding to the issues raised by the Care Quality Commission (CQC) would be presented at the next public Board meeting. She thanked everyone for their hard work and commented on need for this to be sustained consistently in order to ensure that the Trust was removed from Special Measures.

- The Chair advised there would be an opportunity for reflection at the end of the meeting. Board members welcomed this approach, noting that it was in line with best practice.

- The Board requested an update on the Trust's learning from recent major incidents that had been experienced. It was proposed that this should be presented to the meeting of the Board on 3 October 2017.

ACTION: Update on learning from recent major incidents to be submitted for consideration at the meeting of the Board on 3 October 2017.

6. TB/17/50 – Report from Chief Executive Officer (CEO)

- The CEO reported that he and the Chair had recently met with Dr Anne Rainsberry (Regional Director (London), NHS England) and Steve Russell (Regional Director (London), NHS Improvement (NHSI)) to review the London Ambulance Service NHS Trust's initial proposed strategy for the next five years and beyond. It had been a

positive meeting; however, there was further work to do, whilst the Trust ensured that it continued to meet its performance targets.

- Non-Executive Directors requested for further information about the progress that was being made in relation to the key actions set out in the Business Plan agreed by the Board in March 2017, particularly as a number of actions were scheduled to be completed by end of July. The CEO confirmed that a review of progress against the Business Plan would be presented to the meeting of the Board on 3 October 2017.

ACTION: Review of progress against the Business Plan to be presented to the meeting of the Board on 3 October 2017.

- Board members referred to the importance of providing assurance to the Board with regard to progress against the action plan agreed following the computer outage that had affected the handling of 999 calls on New Year's Day 2017. It was confirm that this would be presented to the Board in future.

7. TB/17/51 – Performance Report - June 2016/17

- LB provided an overview of the report, which provided an executive summary of the Trust's performance in relation to quality, operations, workforce and finance. Individual Executive Directors also provided further oral updates and clarifications with regard to their areas of responsibility.

- Board members were advised that the Service remained broadly stable compared with the previous month and the financial position was ahead of plan at month three.

- PW reported June had been a high pressure month operationally following the major incidents experienced in London, for example over 130 personnel had been deployed at Grenfell Tower at the peak of this incident. As this had also been a protracted incident which had severely impacted the Hazardous Area Response Team (HART) in particular, leading to the Trust having to request Mutual Aid; this was provided by four ambulance trusts. In response to a question from the Chair as to whether the Trust had sufficient HART capacity, it was confirmed that this would be considered by the National Ambulance Resilience Unit (NARU) as part of a national review following the serious incidents that had been experienced in 2017.

ACTION: Board members to be briefed on the outcome of NARU review of HART resilience.

- It was noted that the abridged version of the performance report did not contain the level of detail previously provided to the Board. Consideration was given to the question of how much performance information should be provided to the Board and how often. The importance of being able to review trends was emphasised and it was proposed that further consideration be given to the question of the level of detail required in relation to performance reporting to the Board.

8. TB/17/52 – Board Assurance Framework (BAF) and Risk Management

- PH presented the report and reported on the work that was being undertaken with regard to the articulation of the risks contained within the BAF.

- In considering the risks identified as the organisation's top risks, it was suggested that these should include reference to the cyber risks faced by the Trust. Board members considered this an appropriate addition to the BAF and noted that the Audit Committee was due to discuss this risk in more detail at its meeting on 4 September 2017.

- Consideration was given to the process that was followed with regard to risk management throughout the Trust. It was noted that work was ongoing, with a view to be completed for submission to the Board meeting on 3 October 2017, on the articulation of risks on the BAF. This would ensure that they more closely reflected the issues concerning Board and Executive Leadership Team (ELT) members and enabled better discussion of their strategic implications and the actions required to mitigate them. Board members welcomed this approach and the concept of a more dynamic approach to risk, particularly the consideration of risk as an intrinsic part of monthly performance review meetings.

- Board members discussed risk no 29 (risk that there is a lack of ring backs on delayed response calls within EOC and we are therefore unable to monitor patients' safety whilst calls are being held). The closure date of this risk was under review. PW advised that there was not currently sufficient operational capacity to meet demand and that ring backs to patients were the action being taken to mitigate this risk. It was anticipated that the Ambulance Response Programme (ARP) would provide additional capacity to enhance call response times and reduce the need for ring backs.

- A number of risks required more detailed review by individual Board Assurance Committees. It was noted that this would be taken account in future agenda planning for meetings of these Committees.

9. TB/17/53 – Quality Assurance Committee Assurance Report

- RM provided the Board with an overview of the meeting of the Quality Assurance Committee on 11 July 2017.

10. TB/17/54 – People and Organisational Development (P&OD) Committee Assurance Report

- JM provided the Board with an oral update on the meeting of the P&OD Committee meeting on 24 July 2017.

- It was reported that the P&OD committee had endorsed the P&OD Plan for 2017-19, considering it to be a very comprehensive plan. Progress would be monitored and evidenced at the Committee's bi-monthly meetings. In addition, the P&OD Committee considered the plan to improve compliance with mandatory and statutory training. Risks to the achievement of these plans included the accuracy of workforce planning and establishment requirements. These were being considered by the ELT.

- PG provided an update with regard to results from the Q4 2016-17 and Q1 2017-18 Friends and Family test. There had been an improvement, but there was still work to be done to achieve a really positive result.

11. TB/17/55 – Finance and Investment Committee (FIC) Assurance Report

- FC and LB provided the Board with an overview of the meeting of the FIC on 27 July 2017.

- Board members requested an update with regard to the Trust's ability to meet NHS England's conditions for the payment of funding in relation to Band 6 paramedics. It was confirmed that the Trust's job description for Band 6 paramedics was closely aligned to the national profile and therefore the Trust was unlikely to face problems in receiving this funding.

- In response to a query about whether all elements of the Cost Improvement Plans had undergone Quality Impact Assessments, it was confirmed that this would be ensured as part of the assurance of the achievability of these plans. Many Impact Assessments had been completed at project level.

12. TB/17/56 – Serious Incident (SI) Management

- FW presented the SI report advising that the number of overdue investigations had reduced to three.

- Non-Executive Directors emphasised the importance of more detailed information about the SIs, in order to understand what had happened and ensure that the necessary learning was being identified and adopted. The Board was advised that future monthly Quality Report for all SIs would include and executive summary of each closed SI, together with the key learning and actions arising. Wherever possible anonymised information would be shared across the Trust to facilitate reflective practice amongst as many staff as possible.

13. TB/17/57 – Ambulance Response Programme (ARP)

- PW provided an overview of the ARP advising that East Midlands Ambulance Service NHS Trust (EMAS) had undertaken a review of the London Ambulance Services NHS Trust's plans in order to provide assurance of its readiness for the ARP. As implementing the ARP will be a transitional change the Trust would be 'buddying' with EMAS, in order to share experience and gain learning.

- Board members welcomed the briefing, noting that the Trust was continuing to develop its detailed project plan for the implementation of ARP. The ARP was due to be implemented in October, and the Board would be provided with assurance on Trust readiness for the ARP in advance of its implementation. It was noted that the Trust would face a period of transition, as it is changed ways of working and responding to patients. In addition new performance measurements for the remainder of 2017/18 and beyond would require agreement with commissioners in line with ARP implementation.

- Board members noted the likely impact of the ARP. It was anticipated that all areas would be affected.

ACTION: Schedule Board meeting to review and approve assurance with regard to ARP implementation.

14. TB/17/58 – North Central Dispatch Group (NCDG) Trial: The Tethering Principle

- Alex Ewing (Quality, Governance & Assurance Manager (North Central) gave a presentation to the Board on the NCDG trial.

15. TB/17/59 – Trust Board Forward Planner

- The Board noted the forward plan for the remainder of its meetings in 2017.

16. TB/17/60 – Questions from members of the public

- The Patients' Forum (represented by Malcolm Alexander) asked the following questions:

  - The Non-Emergency Transport Service (NETs) problems with efficiency - I understood this to be a very efficient service?

    It was noted that the productivity and cost of running the service was very important in order to determine if it was driving the best value for the public. The CEO stated that there was a need to review the service to see if its size was right, given the volume of patients it was transferring was not in line with plan.

  - ARP has there been patient involvement / feedback i.e. a patient response group?

    FW advised that there is a national patient group that Yorkshire and South West Ambulance services have been working with.

ACTION: FW / PW to meet with Malcom Alexander discuss ARP with regard to patient involvement and impact.

17. TB/17/61 – Any other business

- No other business was raised.

18. TB/17/62 – Review of the meeting

- The Chair offered her apologies to JM for an earlier interruption and noted the importance of allowing others to complete their contributions.

- The Patients' Forum (represented by Malcolm Alexander) suggested that the Board's standard of debate and quality level of challenge had improved. However, he also noted that some issues remained on the agenda which should have been addressed by the Board some time ago.

- Other comments included the timeliness of committee meetings and issuing of papers.

19. Date of next meeting

- The date of the next Trust Board meeting in public would be on 03 October 2017 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.

- The Annual General Meeting would be on 26 September 2017, venue to be determined.

TRUST BOARD - Public Meeting: ACTION LOG

Commenced w.e.f. 25 may 2017

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late	Comments / updates *(i.e. why action is not resolved / completed)*
35.2	Quality Governance Committee Report – Bank Staff: ELT to receive further update re bank staff mandatory training.	Patricia Grealish ~~Karen Broughton~~	28/03/17	25/05/17	**CLOSED**	This is being taken forward through Quality Improvement Planning
TB/17/26	Karen Broughton to provide the Board with a summary of the Trust's strategies, their critical dependencies and plans to deliver them.	CEO ~~Karen Broughton~~	25/05/17	01/08/17	**CLOSED**	See item on agenda
TB/17/39	PH to ensure a new BAF approach is implemented for consideration at the meeting of the Board on 3 October 2017.	Philippa Harding	27/06/17	03/10/17	**1 month late**	To be submitted to the Board meeting on 31 october 2017, along with a proposed amended Risk Management Strategy.
TB/17/41	P&OD Strategy to be circulated to NEDs for comment in advance of Board approval.	Patricia Grealish	01/08/17	03/10/17	**CLOSED**	This was circulated, has been considered by the P&OD Cttee and ELT ahead of its inclusion on the agenda for the Board meeting on 03/10/17
TB17/49	Update on learning from major incidents to be submitted for consideration at the meeting of the Board on 3 October 2017	Paul Woodrow	01/08/17	03/10/17	**CLOSED**	See item on agenda
TB/17/50	Review of progress against the Business Plan to be presented to the meeting of the Board on 3 October 2017	Lorraine Bewes	01/08/17	03/10/17	**CLOSED**	See item on agenda
TB/17/51	Board members to be briefed on the outcome of NARU review of HART resilience	Paul Woodrow	01/08/17			Oral update to be provided at meeting
TB/17/57	Schedule Board meeting to review and approve ARP implementation	Philippa Harding	01/08/17	03/10/17	**CLOSED**	For discussion on 03/10/17
TB/17/60	FW/PW to meet with Malcolm Alexander ato discuss ARP with regard to patient involvement and impact	Fenella Wrigley Paul Woodrow	01/08/17			Oral update to be provided at meeting

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Chair's Report**			
Report Author(s):	**Heather Lawrence, Chair**			
Presented by:	**Heather Lawrence, Chair**			
History:	**N/A**			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

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

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

N/A

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

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

Report of the Chair – 03 October 2017

The Lammy Awards

1. Lambeth Clinical Commissioning Group (CCG) held their Annual General Meeting (AGM) on 6 September and combined this with the Lammy Awards where they celebrate the achievement of people working in and contributing to the lives the residents of Lambeth.

2. This year I was invited to present the "Innovation in Lambeth" award and in addition to receive an award on behalf of the Service. The CCG recognised the Service along with the London Fire Brigade, Metropolitan Police Service, Guy's and St Thomas's Hospital Trust and Lambeth Council for the response to the London Bridge terrorist attack. I accepted the award on behalf of all six organisations, which was both a privilege and humbling.

Meeting with the Mayor

3. The CEO and I met with the Mayor on 6 September 2017, when we discussed a range of issues including our performance, the new ambulance standards that are being introduced under the ambulance response programme and their impact, winter planning, our anticipated Care Quality Commission inspection and the new strategy that we are developing for the Service.

Meeting with Babylon

4. The CEO and I met with Paul Bate, Director of NHS Services and Steve Donald, NHS Development Director of Babylon to discuss potential strategic developments. Babylon is the service provider for NHS111 in North West London.

5. Babylon is a subscription health service provider that enables users to have virtual consultations with doctors and health care professionals via text and video messaging through its mobile application. The service also allows users to receive drug prescriptions, referrals to health specialists, and book health exams with nearby facilities.

Meeting with CEO – Northrop Gruman

6. The CEO, Ross Fullerton (our Chief Information Officer) and I met with Dr Andrew Tyler, Chief Executive - Northrop Grumman Europe, the supplier of the Computer Aided Dispatch (CAD) system on 18 September. This was a productive meeting where we were able to discuss the importance and reliability of the CAD system, its interoperability and their commitment to the Service as well as gaining insight into their future plans. As this is commercially sensitive we will discuss this further in the private board meeting. Importantly both Ross and Garrett now have a relationship with the CEO for future discussions.

NHS Providers – Chairs and Chief Executives Network

7. I attended the NHS Providers Chairs and CEOs Network meeting on 21 September 2017; which is a useful networking opportunity as well as an information gathering event.

8. Dr Kathy McLean, Executive Medical Director and Ruth May, Executive Director of Nursing at NHS Improvement presented their findings on what they had learnt about quality as follows:-

    1. **Leadership**
    Successful organisations have stable leadership and succession planning.

    2. **Engagement**
    Relationship of clinical leaders with front line staff and staff satisfaction. Where Trusts have focused on this there is good staff engagement and good survey results. Where Trusts struggle with this survey results and patient care are poor.

    3. **Quality improvement methodologies**
    Successful organisations embrace a methodology for change where they are applied consistently and apply a 'hearts and minds' approach.

    4. **National Priorities**
    Urgent Care - where there is Board level engagement to demonstrate leadership and focus and where doctors and nurses work together as a team results are better.
    Infection control - data looked at by the Board
    Learning from deaths - this does not yet apply to Ambulance Trusts but will so we need to put systems in place to do so.
    Staff retention - this was seen as an important area to focus on given national recruitment problems ahead of any impact caused by Brexit.

9. Finally there was a panel discussion chaired by Chris Hopson and Sustainable Transformation Partnerships (STP) leads as panel members on the topic of STPs, their role, their future and their relationship with Accountable care organisations and Governance. There was no consensus view, each panel member took a different stance (see appendix)

10. It is important that at LAS we engage strategically as well as operationally with these currently important strategic forms. I will ask Non-executive Directors and Director leads for each STP to report back to the Board on the meetings they attend.

11. As both Urgent Care and Mental Health are priorities, I have invited the National leads in to meet with the CEO and myself and we will report back to the Board.

Saxton Bampfylde

12. I attended an event for Health sector CEOs including the LAS CEO and opened the discussion on the difference between the role of a Chair and CEO, providing insight and observations from both sides of the board table.

Heather Lawrence
Chair

Add to Bd Paper

SUPPORTING PROVIDERS
STPs and accountable care

NHS Providers

To: member chairs, chief executives, finance directors,
strategy directors, directors of operations, commercial directors

21 September 2017

Dear colleague,

Supporting providers: STPs and accountable care

The NHS is changing – from a focus on individual NHS institutions to integrated local health and care systems. NHS trusts and foundation trusts are playing a key, often leading, role through their STPs, by adopting new care models and by moving to accountable care structures. In our recent member survey you told us you wanted more support in these areas. We are therefore launching a major new work programme in response - ***Supporting providers: STPs and accountable care***.

Our offer

We will, as ever, create the detailed work programme in close collaboration with members, over the next six weeks. Based on the member survey feedback and other intelligence it is clear that members and their STPs are at very different stages of development. There is a strong appetite to share learning and, at the same time, national frameworks are struggling to keep up. Members also have strong views on how STPs and accountable care structures should develop. Our work programme will therefore cover all three of our strategic objectives – support, influence and voice.

Support

There are three broad areas where you've told us you want to learn more and need more support, which we will explore in more detail with you and then prioritise to create the programme:

- *Relationships and process.* STPs, new care models and accountable care structures are dependent on new and different relationships between NHS trusts/FTs, local authorities, primary care and commissioners. Understanding how to make these relationships work effectively is important, as are process issues such as the best way to ensure STP level clinical and public engagement. For example, trusts are building relationships with local GPs in a number of different ways and you've told us you want to understand more about these different models and their pros and cons.

NHS Providers
One Birdcage Walk, London SW1H 9JJ
020 7304 6977

enquiries@nhsproviders.org
www.nhsproviders.org
@NHSProviders

- *Specific challenges.* STPs are working across a range of different themes/challenges such as moving care closer to home; reconfiguring acute services; rationalising and getting the most out of the NHS estate; and workforce strategy. For example, you've told us you want to understand more about how different STPs are developing their capital investment strategies. We know many of you also want to understand how to put mental health more at the centre of your STP and make best use of the contribution that specialist and ambulance colleagues can bring.

- *Underpinning enablers.* We need a range of different enablers to support these changes: new contracting mechanisms; different financial flows; adopting risk stratification and whole population health management approaches; and developing STP level governance arrangements. Understanding the detail, benefits and risks of these, as well as accessing some of the actual models/agreements that have been developed, will help to speed progress and avoid having to reinvent the wheel. For example, you've said you want to understand how the most advanced systems are moving towards system control totals and how these will work alongside individual institutional control totals. We know that many of you also want to share good practice and learning on STP governance challenges.

We will use our well-developed sector insight and sense making skills to identify what is happening in the more innovative and advanced systems, and across the wider NHS. We will then share this with the entire membership. Our current plans are to use a range of formats – briefings and reports, roundtable discussions and mini conferences. The range of potential topics is wide, hence asking you to help us prioritise where we should focus.

Influence and voice

STPs and models of accountable care do not exist in isolation. We need to shape the national framework in which they operate. We know, for example, that members want much greater clarity from the arm's length bodies on the purpose of STPs and how they relate to the existing statutory framework. We know you've welcomed our early work on STP level governance issues and that you want us to do more to represent your views on these issues to NHS England and NHS Improvement.

Two examples of early activities we are considering here are:

- collecting feedback on the initial NHS England accountable care system memorandum of understanding (MOU) and suggesting improvements
- identifying how the STP rating system can be developed and improved for the next iteration.

Longer term we need to align the current, individual institution focused, CQC inspection and NHS Improvement strategic oversight (SOF) regimes with the move to integrated local health and care systems.

We will use a range of influencing channels to deliver this work, for example through our membership of the NHS England/NHS Improvement STP advisory group.

Working in partnership

We know there are a large number of other organisations also working on STPs and accountable care structures. Our focus will deliberately be unique and distinctive: supporting providers in the detailed practicalities of making these important

transformations work and representing members' views to the arm's length bodies. We will work hard to avoid duplicating the work of others.

We'll do some of this work ourselves but much of it will be done in partnership. We've already agreed with Simon Stevens and Jim Mackey that we will work closely with NHS England and NHS Improvement. We will also build on existing partnerships, for example, our work to publicise the early lessons from the new care model vanguards involving NHS Clinical Commissioners, the Local Government Association and NHS Confederation. We also want to use the good relationships we've built with the health thinktanks. We will set up a member reference group to guide and input into our activity. And we plan to work with some of the best experts in local government, primary care and commissioning to ensure our work has the appropriate cross system focus it will clearly need.

Your input and next steps

Our work is most powerful and successful when it's done in close collaboration with you, our members. So could you please send Saffron a quick email on saffron.cordery@nhsproviders.org giving initial views of the ideas and plans set out in this letter. For example, it would be good to hear any particular areas/issues where you'd like us to focus. Please also indicate if you'd like to be involved on the member reference group. We will come back to you by mid-October with a more detailed proposal and, crucially, a set of potential activities for you to prioritise.

We're excited by the prospect of supporting members even more effectively as you move into a new landscape and effect some important changes.

Yours faithfully,

Chris Hopson

Gill Morgan

Chris Hopson
Chief Executive

Dame Gill Morgan
Chair

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	3 October 2017			
Document Title:	Chief Executive's Report			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

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

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

Recommendation:

The Board is recommended to note this report.

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

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

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

London Ambulance Service NHS Trust - Chief Executive's Report

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

Performance

2. A8 performance for the month of August achieved 72.1%, which is an improvement of 1.3% against the contract trajectory of 70.8%. Both Red 1 and Red 2 performance were also both above the agreed trajectory. Year to date (to the end of August) cumulative A8 performance stands at 71.2%.

3. For week commencing 4 September 2017, the LAS ranked second for year to date Red 1, Red 2 and A8 performance out of the 5 non Ambulance Response Programme (ARP) reporting ambulance Trusts reporting these metrics.

4. All CCGs saw above 60% in Category A performance, with each STP also returning an improved position compared to August 2016.

5. Activity remained above planned levels with Calls 1.6% above trajectory, Incidents 1.4% above trajectory and Category A Incidents significantly increased at 5.9% above plan for August. As these different rates of growth suggest, the *proportion* of Category A Incidents is also increasing; for April-August 2017 Category A Incidents made up 49.8% of total Incidents, much higher than the same period last year (47.6%).

6. Capacity (in terms of Patient Facing Vehicle Hours) was above the planned hours for August by 4.3%. This was also a significant increase in outturn from the previous year demonstrating a stronger staffing and overtime position, with almost 5,000 more hours (+2.2%) than August 2016.

7. In terms of efficiency, Job Cycle Time was above plan by 1.1 minutes, resulting in a monthly average of 80.4 minutes for August; however, despite this, hospital handover pressures, and the sustained high demand, Job Cycle Time has continued to improve month on month this financial year.

8. The Bank Holiday weekend which saw the annual Notting Hill Carnival in the North West Sector. Extensive planning took place for this event to ensure there was enough capacity to cover the expected levels of demand. The LAS worked with NHSE to provide assurance of the forecasts and action plans, and invoked our mutual aid agreement with neighbouring ambulance trusts to assist with delivery of patient care. The weekend was a challenging one for the trust, a combination of high levels of activity and lower levels of capacity due in part to annual leave and sickness, together with a significant number of events within the Trust's area of emergency provision meant that we did not deliver across all of our operational targets.

Rest Breaks:

9. As a Trust we are focussing on 3 specific areas relating to the allocation of Rest Breaks which are:

    1. Taking action to improve compliance with the existing rest break agreement
    2. Taking action to address late finishes
    3. Introducing a new rest break policy

10. Rest break allocation has improved from 8% in January to an average of 23.5% in August. 23 August was the strongest day of the month when 38% of rest breaks were

delivered. Sector performance can reach over 40% however we recognise that there is still variation at weekends.

Winter Plan 2017/18:

11. The 2017/18 Winter Plan was delivered in early September. The Performance Directorate will continue to monitor and review the developed forecasts at a more granular level in the coming months to further inform resourcing decisions and ensure delivery of a safe service ahead of the festive period.

12. The Performance Directorate continue to help shape the evolving ELT Performance Review Scorecards. In August, reviews were extended to corporate services which included Finance, People and Organisational Development, and IM&T.

Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Assessment:

13. The Trust is required to submit its annual self-assessment as part of the 2017/18 EPRR assurance process. NHS England (London) uses this assessment to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

14. This self-assessment requires 46 EPRR, 14 Chemical Biological Radiological Nuclear (CBRN), 19 Marauding Terrorist Firearms Attack (MTFA) and 21 Hazardous Area Response Team (HART) related standards to be RAG rated against our level of compliance. A 'deep dive' into the Trust's EPRR governance arrangements will also be conducted as part of this year's review. Our first self-assessment was submitted to NHS England (London) on 13 September 2017 together with supporting documents.

15. A full paper documenting the assurance process; our self-assessment results compared to last year; the actions required to deliver our self-assessment submission; and the main risks to receiving 'substantial' compliance will be provided to the Board at its next meeting on Tuesday 31 October. In the meantime, I can confirm that, should the Trust's internal ratings be accepted by NHS England (London), then the Trust will be able to submit a final rating of:

    1. EPRR / HAZMAT & CBRN core standards – Substantial Compliance.
    2. MTFA core standards – Full Compliance
    3. HART core standards – Full Compliance

16. While this would be the same outcome as last year, it should be noted that there are additional core standards this year against which we are assessed. The final result may therefore not recognise the substantial improvements which have been made this year but which were recognised by the Care Quality Commission during their last inspection.

North Central Tethering Pilot:

17. The tethering pilot in the North sectors appears to be having a positive effect. Early signs from North Central are encouraging as the sector achieved an average of 70.22% over August 2017 compared to 66.29% in August 2016. The first few days of the trial showed an ambulance export into other sectors of 2% on the tethered days against 22% in the old normality. A full and comprehensive analysis of the trial will be undertaken by November 2017.

Roster Review:

18. The Trust is committed to undertaking and implementing a review of rosters to better meet the needs of our patients. While the implementation of ARP has meant that the scoping work cannot begin until we go live, an initial meeting took place in early September with Working Time Solutions (a specialist consultancy in workforce planning and management) and key internal stakeholders to start developing the project plan. New rosters will be implemented across the Trust next year.

Finance

19. As reported in detail elsewhere on the agenda the overall financial position for the Trust is £3.1m ahead of the internal plan at Month 5, largely due to on-going vacancies in front-line staff groups and clinical education tutor establishment and training placements. This is despite incident activity running at 2.7% above contract baseline. Executive focus is on urgent acceleration of recruitment to address resilience and catch up with the pipeline required to deliver full establishment.

20. Finance has completed a trust-wide budget sign off and review process which has improved assurance on the forecast, which is to achieve the £2.4m deficit control total. Within this, the CIP savings programme is behind trajectory and additional support is being put in place to build in a more strategic programme approach to savings and efficiency delivery, to ensure that we identify recurrent efficiency savings for 18/19 onwards to replace some element of fortuitous savings to date. CIP delivery will increasingly be managed through the new bilateral executive performance reviews.

21. The original plan for capital spend of £28.8m assumed £5.5m of central programme funding. However only £1m is confirmed to date, which has been funded by NHSE A&E winter streaming funds. It is forecast that through a combination of slippage and reprioritisation and alternative funding sources, that essential programmes such as the IT mobility roll out, medicines management and essential estate and fleet replacement will be affordable this year but the overall forward plan for capital and its funding will need a significant review as part of the LAS Strategy refresh for 18/19.

IM&T

22. This month IM&T have been preparing for the Ambulance Response Programme implementation which has involved changes to a dozen independent IT applications, creating new physical test environments and coordinating their implementation. The technology changes are therefore complex and consuming the majority of the directorate's focus.

23. Good progress towards improving the CAD reliability and resilience has been made with the agreement of a replacement infrastructure specification with Northrop Grumman which will be implemented in Spring 2018.

24. Planning is underway to improve the quality of service provided to 111 users; this area has been under-invested and requires focus to support south east London effectively as well as prepare for potential expansion into the north east.

25. The CQUIN to deliver mobile devices is making good progress; this is worth c. 50% of the Trust's CQUIN this year. Constructive dialogue with commissioners has led to outline agreement for scope and deliverables in line with the Trust's plans. An associated funding opportunity with NHS England was submitted to tight timescales resulting in the award of £998k to LAS.

Strategy

26. We launched our strategy development process with senior staff on 13 September 2017 at our 'Tier 1' staff engagement event. I presented our emerging thinking and our senior managers had the opportunity to discuss, digest and reflect upon the new strategic themes. Crucially, this event means that our senior managers are fully informed and engaged within this process prior to the CEO roadshows, so that they can answer any questions that their staff may have as well as to be ambassadors for this strategy development work. As identified in the Strategy Development Trust Board Paper, we will now engage in a period development, testing and engagement with patients, staff and stakeholders to develop a final strategy which will be formally launched to the public towards the end of 2017/18.

27. As part of the work to develop the overall Trust Strategy, a number of our sub-strategies will need to be refreshed and we are starting that work now. Work is underway with colleagues from across the organisation to develop new Fleet & Logistics and Estates strategies. These strategies will look at what our organisation needs going forward and also how they are affected by the requirements of the Ambulance Response Programme.

Blue Light Collaboration:

28. The service attended Blue Light Collaboration meetings on 17 August and 19 September. We will also be participating in an Inter-Agency Operational Capability Day on 8 November 2017. This will allow the Blue Light Services to showcase some of the ways we respond to key stakeholders including the Mayor and Ministers
29. We are still waiting on the outcome of the Met Police bid for funding in relation to further scoping of Control Services collaboration
30. We successfully appointed a Blue Light Collaboration Lead, Lorraine Russell, who will work across the three services to lead relevant work. Lorraine's first priority will be to refresh the Blue Light Collaboration Strategic Intent document as each of the three services has appointed a new Commissioner/Chief Executive since it was previously iterated

Quality Improvement

31. The development of the CQC action plan for the well led and safety domains is well underway and a draft will come to the October Trust board. It is anticipated a well led review will take place in the first quarter of 2018 and in preparation for this the Trust has short term external support completing the well led gap analysis and preparing the Provider Information Return (PIR) for this domain.

32. Final agreement on the Quality and Assurance directorate structure is now complete and work is underway to implement this. The timescale is later than anticipated due to a more lengthy consultation. Advertising for the senior posts is due to commence in early October with a view to having staff in post in the final quarter of 2017/18, ready for the new financial year.

33. The Quality and Learning Strategy is in development and a draft will be presented to the October Board meeting.

34. The independent Health and Safety Review commissioned by the trust in June 2017 was shared with ELT on 23rd August 2017 and the actions and recommendations agreed. This has also been shared with the unions. For assurance purposes updates on the action plan will go to ELT on a monthly basis. The full report and action plan will be shared with Board at the October meeting.

Medical Directorate

35. On Wednesday 6th September the Medical Directorate held the first of a series of away days. The intention of the first meeting was to share what we are doing across the team and understand how we can maximise our impact both internally and externally. To ensure a unified approach, we delivered an update on the clinical strategy and the key deliverables for the coming year. In addition, Dr Sally Herne presented to the group the new KLOEs for the next CQC inspection.

36. This month the Medical Directorate have also published the Summer editions of the Clinical Update and Insight magazine sharing examples of good practice and areas for learning from Serious Incidents. Subjects include a Maternity Update, a reflective case study on the use of Oramorph, End of Life care and dealing with snake bites.

37. Considerable progress has been made on improving the visibility of the team across the Trust, including providing a number of enhanced care teams to support colleagues from both the LAS and St John Ambulance at Notting Hill Carnival. The team have also provided a number of station based teaching sessions including ECGs, Stroke and resuscitation as well as supporting the recruitment of the next cohort of Advanced Paramedic Practitioners (Critical Care) and Clinical Team Leaders.

38. Following approval by workforce planning, an additional 4 posts have been created within the IPC team to support delivery of the IPC work plan. Considerable work has been undertaken this month to recruit to these posts including an offer for the band 7 position being made to an external candidate. Interviews for the remaining posts will be undertaken in the coming week.

39. **Clinical Audit & Research:** This month all 4 annual reports have been finalised. The Clinical Audit & Research Unit have also undertaken a number of other audits including a re-audit of the use of 1:1000 adrenaline. In addition, audits on pain management and patients suspected of having an undiagnosed mental health condition are in the final stages of approval before publication.

40. **Clinical Education & Standards:** Clinical Education & Standards continues to be busy with the main focus of activities this month on preparing for the launch of CSR 2 online through OLM, and ramping up the induction programs for the new starters in both paramedic and TEAC programs. To embed sustainable maternity education, we recently appointed 7 clinical tutors into newly developing posts of Maternity Education Lead (MEL), including a senior “MEL”. The team is passionate about maternity care and education and will lead across the five sectors of London including the Paramedic academy.

People and Organisational Development

41. **Dignity at Work:** the focus this month has been on improved communication skills and awareness of conflict in teams, reviewing the Freedom To Speak Up role and ensuring it is fit for LAS staff to report concerns, preparing a tender for external mediation and providing an escalation source to staff to raise concerns around conflict and bullying and provide resources to reduce conflict. More training is planned on communication skills and personal resilience.

42. **Business Information and Payroll:** Progress towards delivery of the ESR Workforce Dashboard and eForms system are on track. Delivery will give significant improvement to timely access of key employee data to support management decisions and processes (vacancies, turnover, and sickness) and improve compliance rates in appraisal and statutory and mandatory training. eForms will streamline how we process employee changes and leavers, improve our data quality and financial control.

43. **Recruitment Reporting / Operational Recruitment Outturn:** Our frontline recruitment report has been further developed to bring together data on planning, recruitment, training, staff movements and operations. Linking with the LAS Forecasting and Planning team it is designed to track and ensure we have enough patient facing vehicle hours to meet demand.

44. We have identified additional posts to deliver the 17/18 increased demand. Work has been undertaken with colleagues in Operations to determine how these posts should be allocated across the Sectors and the updated establishment will be reported against from September.

45. Please note that the vacancy rates for both paramedics and the total frontline will increase as a result of these additional posts.

46. We have so far recruited 184 iParas, 27 of whom joined us in July and August and a further 123 are joining in Q4. We are in discussions with the remaining group with a view to starting them in Q1 18/19. A further international recruitment trip to Australia will take place in September. We have recruited 94 UK Graduate Paramedics against our target of 90, 85 of whom are starting in September and October. In July and August we had 76 Apprentice Paramedics who graduated, taking up NQP positions.

47. We have recruited 180 TEACs to date with a further 69 awaiting their C1 driving licence or to be booked on an LAS training course. This still remains a challenge and we are exploring sources of funding to support candidates to complete their C1. This should improve our ability to fill all of our course places.

48. We are behind plan on EMD recruitment and 29 out of 62 places have been filled year to date. An additional 28 EMDs are due to join us in September/October and we have increased course places to bring the plan back on track. Applicant numbers remain high and conversion rates through to shortlisting and interview are improving.

49. We have commenced our planned series of recruitment events (July 2017 to March 2018) and work is progressing to develop a communications campaign to support our Paramedic, TEAC and EMD recruitment.

Royal Society of Medicine: Lessons learned from terror attacks

50. I spoke in September at the Royal Society of Medicine alongside other emergency service leads and doctors about the lessons we have learned from the recent terror attacks in London, highlighting the importance of joint working among emergency services and the safety of our staff during such incidents.

Campaign to tackle increase in alcohol calls

51. We ran an awareness campaign to tackle the anticipated increase in alcohol-related incidents during August, which figures show is our busiest month for alcohol-related calls. ‘He needs his friends … not an ambulance’ was launched with a 90 second campaign film targeted at 21-30 year old men. Throughout the month we shared messaging through media and social media, including live social media events and advertising. Messaging focussed on asking people to drink responsibly and, if their friends did drink too much and needed help, look after them so they didn’t end up alone, vulnerable and in need of an ambulance. The campaign is currently being evaluated.

100,000 Twitter followers

52. Our official Twitter account has exceeded the 100,000 followers mark, making us the biggest NHS trust on Twitter. Twitter is our go-to channel during a major incident, like the recent attacks on London, when we’re instantly able to reach millions of people with life-

saving advice, reassurance that we're responding and updates as they happen. Alongside this, we use social media to support key corporate objectives (recruitment, demand management), highlight the efforts and expertise of our staff, and respond to Londoners who have praised those who have helped them.

Parsons Green

53. Following the major incident declared in Parsons Green, we provided regular updates via the media confirming our attendance and giving an update on the number of patients treated, and updated staff about what was happening. We received almost 40 media enquiries on the day from news organisations including the Daily Express , Evening Standard, Daily Telegraph, Sky News, The Sun, Reuters, Metro as well as CNN, who used our media statements in their reporting. We issued three statements to media and recorded a piece to camera from Assistant Director of Operations Natasha Wills which was shared with the media and on our social media channels. Media interest continued over the weekend. In total we received coverage in 60 publications.

Media stories of note

54. Paramedic mugging: When one of our cycle responders had her phone stolen while on duty, we secured coverage from regional and national media including BBC London TV, Evening Standard, Sky News, The Sun, The Times and Daily Telegraph. Our objective was to send a clear message that we will not tolerate attacks on our staff, and we hoped the publicity might help to identify her attackers and lead to a prosecution.

55. Rise in reports of serious incidents: BBC News online and BBC Radio London reported on a marked increase in serious incidents across the UK's ambulance services, with London Ambulance Service recording the largest increase - rising from 16 reported incidents in 2012-13 to 90 in 2016-17. The story was based on Freedom of Information data obtained by the BBC from ambulance trusts around the UK. Our response, which put the number of reported incidents into context and explained that we encouraged staff to report them, was included in the online media coverage.

56. Ambulance delays: The Evening Standard reported on delays in the handover of patients to hospitals. The story was based on statistics from the LAS Patients' Forum, and included quotes from the worst performing NHS hospitals and from NHS England. Our response was included, which explained that we work with hospitals across London to find solutions to reduce delays to patient handovers.

57. Inquest of Victor Bede: BBC London and the Evening Standard reported on the inquest of Victor Bede who died on New Year's Day when our call taking system was not working. The coroner returned a narrative verdict confirming that Mr Bede died of drug poisoning; she also mentioned that we were delayed in attending him due to increased call volumes and our computer system going down, but concluded it was not possible to say if earlier treatment could have prevented his death. In our statement following the inquest we said we were sorry for the delay to Mr Bede and explained what changes we had made following the investigation into the computer problems.

Notting Hill Carnival

58. We secured wide spread regional and national coverage about our involvement with Notting Hill Carnival, including the Evening Standard, BBC News, Daily Mail, Times and Daily Express. These outlets ran stories based on our live tweeting during carnival, when we provided insight into how we responded to the event, how many people we treated and, with the warm weather, promoted health advice to attendees reminding them to keep cool. Our tweets from the Sunday and Monday earned 872,000 impressions

(number of times users saw the tweet), were liked 4,000 times, achieved 1,400 retweets and 186 replies from followers.

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Integrated Performance Report**			
Report Author(s):	**Key Leads from Quality, Finance, Workforce, Operations and Governance**			
Presented by:	**Lorraine Bewes, Director of Finance and Performance**			
History:	**Presented to the Executive Leadership Team on 20 September 2017**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

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

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

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

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

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

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

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

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

Reputation	☐
Other	☐

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

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUST BOARD EXECUTIVE SUMMARY

September 2017

* All available data is correct as of the 15th of every month.

* Please note that this report relates to performance throughout August 2017 unless otherwise stated.

Delivery of care continues to be safe, but the rising demand pressures on the system continues to remain challenging.
Year to date the position is £1.4m ahead of plan and £3.1m ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.
A8 performance for August ended at 72.1%, 1.3% above trajectory. Demand was 1.4% above plan.
Frontline paramedic turnover has decreased from 9.5% to 9.2%. Appraisal rates have reduced from 68% to 58%.

OUR PATIENTS

- 6 serious incidents were declared in August 2017. This is an increase when compared to the 4 declared in July 2017.
- OWR Hand Hygiene compliance successfully exceeded the Trust Target of 90%.
- Daily reviews of all patient safety incidents graded no harm, low harm and moderate harm are being conducted centrally. Any incidents that are considered to be incorrectly graded are being referred to the Serious Incident Group meeting for review.
- The New Serious Incident Policy has been approved for distribution. The policy includes the new SI process and a number of Standard Operating Procedures to ensure a uniformed approach to all SI investigations.

OUR MONEY

- Plan / Target – Year to date the position is ahead of plan.
- Demand is currently running at 2.7% ahead of contract baseline YTD. This is below the contract variable charge cap of 3% that would be in place if Commissioners met demand management targets, and below the level required to trigger contract.
- Year to date CIPs are £1.8m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.
- Capital spend is £3.4m against a Capital plan of £7.2m, £3.8m behind plan, NHSI have confirmed that the Trust can carry forward last year's under spend on capital (£6.9m). The Trust has only been allocated £0.998m of the £5.5m centrally funded initiatives funding assumed in the initial plan.
- Cash is £33.3m, £6.0m above plan. This is mainly due to receipts from income being £6.2m lower than planned and there are higher than planned creditor payments of £1.8m being offset by under payments of £6.4m on capital, provision of £0.5m and £7.1m on pay.

OUR PERFORMANCE

- A8 Performance for August 2017 was 72.1%, this is 1.3% above trajectory. Red 1 was 6.6% above trajectory at 74.4% and Red 2 was 1% above trajectory at 72.0%.
- There were 45,295 Category A incidents in August, 5.9% above trajectory. Category C demand was below trajectory by 2.6%. Overall demand was at 91,906 incidents, 1.4% above plan.
- Job Cycle Time for August was above trajectory at 80.9 by 1.6 minutes, however this is a decrease from the previous month by 0.5 minutes.
- Capacity in August was 4.3% above plan for patient facing vehicle hours.
- The multiple attendance ratio was successfully below target at 1.27 for August, the target is 1.29.

OUR PEOPLE

- We are currently behind plan for our paramedic, T/EAC and EMD recruitment. Work is being undertaken with colleagues in Operations to determine how the additional posts to reflect 17/18 demand should be allocated across the Sectors. The vacancy rates for both paramedics and the total frontline will increase in September as a result of these additional posts.
- Overall turnover has increased from 9.9% to 10.2%.
- The monthly sickness position for August is 5.2%, an improvement from 5.4% in July.

LAS 111 (SEL) experienced higher than predicted call demand, and still achieved 93.9% for call answering within 60 seconds.
The Patient Transport Service has seen a 28.2% increase in activity from the previous month.

LAS 111 (SOUTH EAST LONDON)

- 111 achieved 90% or more of calls answered in 60 seconds on 27 days in August.
- LAS 111 Referrals made to 999 remain consistently and successfully low.
- As part of the evolution of SEL 111 to an Integrated Urgent Care Service a range of pilots are being undertaken including Direct booking into GP hubs across all SEL CCGs

PATIENT TRANSPORT SERVICE

- August saw a rise in the number of journeys with a total of 4,905 journeys being delivered as compared to the July total of 4,587 journeys.

LAS IMPROVEMENT

Single Oversight Framework

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

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

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

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

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

Key Performance Indicator Report Summary

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

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

	Key Performance Indicator	Aug-17	Jul-17	Jun-17	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↑	↑	
	Vacancy Rate (Frontline)	↓	↑	↑	
	Vacancy Rate (Trust)	↓	↑	↑	
	Turnover Rate (Frontline Paramedic)	↓	↑	↓	
	Turnover Rate (Frontline)	↓	↑	↓	
	Turnover Rate (Trust)	↑	↑	↓	
	Sickness (Trust)*	↓	↑	↔	
	Sickness (Frontline)*	↔	↑	↑	

* These KPIs are reported one month in arrears

	Key Performance Indicator	Aug-17	Jul-17	Jun-17	Chart
PERFORMANCE	A8 Performance	↑	↓	↓	
	A19	↑	↓	↓	
	R1	↑	↓	↓	
	R2	↑	↓	↓	
	Calls	↓	↑	↓	
	Incidents	↓	↑	↓	
	Cat A Incidents	↓	↑	↓	
	Cat C Incidents	↑	↑	↓	
	Patient Facing Vehicle Hours (PFVH)	↓	↑	↓	
	Full Job Cycle Time	↓	↓	↓	
	Job Cycle Time (JCT)	↓	↓	↓	
	Multiple Attendance Ratio (MAR)	↔	↑	↓	
	EOC - Call Answering Rate	↓	↔	↓	
	EOC - FRU Cat C Share	↓	↑	↑	

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

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

KPI Summary

These KPIs underpin the integrated performance report. This is a summary of all the KPIs and their related performance for the last 3 months. The RAG status is calculated against targets/trajectories/thresholds where available.

The Chart column shows the trend over the previous 3 months | The arrows indicate the direction of KPI compared to previous month

Executive Summary: Exception Report (Positive)

Safety

- Daily reviews of all patient safety incidents graded no harm, low harm and moderate harm are being conducted centrally.

- Administration of adrenaline 1:1000 in wrong dose or via wrong route.
- Controlled drugs management.
- Non-controlled drugs incidents.

- OWR Hand Hygiene compliance successfully exceeded the Trust Target of 90%.
- The incident classification will be updated from 1st October and validated by the NRLS.

Actions & Assurance

- Any incidents that are considered to be incorrectly graded are being referred to the Serious Incident Group meeting for review.

- Reduction in incidents to one (this is also only a possible excessive dose).
- No LIN reportable CD incidents.
- Reduction in incidents from previous month, overall downwards trend.
- It was identified that incidents from the 111 Datix system were not being sent to the NRLS and this will be corrected as part of the changes made to the system.

Effectiveness

- New Serious Incident Policy has been approved for distribution. The policy includes the new SI process and a number of SOPs to ensure a uniformed approach to all SI investigations.

- New Terms of Reference for the Serious Incident Group meeting have been approved.

Actions & Assurance

- Compliance with the new process will be monitored by the Quality, Governance and Assurance Team.

- Changes to the Datix SI module have been drafted to reflect the changes in the SI investigation process.

Caring

Actions & Assurance

Executive Summary: Exception Report (Improvement Required)

Safety

- The report of the independent review conducted to assess the level of the Trust's compliance with statutory Health and Safety requirements has been received. The report highlights significant gaps in health and safety compliance across the Trust. The report was presented and agreed by the ELT on 23rd August 2017.

- There are currently 91 actions overdue that relate to closed SI investigations. Of the 91 overdue actions:
    - 17 = 6 months or over
    - 19 = 3 to 6 months over
    - 10 = 3 months over
    - 11 = 2 months over
    - 34 = less than 1 month over
    -
- Increase in breakages of injectable morphine.
- Administration of drugs in breach of PGD indications.

Actions & Assurance

- An action plan has been developed to address the gaps highlighted by the Health and Safety Review Report. The action plan will be closely scrutinised and monitored via monthly reports to the ELT as well as quarterly reports to the Corporate Health and Safety Committee.

- Weekly reminder emails are being sent to those responsible and non-compliance is escalated to the Chief Quality Officer.
- Improvement to the current Datix system to provide action compliance dashboards for all directorate/sectors.
- Improved reporting of overdue actions and the SI investigations they concern.

- Progression of secure drugs rooms to provide bespoke area for medicines preparation.
- Further PGD training programme for APP staff.

Effectiveness

- There remains a risk that SI reports will breach the required deadline despite the support of the Quality, Governance and Assurance Team. Main themes that are being communicated from Lead Investigators is their individual capacity to take on an investigation. An additional concern regarding the lack of communication from Lead Investigators has been highlighted from the Quality, Governance and Assurance Team.

Actions & Assurance

- New escalation process is being developed with Senior Managers for the Trust.
    - Operations escalation will be via the ADO for the sector in the first instance followed by escalation to the DDO for Operations.
    - Control Services escalation will be via the relevant General Manager followed by escalation to the DDO for Control Services

Caring

Actions & Assurance

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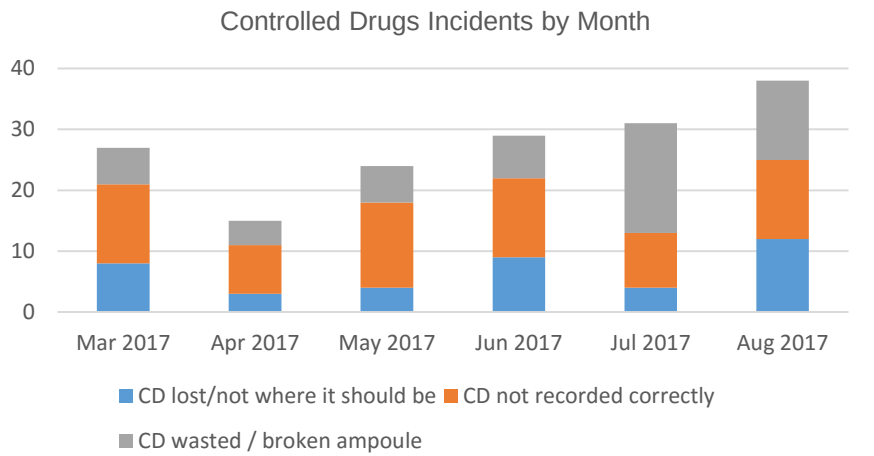
Patient Safety

Measures	Target / Range	RAG	YTD 17/18	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	G	76%	76.2%	87.2%	90.2%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	R	2.9	2.9	2.8	3.0	↑					
Patient related Adverse Events - **NONE**			1100	226	210	214	↑					
Patient related Adverse Events - **LOW**			116	19	23	25	↑					
Patient related Adverse Events - **MODERATE**			72	13	15	17	↑					
Patient related Adverse Events - **SEVERE**			37	6	10	7	↓					
Patient related Adverse Events - **DEATH**			40	6	5	11	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.3	3.0	3.5	3.2	↓					
Staff related Adverse Events - **NONE**			823	145	181	158	↓					
Staff related Adverse Events - **LOW**			684	123	148	126	↓					
Staff related Adverse Events - **MODERATE**			24	5	1	13	↑					
Staff related Adverse Events - **SEVERE**			1	1	0	0	↔					
Controlled Drugs - Non LIN Reportable Incidents	0	R	134	28	31	35	↑					
Controlled Drugs - LIN Reportable Incidents	0	G	1	1	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G		90%	95%	88%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			148	24	12	37	↑					
Serious Incidents declared in-month			27	3	4	6	↑					
Serious Incidents breaching 60 days	0	R	22	5	0	1	↑					
Serious Incidents breaching 40 days	0	R	22	5	0	1	↑					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events	0%	R	5%	6%	8%	3%	↓					
Needle Stick Injuries as % of Staff Adverse Events	0%	R	1%	2%	2%	2%	↑					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	2	0	0	0	↔			LQ25	✓	
Safeguarding Referrals as % of total LAS attended incidents			2%	2.2%	1.9%							
Safeguarding Training (Level One)	90%	R	88%	88.0%	87.8%							
Safeguarding Training (Level Two)	90%	R	76%	76.1%	75.6%							
Safeguarding Training (Specific - Trust Board)	90%	R	32%	31.8%	31.8%							
Safeguarding Training (Specific - Bank)	90%											
Safeguarding Training (Specific - Operational)	90%	G	91%	90.5%	90.1%							
Total Inquests where LAS asked to give evidence - In-Month			33	4	9	10	↑					
Total Inquests where LAS asked to give evidence - Year to Date			84	14	23	33	↑					
Missing Equipment Incidents as % of all reported incidents			3%	3%	2%	2%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			11%	16%	9%	9%	↓					
Number of NRLS uploads In-Month	1	G	5	1	1	1	↔			LQ21		

Medicines Management

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



Summary

- No LIN reportable Controlled Drugs incidents in August 2017
- Total of 35 non-reportable controlled drugs including the following:
  - Morphine retained whilst off-duty and subsequently returned (n=10)
  - Administrative errors in CD register (n=12)
  - Ampoules broken at scene (n=2) or at station (n=8)
  - Drugs discarded due to drawing up error (n=1) and out of date (n=1)
  - Morphine Ampoule found on drugs room floor (n=1)
- Total of seven other drugs incidents including the following:
  - Incorrect dose of intramuscular adrenaline in anaphylaxis (n=1)
  - Inappropriate use of dexamethasone in anaphylaxis (n=1)
  - Administration outside PGD guidance of Calcium Chloride (n=1) and Magnesium Sulphate (n=1)
  - Incorrect dose of oral paracetamol given (n=2)

Actions

- Secure drugs rooms on pilot sites (Ilford & Bromley) now active with evaluation to follow. In addition, the installation of secure drugs rooms should reduce the incidence of ampoule breakages at stations due to appropriate flooring and work surfaces.
- CSR e-learning materials for medicines management including adrenaline administration and cross check procedures nearing completion.
- Awaiting secondment arrangements for Interim Pharmacist.
- Additional PGD and pharmacology training schedule for critical care and urgent care APPs.

Assurance

- Reduction in inappropriate dose/route administration of adrenaline 1:1000
- No LIN reportable controlled drugs issues during August 2017
- Further reduction in non-controlled drugs incidents from 13 during preceding month to 7 this month

Effectiveness (Clinical Measures)

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

Measures	Target / Range	RAG	YTD 17/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	36%	28%	28%	31%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	56%	64%	59%	49%	51%		↑			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	70%	74%	65%	70%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	65%	R	67%	70%	67%	68%	63%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	97%	98%	97%		↓			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:34	00:34		↓					
Survival to Discharge (AQI)			10%	10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	38%					↑					
STEMI- On scene duration (CARU continual audit)				00:41	00:43	00:40	00:42		↑					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	87%	83%	83%	88%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	0.03%	0.18%	0.59%	1.72%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98%	98%	98%		↔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	92%	92%	92%	91%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96%			↑		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		98%		97%		↓			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	6%	28%	51%	79%	89%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)	85%											LQ11	✓	

Actions

- As part of the Service's work on Job Cycle Time, the Clinical Audit Team reviewed all aspects of care in the CPIs with the Deputy Medical Director and specialty leads. The proposed changes will be discussed with the Medical Directorate and frontline staff at a workshop on the 14th September.
- The Non-Traumatic Cardiac Arrest for APPs went live in August 2017. On the whole, compliance was high, and completion (47%) is expected to improve as CPI audits become in embedded in the APP role.

Assurance

- Lower completion in June was largely due to a reduction in the number of staff on alternative duties and decreased Team Leader availability. In order to assist stations with low CPI completion, CARU continue to arrange help from staff on alternative duties at other complexes where completion is high.
- All the above measures have been communicated widely across the Trust and to Complexes via our monthly reports for discussion at the appropriate local forums.

Caring

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

Measures	Target / Range	RAG	YTD 17/18	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	100%	100%	100%	⇔			LQ27	
Friends and Family Test Response Rate			1.8	0.1	0.2	0.1	↓			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	⇔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	48	8	8	23	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.79	0.8	0.8	0.9	↑			LQ29c	
Positive Feedback Compliments			450	88	93	54	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	9.9%	6.6%	7.9%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.1%	1.8%	2.2%	↑				
Mental Health related Incidents as percentage of all calls			5%	5.7%	4.7%	5.3%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.4%	↑				
Rate of Frequent Callers per 1,000 Calls			2.90	2.8	2.7	3.0	↑				
CMC records viewed			11				⇔			LQ30	

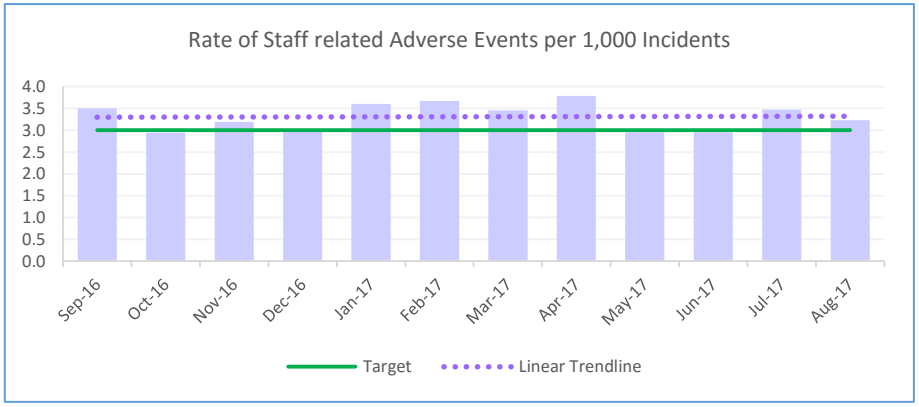
Safety (Health and Safety)

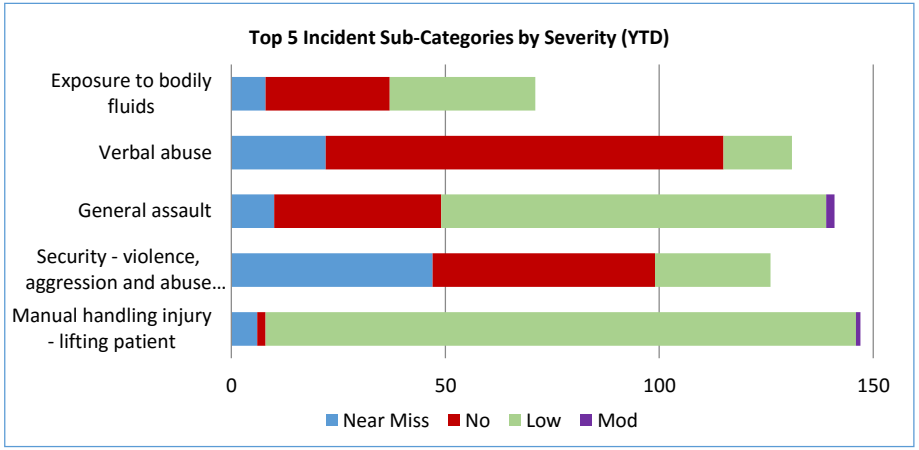
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Trust H&S incidents	Q1'17	July-17	Aug -17
Incidents affecting Patient(s)	2	0	0
Incidents affecting LAS Staff	776	281	227
Incidents affecting Visitors, contractors or the public	24	6	2
Incidents affecting the Trust	38	21	2
YTD Total:	840	308	231

H&S Incidents by Result – Aug 2017	**Near Miss**	**No Harm**	**Harm**
Incidents affecting Patient(s)	0	0	0
Incidents affecting LAS Staff	35	59	133
Incidents affecting Visitors, contractors or the public	0	2	0
Incidents affecting the Trust	0	2	0

Top 5 H&S Incidents by Sub-category	**2017 YTD**
Manual handling injury - lifting patient	147
General assault	141
Verbal abuse	131
Security - violence, aggression and abuse - Other	126
Exposure to bodily fluids	71





- There was a slight increase in the number of incidents reported for Q1 and July 2017 compared to the data previously presented in the July Quality Report. This is due to the recent upload of incidents that were reported through paper incident forms – LA277 and LA52. It has been agreed that all paper reporting forms will be withdrawn by 1st October 2017 following changes to the Trust's Datix System.
- There was a slight decrease in the number of health and safety related incidents reported in August 2017 compared to Q1 and July 2017. The top 5 incident categories however remain the same.
- Report and action plan of the independent review of Trust-wide Health & Safety arrangements and compliance presented to the ELT on 23rd August 2017. The report was accepted and will be presented to the Board in October 2017. The full action plan will be monitored by the Corporate Health and Safety Committee.

Safety (Health and Safety)

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

RIDDOR

RIDDOR Incidents	Apr-17	May-17	June-17	July-17	Aug 17
RIDDOR reportable incidents	10	4	18	10	29

29 incidents were reported as RIDDORs in August 2017. A total of 71 incidents have been reported YTD. A breakdown of the incidents reported in August is provided below:

- Over 7-day injuries – 25
- Major Injury – 3 (Fractures)
- Death – 1 (incident reported at the request of the HSE as part of investigation into death of staff member in 2016).

MHRA/CAS Alerts Management

Alert Date	2017
Total alerts received	62
Total MHRA Alerts Received	8
Total CAS Alerts Received	54
Total CAS Alerts Acknowledged within 2 days	43
Total alerts assessed as relevant to LAS	2
Total (relevant) alerts closed	1
Total outstanding (relevant) alerts	1
Total assessed 'not relevant'	59
Total under assessment	1

Actions:

Security:
Security related incidents accounted for 49% of H&S incidents reported in August and 16% of harm (low/moderate) incidents. Actions taken to address these incidents includes:

- Lone working arrangements under review to enable the implementation of robust measures to mitigate risks.
- Review of Datix security incident categories /descriptors to be completed by 1st October. This will enable better analysis of incidents reported.
- Contact established with the Head of the Met Police Prosecution Unit who has agreed to support LAS with the follow-up of incidents, and ensure that appropriate actions are taken by the Met Police when assault incidents are reported.
- Established direct link with Unison (National Officer, Health Group) to explore joint working to help address the issue of assaults against staff.

Manual handling:

- 16% of H&S incidents reported in August related to 'Manual handling injuries'
- Contributory factors identified include: sudden patient movements, carry/track chairs faults, lifting/assisting patients onto trolleys or to stand.

Actions:

- Agreement received from ELT regarding the provision of practical training to clinical educators in December 2017. Practical Manual handling refresher training to be incorporated into CSR from April 2018.
- Increase in number of track/chair related incidents highlighted. 139 incidents reported between 01/04/17 to 31/08/17. Recommendations from independent review submitted to Manual Handling Implementation group. Full report to be tabled at 13/09/2017 Corporate H&S Committee Meeting.
- Risk assessments completed for all high-risk manual handling activities - task and finish group to be put together to review and agree risk assessments.

Infection Control:

- 71 incidents relating to 'Exposure to bodily fluids' have been reported in 2017/18. Contributory factors include: Non adherence to IPC Practices & wearing of appropriate PPE supplied to staff.

Assurances:

- Quarterly monitoring reports are produced for the Corporate Health, Safety & Security Committee.
- Monitoring of incidents by Corporate Infection Control and Prevention Committee.

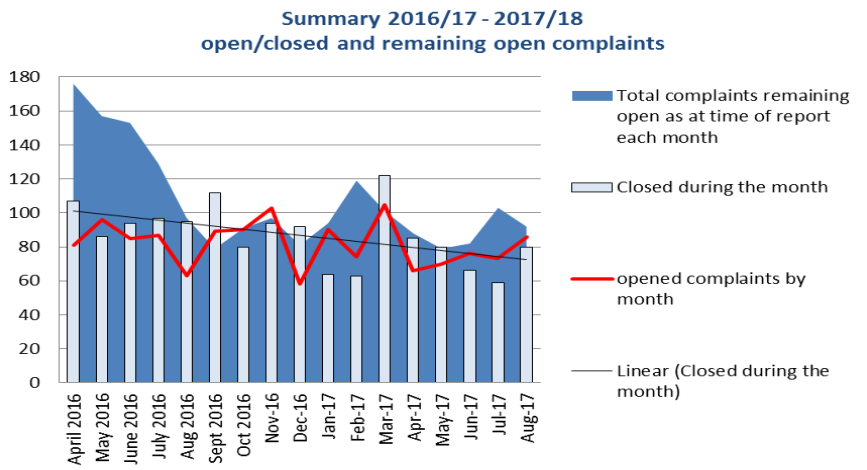
Learning from Complaints

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

Top 5 Key complaint themes Sept 2016 to August 2017

Complaints by subject 2015/17	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Total
Delay	35	29	37	19	36	16	27	21	17	16	14	26	293
Conduct	16	25	22	15	26	27	36	16	19	24	19	19	264
Road handling	14	11	8	8	7	9	16	12	11	13	14	10	133
Treatment	8	14	6	1	3	3	5	1	2	5	1	7	56
Non-convey	0	4	1	1	1	3	4	3	0	4	12	0	33
Total these	73	83	74	44	73	58	88	53	49	62	60	62	779
Overall totals	89	90	103	58	90	74	105	66	70	76	73	86	980

Complaint summary April 2016 to August 2017



Actions

- 86 complaints were received during August. Those where the chief complaint related to the delay in attending increased by 87% over July, despite calls attended being lower than July.
- We have added an Incident Time field to Datix from which we are aiming to prepare data in the future to determine the exact time of each complaint (where appropriate).
- There was an increase in overdue complaints (up to 23). Of these 57% (13) were delayed at Executive Office awaiting sign off and the remainder (10) were awaiting further information.
- We have also added an 'outcome code' by each subject code so that where there is more than one subject, we can record the outcome for each subject. For example a complaint may relate to delay/conduct and treatment but only one of those aspects may be upheld

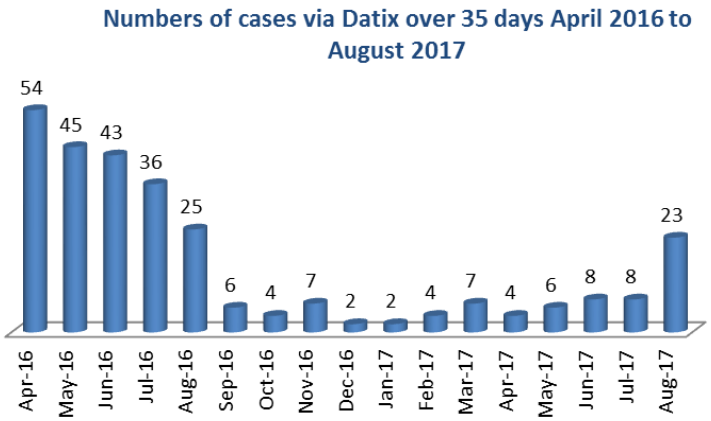
Assurance and learning

- Currently 82 in time complaints remain open.
- 12 complaints, that were closed during August have been upheld, these include:
- A complaint was received where aspects of the care the ambulance staff provided to a maternity patient fell short of the practice standards we expect. The crew have been invited to meet with our Consultant Midwife and a CTL to review the care provided and the areas of practice where their care fell short.
- A complaint was received from the family of a patient who waited a considerable amount of time for an ambulance after she had a seizure. There were some technical shortcomings in the management of the 999 call and extensive feedback will be offered to the call handler concerned with their performance monitored for a period to be decided by their line manager.

Learning from Complaints

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

Performance against 35 day response target



Assurance and learning

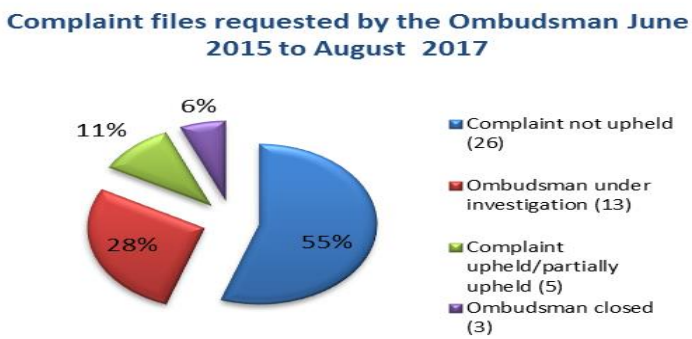
Learning examples from July/August 2017:

Example 1: Interface with NHS111

The Adastra database is an electronic clinical patient management system specifically designed to be used by out-of hours primary care – such as GP's and ambulance services across the UK.

On this occasion the patient was concerned at the content of questions asked by the attending ambulance crew who had been sent a number of possible diagnoses of the patient via the Adastra system (including carpel tunnel syndrome and depression). We have asked the complainant to contact their GOP practice to discuss the electronic record and the information it contains.

Overview of Ombudsman cases 2015-2017



Assurance and learning

Example 2: Non attendance

The patient complained that despite his symptoms, he was declined an ambulance and requested an explanation of that.

The Quality Assurance evaluation identified that the call handler made a technical error when applying the triage protocol which would have otherwise achieved a C1 priority from the outset. Although this priority would have been given to patients determined at a higher categorisation, feedback will be given to the call handler concerned.

Learning from Incidents

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

Learning from Incidents

- Due to the number of overdue actions relating to closed SI investigations the Quality, Governance and Assurance Team have been working with the Datix Leads to include action compliance dashboards which will be accessible to all Senior Managers within each directorate and ELT. Future reports will be run on a monthly basis which will display all actions and the SI investigation they relate to.
- A maternity related 'improving patient care' poster has been distributed to all operational stations to disseminate to front line staff.

- A Maternity Patient Safety bulletin has been issued following a recent SI investigation which found issues regarding:
  - The application of the maternity tool
  - The clinical handover to the receiving hospital
- The Trust has started the process of re-introducing oramorph to areas which have had it temporarily withdrawn
- New 'tamper evident seals' for the oramorph bottles are now being implemented Trust wide

Incidents

SI update	Incidents reviewed In August	SIs declared In August	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	36	8	17	8 (+2 RCA)	6	1	1
Trend on previous week					↓	↓	↓

Serious Incidents & Incidents

Serious Incident Policy has been approved by ELT ready for circulation. This Policy includes the new SI investigation process and timeline.

Additional SOPs have been produced to ensure a uniformed approach to key elements of the investigation process such as:

- Multidisciplinary team meetings
- Completion of the SI report
- SI milestones
- Escalation of concerns

The Governance team is currently updating the Duty of Candour Policy to reflect best practice and national guidance.

New Terms of Reference for the Serious Incident Group have been approved.

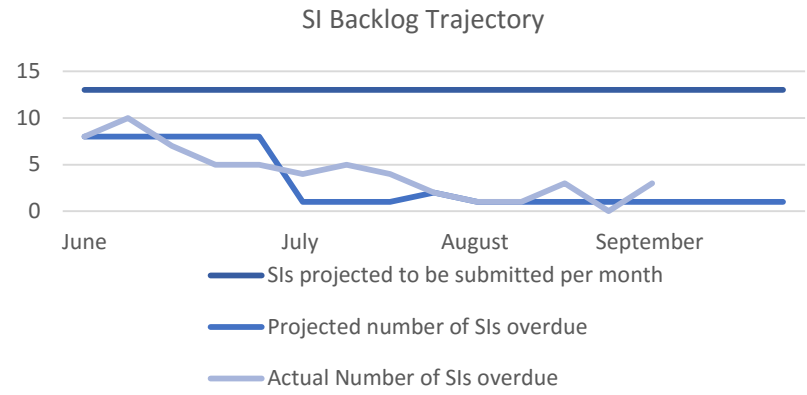
Learning from Incidents

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

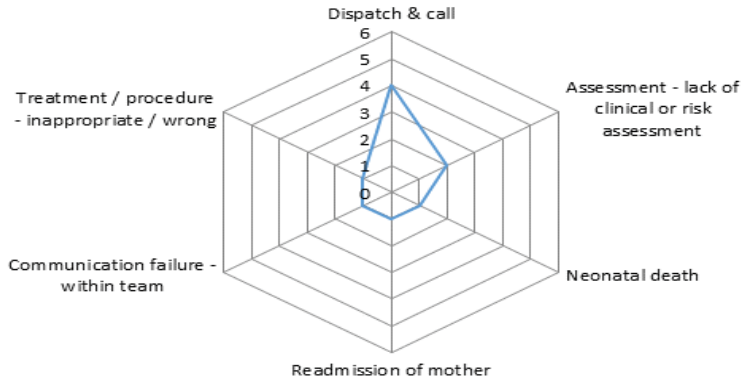
Overdue Serious Incidents Investigations

ELT	STEIS ref	No of days overdue	Due Date	Update
ELT group	2017/13483	**16**	18.08.2017	11.09.17 – report back with the Governance Team for comments post ELT review

SI Trajectory



SIs under investigation as of 10/08/2017



Actions

SI action plan update:

- 91 actions currently overdue relating to closed SI investigations
- Quality, Governance and Assurance Team sending weekly reminders to responsible individuals
- Incomplete actions being escalated to Chief Quality Officer
- Review of Datix to ensure action compliance
- Of the 91 overdue actions:
  - 17 = 6 months or over
  - 19 = 3 to 6 months over
  - 10 = 3 months over
  - 11 = 2 months over
  - 34 = less than 1 month over

Our Performance

Section	Key Headlines	Aug	Jul	Jun
A8 Performance	A8 Performance for August 2017 was 72.1%, this is 1.3% above trajectory.			
Other Performance	A19 performance was at 94.4% in August 2017, this is 0.4% below trajectory. C1 to C4 performance saw increases in August when compared to July.			
Demand	There were 45,295 Category A incidents in August, 5.9% above trajectory. Category C demand was below trajectory by 2.6% at 46,611 incidents. Overall demand was at 91,906 incidents, 1.4% above plan. August 2017 ranked 13th for highest monthly demand to be recorded in Category A Incidents.			
Capacity	The patient facing vehicle hours (PFVH) deployed during August was 4.3% above plan, a decrease from the previous month by 0.3%.			
Efficiency	Job Cycle Time (JCT) for August 2017 was 80.9 minutes. This is above trajectory by 1.6 minutes and is also a decrease of 0.5 minutes compared to the previous month. The multiple attendance ratio (MAR) was 1.27 which is successfully below the target of 1.29.			
EOC – Call Answering	The 5 Second Call Answering for August was at 84.20%.			
EOC – FRU Cat C Share	FRU share of Cat C for August was 8.70%.			
Resource Escalation Action Plan (REAP)	In line with the National Ambulance Resilience Unit recommendations, our REAP identifies the level of pressure the Service is under at any given time, and gives a range of options to deal with the situation. Four levels of escalation are used, which aim to help ambulance services integrate into the wider NHS surge or escalation framework. These levels are used to determine what actions are necessary to protect service delivery and supply the best possible level of service to patients with the resources available. The REAP score is currently at level 2.			

Ambulance Quality Indicators (AQI) Update – July 2017

The AQIs for July 2017 were published on 14th September 2017. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

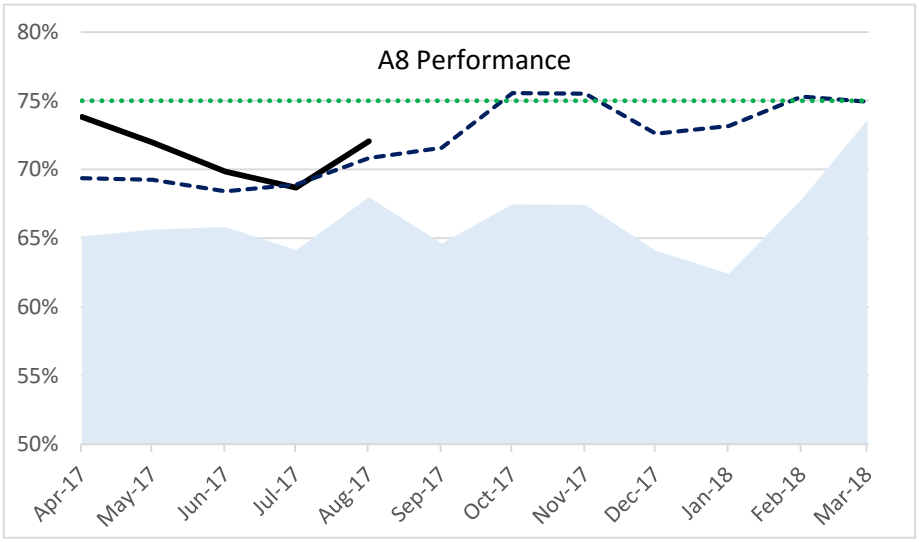
The table below details 7 of these indicators with the description and LAS performance.

Please Note: Due to the Ambulance Response Programme for Category A measures the Yorkshire, West Midlands and South Western Ambulance Trusts are only included in the first two measures in the table below (Ranking Position).

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**			
AQI Indicator Description SYSTEM INDICATORS	**Units**	**Target**	JUL	JUN	MAY	Ranked out of	JUL	JUN	MAY
The time taken to answer 95% of 999 calls in the emergency control room	(secs)	5 secs	52	55	19	11	8	8	5
The percentage of callers who have hung up before their call was answered in the emergency control room	%		1.1%	1.4%	0.4%	11	5	7	3
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	72.4%	73.3%	73.7%	8	3	3	2
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	68.5%	69.7%	71.9%	8	2	3	2
The time taken to reach 95% of Category A (Red 1) calls	(mins)		13.1	12.8	13.0	8	1	1	2
The percentage of Category A calls reached within 19 minutes	%	95%	94.1%	94.3%	95.0%	8	2	2	1
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	(mins)		18.7	18.3	17.2	8	2	2	1

Latest Publication : 14th September 2017 (Jul-17 data)
Date of next publication : 12th October 2017

A8 Performance

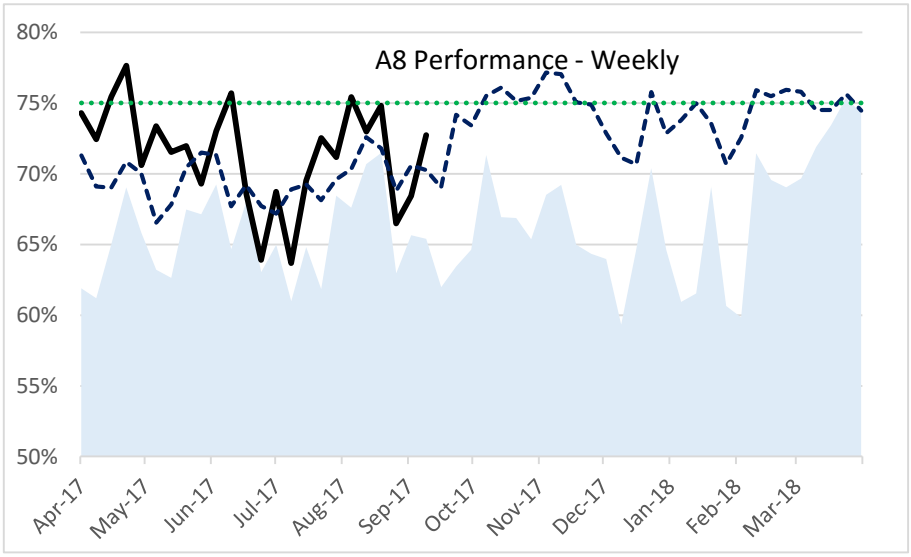


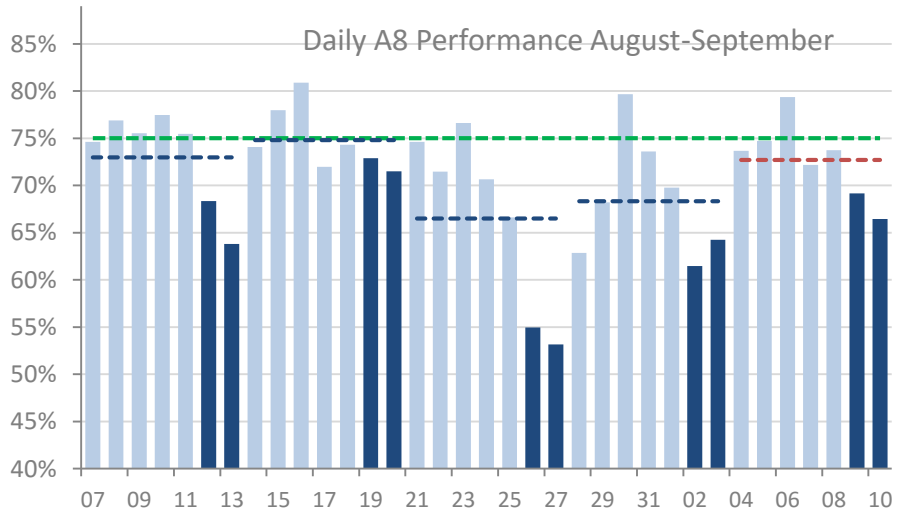
A8 Performance for August 2017 was 72.1%, this is 1.3% above trajectory. For additional context, A8 Performance for August 2016 was 68.0%.

The following factors have contributed to August's Cat A performance:

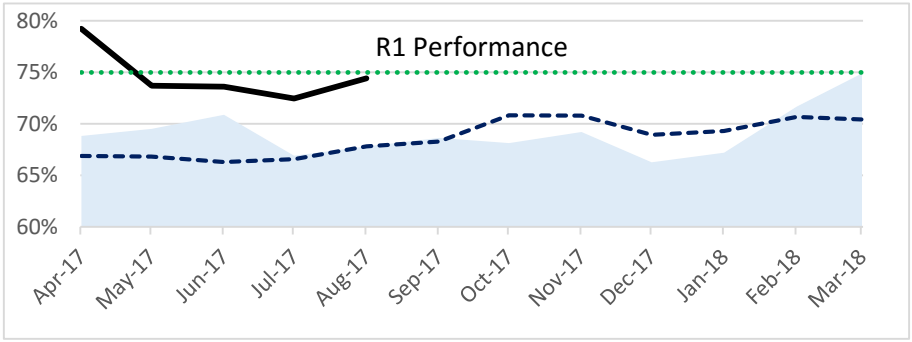
- **Demand** – Overall the number of incidents were 1.4% above plan. Cat A was 5.9% above trajectory and Cat C was 2.6% below plan.
- **Capacity** – Overall patient facing vehicle hours was 4.3% above plan, a 0.3% increase from previous month.
- **Efficiency** - Average job cycle time in August was 80.9 whilst trajectory was 79.3. A decrease of 0.5 minutes from last month. Full JCT was 102.5 whilst trajectory was 100.3 and MAR was 1.27 against a trajectory of 1.29.

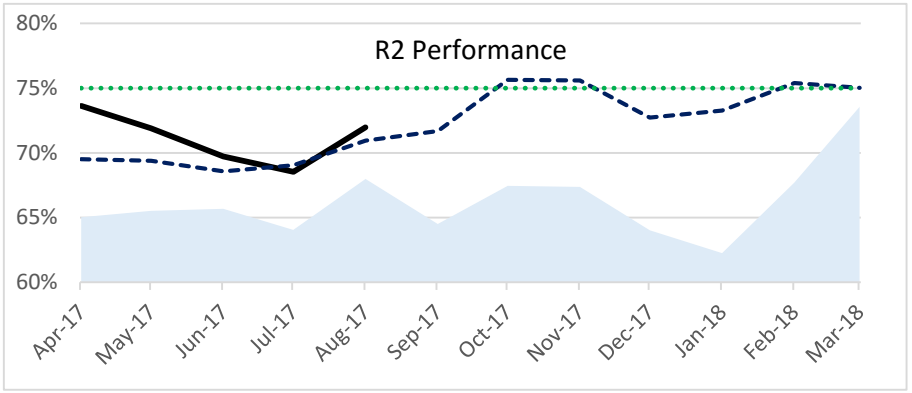
16/17 actual data
17/18 actual data
Trajectory
National target

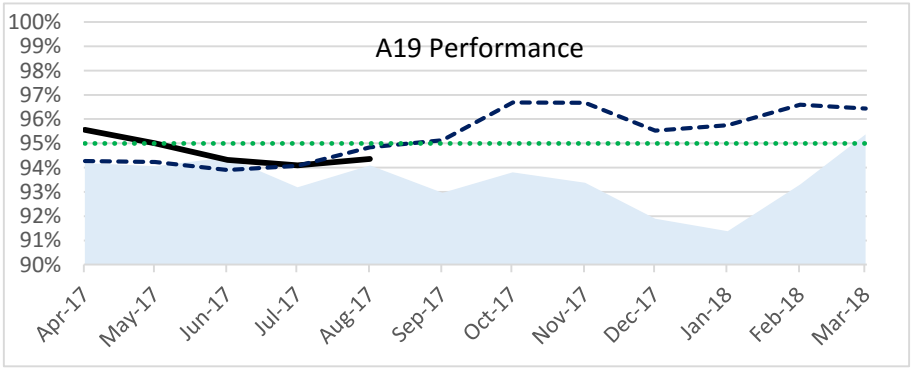




Other Performance







A19 performance was at 94.4% in August 2017, this is 0.4% below trajectory.

- Red 1 was 74.4% - 6.6% above trajectory
- Red 2 was 72.0% - 1% above trajectory
- A19 was 94.4% - 0.4% below trajectory

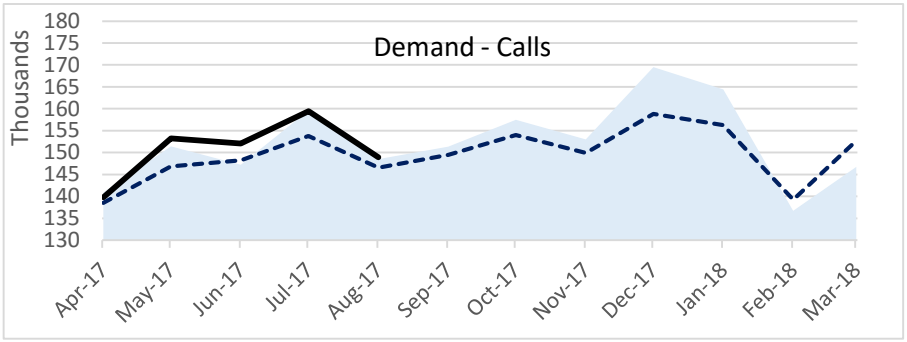
C1 to C4 performance saw increases in August when compared to July.

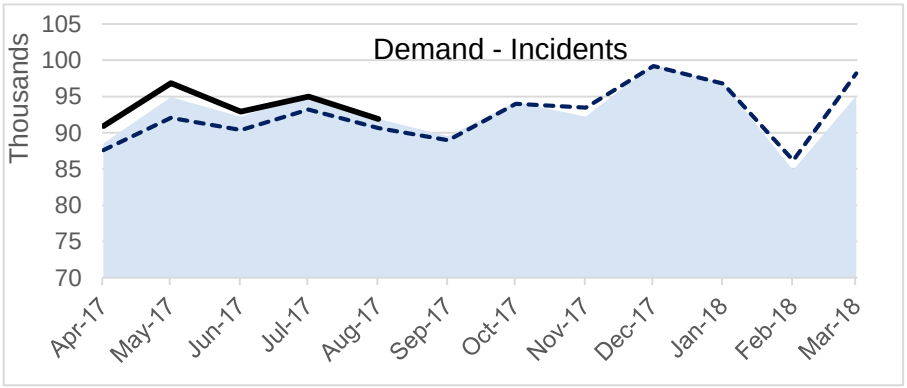
16/17 actual data
17/18 actual data
Trajectory
National target

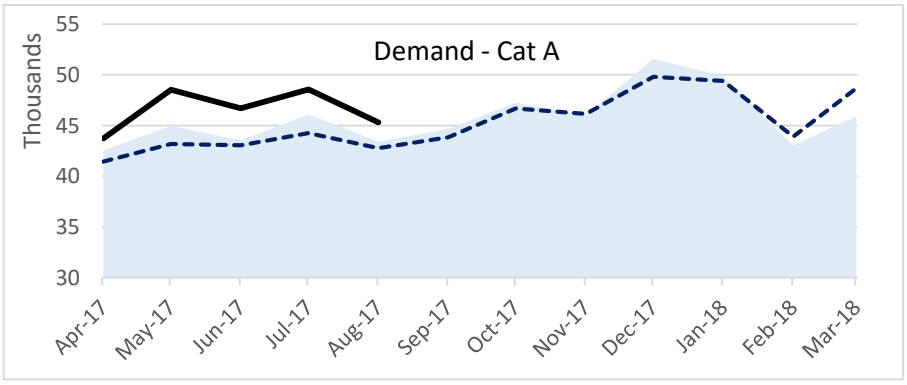
Week ending	A8	A19	R1	R2	C1	C2	C3	C4
13-Aug	73.0	95.6	77.0	72.8	79.9	81.3	82.4	59.9
20-Aug	74.8	95.1	76.5	74.7	81.0	80.3	81.7	60.5
27-Aug	66.5	91.8	68.4	66.4	72.0	76.5	78.4	55.3
03-Sep	68.3	93.7	72.8	68.2	78.1	78.8	79.9	58.8
10-Sep	72.7	95.7	77.5	72.5	82.3	86.3	84.7	66.8

Jun-17	69.8	94.3	73.6	69.7	77.1	81.1	80.9	60.9
Jul-17	68.7	94.1	72.4	68.5	73.8	76.9	76.0	56.3
Aug-17	72.1	94.4	74.4	72.0	79.0	80.8	81.5	60.1

Demand







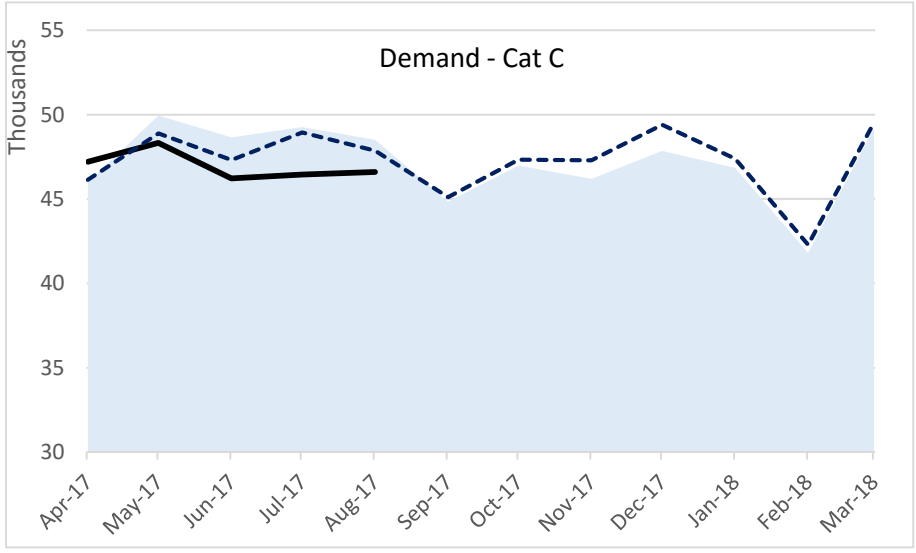
Overall demand for August 2017 was at 91,906 incidents, this is 1.4% above plan but was a 3.3% decrease from last month. August 2016 was at 91,918 incidents.

Cat A demand was 5.9% above trajectory but saw a 6.7% decrease from last month.

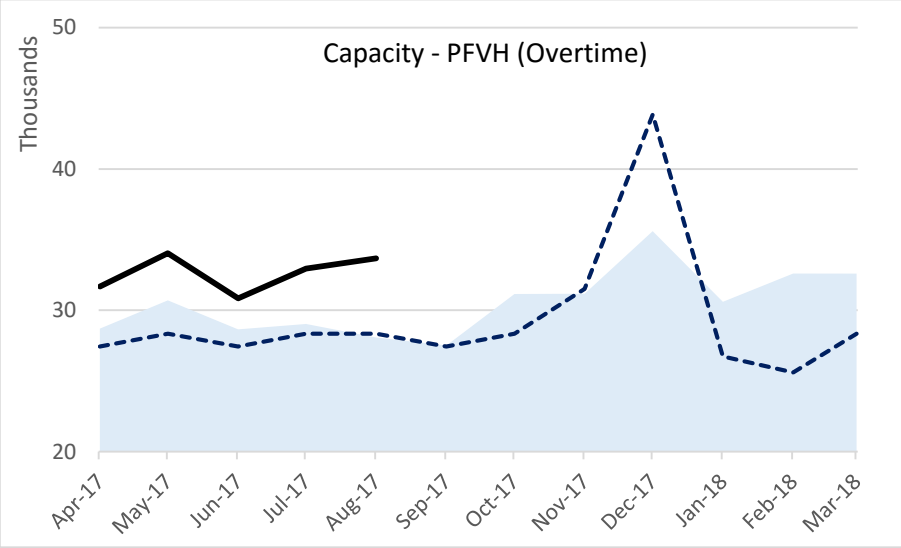
August's Category C incidents 2.6% below plan. There was an increase of 0.3% from the previous month but was 3.9% lower than August 2016's incidents.

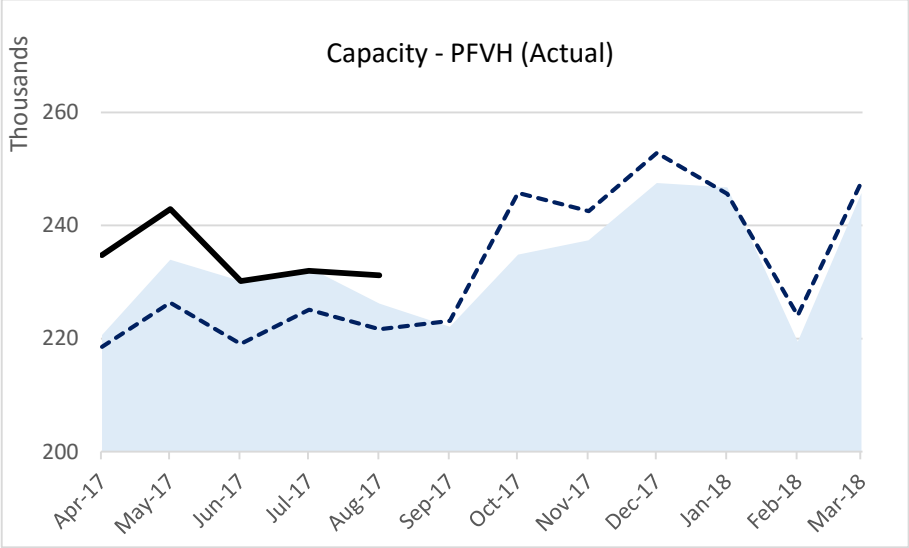
Call volumes were 1.6% above trajectory but 6.6% lower than the previous month.

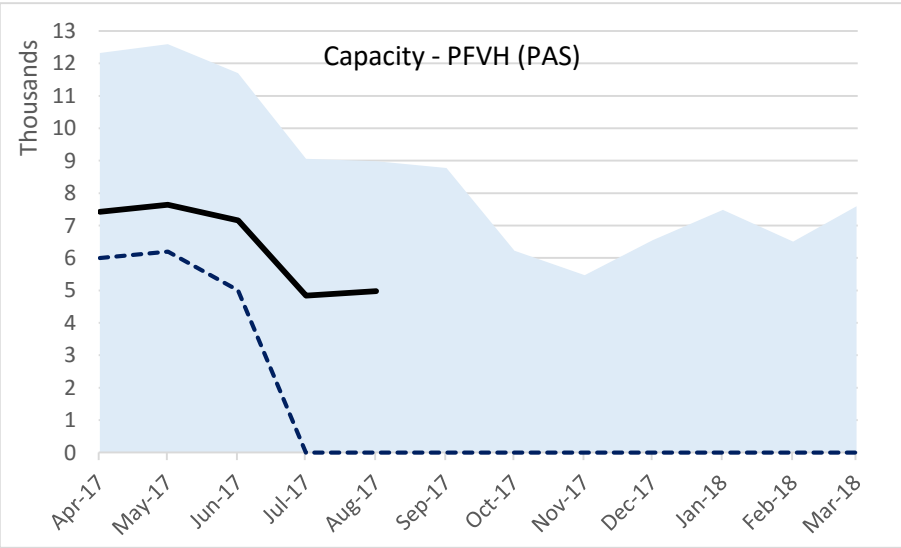
16/17 actual data
17/18 actual data
Trajectory



Capacity





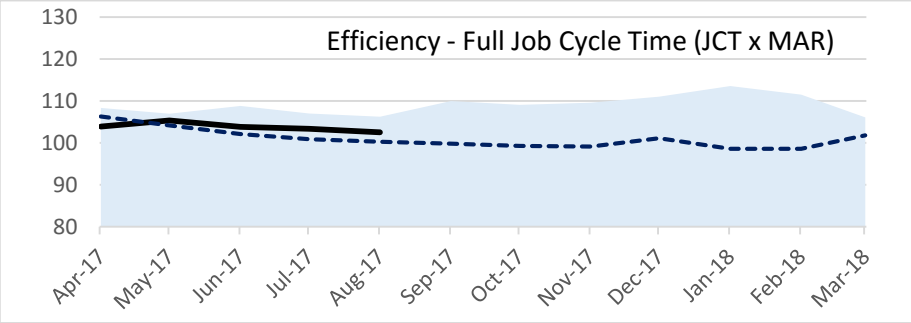


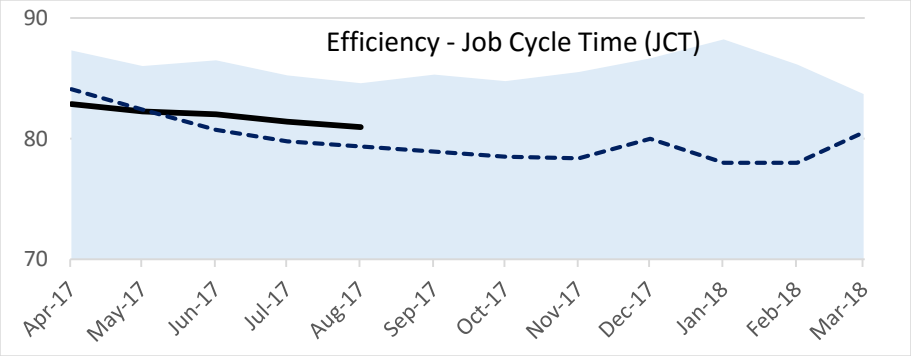
The Patient Facing Vehicle hours deployed in August were 215,877. This was 4.3% above plan and 2.2% above August 2016.

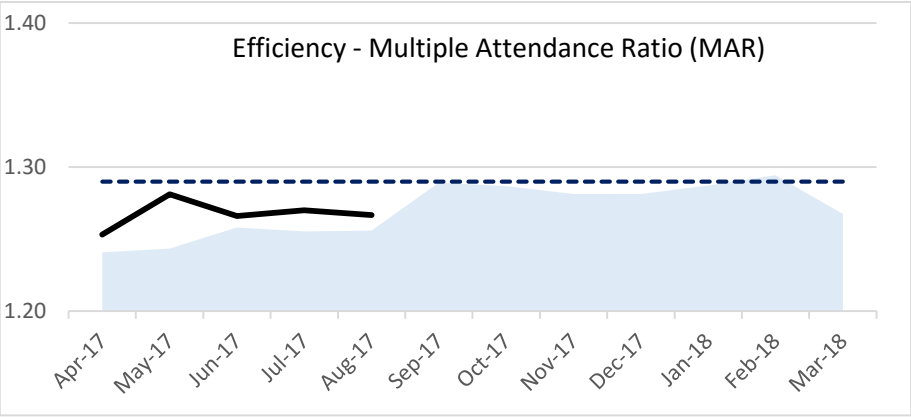
PAS/VAS hours for August 2017 increased by 2.9% from the previous month and was 44.7% below August 2016.

16/17 actual data
17/18 actual data
Trajectory

Efficiency







There is a requirement to reduce JCT from 85 minutes to 78 minutes during 2017/18.

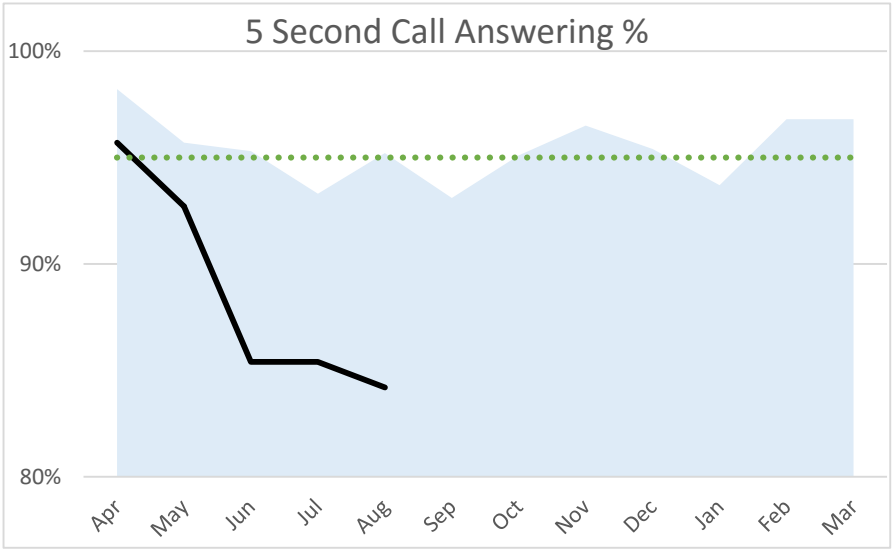
Job Cycle Time for August was 80.9 whilst the trajectory was 79.3 This was an increase of 0.5 minutes from the previous month, however it was 3.7 minutes lower than August 2016 last year.

Full Job Cycle (JCT x MAR) was 102.5 minutes against a trajectory of 100.3. This is also better than August last year by 3.7 minutes.

The Multiple Attendance Ratio (MAR) was successfully below target for August at 1.27.

16/17 actual data
17/18 actual data
Trajectory

Emergency Operations Centre (EOC)

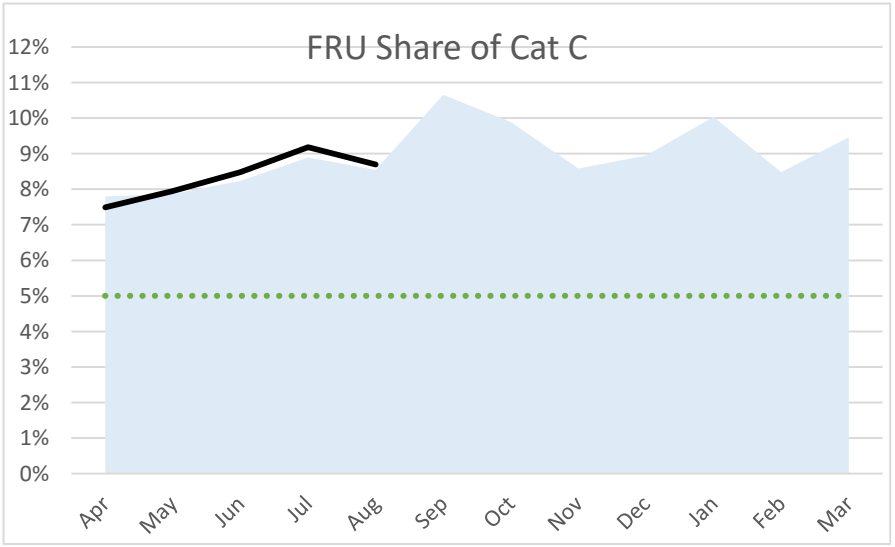


5 Second Call Answering for August 2017 was at 84.2%, the target is 95%.

There are 17 call taking vacancies in EOC and this, together with the competing priorities of different desks in the control room, is currently challenging our call handling performance. A recovery plan is being developed to address this issue.

FRU share of Cat C for August 2017 was 8.7% which is 3.7% above the 5% target.

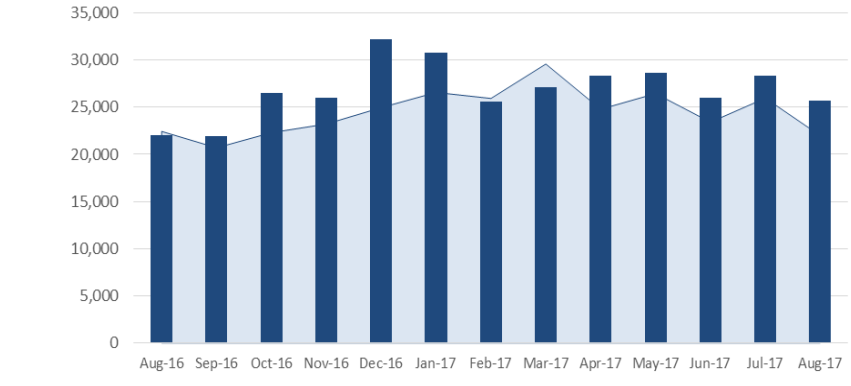
16/17 actual data
17/18 actual data
Target



Month	5 Second Call Answering %	
	2016-17	2017-18
Apr	98.21%	95.70%
May	95.70%	92.70%
Jun	95.30%	85.40%
Jul	93.30%	85.40%
Aug	95.21%	84.20%
Sep	93.10%	
Oct	95.10%	
Nov	96.50%	
Dec	95.40%	
Jan	93.70%	
Feb	96.80%	
Mar	96.80%	

Month	FRU Share of Cat C	
	2016-17	2017-18
Apr	7.80%	7.49%
May	7.87%	7.95%
Jun	8.23%	8.48%
Jul	8.89%	9.18%
Aug	8.54%	8.70%
Sep	10.65%	
Oct	9.89%	
Nov	8.58%	
Dec	8.95%	
Jan	10.03%	
Feb	8.48%	
Mar	9.46%	

LAS 111 (South East London): Demand and Capacity – August 2017



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Calls Answered	22,442	20,697	22,305	23,219	24,963	26,573	25,935	29,586	24,791	26,451	23,419	25,971	21,988
Calls Answered	21,988	21,947	26,505	26,037	32,237	30,826	25,596	27,151	28,381	28,656	26,015	28,321	25,703

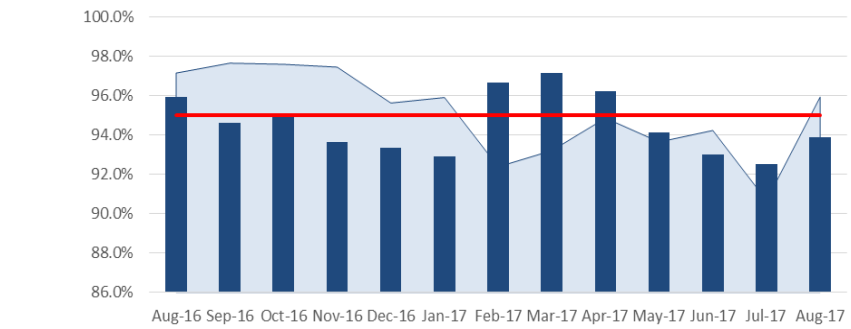
Demand: Call volumes were 17.2% higher than August 2016 but 9.2% lower than in July this year.

Capacity: Induction planning for induction commencing on 04 September to maintain robust Call Handler capacity and increase Clinical Advisor establishment fill. Current vacancy factor for Clinical Advisors is 18.34WTE (65.7%). Established agency workforce in place to mitigate risk.

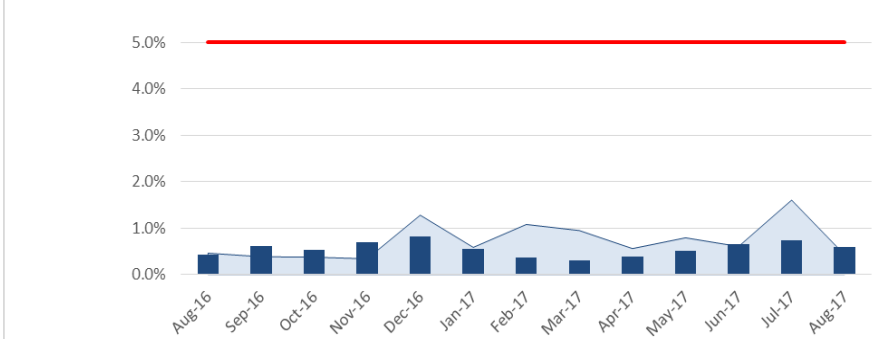
Efficiency: The percentage of calls answered in 60 seconds was 93.9% in August with the target achieved on 27 days.

The operational focus has been on balancing access to the service and minimizing time to clinical call back and saw an increase in call backs achieved within 10 minutes. .

Service Projects: The service focus throughout August has been on SEL 111/IUC Evolution Action Plan and the development of pilots in a range of areas

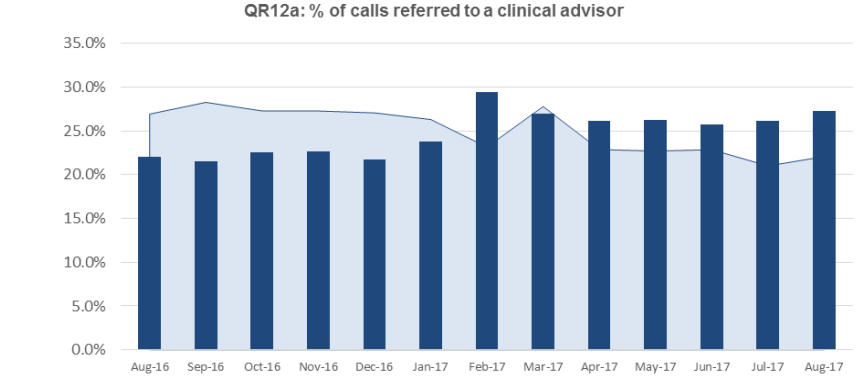


	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%	93.2%	94.8%	93.6%	94.2%	90.7%	95.9%
Current Year	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%	96.2%	94.1%	93.0%	92.5%	93.9%
QR Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%	0.9%	0.6%	0.8%	0.6%	1.6%	0.4%
Current Year	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%	0.4%	0.5%	0.7%	0.7%	0.6%
QR Target	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

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

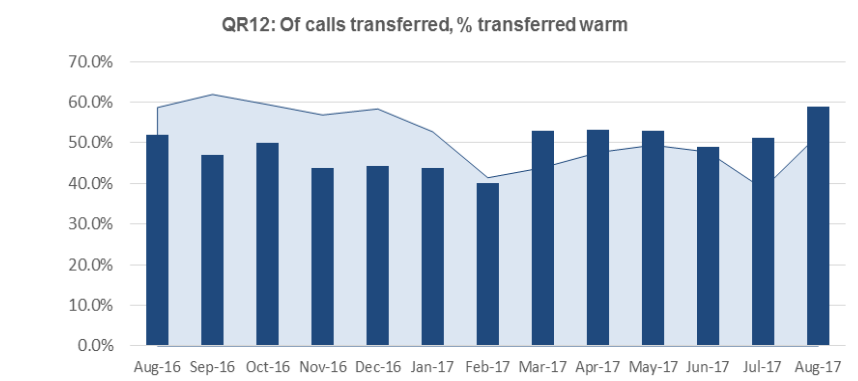


	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	26.9%	28.3%	27.3%	27.3%	27.1%	26.3%	23.2%	27.8%	22.9%	22.7%	22.9%	21.0%	22.1%
Current Year	22.1%	21.5%	22.6%	22.7%	21.7%	23.8%	29.5%	26.9%	26.2%	26.3%	25.7%	26.2%	27.3%

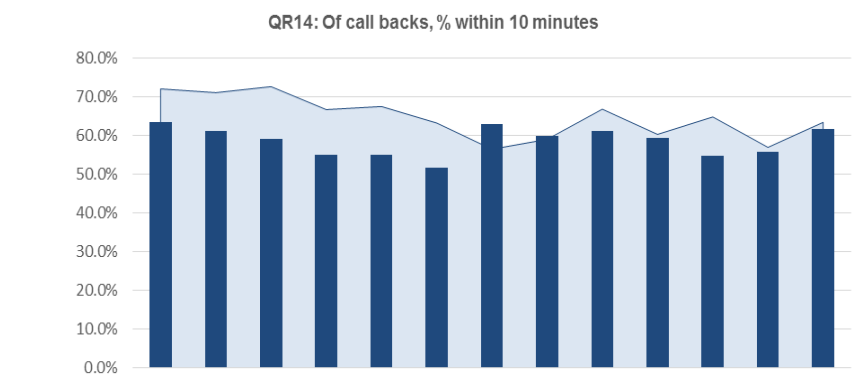
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green ambulance outcomes and availability of Clinical Advisors to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

Safety: There were 131 Incidents in Datix with completed investigations in August. Of these 47.3% (n=62) related to a delay in care, 9% (n=12) related to authorized breaches in confidentiality including safeguarding referrals made with our patient consent, 12.2% (n=16) to failure to follow procedure, 15.5% (n=23) required no further action and the remaining 15.8% (n=18) to other issues. Incidents are under investigation and feedback given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received seven complaints, no HCP feedback and two compliments. The reason for the increase in complaints is being investigated.

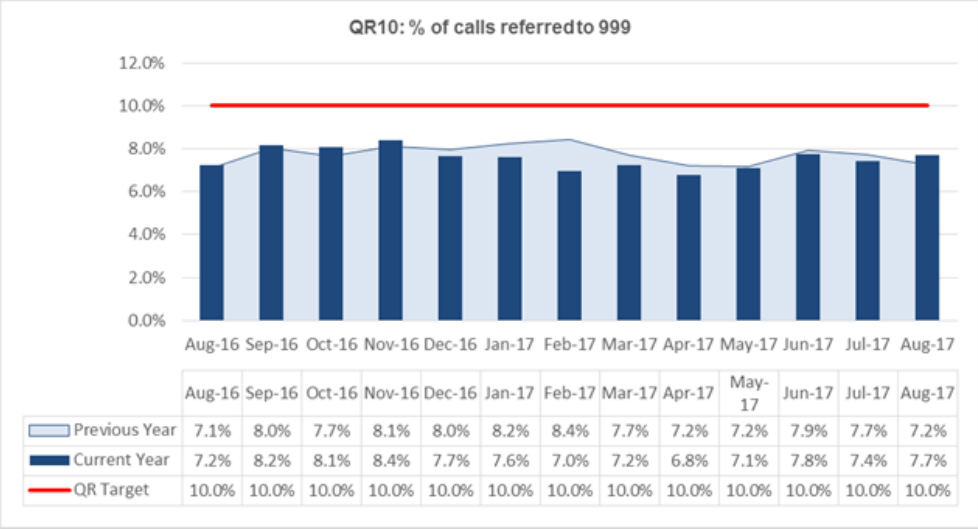


	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	58.7%	61.9%	59.4%	56.9%	58.3%	52.7%	41.4%	43.9%	47.6%	49.4%	47.7%	38.7%	51.9%
Current Year	51.9%	47.0%	49.9%	43.8%	44.4%	43.8%	40.1%	52.8%	53.2%	52.9%	48.9%	51.3%	59.0%



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	72.1%	71.1%	72.6%	66.7%	67.5%	63.2%	56.4%	59.0%	66.8%	60.3%	64.8%	56.9%	63.4%
Current Year	63.4%	61.0%	59.0%	55.0%	55.1%	51.6%	62.9%	59.8%	61.1%	59.3%	54.6%	55.7%	61.6%

LAS 111 (South East London): Triage destinations – August 2017

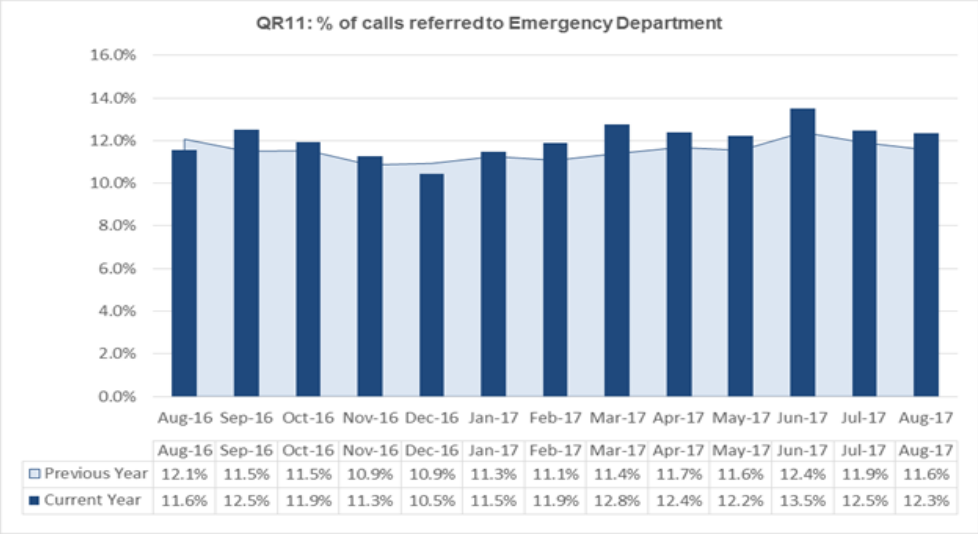


	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%	7.7%	7.2%	7.2%	7.9%	7.7%	7.2%
Current Year	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%	6.8%	7.1%	7.8%	7.4%	7.7%
QR Target	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

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

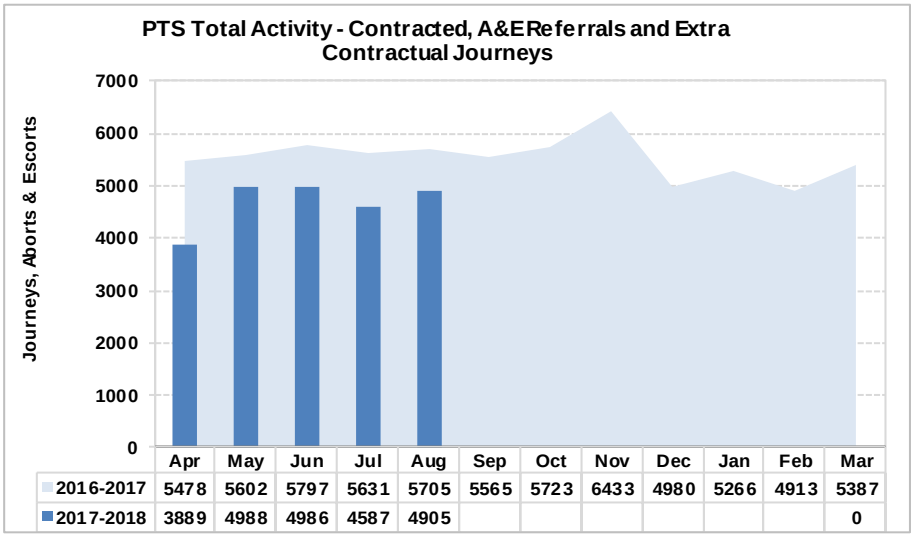
Referrals to Emergency Departments are higher than for other providers, this figure includes Urgent Care Centres and Walk-in Centres.

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



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Previous Year	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%	11.4%	11.7%	11.6%	12.4%	11.9%	11.6%
Current Year	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%	12.4%	12.2%	13.5%	12.5%	12.3%

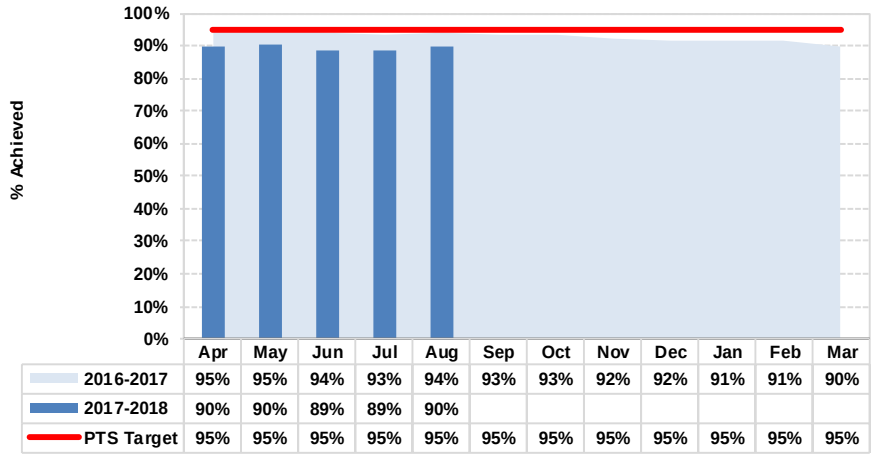
Patient Transport Service – Activity and Profitability Update



August saw a rise in the number of journeys with a total of 4905 journeys being delivered as compared to the July total of 4587 journeys.

Month	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Apr	15044	13227	8495	5478	3889
May	15987	13164	7943	5602	4988
Jun	14852	10129	8967	5797	4986
Jul	16481	10508	8923	5631	4587
Aug	14401	9028	5457	5705	4905
Sep	15002	9602	6097	5565	
Oct	16739	10957	5841	5723	
Nov	15981	10063	5989	6433	
Dec	13986	9250	4943	4980	
Jan	16409	9753	5103	5266	
Feb	15232	9787	5306	4913	
Mar	13978	10520	5264	5387	
Total	184092	125988	78328	66480	23355

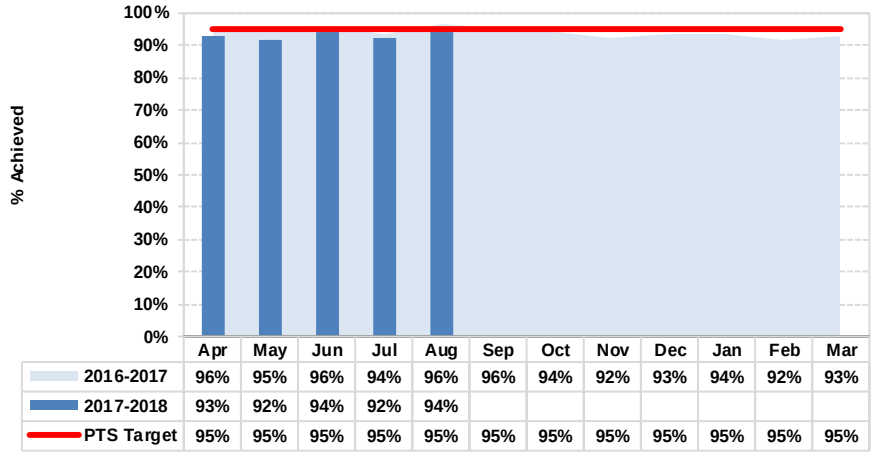
Patient Transport Service – KPI Update



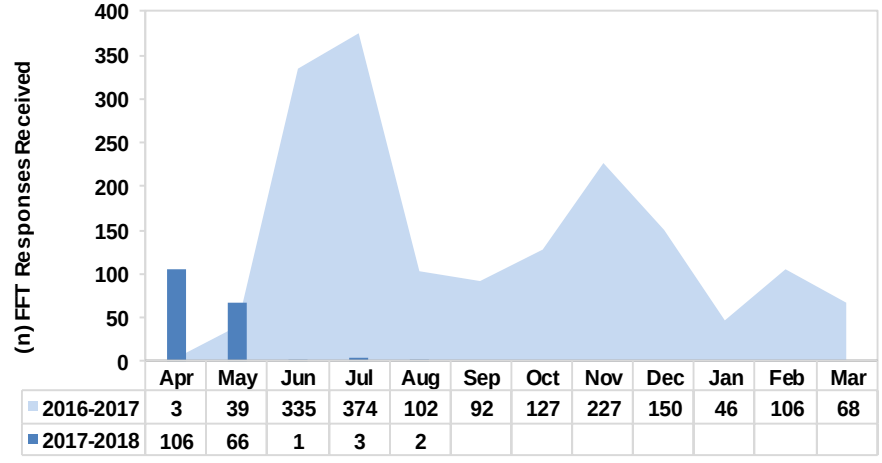
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	95%	95%	94%	93%	94%	93%	93%	92%	92%	91%	91%	90%
2017-2018	90%	90%	89%	89%	90%							
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The arrival at hospital against the appointment time improved by 1% rising to 90% in August even with the increase in overall activity for the month but was still below the 95% target.

Departure against patient ready time also saw an increase from the 92% we had in July back to 94% for August against the background of increased activity. This is below the target of 95%.

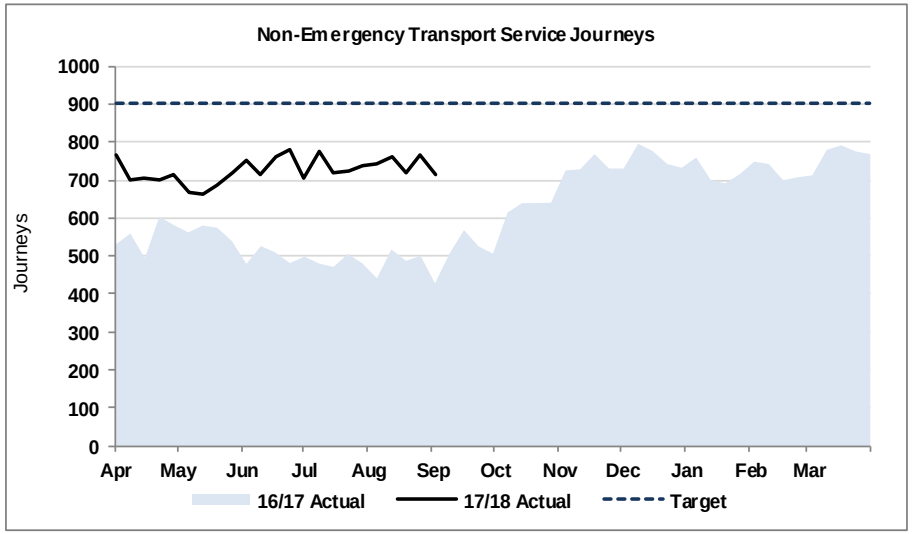


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	96%	95%	96%	94%	96%	96%	94%	92%	93%	94%	92%	93%
2017-2018	93%	92%	94%	92%	94%							
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



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

Non-Emergency Transport Service



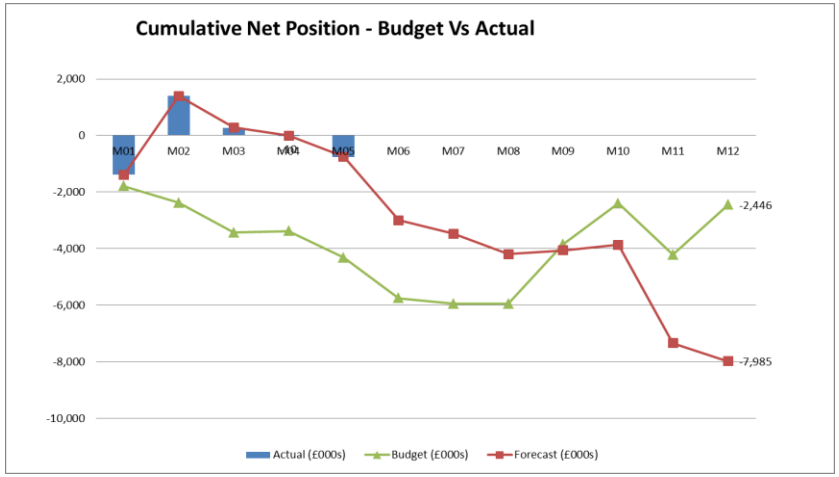
Non-Emergency Transport Update

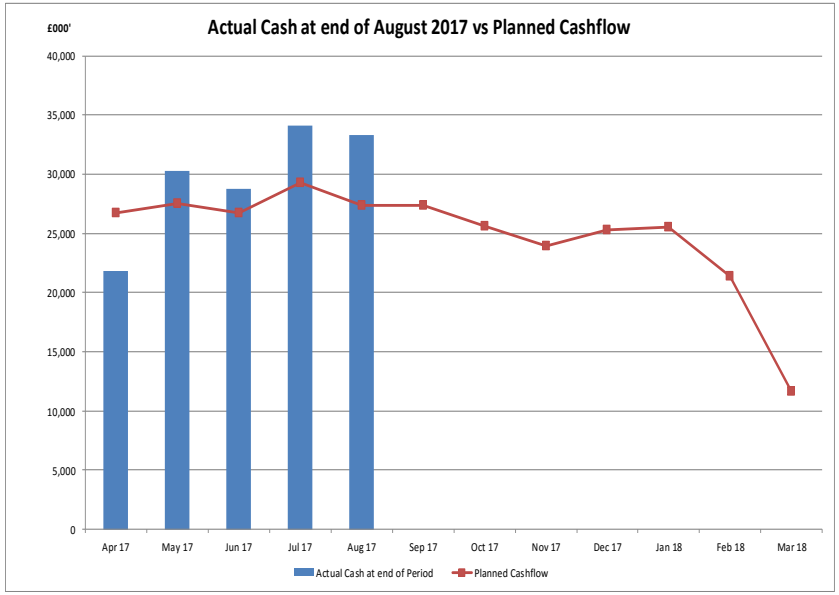
- NETs again saw a stabilization in the month and delivered an average of 745 journeys per week for the month.
- During August we saw the NETs overall weekly performance peak and trough in line with the holiday period impacts of resources and activity levels. The team maintained its continued focus in ensuring the quality and number of calls to the NETS dispatch group was maintained. The average number of calls passed to NETS increased to 974 up from 961 calls per week for the month.
- Performance continued to suffer due to increasingly lengthy handover times at hospitals.
- From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETs and completed.

Our Money

Financial Indicator	Key Headlines	Forecast Outturn	Current Month	Previous month
Surplus/Deficit (Year to date and Forecast)	Year to date the position is £1.4m ahead of plan and £3.1 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. Whilst the month 5 forecast is to achieve plan, there is a risk that the Trust could end the year with a worst case £4.2m deficit if CIP risks materialise and are not mitigated further. Key issues in the position are: • Income is £0.2m adverse compared to re-phased budget due to the budget including over activity at 3% and only 2.7% being achieved YTD. • On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand • Demand is currently running above 2017-18 contracted baseline activity (2016-17 contract activity plus 6%) by 2.7% YTD, lower than the contract cap level of 3%, which is a trigger for re-negotiation.			
Income	Income is £0.1m favourable in month, and £0.2m adverse year to date compared to re-phased budget due to: • PTS £0.3m favourable variance in month as contract was initially budgeted to have ended in July. • Main contract activity for M5 YTD is 2.7% higher than the contract baseline, and the variable income from this has been capped at 2.7% pending confirmation of Commissioner demand management achievement. • CQUIN income on plan in month but will deteriorate against initial plan in future months due to phasing of CQUIN criteria. • There is a risk around band 6 funding as additional criteria has been issued by NHS England that must be met before funding is released.			
Expenditure (incl. Financial Charges)	In month expenditure is on plan to re-phased budget in month, and £3.8m favourable YTD. The key drivers for this are: • On-going vacancies in operational pay (incl. EOC) (£1.6m favourable in month, £8.8m favourable YTD) • PAS overspends to compensate for vacancies (£0.4m unfavourable in month, £2.3m unfavourable YTD) are offset by various underspends in budgeted services spend			
CIPs	Year to date CIPs are £1.8m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.			
Balance Sheet	Capital spend is £3.4m against a Capital plan of £7.2m, £3.8m behind plan, NHSI have confirmed that the Trust can carry forward last year's under spend on capital £6.9m. Significant risk remains due to uncertainty around the centrally funded initiatives £5.5m.			
Cashflow	Cash is £33.3m, £6.0m above plan. The Trust has overdue debts of £12.5m. This includes £6.2m of the paramedic re-banding income that is being credited in September 2017 and new invoices will be raised for £2.1m as agreed with NHS England, for the funding first four months of the year. There is now a risk that the Trust may not receive all of the income for the re-banding. An analysis of the cash position shows that receipts from income are £6.2m lower than planned and there are higher than planned creditor payments of £1.8m are being offset by under payments of £6.4m on capital, provision of £0.5m and £7.1m on pay. Three CCGs are disputing their additional activity invoices totalling £0.8m.			
BPPC	Non-NHS 90%, NHS 90% performance (volume) for this month, performance is improving but still below 95% target.			

Executive Summary - Key Financial Metrics





	2017/18 - Month 5			Year to Date			FY 2017/18
	Re-phased Budget	Act	Var	Re-phased Budget	Act	Var	Plan
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Surplus / (Deficits)	(932)	(751)	181	(4,315)	(752)	3,563	(2,438)
EFL				(8,668)	(14,642)	5,974	12,538
CRL				7,234	3,444	3,790	28,806
Suppliers paid within 30 days - NHS	95%	90%	(5.0%)	95%	72%	(23.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	90%	(5.0%)	95%	86%	(9.0%)	95%
Monitor							
EBITDA %	2.2%	2.3%	0.1%	2.2%	4.4%	2.1%	5.0%
EBITDA on plan	639	668	29	6,992	6,413	(579)	18,185
Net Surplus	(932)	(751)	181	(4,315)	(752)	3,563	(2,438)
NRAF (net return after financing)				(0.0%)	1.0%	1.0%	1.2%
Liquidity Days				(1.43)	6.60	8.03	(9.90)
Use of Resources Rating				3.0	1.0	2.0	2.0

- Year to date the position is £1.4m ahead of plan and £3.1 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. Whilst the month 5 forecast is to achieve plan, there is a risk that the Trust could end the year with a worst case £4.2m deficit if CIP risks materialise and are not mitigated further.
- Income is £0.1m favourable in mth due to PTS contract planned to be completed and adjustments made to the phasing of contract income and cquin.
- On-going vacancies in core frontline staff groups offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand.
- Demand is currently running above 2017-18 contracted baseline activity (2016-17 contract activity plus 6%) by circa 2.7% YTD, lower than the level included in the budget of 3%. Income has been capped at 2.7%. This figure differs from the figures quoted in the weekly performance packs as the weekly performance data includes activity for dates outside the reporting period (i.e. week 1 includes 2016/17 activity and the YTD activity in the weekly performance packs will not align exactly to the end of each month).
- CRL position – the capital plan is £3.8m behind target.
- Cash is £33.3m, £6.0m above plan. The Trust has overdue debts of £12.5m. This includes £6.2m of the paramedic re-banding income that is being credited in September 2017 and new invoices will be raised for £2.1m as agreed with NHS England, for the funding first four months of the year. There is now a risk that the Trust may not receive all of the income for the re-banding. An analysis of the cash position shows that receipts from income are £6.2m lower than planned and there are higher than planned creditor payments of £1.8m are being offset by under payments of £6.4m on capital, provision of £0.5m and £7.1m on pay. Three CCGs are disputing their additional activity invoices totalling £0.8m
- BPPC – Non-NHS 90%, NHS 90% (volume) performance is improving but still below the 95% target.

Forecast and CIP Outturn (I&E)

Divisional Budget Summary	Income and Expenditure						Cost Improvement Plan					
2017/18	YTD			Full Year			YTD			Full Year		
Month 5	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Division	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Central Corporate	9,691	8,072	1,619	26,807	19,857	6,950	(868)	(809)	(59)	(2,899)	(2,304)	(595)
Central Income	(139,773)	(139,171)	(602)	(346,561)	(345,965)	(596)	(650)	0	(650)	(2,225)	(1,575)	(650)
Chairman & Non-Executives	46	47	(1)	111	106	5	0	0	0	0	0	0
Chief Executive	1,519	1,305	213	3,150	2,810	340	(85)	(118)	33	(250)	(249)	(1)
Corporate Services	1,897	1,816	81	4,553	4,507	46	0	0	0	0	0	0
Estates	4,251	4,294	(43)	10,284	10,948	(663)	(105)	(62)	(43)	(250)	0	(250)
Finance	1,345	993	353	3,229	2,749	479	0	0	0	0	0	0
Fleet & Logistics	11,449	13,466	(2,016)	27,016	33,070	(6,055)	(463)	0	(463)	(1,257)	0	(1,257)
IM&T	4,721	4,941	(220)	14,478	14,190	288	0	0	0	0	0	0
Clinical Education & Standards	5,577	3,649	1,928	13,336	11,054	2,282	0	0	0	(250)	0	(250)
Medical	2,087	1,643	445	4,959	4,611	348	0	0	0	0	0	0
111 Service	82	(47)	129	(94)	(245)	151	0	0	0	0	0	0
Central Operations	9,392	9,121	271	22,510	21,801	709	(200)	(471)	271	(500)	(500)	0
Control Services	9,753	10,034	(280)	23,826	23,994	(168)	(1,008)	(470)	(539)	(2,000)	(1,584)	(416)
Core Frontline Central	9,889	16,309	(6,420)	20,248	40,907	(20,659)	(1,426)	(872)	(553)	(6,550)	(2,885)	(3,665)
South East Sector	14,619	13,282	1,337	35,064	31,936	3,128	0	0	0	0	0	0
South West Sector	9,423	9,084	339	22,591	21,857	734	0	0	0	0	0	0
North West Sector	15,758	13,869	1,889	37,798	33,640	4,158	0	0	0	0	0	0
North Central Sector	10,623	9,153	1,470	25,477	22,240	3,237	0	0	0	0	0	0
North East Sector	14,069	11,899	2,169	33,723	29,125	4,598	0	0	0	0	0	0
Non Emergency Transport	2,970	2,591	379	6,937	6,516	420	(222)	(601)	379	(1,000)	(1,420)	420
Patient Transport Service	(331)	(296)	(35)	(331)	(168)	(163)	0	0	0	0	0	0
Performance	474	453	21	1,137	1,099	38	0	0	0	0	0	0
Quality & Assurance	1,089	1,039	50	2,865	2,368	497	0	0	0	0	0	0
Special Measures	42	21	21	100	130	(30)	0	0	0	0	0	0
Strategic Communications	430	381	49	1,032	1,041	(9)	0	0	0	0	0	0
Support Services Senior Mngmnt	92	45	47	221	108	113	0	0	0	0	0	0
Transformation & Strategy	378	356	23	1,808	1,692	116	0	0	0	0	0	0
People & Organisational Development	2,752	2,404	348	6,174	6,037	138	(230)	(56)	(174)	(600)	(353)	(247)
Total	**4,315**	**752**	**3,563**	**2,446**	**2,015**	**431**	**(5,257)**	**(3,459)**	**(1,798)**	**(17,781)**	**(10,872)**	**(6,910)**

	Scenario Analysis		
Forecast - Month 5	Worst Case	Likely Case	Best Case
	£'000	£'000	£'000
Forecast Outturn (Deficit)/Surplus	(4,156)	(2,015)	2,754

- Scenario analysis developed through assessment of the known risks and mitigations identifies a worst case deficit of £4.2m.
- Year to date CIPs are £1.8m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.

NB: Forecast above is before month 5 performance review updates

33

Statement of Comprehensive Income

2017/18 - Month 5				Description	Year to Date					FY 2017/18	
Plan	Re-phased Bud	Act	Re-phased Bud Var		Plan	Re-phased Bud	Act	Plan Var	Re-phased Bud Var	Re-phased Bud	Fcast
£000	£000	£000	£000 fav/(adv)		£000	£000	£000	£000	£000 fav/(adv)	£000	£000
				Income							
27,336	27,148	27,157	9	Income from Activities	141,294	136,599	136,281	(5,013)	(317)	338,044	352,151
1,797	1,797	1,915	119	Other Operating Income	9,626	9,626	9,704	79	79	23,230	10,779
29,132	**28,944**	**29,072**	**128**	**Subtotal**	**150,920**	**146,224**	**145,986**	**(4,934)**	**(239)**	**361,274**	**362,930**
				Operating Expense							
22,537	22,262	21,174	1,088	Pay	113,511	111,545	105,273	8,238	6,272	269,907	260,259
6,307	6,043	7,231	(1,188)	Non Pay	32,365	31,391	34,300	(1,935)	(2,909)	74,658	85,595
28,844	**28,305**	**28,404**	**(99)**	**Subtotal**	**145,876**	**142,936**	**139,572**	**6,303**	**3,364**	**344,565**	**345,854**
289	**639**	**668**	**29**	**EBITDA**	**5,044**	**3,288**	**6,413**	**1,369**	**3,125**	**16,709**	**17,076**
1.0%	2.2%	2.3%	1.3%	**EBITDA margin**	3.3%	2.2%	4.4%	-27.8%	2.1 %	4.6%	
				Depreciation & Financing							
1,217	1,217	1,076	142	Depreciation	5,834	5,834	5,440	394	394	14,487	14,926
350	350	350	0	PDC Dividend	1,752	1,752	1,750	2	2	4,204	4,200
4	4	(6)	10	Interest	18	18	(16)	33	33	42	(35)
0	0	(1)	1	P&L on Disposal of Fixed Assets	0	0	(10)	10	10	0	
1,571	**1,571**	**1,419**	**152**	**Subtotal**	**7,603**	**7,603**	**7,165**	**438**	**438**	**18,733**	**19,091**
(1,283)	**(932)**	**(751)**	**181**	**Net Surplus/(Deficit)**	**(2,559)**	**(4,315)**	**(752)**	**1,807**	**3,563**	**(2,024)**	**(2,015)**
				NHSI Adjustments to Fin Perf							
3	3	3	0	Remove Depr on Donated assets	13	10	10	(3)	0	38	38
0	0	0	0	Remove STP funding 2016/17	0	0	(419)	(419)	(419)	(419)	(419)
(1,280)	**(929)**	**(748)**	**181**	**Adjusted Financial Performance**	**(2,546)**	**(4,305)**	**(1,161)**	**1,385**	**3,144**	**(2,405)**	**(2,396)**

Income

- Commissioners have retained 40% of the Trust's CQUIN income in a Service Development and Improvement Plan (SDIP) which means that it cannot be recognised until its requirements are achieved. CQUIN income is on plan YTD due to CQUIN phasing, however this will slip in future months due to SDIP phasing.
- Main contract activity for M5 YTD is 2.7% higher than the contract baseline, and the income recognised from this has been capped at 2.7% pending confirmation of Commissioner demand management achievement.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £6.3m under re-phased budget, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure (£2.3m YTD) in non-pay. This underspend is expected to reduce with targeted recruitment.
- Private Ambulance expenditure is overspent by £2.3m (this is offset by vacancies as noted) and rent, leases costs and training and recruitment related expenditure are underspent due to differences in the phasing of the budget vs actual expenditure.

Depreciation and Financing

- Overall Financial Charges are £0.4m favourable YTD due to lower than budgeted depreciation.

Risks

- The Trust's main A&E contract incorporates variable income for the first time and as such variations in activity may result in either the Trust receiving additional income or being required to pass back income to Commissioners. This fluid budget structure will need to be carefully managed to ensure resourcing expenditure aligns with income and is managed sustainably.
- If the criteria for STP funding is not met (e.g. Agency restrictions) then £2.0m would be withheld which would put the Trust's control total at risk.

Divisional Summaries

2CCN - Level 2 Cost Centre Name	Full Year Budget 1	Budget 1	Actuals	In Month Variance	YTD Budget 1	YTD Actuals	YTD Variance	
Central Corporate	26,806,992	2,013,704	1,587,674	426,030	9,691,120	8,072,304	1,618,816	Genearal reserves £435k, Specific reserves £1.2m, CIP £435k, Depreciation under (£432k).
Central Income	(346,560,866)	(27,871,807)	(27,647,086)	(224,721)	(139,772,861)	(139,171,237)	(601,624)	Unachieved CIP (appren levy) £650k, activity 3% not achieved £292k, STP income 16/17 (£419k), Other £95k.
Chairman & Non-Executives	110,773	9,231	7,959	1,272	46,155	46,873	(718)	
Chief Executive	3,149,941	221,620	160,715	60,904	1,518,699	1,305,267	213,432	Vacancies (£170k), Meeting room hire (£40k).
Corporate Services	4,552,610	379,384	400,677	(21,293)	1,896,921	1,816,042	80,878	Vacancies (£45k), Course & Conference fees (£62k), Legal overspend £27k.
Estates	10,284,083	857,698	908,152	(50,454)	4,251,027	4,294,324	(43,297)	Consultancy & Prof fees £50k.
Finance	3,228,690	269,058	234,778	34,279	1,345,288	992,725	352,563	Vacancies (£350k).
Fleet & Logistics	27,015,615	2,309,326	2,689,000	(379,674)	11,449,291	13,465,633	(2,016,342)	Agency £220k, Vehicle parts £700k, Unachieved CIP £1.1m.
Im&T	14,477,575	944,215	930,557	13,657	4,721,073	4,940,589	(219,516)	Agency £82k, Cyber review consultancy £120k, Other £20k.
Medical	18,294,894	1,679,315	1,132,849	546,466	7,663,869	5,291,363	2,372,505	Fallow time (£1.5m), Vacancies (£180k), Medicines Management (£260k), Course & Conference fees (£430k).
Operations	227,748,375	19,089,183	19,305,441	(216,258)	96,246,772	94,998,960	1,247,812	Romford pilot income (£207k), Pay underspend (£5.3m), PAS £2.3k, Other Non pay £500k, CIP £1.5m.
People & Organisational Dev	6,174,326	529,960	484,263	45,698	2,752,102	2,403,763	348,339	Vacancies (£77k), Income received LDA (£90k), SD's for B & H and Dev of Leadership Training (£180k).
Performance	1,137,018	94,751	107,818	(13,066)	473,757	453,055	20,702	
Quality & Assurance	2,864,954	217,877	245,404	(27,527)	1,089,386	1,039,404	49,981	Vacancies (£50k)
Special Measures	100,000	8,333	4,754	3,580	41,667	21,052	20,615	
Strategic Communications	1,031,958	85,997	91,268	(5,272)	429,983	381,459	48,524	Vacancies (£10k), Staff recognition -VIP awards (£40k) .
Support Services	220,904	18,409	9,813	8,596	92,044	44,842	47,202	
Transformation & Strategy	1,808,159	75,679	96,797	(21,118)	378,394	355,725	22,669	
London Ambulance Service (Surplus) / Def	**2,446,000**	**931,932**	**750,834**	**181,097**	**4,314,685**	**752,144**	**3,562,541**	

Main Contract Variable Income

Month:	Aug-17	2017-18 Monthly Contract Base (2016-17 Plan plus 6%)			2017-18 Actual Activity			2017-18 Actual Activity Increase / (Decrease) vs Contract Base			Total Incidents Difference to Contract Base (%)	CCG Split Based on Incident Difference - cap at 2.7%
Area	CCG Names	Cat A	Cat C (incl Other)	Total Incidents	Cat A	Cat C (incl Other)	Total Incidents	Cat A	Cat C (incl Other)	Total Incidents		
NEL	NHS City and Hackney CCG	7,268	7,961	15,229	8,028	7,491	15,519	760	-470	290	1.90%	£ 61,190.00
NEL	NHS Newham CCG	8,660	8,945	17,605	9,453	7,835	17,288	793	-1,110	-317	-1.80%	-£ 66,887.00
NEL	NHS Tower Hamlets CCG	7,293	7,062	14,355	8,016	6,540	14,556	723	-522	201	1.40%	£ 42,411.00
NEL	NHS Waltham Forest CCG	6,689	6,786	13,475	6,848	6,100	12,948	159	-686	-527	-3.91%	-£ 111,197.00
NEL	NHS Barking and Dagenham CCG	5,852	6,499	12,351	6,275	5,721	11,996	423	-778	-355	-2.87%	-£ 74,905.00
NEL	NHS Havering CCG	6,618	7,707	14,325	7,187	7,159	14,346	569	-548	21	0.15%	£ 4,431.00
NEL	NHS Redbridge CCG	7,087	7,299	14,386	7,522	6,816	14,338	435	-483	-48	-0.33%	-£ 10,128.00
NEL	**NEL Total**	**49,467**	**52,259**	**101,726**	**53,329**	**47,662**	**100,991**	**3,862**	**-4,597**	**-735**	**-0.72%**	**-£ 155,085.00**
NCL	NHS Barnet CCG	8,712	9,485	18,197	8,902	9,252	18,154	190	-233	-43	-0.24%	-£ 9,073.00
NCL	NHS Camden CCG	7,266	7,506	14,772	7,693	7,545	15,238	427	39	466	3.15%	£ 98,326.00
NCL	NHS Enfield CCG	8,631	7,940	16,571	8,794	7,637	16,431	163	-303	-140	-0.84%	-£ 29,540.00
NCL	NHS Haringey CCG	6,683	6,835	13,518	6,967	6,760	13,727	284	-75	209	1.55%	£ 44,099.00
NCL	NHS Islington CCG	6,111	6,920	13,031	6,800	6,433	13,233	689	-487	202	1.55%	£ 42,622.00
NCL	**NCL Total**	**37,403**	**38,686**	**76,089**	**39,156**	**37,627**	**76,783**	**1,753**	**-1,059**	**694**	**0.91%**	**£ 146,434.00**
NWL	NHS Brent CCG	8,572	8,592	17,164	9,254	8,550	17,804	682	-42	640	3.73%	£ 135,040.00
NWL	NHS Harrow CCG	4,968	5,406	10,374	5,435	5,706	11,141	467	300	767	7.39%	£ 161,837.00
NWL	NHS Hillingdon CCG	8,170	10,169	18,339	9,267	10,104	19,371	1,097	-65	1,032	5.63%	£ 217,752.00
NWL	NHS Central London (Westminster) CCG	7,546	7,390	14,936	8,713	8,046	16,759	1,167	656	1,823	12.21%	£ 384,653.00
NWL	NHS Ealing CCG	8,389	8,687	17,076	9,458	9,135	18,593	1,069	448	1,517	8.88%	£ 320,087.00
NWL	NHS Hammersmith and Fulham CCG	4,678	4,758	9,436	5,097	5,437	10,534	419	679	1,098	11.64%	£ 231,678.00
NWL	NHS Hounslow CCG	6,895	7,254	14,149	7,207	7,040	14,247	312	-214	98	0.69%	£ 20,678.00
NWL	NHS West London CCG	5,716	6,070	11,786	6,701	6,551	13,252	985	481	1,466	12.44%	£ 309,326.00
NWL	**NWL Total**	**54,934**	**58,326**	**113,260**	**61,132**	**60,569**	**121,701**	**6,198**	**2,243**	**8,441**	**7.45%**	**£ 1,781,051.00**
SEL	NHS Bexley CCG	5,573	6,733	12,306	6,035	6,463	12,498	462	-270	192	1.56%	£ 40,512.00
SEL	NHS Bromley CCG	6,954	8,707	15,661	7,230	8,614	15,844	276	-93	183	1.17%	£ 38,613.00
SEL	NHS Greenwich CCG	6,704	7,533	14,237	7,191	7,339	14,530	487	-194	293	2.06%	£ 61,823.00
SEL	NHS Lambeth CCG	8,315	10,167	18,482	9,125	9,507	18,632	810	-660	150	0.81%	£ 31,650.00
SEL	NHS Lewisham CCG	6,804	7,734	14,538	7,409	7,770	15,179	605	36	641	4.41%	£ 135,251.00
SEL	NHS Southwark CCG	8,030	9,967	17,997	8,559	9,800	18,359	529	-167	362	2.01%	£ 76,382.00
SEL	**SEL Total**	**42,380**	**50,841**	**93,221**	**45,549**	**49,493**	**95,042**	**3,169**	**-1,348**	**1,821**	**1.95%**	**£ 384,231.00**
SWL	NHS Croydon CCG	9,338	11,091	20,429	10,276	11,080	21,356	938	-11	927	4.54%	£ 195,702.50
SWL	NHS Kingston CCG	3,353	4,472	7,825	3,790	4,157	7,947	437	-315	122	1.56%	£ 25,742.00
SWL	NHS Merton CCG	3,996	5,458	9,454	4,428	5,324	9,752	432	-134	298	3.15%	£ 62,878.00
SWL	NHS Richmond CCG	3,367	4,636	8,003	3,719	4,463	8,182	352	-173	179	2.24%	£ 37,769.00
SWL	NHS Sutton CCG	4,210	5,772	9,982	4,796	5,486	10,282	586	-286	300	3.01%	£ 63,300.00
SWL	NHS Wandsworth CCG	6,229	7,606	13,835	6,623	7,432	14,055	394	-174	220	1.59%	£ 46,420.00
SWL	**SWL Total**	**30,493**	**39,035**	**69,528**	**33,632**	**37,942**	**71,574**	**3,139**	**-1,093**	**2,046**	**2.94%**	**£ 431,811.50**
London Total		**214,677**	**239,147**	**453,824**	**232,798**	**233,293**	**466,091**	**18,121**	**-5,854**	**12,268**	**2.70%**	**£ 2,588,442.50**

Initial reported activity at M5 YTD was 2.7% above the contract baseline.

On that basis, assuming Commissioners have not met their demand management targets, the LAS would be able to invoice for £2.588m of additional income.

Given that the position on demand management measurement and achievement by Commissioners is as yet unclear, a prudent position has been adopted and income recognised has been capped at the 2.7% limit that would apply if demand management targets had been met (£2.588m).

The YTD activity is based on April, May & June freeze and July & August flex figures.

Cashflow Statement YTD

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	YTD Move	YTD Plan	Var
	Actual	Actual	Actual	Actual	Actual	Aug-17	Aug-17	Aug-17
	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	18,637	21,829	30,268	28,740	34,142	**18,637**	**18,700**	**-63**
Operating Surplus	53	4,215	332	1,146	669	6,415	5,618	797
(Increase)/decrease in current assets	(1,905)	9,094	(5,832)	8,535	965	10,857	17,150	(6,293)
Increase/(decrease) in current liabilities	6,367	(2,149)	4,864	(2,588)	(1,850)	4,644	(62)	4,706
Increase/(decrease) in provisions	134	591	(449)	(175)	87	188	(270)	458
Net cash inflow/(outflow) from operating activities	4,649	11,751	(1,085)	6,918	(129)	22,104	22,436	(332)
Cashflow inflow/outflow from operating activities	**4,649**	**11,751**	**(1,085)**	**6,918**	**(129)**	**22,104**	**22,436**	**(332)**
Returns on investments and servicing finance	2	6	6	4	6	24	40	(16)
Capital Expenditure	(1,459)	(3,318)	(449)	(1,520)	(677)	(7,423)	(13,808)	6,385
Dividend paid	0	0	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(1,457)**	**(3,312)**	**(443)**	**(1,516)**	**(671)**	**(7,399)**	**(13,768)**	**6,369**
Movement	3,192	8,439	(1,528)	5,402	(800)	14,705	8,668	6,037
Closing Cash Balance	**21,829**	**30,268**	**28,740**	**34,142**	**33,342**	**33,342**	**27,368**	**5,974**

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

Cash funds at 31 August stand at £33.3m.

Operating Surplus

- The operating surplus at £6.4m is higher than planned.

Current Assets

- The YTD movement on current assets is £10.8m, a (£6.3m) lower than planned movement.
- Current assets movement was lower than planned due to an increase in receivables (£10.2m), decrease in accrued income £3.0m and increase in prepayments £0.9m.

Current Liabilities

- The YTD movement on current liabilities is £4.6m, a £4.7m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£2.1m), accruals £0.5m and deferred income £6.2m.

Provisions

- The YTD movement on provisions is £0.2m, is a £0.5m increase on plan.

Capital Expenditure

- Capital cash outflow is £6.4m behind plan for the year. This is due to capital slippage and a high level of work-in-progress.

CQUINs

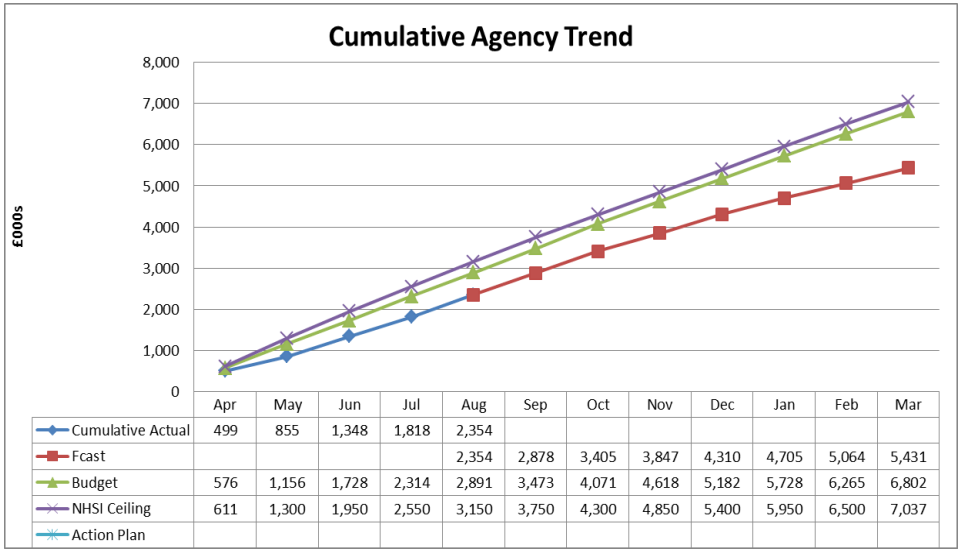
FIC - LAS 2017/18 ES & UC Contract – Commissioning for Quality & Innovation (CQUIN) SCHEDULE & UPDATE – as at August 2017

#	CQUIN Indicator title	ELT lead	Local lead	Final indicator period	Annual value	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Risk/ Issue/Notes
	Note all CQUINs follow a two year contract period and so apply across 2017/18 – 2018/19. The below outlines commitments and funding related to 2017/18 financial year only.									
1a	**National CQUIN 1a:** Improvement of health and wellbeing of NHS staff	Patricia Grealish	Gill Heuchan	Final Period – Q4 17-18	**£263,701**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £263,701	Q1 – update report submitted to commissioners for information on 24th July 2017. Commissioners provided feedback, LAS to respond 8th September 2017.
1b	**National CQUIN 1b: Healthy food** for NHS staff, visitors and patients	Lorraine Bewes	Martin Nelhams	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Q1 – update report submitted to commissioners for information on 24th July 2017. Commissioners provided feedback, LAS to respond 8th September 2017.
1c	**National CQUIN 1c:** Improving the uptake of **flu vaccinations** for front line staff within Providers	Fenella Wrigley	Neil Thomson Julia Hilger-Ellis	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Q1 – update report submitted to commissioners for information on 24th July 2017. Commissioners provided feedback, LAS to respond 8th September 2017.
12	**National CQUIN 12: Ambulance Conveyance**	Paul Woodrow	Various Overall Lead Craig Harman	Final Period – Q4 17-18	**£784,825**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £784,825	Q1 – Submitted proposal. Number of items to be locally agreed with commissioners. Current weighting based on national indicator outline.
STP 1	**National CQUIN: STP Engagement**	Garrett Emmerson	Nikki Fountain/ ADOs	Final Period – Q4 17-18	**£1,569,650**	Q1 = 0% £0	Q2 = 33.3% £523,216	Q3 = 33.3% £523,216	Q4 = 33.3% £523,216	Q1 – update report submitted to commissioners for information on 24th July 2017. Commissioners to provide proposal to LAS detailing CQUIN requirements. *Note that detail & weightings across quarters are still to be confirmed by commissioners – Q1 portion now moved to Q2-4.
STP 2	**National CQUIN: STF Delivery (Control Total)**	Lorraine Bewes	Graeme Dunn	Final Period – Q4 17-18	**£1,569,650**	Q1 = 100% £1,569,650	Q2 = 0% £0	Q3 = 0% £0	Q4 = 0% £0	Achieved, based on 16/17 control total. LAS to provide confirmation to commissioners that the funding will be held in reserve until further notice.
SDIP	**Service Development Improvement Plan**	Trisha Bain	Various – SDIP Working Group	Final Period – Q4 17-18	**£3,139,299**	N/A	N/A	Q3 – 50%* £1,569,650	Q4 – 50%* £1,569,650	*Note that SDIP is yet to be confirmed as a CQUIN – expected 26th September 2017. Assumed equal weighting in Q3 & Q4 – also TBC.
	Total Value (2.5% of contract value)				£7,878,248	£1,569,650	£523,216	£2,092,866	£3,662,516	
	Total Value Achieved				-	-	-	-		

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

Agency Analysis

	In Month				YTD			Full Year	Run Rate
	Budget £000s	Actual £000s	Variance £000s	Actual WTE	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Fcast £000s
Clinical									
Ambulance Staff	0	0	0	0.00	0	0	0	0	0
Nurses	77	100	-23	12.09	439	474	-35	1,123	1,138
Medical Staff	0	0	0	0.00	0	0	0	0	0
Other	0	0	0	0.00	0	0	0	0	0
Subtotal	**77**	**100**	**-23**	**12.09**	**439**	**474**	**-35**	**1,123**	**1,138**
Non Clinical									
Managers & Executives	257	212	44	0.02	1,234	793	441	2,995	1,903
Admin & Clerical	221	167	54	0.06	1,104	798	306	2,411	1,915
Maintenance & Works	23	54	-31	0.02	114	276	-162	274	662
Other	0	2	-2	0.50	0	15	-15	0	35
Subtotal	**500**	**435**	**65**	**0.59**	**2,452**	**1,881**	**571**	**5,680**	**4,515**
Total	**577**	**536**	**42**	**12.68**	**2,891**	**2,356**	**536**	**6,802**	**5,653**



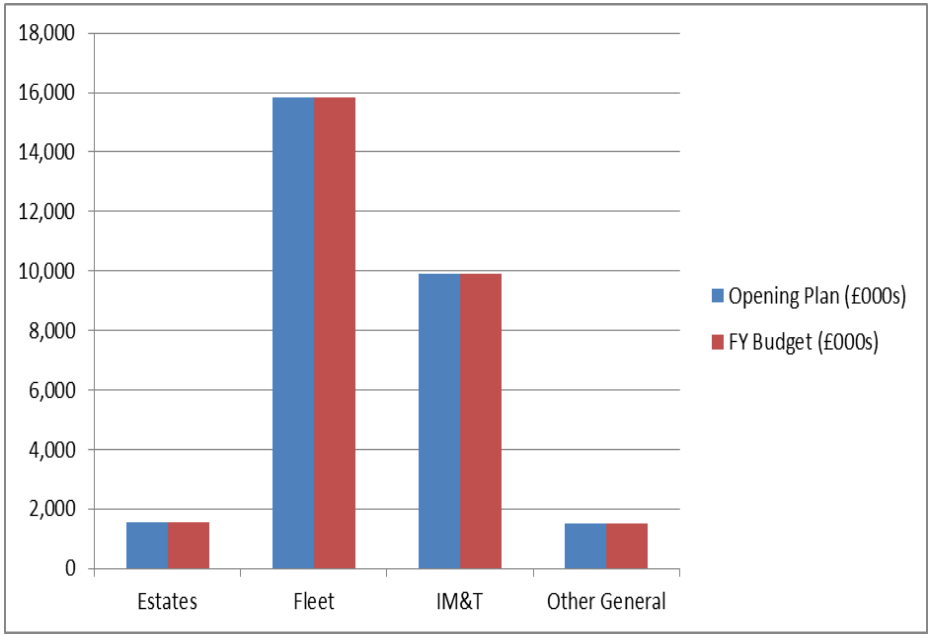
Agency Compliance

Rule	Measurement	Description	Target	Achieved	Variance
Framework	% Agencies used on Framework	Are all agencies used on an approved framework?	100%	91.20%	8.8%
Agency Ceiling	£000s	Is the Trust on Track to deliver on or below its agreed agency ceiling?	7,037	5,653	1,384

- If we do not meet the agency cap of £7m, the £1.9m STF funding will be at risk.
- From 1st October NHSI require additional Agency analysis (Top 20 high cost staff, Top 30 longest serving, Trend spend by Cost Centre). This will be used to hold the Board to account for agency reductions.
- On the 30th November the Trust submitted an agency assurance questionnaire which was signed by the CEO and the Chair.
- YTD The Trust has spent £2.4m on agency which is £0.5m favourable to plan.
- In Month spend is £577k.
- Based on the full year average the Trust would spend £5.6m which is £1.4m below the Trust's maximum agency ceiling of £7.0m.
- Agency reduction actions are on-going with Divisional leads and ELT members. Reductions are being achieved across Q2 and the Trust expects to meets its agency cap target.

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

	Budget YTD (£000s)	Spend YTD (£000s)	Under(Over) spend YTD (£000s)	Opening Plan (£000s)	FY Budget (£000s)	Variance (£000s)
Estates	953	663	290	1,550	1,550	0
Fleet	3,225	2,547	678	15,826	15,826	0
IM&T	3,056	192	2,864	9,918	9,918	0
Other General	0	76	-76	1,512	1,512	0
	7,234	**3,478**	**3,756**	**28,806**	**28,806**	**0**



- The original plan shows £28.8m of Capex.
- Currently, only £16.4m of Capital has been confirmed by NHSI.
- NHSI have approved the carry forward of the 16/17 under spend on capital.
- The initial capital plan assumed £5.5m Central Programme funding. The Trust has received confirmation that it will receive only £0.998m in 2017/18.

Statement of Financial Position: YTD

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Aug-17		
	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000	£000	
Non Current Assets									
Property, Plant & Equip	142,368	141,832	141,216	142,568	142,218	141,629	145,163	(3,534)	-2.43%
Intangible Assets	6,577	6,116	5,901	5,687	5,505	5,322	4,994	328	6.57%
Trade & Other Receivables	0	0	0	0	0	0	0	0	
Subtotal	148,945	147,948	147,117	148,255	147,723	146,951	150,157	(3,206)	-2.14%
Current Assets									
Inventories	3,115	3,124	3,124	3,122	3,134	3,130	3,005	125	4.16%
Trade & Other Receivables	35,467	37,359	28,265	34,099	25,552	24,591	14,657	9,934	67.78%
Cash & cash equivalents	18,637	21,829	30,268	28,740	34,142	33,342	27,368	5,974	21.83%
Non-Current Assets Held for Sale	44	44	44	44	44	44	44	0	
Total Current Assets	57,263	62,356	61,701	66,005	62,872	61,107	45,074	16,033	35.57%
Total Assets	206,208	210,304	208,818	214,260	210,595	208,058	195,231	12,827	6.57%
Current Liabilities									
Trade and Other Payables	(41,463)	(46,813)	(41,952)	(48,953)	(45,746)	(43,872)	(39,531)	(4,341)	10.98%
Provisions	(8,064)	(8,174)	(8,639)	(7,601)	(7,543)	(7,661)	(3,873)	(3,788)	97.81%
Borrowings	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	
Net Current Liabilities)	(49,527)	(54,987)	(50,591)	(56,554)	(53,289)	(51,533)	(43,404)	(8,129)	18.73%
Non Current Assets plus/less net current assets/Liabilities	156,681	155,317	158,227	157,706	157,306	156,525	151,827	4,698	3.09%
Non Current Liabilities									
Trade and Other Payables	0	0	0	0	0	0	0	0	
Provisions	(10,548)	(10,574)	(10,702)	(11,293)	(11,178)	(11,149)	(10,480)	(669)	6.38%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	
Total Non Current Liabilities	(10,655)	(10,681)	(10,809)	(11,400)	(11,285)	(11,256)	(10,587)	(669)	6.32%
Total Assets Employed	146,026	144,636	147,418	146,306	146,021	145,269	141,240	4,029	2.85%
Financed by Taxpayers Equity									
Public Dividend Capital	58,016	58,016	58,016	58,016	58,016	58,016	58,016	0	0.00%
Retained Earnings	36,212	34,822	37,604	36,492	36,207	35,455	31,056	4,399	14.16%
Revaluation Reserve	52,217	52,217	52,217	52,217	52,217	52,217	52,587	(370)	-0.70%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	146,026	144,636	147,418	146,306	146,021	145,269	141,240	4,029	2.85%

Non Current Assets

- Non current assets stand at £147.0m, (£3.2m) below plan. This is due to capital slippage.

Current Assets

- Current assets stand at £61.1m, £16.0m above plan.
- Cash position as at July is £33.3m, £6.0m above plan.
- Within Trade & Other Receivables, Receivables (debtors) at £14.2m are £10.3m above plan, accrued income at £6.8m is £1.3m above plan and prepayments at £3.5m are £1.7m below plan. The increase in receivables relates to 2016/17 CQUIN, QIP investment, additional funding for over activity and 2017/18 under payments on the contract being overdue for payment. The Trust has agreed the billing arrangements for the 2017/18 SLA contract and amended invoices have been issued to the CCGs.

Current Liabilities

- Current liabilities stand at £51.5m, £8.1m above plan.
- Payables and accruals at £37.6m are £1.7m below plan.
- The Trust has a high volume of unapproved trade payables at £4.2m.
- Current provisions at £7.7m are £3.8m higher than plan. This is due to new provisions not included in the plan and lower than expected payments being made to international recruits.
- Deferred Income at £6.3m is £6.1m above plan. The Trust received full payment of £5.3m MTFA funding for the year in May 2017 and invoiced the CCGs for £6.2m paramedic re-banding (full year) in June 2017. However in July we were notified that NHS England will not be releasing the full funding as planned in June. Following discussions with NHSI, Ambulance Services and Unions, NHS England have now agreed to release the funding for the first 4 months of the year.

Non Current Liabilities

- Non current provisions at £11.1m are £0.7m above plan. Borrowings are on plan.

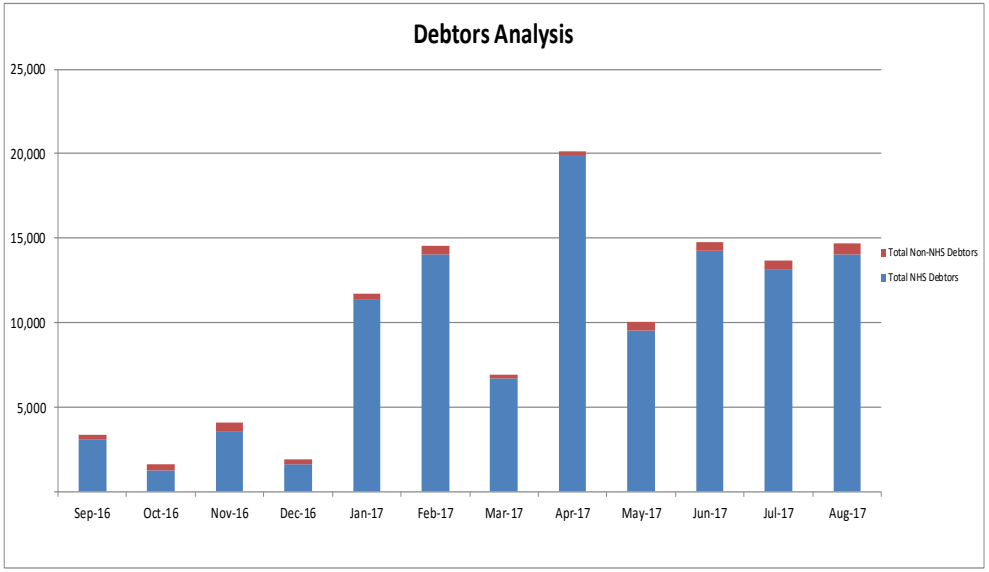
Taxpayers Equity

- The Trust received late STF funding last year not included in the plan and this is contributing to the higher than planned movement on Taxpayers Equity and Retained Earnings.
- Taxpayers Equity stands at £145.3m, £4.0m higher than plan.
- Retained Earnings stands at £35.5m, £4.4m higher than plan.

Debtors Analysis

Aged debtors Summary 31st August 2017

NHS Debtors	Note	Total	Current	1 - 30	31 - 60	61 - 90	91 - 180	181 - 365	>365
Nhs Havering Ccg	1	1,221	394	284	68	303	170	1	-
Nhs Redbridge Ccg	1	1,015	177	269	71	313	180	5	-
Nhs Barking And Dagenham Ccg	1	938	199	221	59	266	148	44	-
Nhs Barnet Ccg	1	808	100	337	91	280	-	-	-
Nhs Camden Ccg	1	692	108	278	75	231	-	-	-
Nhs Bromley Ccg	1	673	462	211	-	-	-	-	-
<673,000	1	8,690	210	5,036	456	2,821	18	26	123
Total		**14,037**	**1,650**	**6,635**	**821**	**4,214**	**517**	**77**	**123**
Non-NHS Debtors									
Heathrow Airport Ltd	2	217	217	-	-	-	-	-	-
All England Lawn Tennis Club	3	102	102	-	-	-	-	-	-
Sodexo Healthcare	4	45	22	-	4	14	4	-	-
London Stadium 185	5	43	43	-	-	-	-	-	-
<£43,000	6	238	144	1	2	9	5	16	62
Total		**645**	**529**	**1**	**6**	**23**	**8**	**16**	**62**
TOTAL DEBTORS 31st August 2017		**14,682**	**2,178**	**6,637**	**827**	**4,238**	**525**	**93**	**185**



Debtors Position: 31st August 2017

Total outstanding NHS and Non-NHS debtors as at 31st August 2017 amounted to £14.7 million.
The NHS over 60 day's figure of £4.9m includes amounts due from both CCGs £4.8m and NHS Trusts £0.1m.
1. CCGs
As at 7th September 2017 the main overdue amounts are:

- 2016/17 CQUIN Funding - £1.1m (top 3 aged debtors - Croydon CCG, Wandsworth CCG and Barnet CCG). £0.4m has been confirmed for payment in September 2017.
- 2016/17 Additional Activity Funding - £1.0m (top 3 aged debtors - Barking & Dagenham CCG, Havering CCG and Redbridge CCG). Three CCGs are disputing the charges £0.8m, the LAS is in discussions with the CCGs to resolve the dispute.
- 2016/17 QIP Investment Funding - £1.0m (top 3 aged debtors – Barnet CCG, Newham CCG and Enfield CCG). £0.5m has been confirmed for payment in September 2017.
- 2017/18 Main SLA April – August - £2.8m (top 3 aged debtors - Barnet CCG, Havering CCG and Redbridge CCG). £0.2m has been confirmed for payment in September 2017.
- 2017/18 50% CQUIN April – August - £0.2m (top 3 age d debtors – Barnet CCG, Newham CCG and Enfield CCG). £0.1m has been for payment in September 2017.
- 2017/18 Paramedic Re-banding income £5.9m for the full year has been credited and invoices raised for the first 4 months £2.1m.

The trust is actively pursuing the outstanding debts.
2. Heathrow Airport - £217k has been approved and payment will be made on the 8th September 2017.
3. All England Lawn Tennis Club - £102k has been approved and payment will be made on the 15th September 2017.
3. Sodexo Healthcare – £23k (4 NET Operational) invoices have been queried. PTS Manager has been looking into the query and has sent relevant information to Sodexo in regards to the queried invoices.
4. London Stadium 185 – £43k (5 Invoices) – payment was received on the 1st September 2017.
6. Non-NHS Debtors - £238k consists of; £95k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £44k of stadia events, the stadiums are been chased for payment on a regular basis. The remaining £104k is due from local Government bodies and other miscellaneous organisations.
The graph to the left shows the debtors trend for the last 12 months.

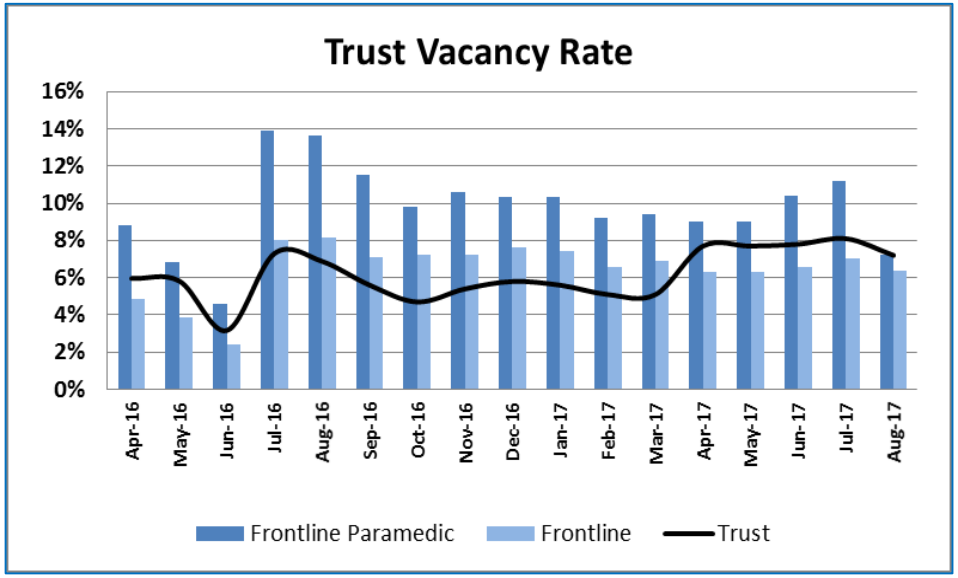
Our People

Section	Key Headlines	Aug	Jul	Jun
Vacancy and Recruitment	• The overall vacancy rate has decreased from 8.1% to 7.2% against a 5% target. We have identified additional posts to deliver the 17/18 increased demand. Work has been undertaken with colleagues in Operations to determine how these posts should be allocated across the Sectors and the updated establishment will be reported against from September. Please note that the vacancy rates for both paramedics and the total frontline will increase as a result of these additional posts.			

Turnover	• Total Trust turnover has increased from 9.9% to 10.2% against a threshold of 10%.
	
	  • Frontline turnover has decreased from 8.6% to 8.5%. Please note this does not include Control Room or NHS 111 leavers.
	
	  • Frontline paramedic turnover has decreased from 9.5% to 9.2%			

Sickness	• Monthly sickness for August is 5.2% against a target of 5%. • Frontline sickness remains at 5.6%.			

Vacancy – Trust wide



	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	**5,301.36**	**4,917.31**	**384.05**	**7.2%**
Total Ops Frontline	*3,285.32**	*3,145.34*	*139.98*	*4.26%*
Paramedics	*2,058.44**	*1,907.02*	*151.42*	*10.4%*
EAC / TEAC/EMT	*1,226.88**	*1,238.32*	*-11.44*	*3.1%*
EOC	429.00	411.13	17.87	4.16%
Corporate and other staff	1,587.04	1,360.84	226.20	14.3%

Paramedic recruitment

- iPara - we have so far recruited 184 iParas, 27 of whom joined us in July and August and a further 123 are joining in Q4. We are in discussions with the remaining group with a view to starting them in Q1 18/19.
- A further international recruitment trip to Australia will take place in September.
- We have an additional 10 qualified UK Paramedics whom we also hope to start in Q4.
- We have recruited 94 UK Graduate Paramedics against our target of 90, 85 of whom are starting in September and October.
- In July and August we had 76 Apprentice Paramedics who graduated, taking up NQP positions.
- *Source of data: ESR*

Trainee Emergency Ambulance Crew recruitment

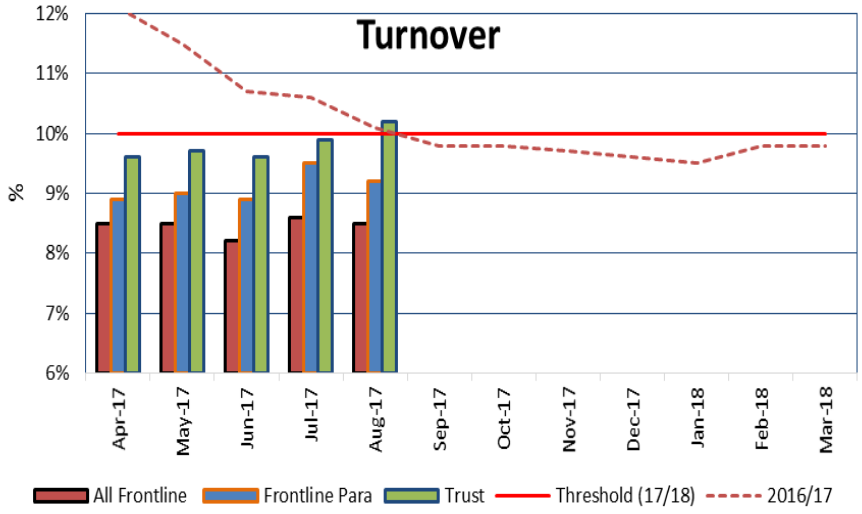
- We have recruited 180 TEACs to date with a further 69 awaiting their C1 driving licence / to be booked on an LAS training place. This still remains a challenge and we are exploring sources of funding to support candidates to complete their C1. This should improve our ability to fill all of our course places.

EOC recruitment (Emergency Medical Dispatchers)

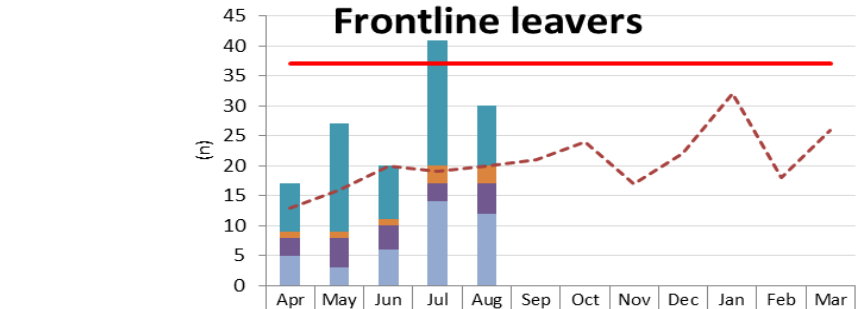
- We are behind plan on EMD recruitment (29 out of 62 places have been filled year to date). An additional 28 EMDs are due to join us in September/October. Additional course places have been agreed to catch up on the plan. Applicant numbers remain high and conversion rates through to shortlisting and interview are improving.

* *Frontline Budgeted FTE will increase next month to reflect newly allocated positions and vacancy rates will increase as a result of this.*

Turnover/Leavers – Trust wide



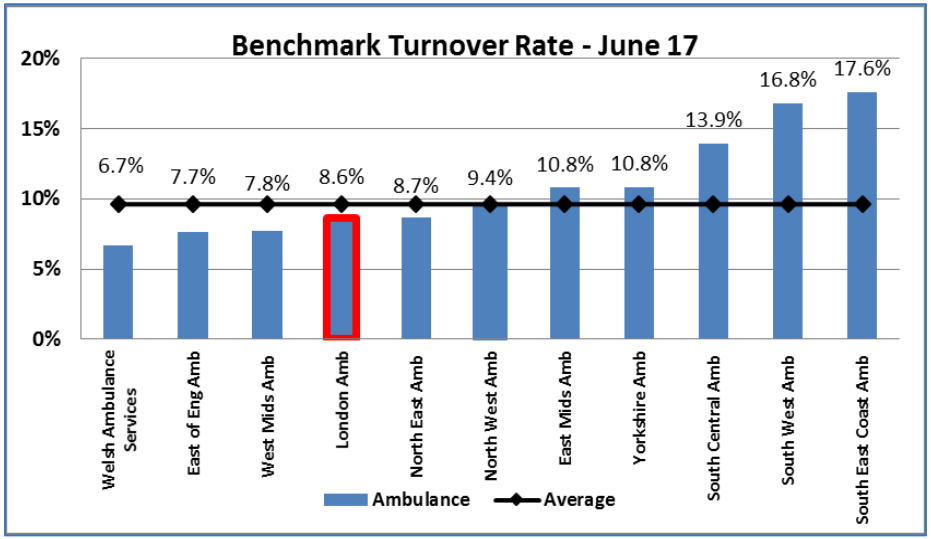
- The total Trust turnover has increased from 9.9% to 10.2% (12 month rolling figure).
- Frontline turnover has improved from 8.6% to 8.5% Please note that this figure does not include Control Team or NHS 111 leavers.
- Frontline paramedic turnover has decreased from 9.5% to 9.2%.



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

- There were 53 leavers in August, 30 of whom were in frontline posts (see table opposite).
- 87% of the frontline leavers (27 staff) were unplanned i.e. resignations.
- 39% of frontline leavers were from EOC.
- 33% of all unplanned frontline leavers left for reason of relocation.

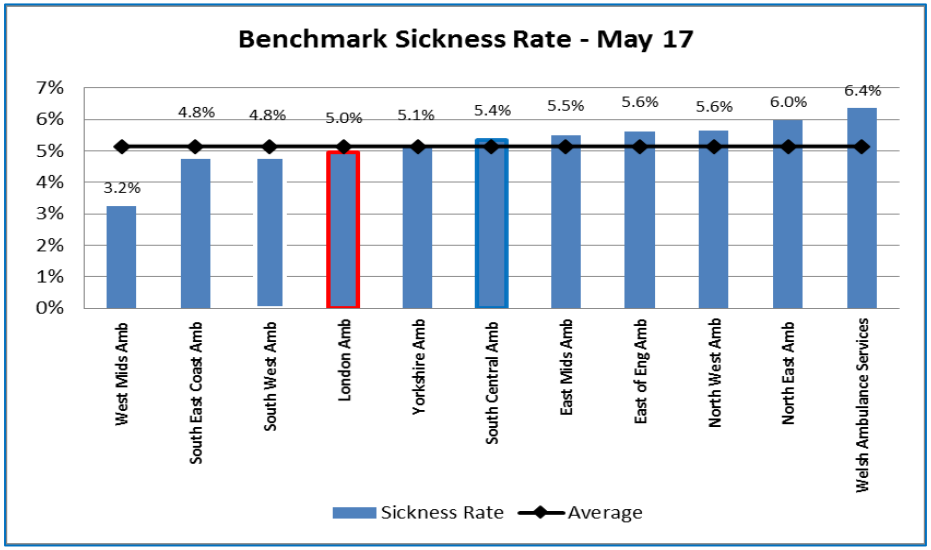
Benchmarking Turnover/Sickness – Trust wide



This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.

- The London Ambulance Trust has remained in 4th place.
- The LAS is below the national average of 9.62%.

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

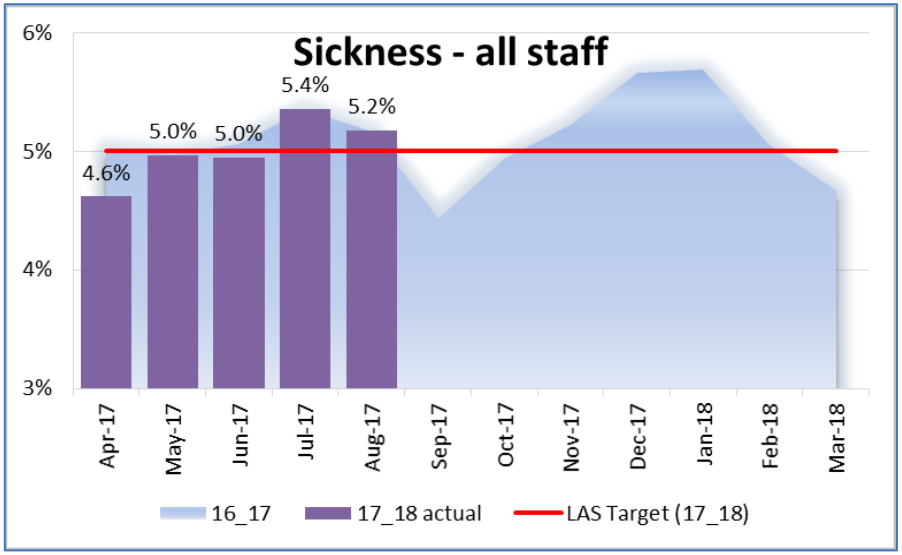


This graph shows the sickness rate for all 11 Ambulance Trusts.

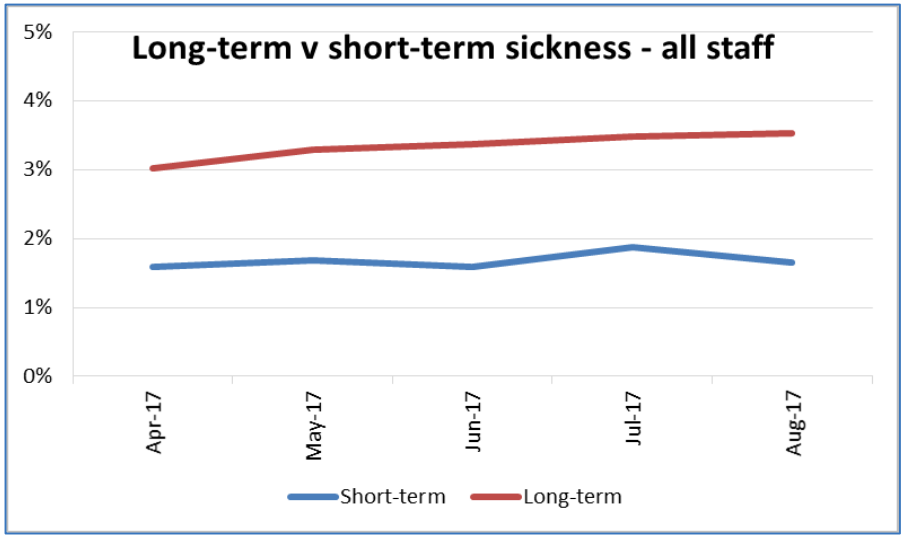
- The London Ambulance Service has remained in 4th place.
- The LAS is below the national average of 5.1%.

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

Sickness Absence – Trust/Sector level



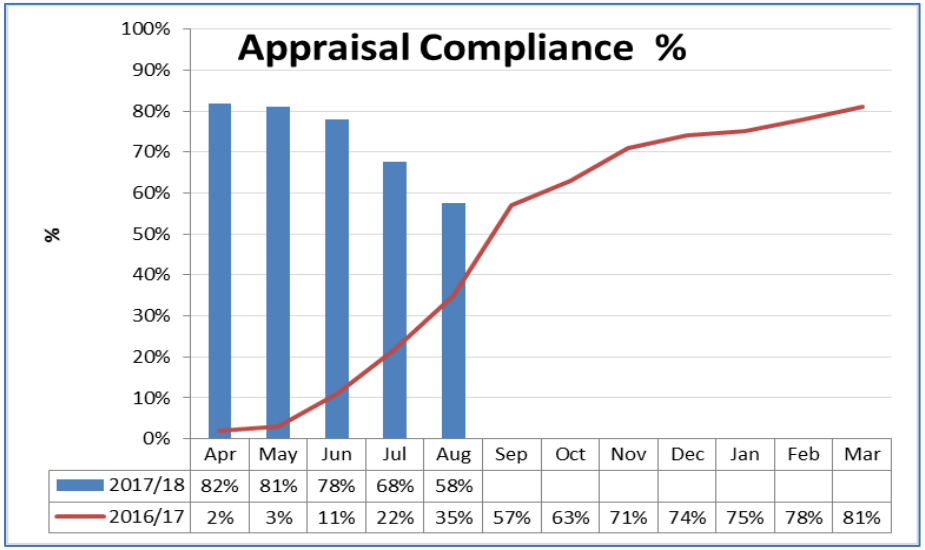
- Trust wide sickness for August was 5.2% (789 episodes, 8,391 days).
- This is equal to 96,496 days lost or an average of 25 days for each of our 5,159 staff for the 12 month period.
- Frontline sickness has remained at 5.6%.
- Corporate sickness is at 2.1%.



This graph shows the sickness rate for all staff split by short-term and long-term sickness.

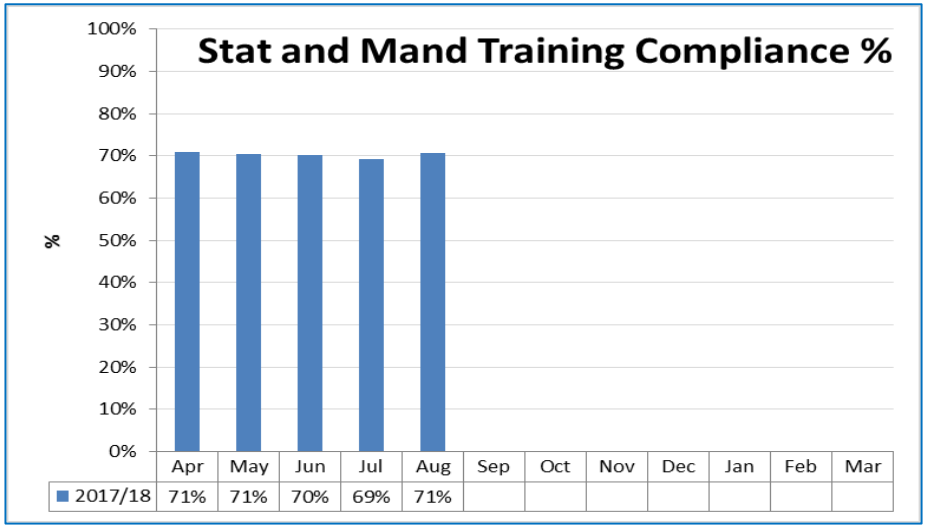
- The LAS 17/18 target for sickness is 5% (2% short-term, 3% long-term), a reduction of 0.5% from 16/17.
- In August there were 563 episodes of short-term sickness (2,607 days sickness). The average length of each episode was 4.6 days.
- Long-term sickness is any continuous episode of sickness lasting for 28 days or longer. In August there were 226 episodes of long-term sickness (5,784 days). Long-term sickness accounts for 69% of all sickness.

Appraisal/Statutory and Mandatory Training Compliance



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

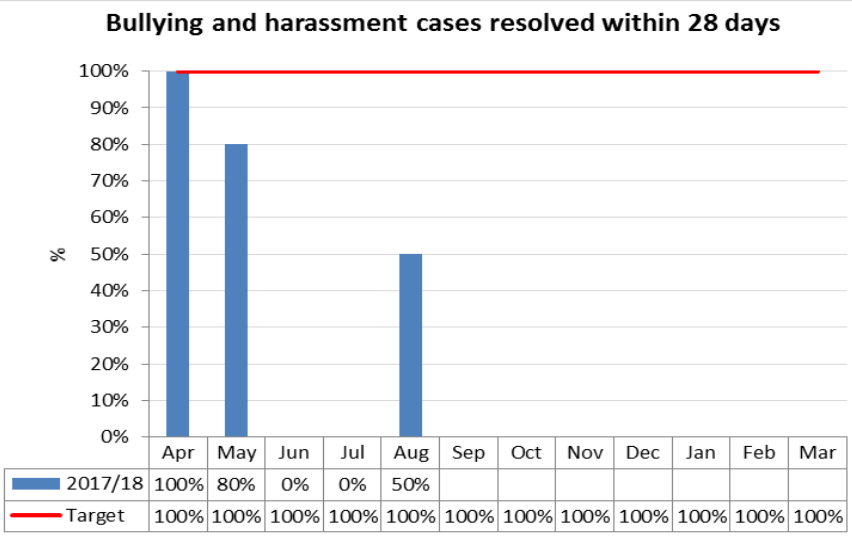
- From 1st September 2016 to 31st August 2017 there have been 2,713 appraisals completed out of 4,574 eligible staff (we exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS).
- We therefore have an 58% compliance rate (Operations 60.8%, Corporate 31%).
- A total of 1,861 staff (42%) have an overdue appraisal.
- A total of 664 (15%) have no recorded appraisal.



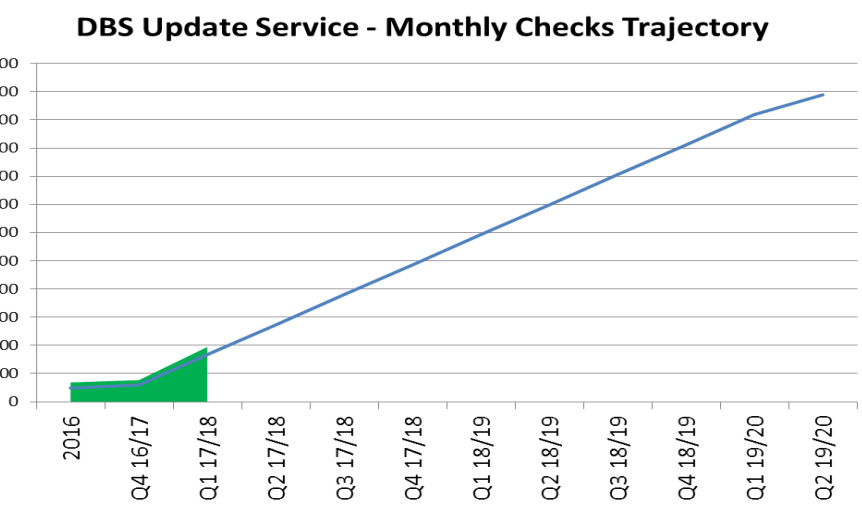
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	71%	71%	70%	69%	71%							

- August has seen a slight increase in trust wide compliance from 69% to 71%. The launch of the new ESR Portal on 18th September will provide all staff with their own training compliance dashboard. This will help staff to identify what has been completed and what is outstanding.
- CSR 2017.2 for clinical staff is an e-learning CSR and will go live on 9th October. Staff will be able to complete this via the new ESR Portal and will be given until March 2018 to complete the 7 modules.
- CSR 2017.3 reverts to face to face delivery and will commence in December 2017.

Bullying & Harassment/DBS

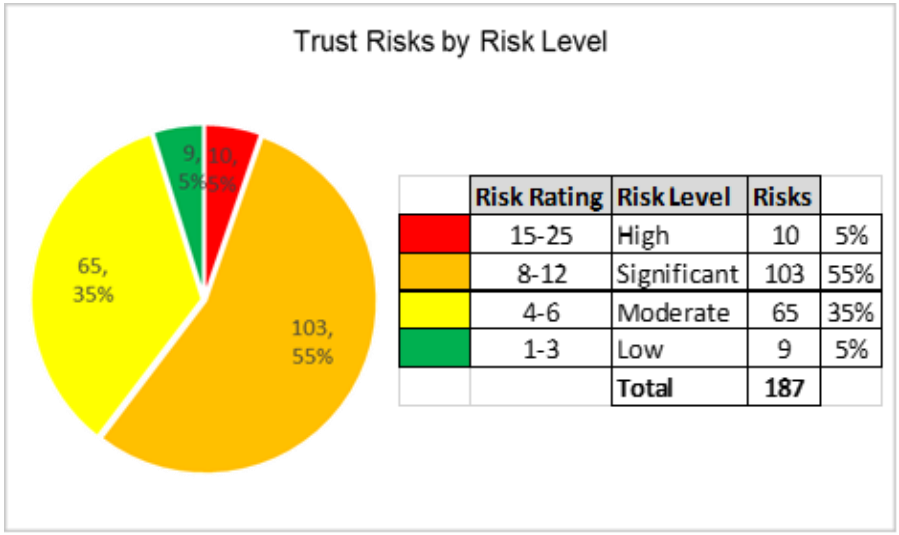


- Formal B&H cases – in August there were two formal bullying and harassment cases open, one of which has breached our 28 day indicator.
- Since mid-July Cathe Gaskell has returned to focus on a specific scope of work which included reviewing B&H and conflict and communication post the major incidents in June and July. Cathe is capturing data which reflects the significant activity she undertakes to support and advise staff and managers. This work accounts for approximately 40% of her time and should have a positive impact in avoiding formal cases, staff well-being and retention. To date, 19 staff have contacted her for advice on managing bullying behaviours in the workplace or to report being bullied at work.
- Approximately 10 round tables have been arranged since July and the round table skills are being refreshed by two intensive training days on 22nd Sept and 6th Oct for 25-30 staff who wish to take this forwards.

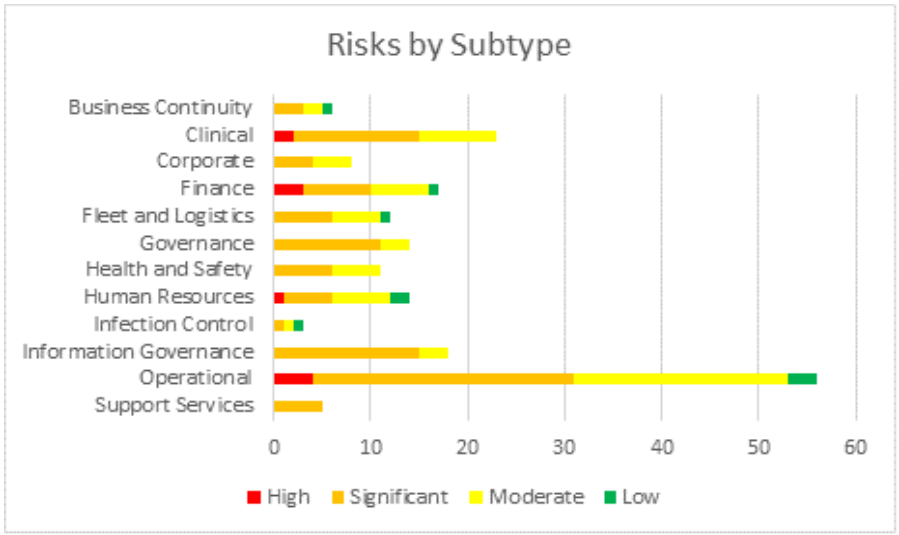


- *DBS rechecking* - as at 31st July we have processed 493 checks against our plan of 568. 236 are cleared and 257 are in progress with the DBS. This leaves us slightly behind plan for Q2 (75 checks) although we have 61 who have started the process.
- The plan remains to complete the 4,500 checks by September 2019 (three years). To meet this target we need to ensure that 142 applications are in progress with the DBS each month.
- HR teams continue to work with their local management teams to identify staff availability and escalate any resourcing or compliance issues.
- *DBS Update Service* - all starters from 1st April 2017 have a contractual term which requires them to sign up to the DBS Update Service. All recruitment adverts also highlight this requirement.

Our Risks



	Risk Rating	Risk Level	Risks	
	15-25	High	10	5%
	8-12	Significant	103	55%
	4-6	Moderate	65	35%
	1-3	Low	9	5%
		Total	**187**	



The register of risks approved showed the following at 11th September:

Nearly two-thirds of the Trusts risk register has a risk level of High or Significant (60%).

Just under a third of the overall Trusts risks are Operations risks (30%), with Clinical risks accounting for 12%, and Information Governance risks at 10%.

There are 10 risks with a risk level of High, these sit in Operations (3), Finance and Performance (3), Medical directorate (Clinical) (2), HR/Workforce (1), and IM&T (1). The highest risk scores at 20, with the others at 15 or 16. These risks are:

- 214 – Finance - Managing within available resources – rating increased from 20 to 15 in March 2017
- 217 – Finance - Delivering cost improvement plans – rating unchanged since added to Datix
- 279 – Clinical - Ability to download defibrillation data from LifePaks – rating unchanged since added to Datix
- 339 – Operational - Delivery of ring backs – rating unchanged since added to Datix
- 430 – Operational - Availability of resources at shift changeover time – rating unchanged since added to Datix
- 445 – Clinical - Recognition of ventricular fibrillation (VF) – rating unchanged since added to Datix
- 533 – HR - Ability to recruit the required number of Paramedics – rating unchanged since added to Datix
- 577 – IM&T - Failure of the CAD system due to usage above contracted baseline – rating unchanged since added to Datix
- 598 – Operations - Obsolete Personal Digital Assistants for PTS/NETS – rating increased from 10 to 15 in April 2017
- 647 – Finance – Ability to meet contractual CQUINs – rating unchanged since added to Datix

These charts reflect the trust risks by risk level and risk subtype. These are the approved risks rated 10 and above approved by RCAG and risks 9 and below which have been locally approved as at 11th September 2017.

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description
A19	Category A incidents requiring an 19 minute response
A8	Category A incidents requiring an 8 minute response
ADO	Assistant Directors of Operations
APP	Advanced Paramedic Practitioners
AQI	Ambulance Quality Indicator
BME	Black and Minority Ethnic
CARU	Clinical Audit and Research Unit
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDLO	Controlled Drugs Liaison Officers
CISO	Clinical Information & Support Overview
CPI	Clinical Performance Indicator
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRU	Cycle Response Unit
CSR	Core Skills Refresher (Training)
DBS	Disclosure & Barring Scheme
DOC	Duty of Candour
EAC	Emergency Ambulance Crew
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Dispatcher
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ESR	Employee Service Record
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)
FFT	Friends and Family Test
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale
FRU	Fast Response Unit
GCS	Glasgow Coma Scale

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

LAS 111 (South East London): Glossary August 2017

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

London providers – areas covered:

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

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	3 October 2017			
Document Title:	Board Assurance Framework and Risk Management			
Report Author(s):	Philippa Harding, Governance Improvement Director			
Presented by:	Philippa Harding, Governance Improvement Director			
History:	Presented to the Executive Leadership Team in correspondence Presented to the Audit Committee on 4 September 2017			
Status:	☒	Assurance	☒	Discussion
	☒	Decision	☒	Information

Background / Purpose:

This paper provides the Board with an update on work that is being undertaken to refresh the Board Assurance Framework (BAF) and Trust Risk Register (TRR). Board members are asked to note the work which is being undertaken and comment upon the new presentation of the BAF.

Recommendation:

The Board is asked to

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

This paper sets out the content of the BAF.

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

Reputation	☒
Other	☒

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

Board Assurance Framework (BAF) and Trust Risk Register (TRR)

1. Board members will be aware that BAF risks are maintained in the Datix Risk Management system and presented to Board meetings regularly. At the last meeting of the Board, as well as considering the risks identified within the BAF, Board members discussed what they considered to be the top risks faced by the London Ambulance Service NHS Trust. With the exception of cyber risk (which was identified by Board members for inclusion as a new BAF risk), these were considered to be broadly aligned to the BAF risks. It was therefore considered appropriate that further work should be undertaken ahead of the Board meeting on 3 October 2017 to better articulate the BAF risks, in order to ensure that they represented the Trust's top risks as accurately as possible. This paper sets out the work that has been undertaken on this so far.

Current status of the BAF

2. There are currently 10 risks on the BAF, two of which are owned by the Director of Finance, four by the Director of Operations, two by the Director of People and Organisational Development, one by the Medical Director and one by the Chief Information Officer. The detail of these risks is set out at Annex A to this report. Information about risks that are proposed to be removed from the BAF can be found at Annex B to this report.

3. The following risk has been added to the BAF, following the Board's agreement at its meeting on 1 August 2017 that cyber risk should be included in the BAF:

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

4. At its meeting on 4 September 2017, as directed by the Board, the Audit Committee received a report setting out the Trust's current known risk position in relation to cyber threats.

5. The Governance Improvement Director and the Risk and Audit Manager have been working with the owners of each risk in order to ensure that they are appropriately articulated and scored, as well as confirming that the information set out in relation to controls, assurance and actions is accurate and concise. As a result the following risks are proposed to be removed from the BAF:

    - BAF Risk 14 - It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.

    - BAF Risk 34 - NHSI expects all NHS trusts to achieve financial balance in 2017/18, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.

6. A further new risk has also been added to the BAF:

    - BAF Risk 44 - There is a risk to achievement of the LAS control total for 2017/18 and a risk to achieving the LAS strategy in the long term if it does not have a sustainable financial plan due to (a number of work streams not being fully implemented).

7. Two risks have been proposed for de-escalation since the BAF was last presented to the Board. Following discussion at the Risk and Compliance Assurance Group meeting on 17 August 2017, the following risks were de-escalated from the BAF (but will remain on the Trust Risk Register) as a result of a change of their scoring (both moved from a score of 16 to 12):

    - BAF Risk 25 - There is a risk that there may be insufficient range and volume of equipment to meet demands. Staff will not have equipment required to provide appropriate patient care.

    - BAF Risk 26 - There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care.

8. It is anticipated that the following risk will be proposed for de-escalation from the BAF in October, to be replaced by risks associated with the implementation of the Ambulance Response Programme:

    - BAF Risk 37 - There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.

Proposed new format of the BAF

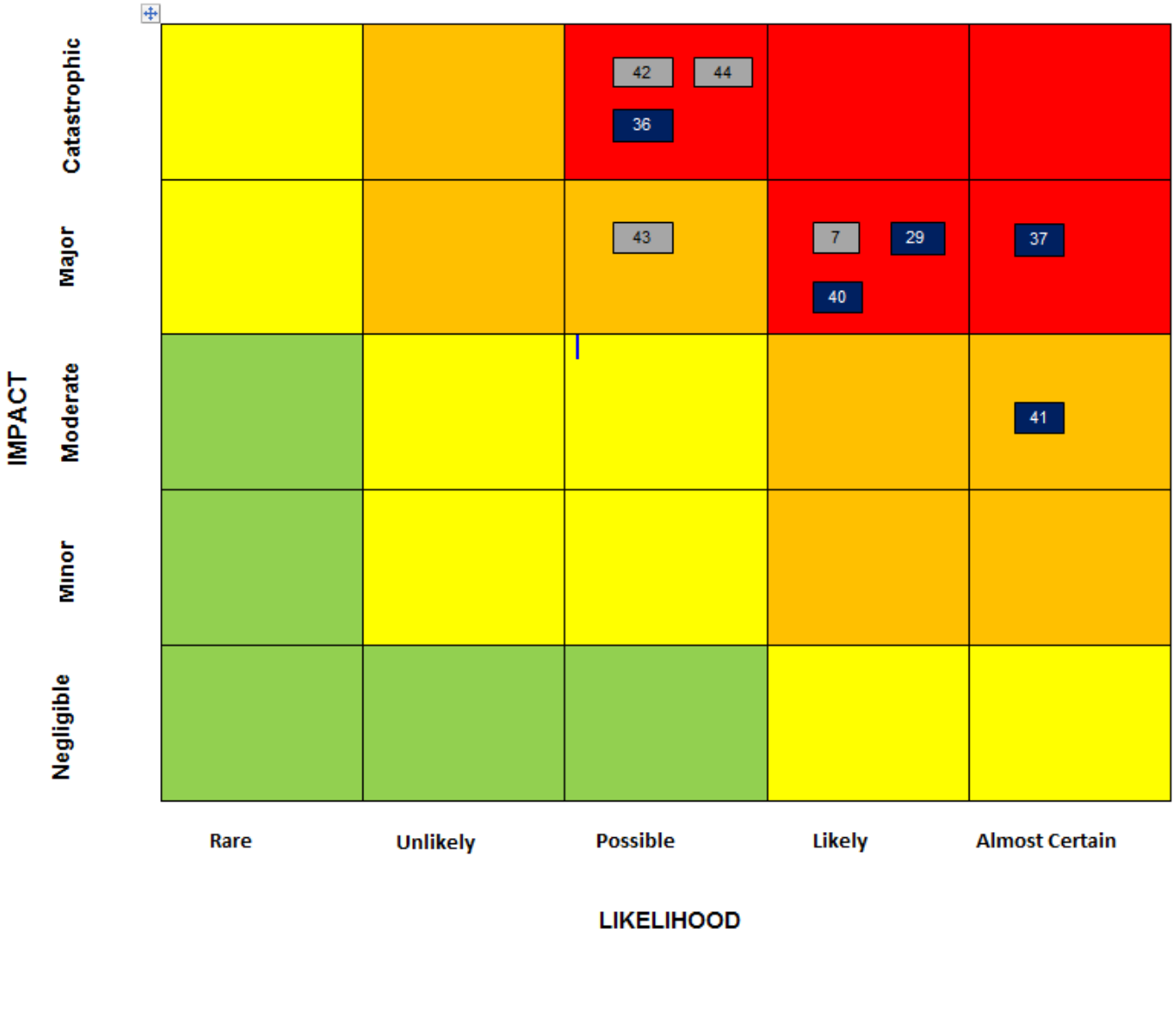
9. Consideration has been given to the format of the BAF itself, with a view to ensuring that it facilitates the most useful consideration of the Trust's strategic risks. A proposed new format is attached at Annex C to this report. It has been developed to align risks with Business Plan goals and objectives. The first section groups the risks in relation to these goals and objectives, the second section lists the BAF risks in net rating order, focussing on current controls, assurances and further mitigating controls required. Audit Committee members are asked to comment on this proposed new format, noting that it is presented for illustrative purposes and is not currently a comprehensive presentation of the BAF risks and their mitigations.

Risk Management Strategy and Policy Review

10. At their meeting on 4 September 2017, Audit Committee members were also informed of work being undertaken to review the Trust's Risk Management Strategy. This is following the findings of an internal audit review at the end of 2016/17 and in preparation for the return of the Care Quality Commission. The outcome of this review and any proposed changes to the Strategy will be submitted to the Board meeting on 31 October 2017, having been reviewed in correspondence by the Audit Committee.

Philippa Harding
Governance Improvement Director

Board Assurance Framework – August 2017



BAF Risk 37
The agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.

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

BAF Risk 7
Performance falls at staff changeover time.

BAF Risk 29
Lack of ring backs on delayed response calls.

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

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

BAF Risk 36
Delays to defibrillation where fine VF is not recognised

BAF Risk 41
Obsolete Personal digital Assistance in use by PTS and NETS staff.

BAF Risk 44
Not achieving the LAS control total for 2017/18 and to achieving the LAS Strategy in the long term.

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

Key

Net risk rating

Gross risk rating = net risk rating

Risk Severity

High Risk (15-25)

Significant Risk (8-12)

Moderate Risk (4-6)

Low Risk (1-3)

Risk ID: 37	Description:	Risk opened:	14/11/2016
	There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.	Expected risk closure:	01/10/2017
Linked Risk(s):		Is this risk on track for closure?	Yes
531	Risk Owner: Director of Operations	Proposal made by DDO Peter McKenna and Ats Khan, Deputy Director of Performance to de-escalate risk to a major x unlikely = 8. Risk on track for closure in October 2017 when ARP (Ambulance Response Programme) is implemented.	

Low Risk	Medium Risk				High Risk			
	8	9	10	12	15	16	20	25
				T			G N	
Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
20	20	20	20	20	20	20	20	20

Risk ID: 42	There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs.	Risk opened:	22/06/2017
	Risk Owner: Director Finance	Expected risk closure:	
Linked Risk(s):		Is this risk on track for closure?	
647		Risk needs to be updated in Datix	

Low Risk	Medium Risk				High Risk			
	8	9	10	12	15	16	20	25
			T		N		G	
Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
							15	15

Risk ID: 7	Description:	Risk opened:	08/12/2006
	There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	Expected risk closure:	30/09/2017
Linked Risk(s):		Is this risk on track for closure?	Yes
430	Risk Owner: Director of Operations		

Low Risk	Medium Risk				High Risk			
	8	9	10	12	15	16	20	25
	T					N	G	
Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
16	16	16	16	16	16	16	16	16

Risk ID: 29	Description:	Risk opened:	28/02/2015
	There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.	Expected risk closure:	31/03/2018
Linked Risk(s):		Is this risk on track for closure?	Yes
339	Risk Owner: Director of Operations	Expected closure date revised from 30/06/2017	

Low Risk	Medium Risk				High Risk			
	8	9	10	12	15	16	20	25
	T					G N		
Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
16	16	16	16	16	16	16	16	16

Risk ID: 40	Description:	Risk opened:	06/03/2017

Low Risk	Medium Risk	High Risk

	There is a risk that the Trust may not be able to recruit sufficient Paramedics to meet workforce profile requirements in 2017/18. Risk Owner: Director of People and Organisational Development	**Expected risk closure:**	31/05/2019		8	9	10	12	15	16	20	25
Linked Risk(s): **533**		**Is this risk on track for closure?**	Yes		T					G N		
				Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
								16	16	16	16	16

Risk ID: 43	There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management. Director of People and Organisational Development	**Risk opened:**	04/07/2017	**Low Risk**	**Medium Risk**				**High Risk**			
		Expected risk closure:	31/10/2017	4	8	9	10	12	15	16	20	25
Linked Risk(s): **650**		**Is this risk on track for closure?**	Yes	T				N		G		
		Risk proposed for de-escalation to major x possible = 12 by Director of People and Organisational Development.		Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
											16	12

Risk ID: 36	**Description:** There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised. Risk Owner: Medical Director	**Risk opened:**	28/07/2016	**Low Risk**	**Medium Risk**				**High Risk**			
		Expected risk closure:	31/12/2017	5	8	9	10	12	15	16	20	25
Linked Risk(s): **445**		**Is this risk on track for closure?**	Yes	T					G N			
		Pending the planning of future training / supervisory support for clinical staff.		Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
				15	15	15	15	15	15	15	15	15

Risk ID: 41	**Description:** The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed. The current losses of devises means that not enough devises are available for operational crews and journeys are being dispatched via voice instructions from control. Risk Owner: Director of Operations	**Risk opened:**	12/05/2017	**Low Risk**	**Medium Risk**				**High Risk**			
		Expected risk closure:	31/10/2017	6	8	9	10	12	15	16	20	25
Linked Risk(s): **598**		**Is this risk on track for closure?**	Yes	T					G N			
		Risk Reviewed on 8th August 2017 - 4 New devices being operationally tested. Plan to commence rollout from week commencing 14th August with completion by end of September.		Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
									15	15	15	15

Risk ID: 44	Description:	Risk opened:	22/08/2017
Linked Risk(s):	There is a risk to achievement of the LAS control total for 2017/18 and a risk to achieving the LAS strategy in the long term if it does not have a sustainable financial plan due to (a number of work streams not being fully implemented). Owned by Director of Finance	Expected risk closure:	
		Is this risk on track for closure?	

Low Risk	Medium Risk				High Risk			
6	8	9	10	12	15	16	20	25
			T		N		G	

Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
								15

Risk ID: 45	Description:	Risk opened:	
Linked Risk(s):	There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period Owned by Chief Operating Officer	Expected risk closure:	
		Is this risk on track for closure?	

Low Risk	Medium Risk				High Risk			
6	8	9	10	12	15	16	20	25

Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017

BAF Risk no. 37	**There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth**				
Risk Classification: Operational	**Risk Owner:** Woodrow, Paul			**Scrutinising Committee:** Audit Committee	
Underlying Cause/Source of Risk: Demand, productivity, financial constraints				**Gross Rating**	**Current/Net Rating**	**Target Rating**
				20	**20**	**12**
Existing Controls	**Positive Assurance of Controls**		**Further Actions**		**Due Date**
1.Surge Plan 2.REAP 3.OOS hub 4.Clinical Hub 5.Dispatch on Disposition 240 seconds implemented on 4th October 2016 6.Static defib performance recovery group 7.Non-clinical vacancy freeze and financial controls implemented in order to target additional spending at operational capacity 8.Sickness management on-going 9.Removed cat C determinants from FRU 10. Robust management of activity and performance trajectories from 2017/18 contractual agreements 11. alert and escalation: Gold Groups/daily calls arranged during periods of excessive demand reviewing clinical safety levels 12. Increasing NETS/taxi journeys Additional Resources added to METDG desk function **Gaps in Controls** None identified	NHSE regional oversight group monthly review (1) Strategic commissioning management board monthly review (1) Service Delivery Group (2, 3, 4, 9, 10) A&E Resource Group (9) Operations Board Weekly tri-partite calls with NHSI, NHSE, and lead commissioners. Contract and performance meetings Strategic Commissioning management Board **Gaps in Assurance** None identified	**2029** **2031** **2032** **2033** **3487** **4638**	Reduction in JCT of 7 minutes from baseline by. Development of performance improvement programme (over-arching programme of recovery actions) Co-responding schemes full rollout across London (MPS / LFB) Increase operational in-post from 95% to 100% Increase operational establishment by (WTE TBC) posts funded through additional investment from CCGs as part of the 2017/18 contract. Complete planning for ARP implementation	30/06/2017 30/06/2017 30/06/2017 29/09/2017 31/03/2018 01/10/2017

Signed: Woodrow, Paul **Date Reviewed:** 15/08/2017

Proposal made by DDO Peter McKenna and Ats Khan, Deputy Director of Performance to de-escalate risk to a major x unlikely = 8. Risk on track for closure in October 2017 when ARP (Ambulance Response Programme) is implemented.

BAF Risk no. 42	**There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs**				
Risk Classification: Finance	**Risk Owner:** Lorraine Bewes		**Scrutinising Committee:** Audit Committee		
Underlying Cause/Source of Risk: Failure to deliver CQUINs in methodology agreed with Commissioners and CQUIN owners. Some national CQUINs are outside of the sphere of influence of the LAS and may be unrealistic to achieve. Other priorities in place across the Trust, resulting in a lack of engagement and ownership of CQUINs.			**Gross Rating**	**Current/Net Rating**	**Target Rating**
			20	**15**	**10**
Existing Controls	**Positive Assurance of Controls**		**Further Actions**		**Due Date**
1. A full review of all reports prior to submission undertaken to ensure achieving as specification 2. CQUIN briefing papers distributed to all Directors and CQUIN leads 3. Contracting and Commissioning Team hold monthly catch up calls with all CQUIN owners 4. Quarterly, face to face, meetings held with the Director of Transformation and Strategy, in conjunction with the Contracting and Commissioning Team 5. Monthly CQUIN working group established in partnership with the commissioners to recover a particular CQUIN 6. Monthly meetings now amended to fall in sequence with submission dates and external CQUIN meetings **Gaps in Controls** No gaps identified	1. Reports to be submitted to ELT updating progress against all key milestones 2. Update reports to FIC and Trust Board where required **Gaps in Assurance** No gaps identified		1 Fortnightly meetings between contract and commissioning team internally and external LAS contracting team 2. Assign all CQUINs to a lead Director, explaining the importance of following the exact wording 3. Improving relationships with the external commissioning team 4. Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies 5. Creation of a finance and reporting tracker and reviewed at monthly performance meetings		Completion dates to be agreed with commissioners
Signed: Lorraine Bewes	**Date Reviewed:** 18/07/2017				

BAF Risk no. 7	**There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.**				
Risk Classification: Operational	**Risk Owner:** Woodrow, Paul		**Scrutinising Committee:** Quality Assurance Committee		
Underlying Cause/Source of Risk: Roster configuration, Rest break arrangements, Increased OOS, High demand, Response model, Staff wanting to finish their shifts on time and avoid late finishes			**Gross Rating**	**Current/Net Rating**	**Target Rating**
			20	**16**	**8**
Existing Controls	**Positive Assurance of Controls**	**Further Actions**			**Due Date**
1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 5 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Current negotiations with the Trade Unions regarding the implementation of a new rest break policy 6. On-going rigorous management of out of service. **Gaps in Controls** 1. Culture and behaviour of staff being driven by perverse incentives within the current rest break agreement 2. The want of staff to end their shift on time and avoid late finishes 3. Sufficient management capacity within EOC 4. Management of non-compliance with rest break allocations 5. New rest break policy will not be implemented, focus on improving compliance with existing policy	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the scrutinising committees on progress and compliance 5. Sector GSM will spend time on DDS desk in EOC to challenge non-compliance issues in real time 6. Instigation of New Dispatch Model Trial in North Area to include tethering to Sectors which will make rest break implementation easier. Extension of critical cover at end of shift for NC Sector FRUs **Gaps in Assurance** 1. There appears to be a relationship between the number of rest breaks allocated per day and out of service (OOS)rates at shift end. The more rest breaks that are given the higher the end of shift OOS and this is being looked into	**3847**	Review management capacity within EOC	31/03/2017
		4631	Commence operational roster review	01/07/2017
		4632	Enact end of shift protection arrangements	01/07/2017
Signed: McKenna, Peter		**Date Reviewed:** 14/08/2017			

BAF Risk no. 29	**There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.**				
Risk Classification: Operational	**Risk Owner:** Cranmer, Pauline	**Scrutinising Committee:** Quality Assurance Committee			
Underlying Cause/Source of Risk: Availability of frontline resources Availability of EOC staff Demand		**Gross Rating**	**Current/Net Rating**	**Target Rating**	
		16	**16**	**8**	
Existing Controls	**Positive Assurance of Controls**	**Further Actions**			**Due Date**
1. Clinical Hub scrutiny of held calls 2. Ring back status monitors. 3. Redistribution of staff to ringback functions as required 4. On-going recruitment and retention activities 5. Operational Procedures on ring backs (OP23) 6. Exit messaging – worsening advice **Gaps in Controls** 1. On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high. 2. ORH report received due to go to ELT, identifies minimum of 31 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level. 3. Additional front line resources are required.(covered by BAF risk 265 and 388) 4) Recruitment of additional EMDs to EOC against the establishment. Plan for 2017/18, but filling courses proving challenging.	Hub activity report weekly (1) Watch Manager live monitoring (2) IDM handover report and call taking manager's log (3) Serious Incident types reported through Control Services **Gaps in Assurance** ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level.	**2120**	Delivery of EOC improvement programme (ringback process and desk realignment)		31/09/2017
		4278	Recruitment of EMDS to EOC		31/03/2018
		4280	Review the possibility of additional Operational staff to support EOC ringback function		31/03/2018
Signed: Pauline Cranmer		**Date Reviewed:** 01/08/2017			

BAF Risk no. 40	**There is a risk that the Trust may not be able to recruit sufficient Paramedics to meet workforce profile requirements in 2017/18.**				
Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish			**Scrutinising Committee:** People & OD Committee	
Underlying Cause/Source of Risk: Increase in paramedic numbers over and above planned 2016 levels in order to meet agreed 2017/18 contract; existing and known shortfall in supply of UK graduate paramedics, exacerbated by "fallow year" in 2017 due to degree programme extending from 3 to 4 years.			**Gross Rating**	**Current/Net Rating**	**Target Rating**
			16	**16**	**8**

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
• Recruitment Plan for 2017/18 developed against initial requirement for paramedics (prior to agreed projected increase in demand) • Based on anticipated graduate numbers (90) and apprentice paramedics (76), an additional requirement for c.400 has now been confirmed, 300 of which we have already planned to source internationally. • Clinical Education capacity identified **Gaps in Controls** • Skill mix profile as yet undefined/unconfirmed. • Identify source of supply of c. 100 additional paramedics **Gaps in Assurance**	• Initial recruitment Plan for 2017/18 developed and is evolving • Weekly meetings now take place at an operational level to review recruitment activities, education capacity and outcomes and numbers released to operations (A&E Resourcing) • Monthly reporting to ELT on front line recruitment • Progress against recruitment plan a standing item at People and OD Committee • Number of Paramedics required identified • International Recruitment campaign underway in Australia with second visit planned for September/October 2017 • Healthy TEAC recruitment pipeline • Working with universities to encourage graduates to London • Implementation of Band 6 - will reduce migration to other Trusts • Development of an improved workforce planning report • Closer working relationships with HEE • Potential conversion of other HCPS	**3259**	Improved workforce planning and reporting	30/03/2018
		3258	International Recruitment of paramedics (2nd visit 2017)	31/12/2017
		4135	Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'.	31/07/2017
		4132	Continue to identify additional partner Universities	31/10/2017
		4133	Review mentoring capacity	31/12/2017
		4128	Review skill mix in line with clinical strategy	31/12/2017
		4129	Review skill mix in line with ARP	31/12/2017
		4130	Apprentice paramedic pipeline including EAC progression	31/12/2017
		4131	further development of LAS Academy pathway	31/12/2017

Signed: Patricia Grealish **Date Reviewed:** 16/08/2017

BAF Risk no. 43 There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management.

Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** Audit Committee

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

Existing Controls	**Positive Assurance of Controls**		**Further Actions**	**Due Date**
HR to prioritise DBS checks for all bank workers and volunteers; All external Bank workers go through full recruitment process (as per substantive employees); External bank workers (i.e. not-ex LAS) are Paramedics required to uphold their professional registration. Core skills must be maintained to successfully re-register. There is now a co-ordinator in post to manage Bank Workers. For performance management it is proposed to allocate Bank Workers to a sector, central control will be held by Resourcing who will ensure compliance with necessary checks (driving licences, DBS and training). **Gaps in Controls** No gaps identified	Report to ELT 27 June 2017; Report to P&OD 24 July 2017 Meeting with Head of Resourcing 3 August 2017 to review Bank arrangements and agree actions. Bank Co-Ordinator recruited and refresh of Bank Register is underway. Bank Worker training records will be included in Stat Man training reports once refresh complete. Solution to CSR training (not paid for Bank workers) to be considered as part of the Bank Register refresh. **Gaps in Assurance** No gaps identified	**5154**	Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts	06/09/2017

Signed: Patricia Grealish **Date Reviewed:** 15/08/2017

Risk proposed for de-escalation by Director of People and Organisational Development to major x possible = 12.
Good progress has been made with the appointment of a Bank Co-Ordinator. A refresh of the Register is underway to ensure that only Bank Workers that are working shifts and have the right checks and training are included. This will also significantly reduce the size of the Register.
Regular meetings are schedule with Resourcing (who hold responsibility for managing the Bank Worker Register and allocating to rotas) to check progress. In relation to training, once the Refresh is complete the Bank Workers will be included as a group on the Trust's Stat Man training reports.

BAF Risk no. 36	**There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised**				
Risk Classification: Clinical	**Risk Owner:** Wrigley, Fenella			**Scrutinising Committee:** Quality Assurance Committee	
Underlying Cause/Source of Risk: There have been a number of cases identified by telephone during clinical on-call and during attendance at resuscitation attempts where staff have identified VF but failed to deliver shocks as they have judged that the ECG demonstrates fine VF and their interpretation of current LAS guidance is that Trust policy is not to shock fine VF and to continue resuscitation until such time as the VF coarsens.				**Gross Rating**	**Current/Net Rating** / **Target Rating**
				15	**15** / **5**
Existing Controls	**Positive Assurance of Controls**		**Further Actions**		**Due Date**
FAQ document released on use of AED mode Short video released on Pulse and LiA on use of AEd mode Card attached to all payslips showing VF and VT ECGs with 'see it shock it slogan' (before AED mode mandated) Cardiac circular 007 updated to reflect use of AED mode. Above bulletins and FAQs and cardiac circular 007 available on app as well as Pulse. CSR updated with revised training notes for current training schedule of CSR2016.2 **Gaps in Controls** No gaps identified	Increasing numbers of monitor-defibrillator downloads are being obtained by Advanced Paramedic Practitioners and Clinical Team Leaders which will enable treatment of VF to be monitored. Records are maintained of staff attending CSR training. **Gaps in Assurance** Overall, the number of monitor-defibrillator downloads obtained as a proportion of the total number of resuscitation attempts within the Service remains relatively low.	**2128** **1201**	To monitor the incidences of VF arrests where there has been a delayed time to shock Increase number of defibrillator downloads to monitor trends		31/12/2017 31/12/2017
Signed: Nevett, Joanne		**Date Reviewed:** 31/08/2017			

BAF Risk no. 41	**The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed**			
Risk Classification: Operational	**Risk Owner:** Woodrow, Paul		**Scrutinising Committee:** Quality Assurance Committee	
Underlying Cause/Source of Risk: Issues raised by control and crew staff.			**Gross Rating**	**Current/Net Rating**	**Target Rating**
			15	**15**	**6**
Existing Controls	**Positive Assurance of Controls**		**Further Actions**		**Due Date**
Hand held airwave radios. Crews personal mobile phones. Data collection currently verbally relayed to control. Crews advised to contact control every 20 minutes where delays occur. **Gaps in Controls** No device supplied by the LAS for consistent collection of data and means of communication	Manually collected data is recorded in Meridian and Command Point. Telephone conversations with crews are recorded within EOC. **Gaps in Assurance** No automatic flagging of delays by system, should crews not make contact verbally.	**3696**	Roll out on NETS Devices to NET Operational Devices		29/09/2017
Signed: Nic Daw on behalf of Paul Woodrow		**Date Reviewed:** 08/08/2017			

BAF Risk no. 44 **There is a risk to achievement of the LAS control total for 2017/18 and a risk to achieving the LAS strategy in the long term if it does not have a sustainable financial plan due to (a number of work streams not being fully implemented)**

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance and Investment Committee		
		Gross Rating	**Current/Net Rating**	**Target Rating**
		20	**15**	**10**

Underlying Cause/Source of Risk:

1. Budgets are not signed off and owned by budget holders and therefore not delegated in accordance with SOs/SFIs; (links to Control 3 and Action 1)
2. Budget holders are not engaged with producing forecasts and therefore a disconnect between operational decisions and financial reporting; (links to Control 3 and Action 2)
3. There is insufficient focus and capacity to develop granular CIP and efficiency plans by budget holders to meet additional savings to achieve break-even;(links to Control 6 and Action 1)
4. Budget holders do not have sufficient financial awareness of costs, income & EBITDA of their services and/or capacity to support cases for development and transformation of LAS services; (links to Control 3 and Action 2)
5. The capital budget to support the £28.8m is not secured; (links to Control 8 and Action 3)
6. The LAS does not deliver operational requirements to gain planned variable income such as CQUIN, Paramedic Band 6 funding and contract activity over-performance. (links to Control 1 and 4)
7. The LAS has a deficit plan of £2.4m which needs to improve to achieve a sustainable surplus to achieve its strategic objectives. (links to Control 6 and Actions 1 and 5)
8. Up until 2017/18, the LAS operated within a block contract and fixed income financial envelope and has been in special measures over the last year, with the result that priority could not be given to developing financial and commercial awareness of budget holders to develop a devolved service level management model in line with the norm in other NHS organisations. (links to Control 3 and Action 2 and 4)
9. Instead, budget control has largely been achieved through central management and contingency accounting. (links to Control 3 and Action 2 and 4)
10. From 2017/18 the LAS contract income has and will become more variable with performance, the LAS strategy is to become the integrated emergency & urgent care provider and a significant transformation of service delivery is required. (links to Action 2, 4 and 5.)

Effect

All the above will require a deeper understanding of service level profitability to:

1. enable decisions to bid for new services and potentially exit existing services;
2. to manage the financial consequences of demand and capacity changes at service level
3. to support transformational efficiency programmes as part of CIP delivery

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Contract has been signed off with Commissioners for 17/18 with clarity on CQUIN, activity funding and STP funding requirements. Cycle of strategic, contracting and technical meetings with commissioners is in place. 2. Financial Plan for 17/18 has been signed off by Executive Leadership Team and detailed budget provision	Internal and External Audit reports; NHSI and NHSE reports and Finance and Investment Committee report to the Board.	1. Robust CIP governance process to be implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance;	Month 5 Cycle Month 6 Cycle

has been made by outgoing FD; this is clearly understood by the senior finance team reporting into FD and Deputy. 3. Budget sign off process & review of forecast assumptions has been commissioned by interim FD to be completed for M4 Performance Management cycle. 4. Financial plan is allocated to budget owners for holding to account through the Performance Management meetings for M4 for I&E, Capital, CQUIN & CIPs. CQUIN progress reported regularly to ELT. 5. Risks to Financial Control Total are reported to the Finance & Investment Committee and will be tracked through the finance report monthly. 6. CIPs have been allocated to owners and PIDs completed (though this has been done centrally if no response); 7. ELT report on Paramedic Band 6 funding requirements is in place with Director of HR and Quality in the lead. 8. FD escalation of Capital underspend from 16/17 and Safety Bids with NHSI.	Commissioner feedback through meetings and formal response to CQUIN quarterly reporting.		2. Budget management training and support based on best practice (Future Finance Focussed & HFMA programmes) to be introduced; 3. Robust Capital Programme governance process to be implemented for 17/18 including benefits realisation process. 4. Review Finance structure and prepare case to Trust Board to enable business partnering support 5. Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme	Month 5 Cycle TB sign off by October 2017 31st October 2017
Signed: Lorraine Bewes **Date Reviewed:** 22/08/2017				

BAF Risk no. 45	**There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.**		
Risk Classification: IM&T	**Risk Owner:** Ross Fullerton	**Scrutinising Committee:** Logistics & Infrastructure Committee	
Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats has accelerated rapidly in the last 5 years; cyber-attacks are regularly successful at disrupting many organisations in ways that weren't considered possible only a short time ago. This is compounded by an under-investment in IT security at LAS over the same time frame. As a consequence there is a deficiency in the overall awareness of cyber risk inside and outside of IM&T and we lack the skillsets, processes, governance and tools to mitigate the evolving threat profile effectively.		**Gross Rating**	**Current/Net Rating** / **Target Rating**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**	**Due Date**
1. Existing defences have mitigated threats to-date; these include various technical and procedural elements 2. Independent review by PA Consulting has identified necessary mitigations for CAD system **Gaps in Controls** The existing controls do not meet good practice requirements as defined by HMG's National Cyber Security Centre.	1. Reports to Information Governance Group of cyber-related incidents each quarter 2. Reports from IGG to RCAG **Gaps in Assurance**	NHS Digital led review of LAS cyber security (November 2017). Implementation of recommendations from PA Consulting report. Implementation of HMG good practice in cyber controls Introduce scenario planning and rehearsals for response to a major cyber attack on LAS	

Signed: Ross Fullerton **Date Reviewed:** 31/08/2017

Annex B – Board Assurance Framework August 2017 – proposed risks to be removed

Risk ID: 14	Description:	Risk opened:	20/06/2016	Low Risk	Medium Risk				High Risk			
	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.	Expected risk closure:	30/06/2017	6	8	9	10	12	15	16	20	25
Linked Risk(s):		Is this risk on track for closure?	Yes	T							G N	
217	Risk Owner: Director of Finance	Risk closed by Director of Finance. New Strategic Finance risk drafted (BAF 44)		Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017
				20	20	20	20	20	20	20	20	20

Risk ID: 25	Description:	Risk opened:	21/05/2015	Low Risk	Medium Risk				High Risk			
	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care.	Expected risk closure:	31/08/2017		8	9	10	12	15	16	20	25
Linked Risk(s):		Is this risk on track for closure?	Yes		T			N		G		
121	Risk Owner: Director of Finance	Risk discussed at RCAG 17/08/2017 where de-escalation to current rating of major x possible = 12 was agreed. Take to Audit Committee to propose removal from the BAF.		Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
				16	16	16	16	16	16	16	16	12

Risk ID: 26	Description:	Risk opened:	21/05/2015	Low Risk	Medium Risk				High Risk			
	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care.	Expected risk closure:	31/08/2017		8	9	10	12	15	16	20	25
Linked Risk(s):		Is this risk on track for closure?	Yes		T			N		G		
120	Risk Owner: Director of Finance	Risk discussed at RCAG 17/08/2017 where de-escalation to current rating of major x possible = 12 was agreed. Take to Audit Committee to propose removal from the BAF.		Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017
				16	16	16	16	16	16	16	16	12

Risk ID: 34	Description:	Risk opened:	17/11/2015	Low Risk	Medium Risk				High Risk			
	NHSI expects all NHS trusts to achieve financial balance in 2017/18, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.	Expected risk closure:	31/03/2018		8	9	10	12	15	16	20	25
Linked Risk(s):		Is this risk on track for closure?	Yes				T		N		G	
214	Risk Owner: Director of Finance	Risk closed by Director of Finance. New Strategic Finance risk drafted (BAF 44)		Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	July 2017
				20	20	20	20	20	20	15	15	15

BAF Risk no. 14 **It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.**

Risk Classification: Finance	**Risk Owner:** Lorraine, Bewes	**Scrutinising Committee:** Finance & Investment Committee

Underlying Cause/Source of Risk: • Appropriate supporting evidence not available • CIPs not supported by detailed milestone plan. • CIPs not embedded in budgets. • CIPs not owned by relevant manager. • Benchmarking of CIPs not undertaken. • CIP governance not clearly defined and in place. • Board/FIC scrutiny of CIP planning and delivery not in place. • CIPs not delivering in line with expectations. • Capacity and capability not available to support delivery.	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	20	**20**	**6**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments. **Gaps in Controls** See actions to be taken	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee **Gaps in Assurance** None identified	**2609**	Review 17/18 CIP plan and develop detail and ownership (see sub actions)	**Complete**
		3918	Re-establish Environment & Resources Group	**31/07/2017**
		3919	Review QIA Process to ensure Best Practice	**31/07/2017**
		3922	Finalise 2017/18 PIDs with Executive Leads	**Complete**
		3923	Integrate CIP programme with Trust Business Plan for 2017/18	**14/06/2017**
		3958	Appoint a benefits manager to support the delivery of sustainable multi year CIP and realise benefits from investments in the Transformation programme	**Complete**
		3924	Develop a detailed 2 year CIP plan	**30/09/2017**
		3920	Review and Update CIP Processes and procedures ahead of 18/19 planning cycle	**30/09/2017**
		3917	Develop Dynamic Benchmarking information through leading as an Ambulance Pilot in the Model Hospital Programme	**30/09/2017**
		3921	Embed all Internal Audit agreed recommendations from April 2017 report	**31/03/2018**

Signed: Lorraine Bewes **Date Reviewed:** 21/08/2017

Risk closed by Director of Finance. New Strategic Finance risk drafted (BAF 44)

BAF Risk no. 25	**There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care**				
Risk Classification: Finance	**Risk Owner:** Lorraine Bewes			**Scrutinising Committee:** Finance and Investment Committee	
Underlying Cause/Source of Risk: There is a perrenial challenge in the nature of our business and our operating model in the context of increasing demand that we may have cricumstances where equipment might be moved between vehicles or used or lost throughout the course of a shift.		**Gross Rating**	**Current/Net Rating**	**Target Rating**	
		16	**12**	**8**	
Existing Controls	**Positive Assurance of Controls**	**Further Actions**			**Due Date**
1. Agreed 'standard load list' of vehicle equipment including re-usable v disposable in place. 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit 6, A “core” equipment list for DCA & FRU has been defined and agreed 7, Funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed. 8, An equipment amnesty and physical review all stations and complexes for “retained” equipment has been undertaken. 9, A new paper based VP VDI form has been introduced. 10, Pilot to assess benefits of VP proposal carried out and documents describing benefit drafted. 11, BC for roll out of VP system pan London developed. 12, Board approval gained for BC 13, Project board and working group developed 14, Project plan defined and agreed 15, Additional equipment purchased to support roll out 16, project reclaiming, decontaminating and resupplying medical equipment established. 17, 'Managed stores' system established to support VP and daily supply of medical consumables 18, 'Blanket' trial and evaluation established and recommendations developed. 19, KPIs developed and monitored for the completion of wash and stocking of vehicles 20, Medicines management programme defined encapsulating all aspects of prep, supply and delivery, collection and disposal. 21, Development of Bag Review Group in April 2017 working schedule to review and replace modular bags as required and for personal issue equipment to be phased out	1. Progress made in agreement of core equipment and further equipment amnesty. 2. Decontamination of equipment commenced and robust. 3. Analysis of asset tracking systems being undertaken. 4. VP VDI improved 5. Ops VDI process changed and LA1 updated 6. required committees and working groups have been established to review **Gaps in Assurance** None	**498** **499**	Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG		31/08/2017 20/07/2017 Partially completed

Gaps in Controls Review of all logistics processes. Review of KPIs detailing equipment supply on shift by shift basis Review of equipment inventory including maintenance records Review of contracts for equipment support Development of project group to support the aim of vehicle based equipment removing 'personal issue' equipment from staff. Real time reporting of asset tracking				
Signed: Wand, Justin **Date Reviewed:** 05/07/2017 Risk discussed at RCAG 17/08/2017 where de-escalation to current rating of major x possible = 12 was agreed. Take to Audit Committee to propose removal from the BAF.				

BAF Risk no. 26	**There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care**				
Risk Classification: Finance	**Risk Owner:** Lorraine Bewes			**Scrutinising Committee:** Finance and Investment Committee	
Underlying Cause/Source of Risk: There is a perrenial challenge in the nature of our business and our operating model in the context of increasing demand that we may have circumstances where equipment might be moved between vehicles or used or lost throughout the course of a shift.		**Gross Rating**	**Current/Net Rating**	**Target Rating**	
		16	**12**	**8**	
Existing Controls	**Positive Assurance of Controls**	**Further Actions**			**Due Date**
1, Serial numbers on all re-usable equipment that can be accurately tracked. 2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role 8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 9, Current VP contract reviewed and any immediate changes are agreed 10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed 11, Pilot project in NE area to provide and resupply equipment store implemented. 12, Business case for the roll out of VP pan London has been agreed 13, Project board and working groups established. 14, Review of delivery standards completed 15, New KPIs reported through to QIP 16, Deep dive by QIP panel completed 17, Preparation of tender documents and standard commencing DEC2016	1. Clinical Equipment Group; 2. Asset tracking report; 3. VP reports; 4. VP Contract; 5. Equipment Process; 6. Project completion 7. Board reports and meeting minutes. **Gaps in Assurance** None	**1801** **1802** **1803**	Roll out Vehicle Preparation to rest of service Ensure adequate stocks of consumables and equipment are available to VP staff Fully develop equipment database reports to indicate where any equipment is missing		**31/08/2017** **31/08/2017** **31/08/2017**

18, Contract variations being developed to increase scope of works to include FRU and NETS vehicles 19, Proposal developed for the implementation of a depot based make Ready managers and 2 Make Ready Operations Managers to oversee the delivery of the contractor, coordinate more effectively with Fleet Workshop managers and local operational management teams on a daily basis. 20, Additional equipment is being sourced to facilitate the roll out where needed. 21, Vehicle equipment being recovered pan Trust. To date £350K (Nov2016) 22, Implementation of 'managed stock' project across the Trust in line with VP roll out. 23, Approval of BC for new vehicles for delivery during 2017 **Gaps in Controls** Review of processes and controls in Logistics team Review of medical device registers Need for the development of a planned replacement programme for Medical equipment. Development of a process that records missing equipment via CSU (PD33). Approval of Fleet Strategy with aligned 'unit' equipment.				
Signed: Wand, Justin **Date Reviewed:** 05/07/2017 Risk discussed at RCAG 17/08/2017 where de-escalation to current rating of major x possible = 12 was agreed. Take to Audit Committee to propose removal from the BAF.				

BAF Risk no. 34 **NHSI expects all NHS trusts to achieve their control total in 2017/18, managing within available resources. Failure to achieve this will mean the Trust will see a deterioration in its long term financial viability, loss of STP funding and will be subject to further scrutiny and challenge by regulators.**

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee		
Underlying Cause/Source of Risk: Failure to achieve this will mean the Trust is in deficit and will see deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		20	**15**	**10**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles 2. Clear view on operational capacity required to deliver ambulance performance targets 3. Clear view of achievable productivity targets which support performance targets 4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered 5. Funding from CCGs is consistent with capacity, productivity and demand assessments 6. Other factors such as investment for CQC are clearly understood, and associated funding identified 7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered. 8. Inflationary pressures are understood and managed within the overall financial position 9. Capital investment plans and their revenue consequences are understood. **Gaps in Controls** See actions to be taken	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee. The Trust has agreements in place on Band 6 funding and with lead commissioners around additional capacity funding. The Trust has improved its forecast outturn to £2.8m deficit subject to securing all agreed funding and STP incentives. On this basis it is appropriate to improve the net risk rating to 'possible' delivery to reflect this improvement.This was agreed at ELT on 22/3/2017 **Gaps in Assurance** None identified	**3935** **3929** **3930** **3931** **3932** **3933** **3956** **3934**	Ensure Trust adheres to all agency caps and controls (including IR35) Appropriately funded contract agreed with commissioners and signed off by all CCGs All areas of investment approved and agreed including the Trust Strategy and Transformation Programme Ensure CIP plans are robust Ensure Capex investment plans and associated revenue funding are defined and agreed for IM&T, Fleet and Estates Ensure Fleet, IT and Estatets Strategies are agreed and ratified by the Logistics and Infrastructure Committee Procure and Implement a more user friendly Forecasting system that can be readily informed and accessed by non finance staff Ensure Agreed Trust Strategy is aligned with financial plans	**Completed** **31/05/2017** **Completed** **Completed** **Completed** **30/06/2017** **31/09/2017** **31/10/2017**

Signed: Lorraine Bewes **Date Reviewed:** 21/08/2017

Risk closed by Director of Finance. New Strategic Finance risk drafted (BAF 44)

GOAL 1	Patients Receive Safe, Timely & Effective Care

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

Links to Objectives	BAF Risk	Further mitigation required
1, 3	37 There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.	• Development of performance improvement programme (over-arching programme of recovery actions) • Co-responding schemes full rollout across London (MPS / LFB) • Increase operational in-post from 95% to 100% • Increase operational establishment by (WTE TBC) posts funded through additional investment from CCGs as part of the 2017/18 contract. • Complete planning for ARP implementation
1, 2, 3	7 There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	• Review management capacity within EOC • Agree the new rest break policy with Trade Unions • Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements
1, 3	43 There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts
2.	36 There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised.	• To monitor the incidences of VF arrests where there has been a delayed time to shock • Increase number of defibrillator downloads to monitor trends
1, 2, 3	40 There is a risk that the Trust may not be able to recruit sufficient Paramedics to meet workforce profile requirements in 2017/18.	• International Recruitment of paramedics (2nd visit 2017) • Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1, 2	41 The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.	• Roll out on NETS Devices to NET Operational Devices
1	42 There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Assign all CQUINs to a lead Director, explaining the importance of following the exact wording • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies • Creation of a finance and reporting tracker and reviewed at monthly performance meetings

1,2	29 There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.	• Delivery of EOC improvement programme (ringback process and desk realignment) • Recruitment of EMDS to EOC • Review the possibility of additional Operational staff to support EOC ringback function

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

Links to Objectives	BAF Risk	Further mitigation required
1	40 There is a risk that the Trust may not be able to recruit sufficient Paramedics to meet workforce profile requirements in 2017/18.	• International Recruitment of paramedics (2nd visit 2017) • Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1	43 There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts
4	41 The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.	• Roll out on NETS Devices to NET Operational Devices
		•
		•
		•
		•

GOAL 3	Partners are Supported to Deliver Change in London

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

Links to Objectives	BAF Risk	Further mitigation required
4	42 There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Assign all CQUINs to a lead Director, explaining the importance of following the exact wording • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies • Creation of a finance and reporting tracker and reviewed at monthly performance meetings
		•
		•
		•
		•
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		•

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

Links to Objectives	BAF Risk	Further mitigation required
1	42 There is a risk that the Trust may not receive the full £7.8 million attached to the contractual CQUINs.	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Assign all CQUINs to a lead Director, explaining the importance of following the exact wording • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies • Creation of a finance and reporting tracker and reviewed at monthly performance meetings
4	7 There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	• Review management capacity within EOC • Agree the new rest break policy with Trade Unions • Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements
3	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
1	44 here is a risk to achievement of the LAS control total for 2017/18 and a risk to achieving the LAS strategy in the long term if it does not have a sustainable financial plan due to (a number of work streams not being fully implemented).	• 1. Robust CIP governance process to be implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; • 2. Budget management training and support based on best practice (Future Finance Focussed & HFMA programmes) to be introduced; • 3. Robust Capital Programme governance process to be implemented for 17/18 including benefits realisation process. • 4. Review Finance structure and prepare case to Trust Board to enable business partnering support • 5. Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme

London Ambulance Service NHS Trust

Assurance report:	**Audit Committee**	**Date:**	**04/09/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**03/10/2017**
Presented by:	John Jones, Non - Executive Director, Audit Committee Chair	**Prepared by:**	Kate Wilkins, Committee Secretary, John Jones, Audit Committee Chair

Matters for escalation:

The Committee agreed the following items for escalation:

The risk that the Trust may not be able to recruit sufficient paramedics to meet the workforce profile requirements 2017/18. (BAF Risk 40).
The Committee was concerned to learn that the recruitment position was worsening. It was noted that, although plans were in place to address the issue, the risk was unlikely to be closed for some time.

Proposed new format of the Board Assurance Framework (BAF)
The Committee noted the work to date on the refresh of the BAF and the link of risks to 2017/18 goals. A further update is expected to be presented to the Trust Board meeting on 3 October 2017.

Risk Management Strategy (RMS)
The Committee noted and agreed the proposed approach to a review of the Trust's Risk Management Strategy and Policy. The revised format of the RMS is expected to be presented to the Trust Board at its meeting on 31 October 2017.

Other matters considered:

As well as giving detailed consideration to the BAF, the Committee reviewed the following items:

terms of reference of the Committee;

the approach to assessing the effectiveness of the Committee;

the losses and special payments report and tender waivers for the first quarter of the year.(It is clear that improvements can be made in the cost of vehicle accidents and the tender waiver process and these will continue to be a focus for the Committee);

progress on the data quality assurance framework;

progress on the internal audit and counter fraud tender process; and

the Committee's forward plan.

	The Committee also considered Internal Audit reports on: the procurement maturity assessment; contract management; fleet preparation and clinical education. The following reports of the Local Counter Fraud Specialist (LCFS) were also reviewed: the progress report; pre-employment checks; pre contract procurement and fleet purchasing.
Key decisions made / actions identified:	The Committee approved both the proposed amendments to its terms of reference and the adjustments to the scheme of delegation. It was agreed that these be recommended to the Board for approval. These are attached to this report.
Risks:	Risks are as described in the BAF. The Committee agreed that **cyber risk (BAF risk 45)** was of particular importance and a briefing paper was received. It was noted that a cyber-attack could materially disrupt the trust's ability to operate for a prolonged period. The report notes that, whilst a number of measures are in place, there are identified gaps and an improvement plan is being developed to address the issues identified. It was also noted that two further risks might be added to the BAF following evaluation. These were in relation to items noted in the recent health and safety review and mobile data terminals.
Assurance:	Assurance to the Committee was provided by the reports of the internal auditor and the LCFS. All the reviews noted above produced a red/amber rating of partial assurance with improvements required. All of the recommendations made have been accepted by management and are in the process of being implemented. Additionally both representatives of the internal and external auditors were present at the meeting.

London Ambulance Service NHS
NHS Trust

Terms of Reference
September 2017
Audit Committee

1. Authority

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board of Directors.

1.2 The Audit Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.3 The Audit Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The primary focus of the Audit Committee shall be the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

2.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

2.3 The Committee shall review the corporate risk register and the Board Assurance Framework and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.

2.4 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

2.5 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

2.6 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

2.7 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

2.8 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Assurance Committees of the Board and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

3. Internal Audit

3.1 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.1.1 approval of the appointment of internal auditors and any question of resignation and dismissal. review and approval of the Internal Audit strategy,

3.1.2 operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

3.1.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

3.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

3.1.5 an annual review of the effectiveness of Internal Audit.

4. External Audit

4.1 The external auditor is appointed by the Trust Board on recommendation from an Auditor Panel established through the Audit Committee.

4.2 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

4.3 The auditor panel's functions are to:

4.3.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules

- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

4.3.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed external auditor;

4.3.3 Advise (if asked) the Trust Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

4.3.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

4.3.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor

4.4 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

4.4.1 consideration of the performance of the External Auditor;

4.4.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

4.4.3 discussion with the External Auditors of their local evaluation of audit risks;

4.4.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

4.4.5 discussion and agreement on the Trust's Annual Governance Statement.

5. Risk and Assurance Functions

5.1 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

5.1.1 review of the work of the Quality Assurance Committee in the management of clinical risk including assurance gained from the clinical audit function;

5.1.2 review of the work of the Finance and Investment Committee in the management of financial risk;

5.1.3 review of the work of the People and Organisational Development Committee in the management of workforce risk;

5.1.4 review of the work of the Logistics and Infrastructure Committee in the management of risk relating to IM&T, Estates, and Fleet & Logistics;

5.1.5 review of the Executive Leadership Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Risk Compliance and Assurance Group;

5.1.6 review the board assurance framework to ensure that it is focussed on the key strategic risks to the business and clearly identifies controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;

5.1.7 review of the findings of any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);

5.1.8 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

6. Counter Fraud

6.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

7. Management

7.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

8. Financial Reporting

8.1 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;

- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

8.2 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

9. Whistleblowing

9.1 The Committee shall ensure that arrangements are in place for investigation of matters raised in confidence by staff relating to matters of financial reporting and control, clinical quality and patient safety, or other matters.

10. Membership

10.1 The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.

10.2 At least one member of the Audit Committee must have recent and relevant financial experience.

10.3 One non-executive director member will be the Chair of the Committee and, in their absence, another non-executive member will be nominated by the others present to deputise for the Chair.

10.4 The Director of Finance, Director of Corporate Governance or their deputy should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

10.5 The non-executive Chair of the Quality Assurance Committee should be invited to attend all Audit Committee meetings.

10.6 Other executive directors should be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director.

10.7 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

11. Accountability

11.1 The Audit Committee shall be accountable to the Trust Board of Directors.

12. Responsibility

12.1 The Audit Committee is a non-executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

13. Reporting

13.1 The minutes of Audit Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board.

13.2 The Chair of the Audit Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action.

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.

14. Administration

14.1 Secretarial support will be provided by the Corporate Governance Team and will include the agreement of the agenda with the Chair of the Audit Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

14.2 Papers will be made available to the Committee at least seven calendar days before each meeting.

14.3 The draft minutes and action points will be available to Committee members within five working of the meeting.

14.4 Late and additional papers will be tabled will be at the discretion of the Chair of the Audit Committee.

15. Quorum

15.1 The quorate number of members shall be 2 which will include the following:

- Chair of the Audit Committee or the nominated deputy (who must also be a Non-Executive Director);
- In the absence of the Chair, Committee members will nominate a deputy chair for the purposes of that meeting.

16. Frequency

16.1 The Committee shall meet a minimum of 4 times per annum.

16.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

17. Review of Terms of Reference

17.1 The Audit Committee will review these Terms of Reference at least annually from the date of agreement.

17.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in Committee or Trust governance arrangements.

London Ambulance Service NHS Trust

Assurance report:	**People and Organisational Development Committee**	**Date:**	**07/09/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**03/10/2017**
Presented by:	Jayne Mee, Non-Executive Director, People and Organisational Development Committee Chair	**Prepared by:**	Jayne Mee, Non-Executive Director, People and Organisational Development Committee Chair

Matters for escalation:

Recruitment: Particular attention was given to the Trust's current recruitment target for frontline staff, particularly paramedics.

The Committee discussed whether achieving this target was either feasible or the best way forward for the Trust.

In the light of the above and after detailed discussion the Committee agreed that;

- Current targets were not as clear or as realistic as they should be and therefore required review as soon as possible.
- Skill mix would be reviewed as a result of the Ambulance Response Programme (ARP). It was likely to be more effective to recruit Trainee Emergency Ambulance Crews (TEACs)
- That existing staff should be utilised more effectively, in particular for Winter Planning.

The Committee agreed that the Board through the CEO Report should be provided with an update regarding paramedic and TEAC recruitment. The report will detail the above discussion and conclusions.

A report on the Operations Directorate restructure following a wide ranging debate at the Committee will be presented to the Board on 31 October 2017

Other matters considered:	Particular consideration was given to the following elements of the *talent* section of the People & OD Plan 2017/2020: **Skill mix review:** It was noted that progress against was RAG rated as red. It was also noted that this review was linked to both the roster review and the introduction of ARP. The committee was reminded that a comprehensive skill mix would involve both the operations and medical directorate. **Rostering:** PW advised that he was meeting with Working Time Solutions (WTS) to look at this. In answer to questions regarding the roster implementation review, PW advised that this would be completed by the end of January. He added that the revised roster would be rolled out sector by sector. **Job Cycle Time Programme:** It was noted that this related to the effective use of existing staff and included the review of shift patterns and annual leave. The committee was informed that the annual leave policy was significantly out of date (2003) and not fit for purpose. PW advised that the policy allowed for 15% of staff *in post* to take leave which in some cases meant a reduction in cover by c. 50%. **Rest breaks:** PW said that negotiations were on going with the trade unions about this but that so far no agreement had been reached. He added that the GMB had registered this as a dispute. The committee concluded that there were many variables all of which had a link or impact on the Operational Restructure, so this was complex and somewhat messy. Whilst these objectives appear in the P&OD plan, it was noted that the planned business plan update to the Board would explain the above in greater detail including timescales as these objectives were organisationally cross cutting.
Key decisions made / actions identified:	• To recommend the People & Organisational Development Strategy to the Board at the meeting on 3 October 2017 • The Committee noted that Cathe Gaskell had produced an interim report and recommendations regarding bullying and harassment. PG said she was considering the recommendations and that she would be mapping them against what was already in place to deal with the issue and against the P&OD Strategy. She added if there were gaps she would look at what was needed to address these. • The implications for Freedom to Speak Up (FTSU) were also considered. It was agreed that the work on both FTSU and the prevention of bullying and harassment would need time to be embedded across the organisation. Patricia Grealish will follow up with Theo De Pencier.

Risks:	• Delay in Operational Restructure and its affiliated changes of skill mix, rostering, annual leave, JCT, rest breaks. This was being discussed with the CQC to keep them appraised of developments given that we had indicated that this would be completed by July. • Recruitment to proposed and modified workforce plan
Assurance:	• Excellent recruitment campaigns which also incorporate WRES activity. PW agreed to support campaigns with operational staff possibly seconded to support the Autumn events in particular. • The P&OD Plan is largely on track where PG can control delivery • Statutory and Mandatory training levels had seen a significant increase during the month of August. • Staff survey will be 100% online and preparations are in motion • The Cultural Behaviour Project was progressing well and the first session to engage people would take place on 13 September 2017 to start to embed the LAS behaviours. The CQC would receive an update as part of the action plan.

London Ambulance Service NHS Trust

Assurance report:	**Finance and Investment Committee**	**Date:**	**21/09/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**03/10/2017**
Presented by:	Fergus Cass, Non-Executive Director, Finance and Investment Committee Chair and Lorraine Bewes, Director of Finance and Performance	**Prepared by:**	Fergus Cass, Non, Executive Director, Finance and Investment Committee Chair

Matters for escalation:

- The Director of Finance and Performance will update the Board on the year to date and the forecast year-end position. By the end of August the net deficit, at (£0.8m), was £1.4m better than plan and £3.1m better than the re-phased budget. This was mainly due to an underspend in pay and in other areas, partly offset by increased spending on Private Ambulance Services (PAS). The year's target of (£2.4m) is expected to be achieved **:** a shortfall in delivery of the Cost Improvement Programme (CIP) target of £17.8m will be offset by reserves and once-off savings.
- The Board will be briefed on the action plan to significantly improve the planning and management of the CIP.
- Capital expenditure is likely to fall below the planned level of £28.8m due to a delay in allocating £4.5m that was expected to come from centrally funded initiatives. The capital spending programme is being reprioritised. IM&T expenditure, while below plan, is expected to be at least £6.4m.
- A recent audit assessed Procurement Maturity, resulting in an Amber/ Red rating (Partial assurance with improvements required). Issues include: the extent to which the Procurement Department is involved in procurement decisions across the Trust; weaknesses in contract management; and the scope for higher savings in non-pay expenditure (currently around £70m per annum). An action plan is being developed.

Other matters considered:

- At the end of August, the cash balance was £6.0m above plan. It is expected the year-end cash target will be exceeded, provided that the deficit target is achieved.
- The Committee noted the progress in obtaining sign-offs from budget holders in respect of the 2017/18 budgets. It was informed that

	outstanding issues are expected to be resolved and that overall budget totals have been confirmed. • The Committee received a report indicating that the Trust is compliant with all relevant tax requirements. To provide further assurance, compliance with rules relating to off-payroll working is being audited.
Key decisions made / actions identified:	• The Committee reviewed the principal risks and mitigations relating to achievement of the planned deficit. The following steps were agreed in order to provide additional assurance: a review of forecast PAS and overtime expenditure in the months ahead in the light of recruitment shortfalls; confirmation of criteria for full payment of CQUINs; and confirmation of the criteria for full payment of funding for Band 6. • In relation to the CIP, the Committee supported the proposed improvements in the governance, planning and management of the CIP. It recommended a strategic approach to the setting of cost improvement targets, involving early identification of the required scale of the programme and of the principal projects and being ready to communicate and engage through next year's Business Planning process when it is launched in November. • In relation to capital spending, the Committee noted the intention to form a Capital Programme Group as a sub-committee of the Executive Leadership Team (ELT). • The Committee supported the proposed approach to developing the financial plan for 2018/19. It recommended that work on key elements, especially the CIP, should commence as soon as possible and should take the conclusions of the strategic planning exercise into account. • In relation to the procurement action plan, the Committee recommended that it should be finalised quickly and that it should set ambitious savings targets. • The Committee noted that the overall cost of agency staff was forecast to be below the target but recommended that expenditure on non-clinical agency staff should be examined in depth and plans made for a reduction.
Risks:	• The worst case scenario for the net deficit for the year indicates a deficit of £4.2m, reflecting risks around CIP delivery. This risk is currently rated low. As noted, action is being taken to strengthen management of the CIP. Actions to provide additional assurance were noted above. • Capital spending up to the end of August is £3.5m. There is a risk of shortfall against the revised funding total of £24.3m, although discussions with budget managers have indicated a high level of

	confidence that capital budgets will be spent. As noted, a Capital Programme Group has been formed and one of its tasks is to ensure that plans are delivered.
Assurance:	• On the basis of the results to date and the reports and analyses reviewed by the Committee, the deficit target of (£2.4m) for the full year is expected to be achieved, although risks remain, especially in respect of CIP delivery and certain other budget items. • The cash flow report and projection, which includes a risk assessment, indicates that year-end cash targets will be exceeded.

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**26/09/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**03/10/2017**
Presented by:	Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair	**Prepared by:**	Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair

Matters for escalation:

- Health and Safety - The Trust has instigated an independent review which has identified significant deficiencies. We were assured that there is a comprehensive action plan, resources have been agreed and a new HS&S Manager is in post. The Unions are participating and there will be monthly updates on progress.
- The Internal Audit report on Clinical Education identified significant challenges in recording of attendance and signing off on completion of qualifications and courses. These failings will be addressed by a new governance manager appointment and a new electronic student record system which will link to the OLM staff training record. However, this review has identified a major problem around storage and access to paper HR records and the Executive Leadership Team (ELT) will be asked to address this issue.
- There is continued concern about recruitment and retention of EOC staff and the high (18%) annual turnover with a noticeable effect on training requirements and stretched staff numbers at weekends.

Other matters considered:

Serious Incidents – The Chief Quality Officer outlined an improved SI process including a clinical assessment of all incidents and a robust process for ensuring timely completion of actions. The current backlog of uncompleted actions, none of which are major, should be resolved in two weeks.

Statutory and Mandatory training- New processes are in place to record and identify the gaps in training for all staff (including bank staff). Oversight will be by metrics in the Quality report.

	The Quality Report for August was discussed with the recent Quality Oversight Group report and minutes. We were pleased to hear the first personal issue hand held devices would be issued this year. Alison Blakely (QGAM) and Darren Farrer (ADO) presented their work on Quality in the SE sector. The Chief Quality Officer outlined plans to prepare for the CQC re-inspection. The relevant BAF risks to Quality were not available for review at this meeting. A quality impact assessment on the CIP is still outstanding. An update was provided on the Clinical Strategy.
Key decisions made / actions identified:	The Committee was pleased to support plans to standardise the format of reports and reviews to make the information more accessible to these meetings.
Risks:	There is a risk that that not all training required will be delivered within the present resource (including clinical updates, learning from SI etc. and the substantial time spent on MAST). As the work of LAS becomes wider and more complex there is a need for more resource to be directed towards ongoing governance and education. This includes educational staffing, time for clinical supervision and time for operational staff to be freed from their regular work for training. Also, recruitment to the governance team has been slow with many interim posts.
Assurance:	Four 2016/2017 Annual reports were reviewed (STEMI, Cardiac Arrest, Stroke and Major Trauma). The quality of these reports is good and we were pleased to be assured that high standards had been maintained for these critically ill groups of patients. Safety during Surge Purple and above. Responding to a question raised at our July meeting Fenella Wrigley explained that whenever the surge protocols were brought in there was a same day review of all critically ill and vulnerable calls. We were assured this was more effective than occasional systematic reviews in ensuring safety was maintained

despite the pressure on the service.

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Serious Incident (SI) Reporting**			
Report Author(s):	**Dr Patricia Bain, Chief Quality Officer**			
Presented by:	**Dr Patricia Bain, Chief Quality Officer**			
History:	**Presented to the Executive Leadership Team on 20 September 2017** **Presented to the Quality Oversight Group on** **Presented to the Quality Assurance Committee on 26 September 2017**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The report provides information in relation to the current status of serious incidents.

Over the last four months a review of the systems and processes for SI/incident reporting has taken place. The outcome of this is further development and improvements in these systems to provide assurance to the Board that serious incidents in particular are being managed, lessons learned and actions completed. More generally, further work has been undertaken to ensure more robust monitoring and assurance of the process.

The document appended to the monthly report is an assurance report in relation to overdue action plans.

Recommendation:

The Board is asked to note the declared and closed SIs and receive assurance in relation to overdue actions.

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

Links to BAF risk in relation to the Trusts special measures status.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☐
Financial	☐

Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

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

London Ambulance Service NHS Trust

Serious Incidents Monthly Report

September 2017

Presented to: Trust Board, CQRG, Quality Oversight Group

Introduction

- The purpose of this report is to give a high level overview of the London Ambulance Service's position and progress.
- This report will cover activity in the previous month otherwise stated, in this case August 2017 although the analysis itself may take into account activity prior to these dates.

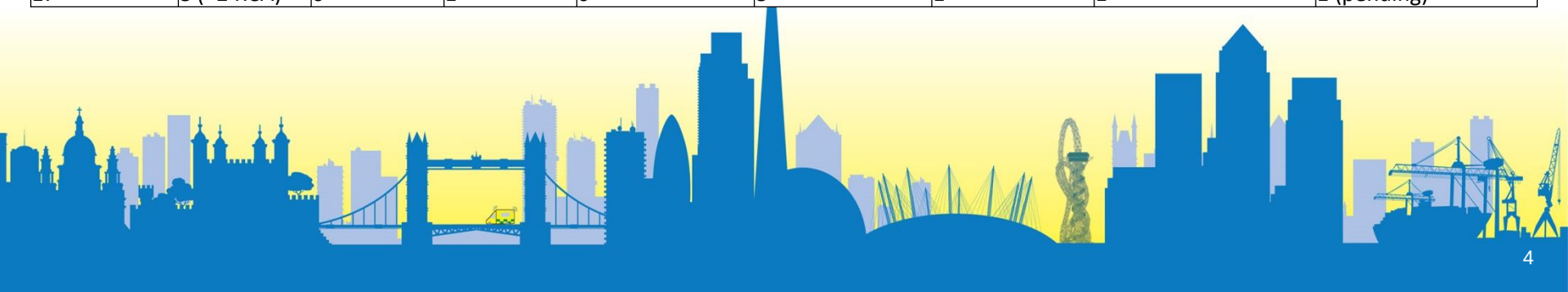
Serious Incidents - Activity

- In June there were 36 incidents raised to SIG, with 8 declared as SIs and 2 RCAs. The number raised was slightly higher than the previous month, and the number declared is currently at a lower level compared to the previous financial year.
- For 2016-17 on average 45 incidents were reviewed and 9 SIs were declared each month.
- Of the 8 SIs declared in August 2017:
  - 2 concerned Major Trauma Patients being conveyed to local A&E departments
  - 1 concerned a pedestrian involved in an RTC with an ambulance
  - 1 concerned a drug error
  - 2 concerned a delayed response
  - 1 was highlighted via the re-contact audit
- As of 11/09/2017 there are currently 11 SIs under investigation, with 1 overdue, a decrease of 1 on the previous month and slightly higher than the trajectory. The overdue report the Governance Team are currently working on comments from ELT before submission.
- 5 reports were submitted in August, in line with the projected figure.

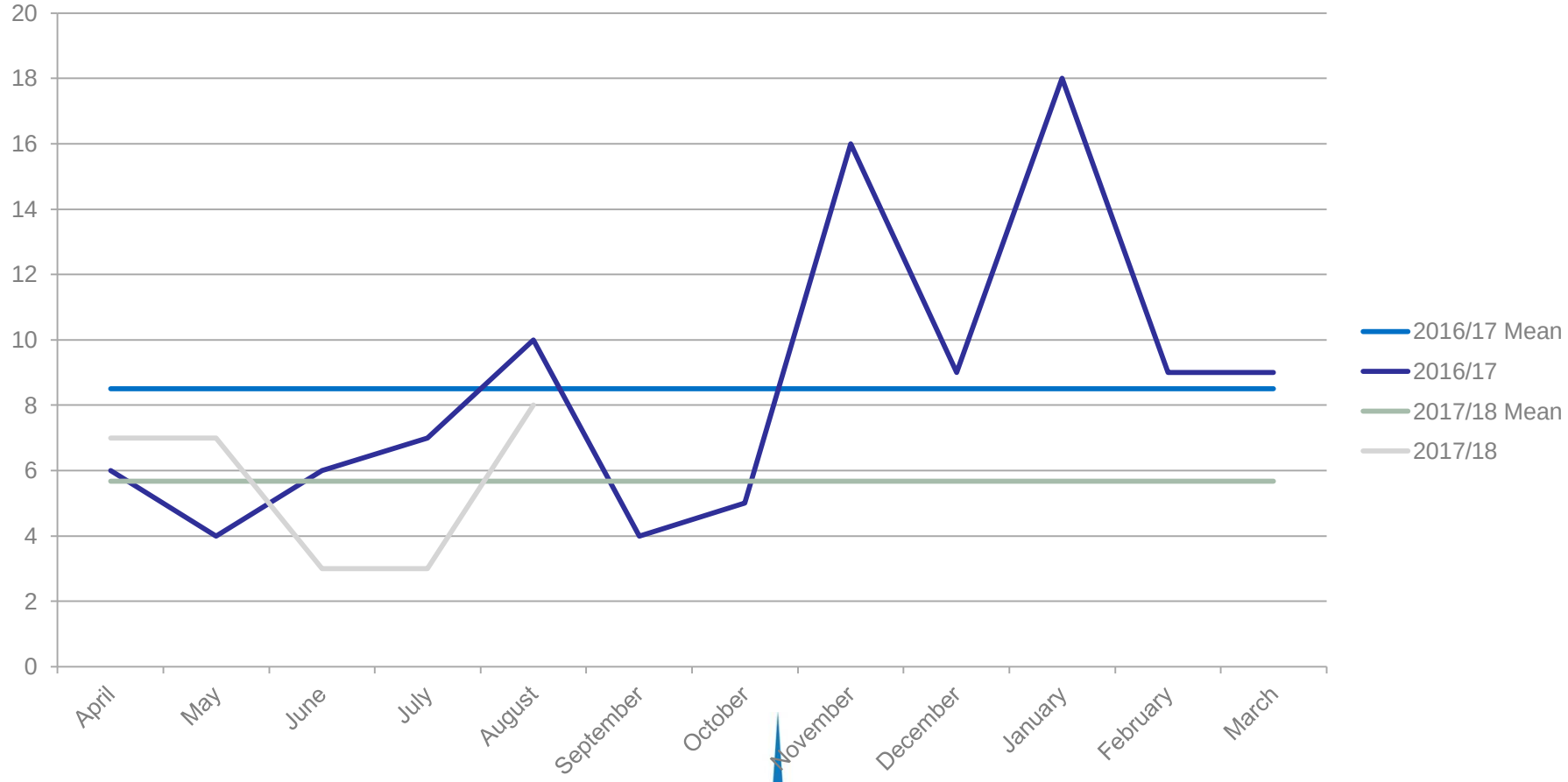
Serious Incident Group Activity

	Number of Incidents raised to SIG	Number of incidents declared as SIs	Number of SIs declared within 2 working days of reporting	Number of SIs declared within 5 working days of reporting	Number of SIs declared after over 5 working days of reporting	% of SIs declared within 2 days of reporting	Number of SIs entered onto STEIS within 48 hours	% of incidents put on STEIS within 48 hours	Number of SIs requested for de-escalation from this reporting month
Sep-16	40	4	1	2	1	25%	4	100%	1
Oct-16	33	5	1	1	3	20%	5	100%	1
Nov-16	50	16	10	5	1	63%	16	100%	2
Dec-16	48	9	2	3	4	22%	9	100%	3
Jan-17	48	18	5	4	9	27%	18	100%	2
Feb-17	55	9	4	2	3	44%	9	100%	0
Mar-17	55	9	2	6	1	22%	9	100%	2
Apr-17	28	7	4	6	1	57%	7	100%	1
May-17	47	7	5	1	1	71%	7	100%	0
Jun-17	25	3	2	1	0	66%	3	100%	0
Jul-17	33	3	0	2	1	0%	3	100%	1
Aug-17	36	8	1	0	7	12%	8	100%	1

Overview into Open SIs as of 11/09/2017								
Number of Open SIs on STEIS	Number within 30 days	Number between 30 and 60 Days	Number overdue	Number on Stop the Clock	Number Submitted awaiting feedback or closure	Number requesting further information – outstanding	Number of De-escalation requests submitted in August	Number of De-escalation requests submitted in August
17	8 (+2 RCA)	6	1	0	8	1	1	1 (pending)



Serious Incidents Activity



Declared SIs – The detail

Incident date	Date reported to STEIS	STEIS Ref:	Category	CCG	Due Date
26.04.17	17.08.17	2017/20697	Trauma Audit – Patient triggered trauma tool however was conveyed to local ED	Barnet	13.11.2017
28.06.17	24.08.17	2017/21237	Paediatric cardiac arrest – drug errors	Ealing	17.11.2017
02.07.17	18.08.2017	2017/20749	Trauma Audit – Patient triggered trauma tool however was conveyed to local ED	Barking & Dagenham	13.11.2017
11.07.17	17.08.17	2017/20764	EOC – gazetteer related issues	Harrow	13.11.2017
12.07.17	24.08.17	2017/21257	Delayed response	Hillingdon	17.11.2017
20.07.17	03.08.17	2017/19503	Incorrectly managed 'running call'	Newham	27.10.2017
31.07.17	10.08.17	2017/20068	Collision involving an ambulance and pedestrian	Enfield	03.11.2017
16.08.17	24.08.17	2017/21262	Re-contact audit	Hounslow	17.11.2017

Duty of Candour compliance

The Trust reported 8 Serious Incidents onto STEIS that met the threshold for Duty of Candour in July.

Of these incidents –
5 patients/ Next of Kin(s) have been contacted, apologised to and been followed up in writing
1 patient's duty of candour work is being led by Police as part of a criminal investigation.
1 NOK has been contacted and will be followed up with a letter
1 patient's DoC was delayed due to the nature of the incident – Senior Operational Manager appointed to undertake DoC which is now compliant

Final reports from investigations will be shared with the patients/ NOK where they are happy to receive them.

Overdue Serious Incident Investigations as of 07/08/2017

ELT	LI	STEIS ref	Datix ref	No of days overdue	Due Date	Update
ELT group	Sue Watkins and Tracy Pidgeon	2017/13483	8718	**16**	18.08.17	11.09.17 – report back with the Governance Team for comments post ELT review

Serious Incident Action Compliance as of 11/09/2017

A total of 169 actions were overdue relating to SI investigations which had been completed and closed as of the 28th July 2017. A total of 96 actions are now outstanding which is a reduction of 73. There were a number of more specific actions which suggested reviewing training materials and current Trust polices. The majority of the actions were in the East Sector followed by EOC, North East and North Central Sectors.

The Quality, Governance and Assurance Team (supported by the QGAMS) have undertaken a review of the actions and contacted the individuals responsible for completing the actions and escalated to the Senior Manager Leads for the sectors to which the actions relate.

Of the 91 overdue actions:

- 17 = 6 months or over
- 19 = 3 to 6 months over
- 10 = 3 months over
- 11 = 2 months over
- 34 = less than 1 month over

The majority of the overdue actions related to staff feedback, round table meetings or Trust wide learning via a bulletin/RIB. Weekly reminder emails are being send by the Quality, Governance and Assurance Team and escalated to the Chief Quality Officer.

Serious Incident Action Compliance as of 11/09/2017

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- Of the 91 overdue actions:
  - 17 = 6 months or over
  - 19 = 3 to 6 months over
  - 10 = 3 months or under
  - 11 = 2 months or under
  - 34 = less than 1 month

- The majority of the actions were in the East Sector followed by EOC, North East and North Central Sectors.
- The majority of the overdue actions related to staff feedback, round table meetings or Trust wide learning via a bulletin/RIB.
- There were a number of more specific actions which suggested reviewing training materials and current Trust polices.
- Weekly reminder emails are being send by the Quality, Governance and Assurance Team and escalated to the Chief Quality Officer.

Activity analysis as of 11/09/17

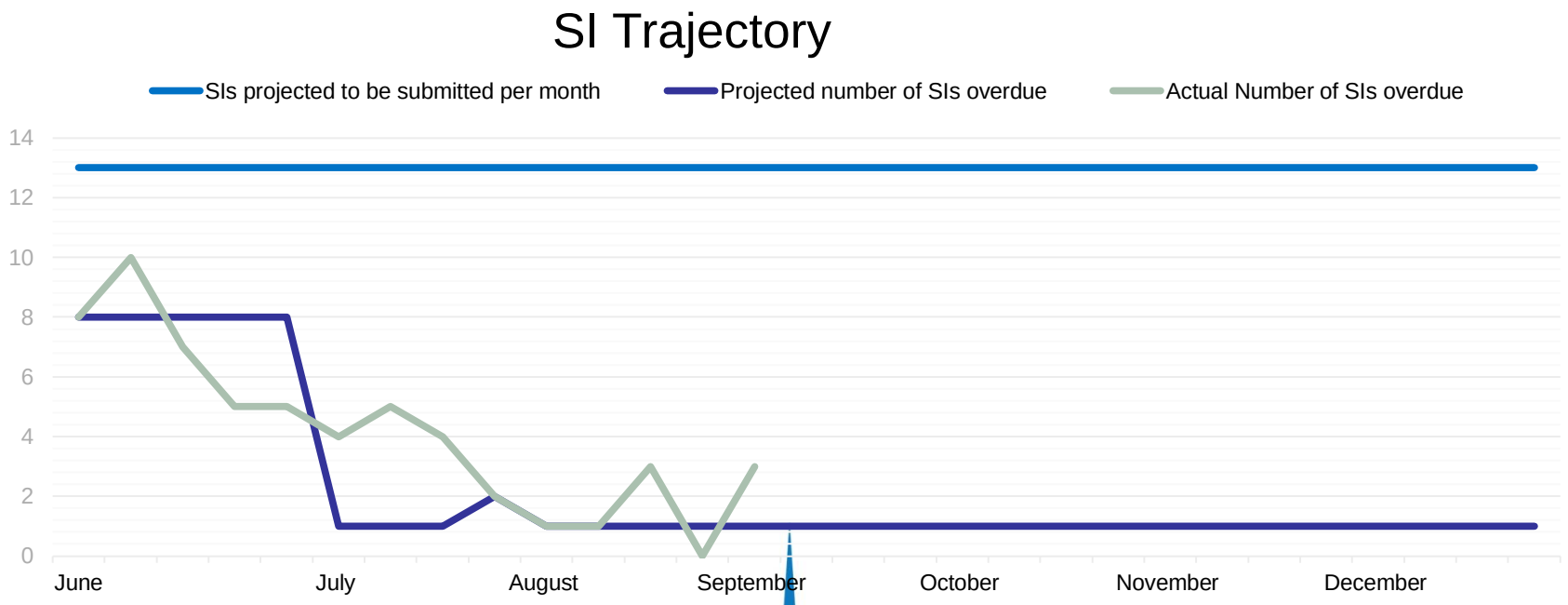
- There is currently 1 report overdue with a further 2 due by the end of September, 4 due in October and 7 due in November. Therefore over the next three months 13 reports will need to be completed and submitted in order to ensure a minimal number of SIs are overdue and that the Trust continues to work on SIs that are in date.

- As a result of the backlog, an action plan was put in place which is being monitored weekly by the Chief Quality Officer with updates into ELT. Key actions include;
  - Review of capacity in the department
  - Rewriting of SI process and policy
  - Training of 15 preferred Lead Investigators, including human factors and use of datix
  - Reduction of ELT escalation threshold from 40 days to 30 days
  - Review of the Datix module for serious incidents

This action plan is subject to additions once the SI process is signed off.

SI Trajectory graph

This trajectory is based upon 9 SIs being declared per month and 13 reports submitted per month, which is the capacity of the current resource in place.



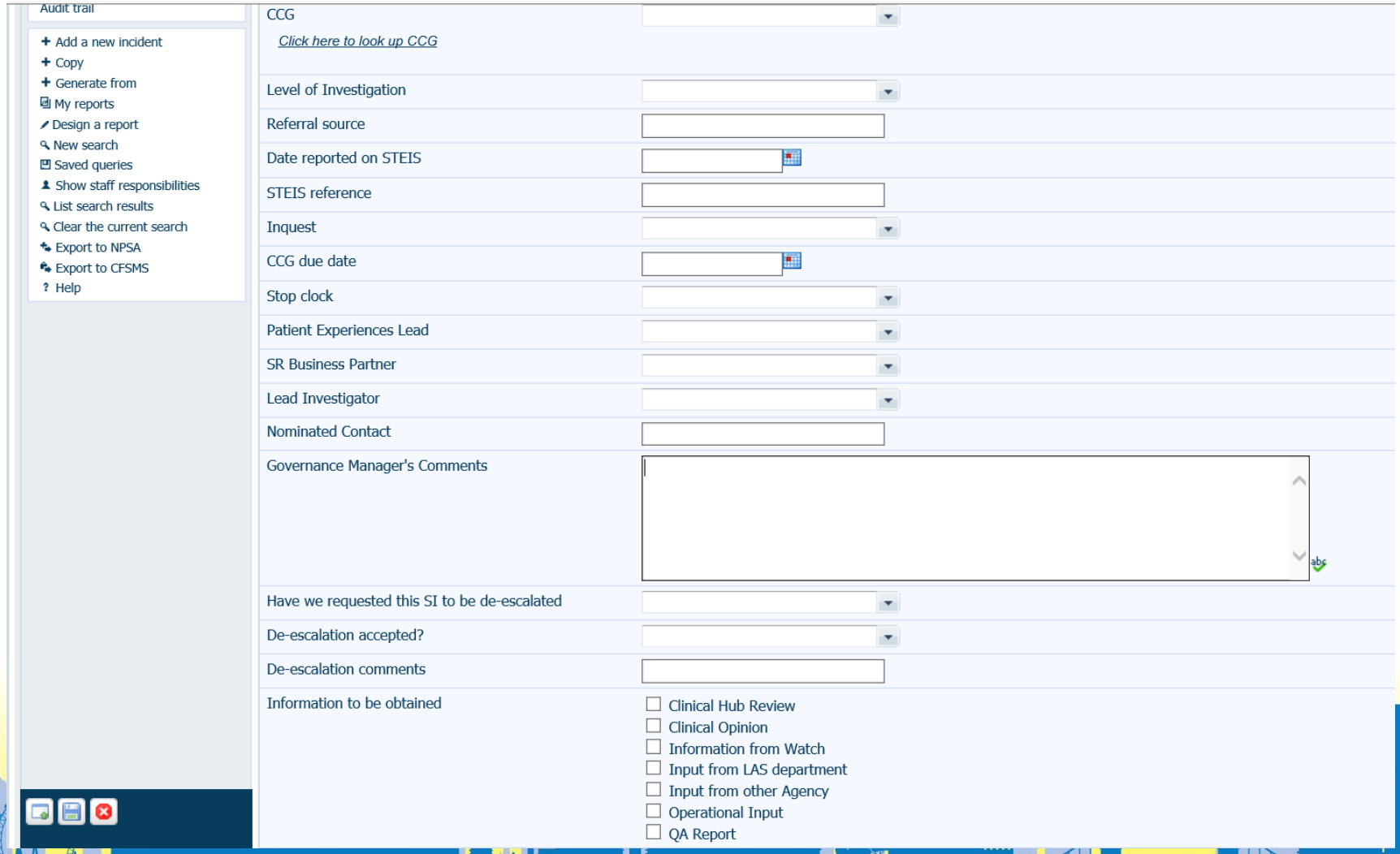
SI Backlog Action plan

Action No.	Action Required	Lead	Time Frames	Status
1	Review of SI case management within Datix system	Jason Ramchurn & Kirstie Smith	01.10.2017	Complete
2	Review of action compliance management concerning SI investigations (including Senior Management/ELT dashboards)	Jason Ramchurn & Kirstie Smith	01.10.2017	Initial review complete and test report run in Datix test system
3	Implementation of feedback mechanism for incident reporters	Jason Ramchurn	01.10.2017	On track
4	Communication for all Datix users to provide comprehensive information regarding Datix upgrades	Jason Ramchurn	22.09.2017	On track
5	Produce Incident Reporting and Management SOP	Jason Ramchurn	22.09.2017	Drafted
6				
7				
8				
9				
10				
11				

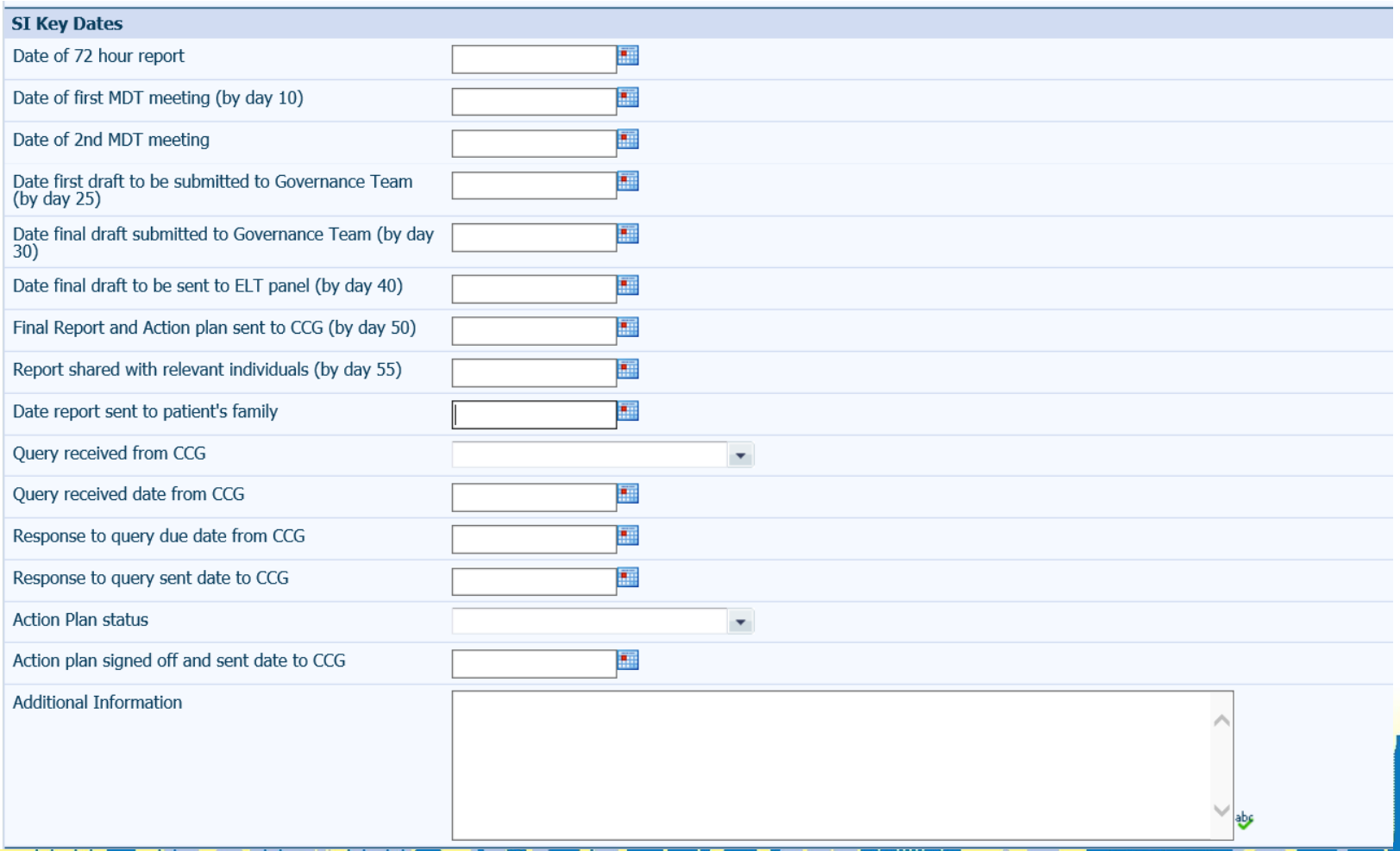
Datix Review

- Changes to the Datix SI module have been drafted to reflect the changes in the SI investigation process
- Specific fields to capture key individuals and dates will enable to Quality, Governance and Assurance Team to better monitor compliance throughout the investigation process
- An additional function ‘reporter feedback’ function is due to go live 1st Oct 2017. This will provide an automated email to the incident reporter with the findings of the investigation and any learning/recommendation that have been provided.
- Changes to the SI Action Tracker have been drafted to provide sector based dashboards available to Senior Managers and Executive Directors
- The revised action plan will ensure the Quality, Governance and Assurance Team are able to monitor action compliances related to specific SI reports.

Datix Review – SI screen shots



Datix Review – SI Screen shots



Overdue Serious Incident Action Status Report

Overdue serious incident (SI) actions relating to closed SI reports

1. Introduction

1.1 An internal audit was conducted to review the completion and closure of actions relating to closed SI investigations within the Datix Web system.

The audit incorporated all overdue actions within the system that were linked to SI investigations that had been closed by the Clinical Commissioning Group (CCG).

1.2 Any actions that derive from SI investigation recommendations are uploaded onto Datix once the report has been submitted to the CCG. The deadlines for the proposed actions are provided by the Lead Investigator and are assigned to an appropriate individual with the correct level of authority to complete the action.

1.3 Datix will send an automated alert via email to the individual responsible for completing the action informing them of the action details they have been assigned. Once the action is overdue the system will send both the responsible individual and the Senior Manager accountable for overseeing compliance, daily emails informing them that the action is now overdue.

2. Audit outcome

2.1 The audit revealed that the Trust had 169 overdue actions (as of 28th July 2017) that related to closed SI investigations. SI investigations that had not yet been closed by the CCG were not included in the audit as the actions would not have passed the deadline for completion.

2.2 The majority of these actions related to staff feedback, familiarisation training, round table meetings or Trust wide learning via a bulletin/RIB.

There were a number of more specific actions which suggested reviewing training materials and current Trust policies.

The majority of the overdue actions were in the East Sector followed by EOC, North East and North Central Sectors.

3. Action taken

3.1 A meeting was arrange with the Quality, Governance and Assurance Managers (QGAMs) for each sector and the Head of Quality Assurance for EOC. The purpose of the meeting was to share the information gained from the audit and formulate a plan to resolve the identified issue.

3.2 It was agreed that each QGAM would review the actions that were assigned to managers within their sector and follow up with the respective managers on its progress. The Head of Quality Assurance for EOC would review the actions assigned to EOC managers and the Interim Head of Quality, Governance and Assurance would review all outstanding actions that sat outside operations (training, IM&T etc).

3.3 It was noted during the meeting that certain actions had been completed however the evidence to support this had not been uploaded and the action had not been recorded as complete. This would be followed up by the respective manager. No action would be closed without the relevant evidence/supporting documented being uploaded onto Datix.

4. Further action and assurance

4.1 It was noted that some of the action descriptions were vague and not in accordance with the SMART framework; particularly ‘specific’ and ‘realistic’.

In order to address this the Quality, Governance and Assurance team proposed an additional multidisciplinary team meeting into the SI investigation process (Appendix 2) to ensure ownership and accountability for actions was clear and all actions have been signed off and agreed prior to sending report to CCG.

4.2 It is accepted that SI’s that occur within the Trust are rarely isolated to one area of the service. It cannot be guaranteed the Lead Investigators will have a robust

working knowledge of the intricacies of each department/directorate/sector in order for them to form SMART objectives/actions to fully address a recommendation. As such it has been suggested that the Action Plan MDT meeting is held to enable the Lead Investigator to present the findings of the report and their recommendations to a team of Senior Managers from each of the departments involved in the SI.

4.3 This will enable subject matter experts to provide support and guidance to the Lead Investigator on the most appropriate and effective way to achieve the recommendations. The senior manager representing the department/sector/directorate must have the appropriate level of authority to agree and assign an appropriate individual to implement the action. It is expected that this will typically be heads of departments or their representative.

4.4 In addition, to ensure that future actions relating to SI investigations are completed by the required deadline the Quality, Governance and Assurance Administrators will be provided access to the purpose built report within the Datix system to run monthly reports for the Head of Quality, Governance and Assurance to review/monitor. Actions that are duplicate or trust wide will be identified and linked via a thematic review. Those actions causing concern regarding completion will be flagged to the responsible individual and escalated to the Quality, Governance and Assurance Manager (or equivalent) for the sector/department. Further work is being undertaken with the Datix Lead for the Trust to review and improve the current reporting process. The status of actions will also be reported within the Quality report and at performance meetings.

5. Action compliance to date

5.1 As of the 8th September the current status of actions is:

- From the original 169 to a current position of 78 overdue
- Seventeen are over 6 months from action
- 29 are over 3 - 6months
- 21 up to 3 months
- Remaining 34 actions are within 3-4weeks.

5.2 The majority of actions are individual staff feedback (12) the rest relate to training materials. Actions that are assigned to members of staff who have left the organisation have been flagged to the relevant managers to be re-assigned.

5.3 Weekly reports are being run by the Governance Administrator and reminder emails sent to responsible Senior Managers and a communication from the Chief Quality Officer has been sent to all relevant managers to express the importance and urgency of closure of actions.

Additional systems and process improvements are set out in Appendix 1.

Appendix 1: Additional system and process actions.

Further work is being undertaken within the quality and assurance directorate to improve the serious incident investigation process and incident reporting more generally. They are set in the bullet points below

- A revised serious incident investigation process, now being implemented (Appendix 2)
- An additional process for sectors to agree and sign off action plans so that accountability and ownership of actions are clear.
- An assurance process conducted by the Quality Governance and Assurance teams quarterly to identify evidence of implementation of actions and regular monthly reporting via the quality report to the Board.
- A daily clinical review of all Datix incidents so that incidents, themes, trends can be identified and incident scoring reviewed i.e. no harm may be allocated to an incident by a reporter through lack of understanding of correct scoring criteria, this would not then be considered at the Serious Incident Group.

Additional assurance mechanisms:

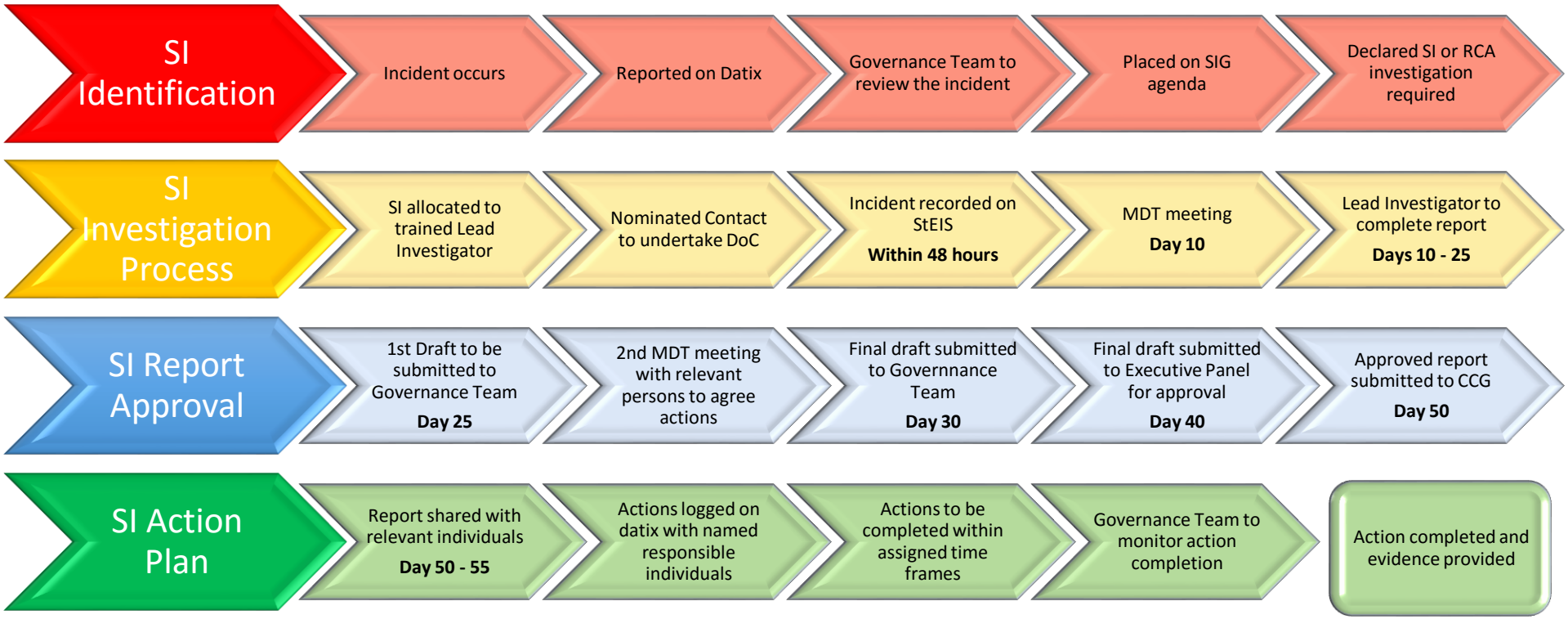
- A methodology and information systems are being developed so that quarterly reviews can be undertaken of patient safety issues/incidents that may occur during times of surges in demand (purple and red).
- Additional information is also provided in the monthly update to ELT/Board members via access to the serious incident portal so that access to the completed and closed reports is available. In addition executive summaries, using a revised format, will be included in monthly reports from September onwards.
- The revised quality report identifies themes and trends from incident and KPIs to reflect whether or commonly occurring incidents are reducing in number as an outcome of improvement initiatives. In addition sector heat maps for safety are included to identify trends in particular sectors and if an Intensive Support Programme needs to be enacted for example currently being conducted in

North East Sector. This programme has already shown improvements on all KPIs.

- More accurate and improved process for ensuring compliance with Duty of Candour – this will be reflected in the Duty of Candour policy to be approved in September policy group.
- Current review of the Datix system to ensure it is structured to capture evidence and learning documents and codes are matched to national reporting data.
- System wide coding - i.e revised incident category and subcategory is underway.
- E-learning New Content request form has been submitted - this will be reviewed by People & Organisational Development Team in the next few weeks for approval for incident and risk management modules.
- Site visits scheduled with East of England Ambulance Service and calls with Scottish Ambulance Service/South East Coast Ambulance Service.
- Review of Patient Experience module set up has taken place and advised re-configuration will take place after 1 October 2017.

Overdue Serious Incident Action Status Report

Appendix 2 – New SI investigation process



London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**				
Date of meeting:	**3 October 2017**				
Document Title:	**Lessons Learned from Major Incidents**				
Report Author(s):	**Kevin Bate, Deputy Director of Operations (Central Operations) and Brian Jordan, Business Manager to the Director of Operations**				
Presented by:	**Paul Woodrow, Director of Operations**				
History:	**Presented to the Executive Leadership Team on 20 September 2017**				
Status:	☒	**Assurance**	☒	**Discussion**	
	☐	**Decision**	☒	**Information**	

Background / Purpose:

At its meeting on 1 August 2017, the Board requested an update on learning from recent major incidents be submitted for consideration at its meeting on 3 October 2017. In response to that request, this paper provides a high level briefing on the lessons learned from the four major incidents which occurred between November 2016 and June 2017 and contains the following information:

- A background summary;
- How the London Ambulance Service NHS Trust learns lessons from major incidents;
- Incident timescales and data;
- The key learnings; and
- The next steps.

Please note that, due to the timing of its submission, this paper does not include information and learning from the Parsons Green incident on 15 September 2017.

Recommendation:

The Board is asked to note the information provided within this paper.

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

This paper provides evidence that the Trust is a learning organisation. The content demonstrates that we continue to strengthen our resilience through ensuring that we respond appropriately and effectively to all major incidents.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒

Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

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

LESSONS LEARNED FROM MAJOR INCIDENTS

1.0 Background

1.1 The category one status of Ambulance Trusts under the Civil Contingencies Act 2004, and its secondary provisions including the Cabinet Office emergency response and recovery doctrine, create clear legal obligations for Ambulance Trusts to identify and learn lessons from major incidents at a national and local level.

1.2 NHS England's emergency preparedness, resilience and response (EPRR) core framework standards (which form part of the Trust's commitments under the standard ambulance contract) also require NHS funded organisations to identify and learn lessons. In addition to this, the Trust is required to share learning identified through incident response or incident exercising across the wider NHS through a common process co-ordinated through the Local Health Resilience Partnership (LHRP).

1.3 Over the last ten months, the Trust has responded to the following major incidents:

- November 2016 - Croydon tram crash
- March 2017 – Westminster Bridge terrorist attack
- June 2017 – London Bridge terrorist attack
- June 2017 – Grenfell Tower fire

1.4 Following these incidents, comprehensive reviews have been undertaken to identify areas of good practice, areas for improvement and to evaluate the Trust's capability to respond to the changing methodology of terrorist attacks.

2.0 Learning Lessons

2.1 1The Trust's *EPRR Lessons Identified and Lessons Learned Framework* identifies the methods which are used to identify and capture learning, and how this learning is shared, following a major incident or other incidents of note. This process is based on national best practice.

2.2 The purpose of the *EPRR Lessons Identified and Lessons Learned Framework* is to:

- Provide a process whereby the EPRR department and wider service can learn effectively from incidents, events and exercises in order to validate plans, policies and procedures and improve incident management
- Ensure the lessons identified are meaningful and disseminated to the appropriate groups both within the Trust and to external agencies
- Ensure the identified lessons are acted upon at the most appropriate level in the organisation and escalated where necessary

- Ensure lessons are fully embedded into operational practice.

2.3 The Trust is required to participate in the national Joint Organisational Learning (JOL) process with other ambulance services and external partner agencies following the identification of learning. This specific database has been created by the national Joint Emergency Services Interoperability Programme (JESIP) team which is hosted on *ResilienceDirect*. This is a secure system which is essentially a collection point for the lessons learned nationally by all emergency services. Access to the JOL is limited to an identified Single Point of Contact (SPOC) from every emergency service and Local Resilience Forum.

2.4 The lessons which the Trust has identified from the major incidents noted in 1.0.3 have been sourced in a number of ways including from:

- **Log Books** – operational commanders complete an LA434 (incident log) which includes an impact assessment tool, scene reports, role allocation, briefing information, a decision making tool, vehicle movements, casualty tracking and a debrief tool. These log books are returned to EPRR for review and to capture lessons.

- **The National Ambulance Resilience Unit (NARU) Commander Assessment Tool** – this is used as a monitoring tool either during exercises by umpires/facilitators or on scene at an incident and is collated by EPRR.

- **Hot Debriefs** – these are used to capture instant reactions from the incident/event and to learn from the experiences gained. All Emergency Planning Resilience Officers (EPROs) receiving formal training in the delivery and capturing of information from debriefs. This technique is trained through the operational and tactical commander courses.

- **Cold Debriefs (Single/Multi-agency/Structured)** – these are conducted after the event and are often facilitated by a member of the EPRR team who was not directly involved in the incident/exercise.

- **Internal / External Reports and Recommendations** – formal notification of lessons may be received via the Trust wide reporting mechanisms such as Datix, through associated governance groups or from written exercise/incident reports.

- **External agencies** may also share lessons through national reporting systems such as the JOL, coroners' directives or locally through resilience partnerships and the national EPRR networks.

3.0 Major Incident Response - Timescales and Data

Incident	Incident Outline	Date	Time of 1st Call	No. of Calls Received	Time Major Incident Declared	Time 1st LAS Response On Scene	No. LAS Staff On Scene	No. LAS Vehicles On Scene	No. EOC Staff to SOC	No. Casualties Conveyed	No. Deceased Patients
Croydon Tram Crash	Tram derailment	09/11/2016	06:12 hrs	16	06:34 hrs	06:25 hrs	84	49	10	56	7
Westminster Bridge Attack	A vehicle driven at speed colliding with a number of pedestrians. An assailant exited the car and proceeded to attack police officers with bladed weapons.	22/03/2017	14:40 hrs	65	14:51 hrs	14:45 hrs	97	63	15	23	6 (+1 assailant)
London Bridge Attack	A vehicle driven at speed colliding with a number of pedestrians. Assailants exited the van and proceeded to attack members of the public with bladed weapons.	03/06/2017	22:09 hrs	134	22:19 hrs	22:13 hrs	98	66	14	45	11 (+3 assailants)
Grenfell Fire*	Fire engulfed a multi storey building.	14/06/2017	01:29 hrs	41	02:26 hrs	01:45 hrs	126 (pre 05:30)	74	12	64	Potentially 80

4.0 Key Learning

4.1 Being Repeatedly Tested

4.1.1 The number, cause and scale of the major incidents experienced over the last ten months has placed unprecedented pressure on the personal resilience of the Trust's managers and frontline staff and on Trust-wide administrative systems.

4.1.2 Due to the frequency of these incidents, and the recurring exposure of many staff to such difficult and tragic incidents, the Trust sought and received external trauma risk assessment (TRiM) support from South Central Ambulance Service, Defence Medical Services and South London and Maudsley NHS Foundation Trust to ensure that timely support was provided to affected staff. Approximately 1,000 assessments have been undertaken this year.

4.1.3 The long term impact on staff from exposure to incidents such as Grenfell cannot be quantified within this paper however it must be recognised that the long term monitoring of the welfare of staff exposed to these incidents needs to be considered and reviewed over the next six months.

4.1.4 The national model of incident response means that, in areas of high activity such as London, staff who are trained in certain specialities (such as the Hazardous Area Response Team) will possibly be repeatedly exposed to incidents which will have a significant psychological impact. The suitability of this incident response model will be reviewed by NARU who did address this matter at their national learning event which was held on Tuesday 12 September 2017.

4.1.5 The coronial and criminal investigative activity which has resulted from the terrorist related incidents, and which is anticipated for the Grenfell fire investigative and enquiry process, has or will result in significant numbers of requests for documentation, audio recordings, transcripts and interviews with Trust staff. Although not a direct recommendation from an incident debriefing process, should the frequency and severity of such incidents continue then consideration will need to be given to the capacity of the current organisational structure to deal with this level of activity. A standalone unit may need to be developed to manage such post event activity.

4.2 Operational Learning

4.2.1 The majority of the issues identified from the staff debrief sessions relate to some inconsistencies in the application of current operational policies during major incidents because of the historic infrequency of incidents and the limited exposure that frontline staff have had to such incidents. The recommendations from these debrief sessions have been reviewed and appropriate training packages are being developed to address the issues identified. Appropriate refresher training sessions will be scheduled to ensure that learning is maintained. The full and detailed reports which have been published following each of the debrief sessions are available to any executive or non-executive director on request.

4.2.2 The method of attack which was used during the two terrorist attacks at Westminster Bridge and London Bridge resulted in the Trust being initially informed of road traffic collisions as opposed to potential acts of terror. The new challenge for the Trust is therefore that terror attacks may not be immediately recognised. This is understood by NARU who, following their national learning event on 12 September 2017, will review and, if necessary, refresh the national joint operational procedures for terror related incidents involving hostile vehicle attacks. In the meantime, the Trust has recognised (through learning applied at London Bridge and Parsons Green) that by rapidly de-activating the auto-dispatch of vehicles during major incidents, we are able to keep our staff safe by sending them to designated rendezvous points and can maintain communication with them during incidents.

4.2.3 The national police guidance to 'run, hide, tell' was used at London Bridge however this made the tracking of some casualties more complex. Triage categories can also change depending on the time spent on scene and/or on arrival at hospital. Due to the speed and dynamic nature of incidents like London Bridge, hospitals may receive casualties prior to any declaration from the Trust. Given these difficult circumstances, workshops have been hosted by NHS England (London), and attended by the Trust and other London hospitals, to review and standardise the incident notification processes during a major incident.

4.2.4 The number of available incident-trained managers within the central London area was identified at a number of debriefs as the cause of some operational difficulties which were experienced during either (1) the response phase to either support these incidents or (2) to maintain support to normal operational service delivery during the incident. This matter has been immediately addressed through the introduction of a temporarily seconded Incident Response Officer (IRO) team which is now situated in a central London location. This has increased the number of IROs available across the 24 hour period for both incident management purposes and is also being used to support service delivery during the peak winter period.

4.2.5 The use of hand portable radios has been consistently identified as an issue during the debrief sessions due to the difficulty of staff being able to hear transmissions in the major incident environment. The major incident control method of open broadcasting also means that confidential and sensitive patient information could be broadcast and heard by members of the public. In order to address this concern, radio earpieces for all staff are being costed and considered. Initial costings confirm that funding of £35,000 would be required to personally issue these earpieces to all staff. It is currently unclear as to what the recurring annual costs would be however further detailed work is being undertaken and a gating template is being developed by the Deputy Director of Operations (Central Operations) for consideration by the Executive Leadership Team (ELT) next month.

4.2.6 The number of major incidents (and the subsequent high levels of activity required to support debriefing; the identification/follow through of learning; report writing; and policy reviews) has put pressure on the EPRR department's current capacity levels. Options for increasing capacity within EPRR are currently being assessed and costed by the Deputy Director of Operations (Central Operations).

4.3 Joint Working with Emergency Services

4.3.1 It is clear from the succession of major incidents over the last ten months that the strength of our joint working with the other London emergency services has helped to improve our response to major incidents. This has been evident through:

- Tri-service telephone calls with ambulance, police and fire services to rapidly understand what is happening during an incident. Phone lines were often kept open for longer periods to ensure strong co-ordination
- Formal control points have been in place at incident scenes for specialist commanders across ambulance, police and fire services to co-locate and work together
- Using the JESIP principles and the joint decision model.

5.0 Next Steps

5.0.1 An overarching action plan is currently being developed which will capture the issues presented within this paper as well as the further operational issues which have been captured in the individual debrief reports.

5.0.2 This action plan will be presented to the Emergency Preparedness and Response Strategy Group at their October 2017 meeting. The plan will then be ratified at the Operations Board in November 2017 where progress will be tracked on a quarterly basis.

5.0.3 The ELT will receive a further progress report in six months' time.

Paul Woodrow
Director of Operations

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Strategy Development Update**			
Report Author(s):	**Angela Flaherty, Director of Strategy (Acting) and Adam Levy, Business Manager**			
Presented by:	**Angela Flaherty, Director of Strategy (Acting)**			
History:	**None**			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

The London Ambulance Service NHS Trust (LAS) commissioned McKinsey and Co. to assist its development of a new medium term, 3-5 year strategy. Over the course of that commission, the McKinsey team met with LAS subject matter experts, interviewed several external stakeholders and facilitated a number of workshops with the Executive Leadership Team (ELT) and the Trust Board.

The purpose of this paper is to seek approval from Trust Board on the proposed approach and timeline to finalise the new LAS medium term strategy. This timeline includes robust engagement with staff, patients and stakeholders.

Recommendation:

The Board is asked to:

1. approve the engagement approach outlined in this paper; and
2. approve the timeline for delivery outlined in this paper.

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

A refreshed strategy might not align with the needs of our stakeholders, hence the engagement proposals set out in the paper

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒

Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

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

LAS Strategy Development Update

Trust Board Report

Tuesday 3rd October 2017

1. Purpose

1.1 The purpose of this paper is to seek approval from Trust Board on the proposed approach and timeline to finalise the new LAS medium term strategy. This timeline includes robust engagement with staff, patients and stakeholders.

2. Background

2.1 The London Ambulance Service commissioned McKinsey and Co. to assist the development of a new medium term, 3-5 year strategy. Over the course of that commission, the McKinsey team met with LAS subject matter experts, interviewed several external stakeholders and facilitated a number of workshops with ELT and Trust Board.

2.2 Based on the outcome of these interactions, McKinsey produced three key documents; McKinsey Summary of Strategy Documents, Case for Change and LAS Strategy Summary.

3. Continuing the Strategy Development Process

3.1 Whilst a significant amount of work has gone into developing these documents there are elements of best practice strategy development that have not yet taken place. This best practice is found from two main sources the Strategy Development Toolkit (formally the Monitor toolkit) and the CQC "well-led" KLOE (key lines of enquiry) guidance.

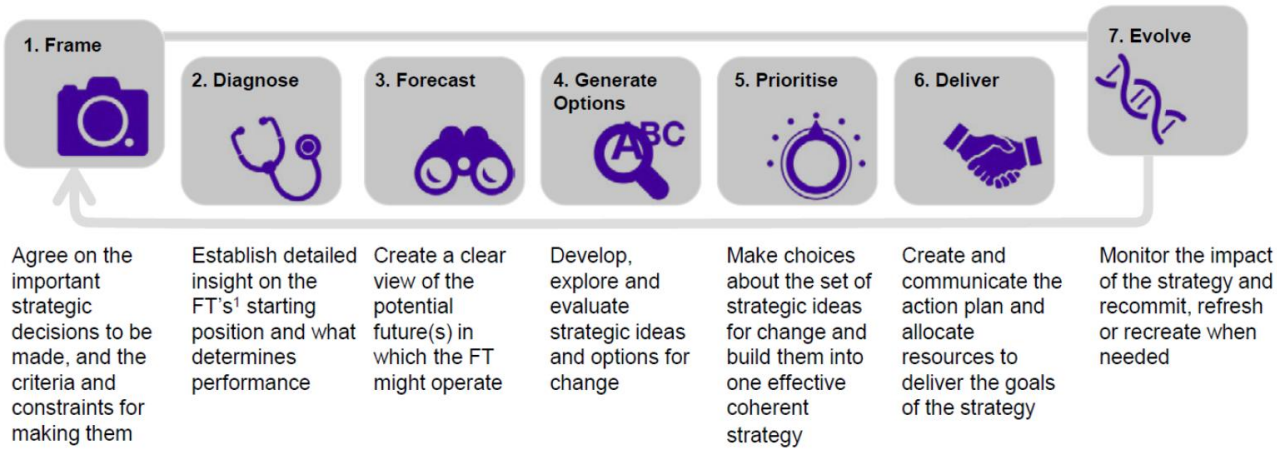
3.2 The Strategy development toolkit, developed by Monitor and now adopted by NHSI, identifies the steps that should be taken in order to produce a robust, well developed and well understood strategy.

3.3 The strategy toolkit explains that "a recent study identified the differences between successful and failing strategies across all business sectors. Successful strategies are built on common principles and broken down into stages. This applies to successful strategy formulation in Trusts, and we [Monitor] have developed a seven-stage strategy development framework that is the basis for the toolkit."

3.4 The document goes on to say that the toolkit has been "developed to support acute, community, mental health and ambulance trusts" and that strategies should "set out how they intend to meet the challenges of delivering quality care for their patients and adopting new clinically effective treatments and technologies while remaining financially sustainable"

3.5 The seven strategy development stages are:

Figure 1: NHSI Strategy Development Toolkit Summary



3.6 We have conducted a high level gap analysis against the seven stages above (five of which are relevant for the strategy development stage we are currently in) against the work that has been carried out to date. The extensive work carried out by McKinsey, in particular with Trust Board and the Executive Leadership Team has achieved a large number of the outcomes identified in the toolkit. However, there are some elements that could be more rigorously covered, in particular engagement with key groups:

- Staff
- Patients and the Public
- Stakeholders (this has been done to an extent already but could be broadened to involve; engagement with a wider audience).

3.7 We have also reviewed the new CQC KLOEs to identify how the CQC expect strategies to be developed. One of the questions that the KLOEs ask and will form part of any future inspection is: "have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?"

3.8 Based on the best practice guidance and the CQC expectations, following discussions with the Chair, Chief Executive and one of the Non-Executive Directors, we propose that we now engage in a more robust period of engagement on our strategy development.

3.9 The outcome of the strategy development process will be a detailed strategy for the London Ambulance Service, outlining how our triage, clinical response, workforce and infrastructure will align to provide the right care at the right time for our population. The strategy will be a holistic approach, including capital plans associated with the delivery plan to ensure that it is both a high level strategic vision and also a technical document that will outline specifically how we will achieve that vision.

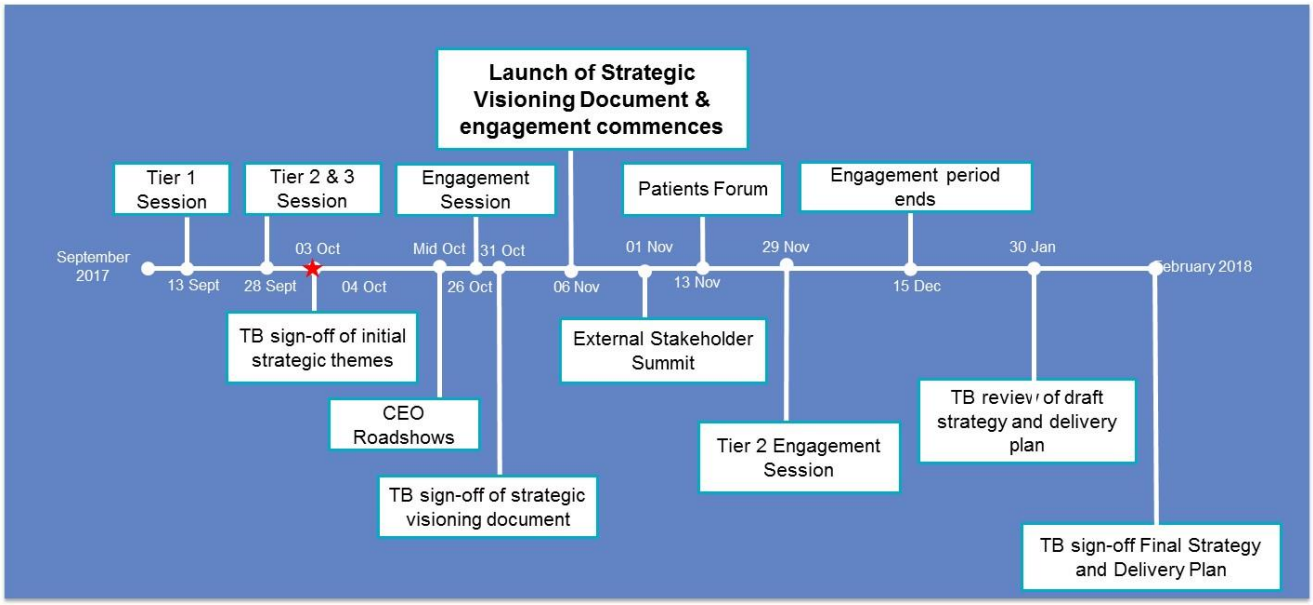
3.10 As part of this approach we are also developing a Reference Case. This reference case, developed by our Forecasting and Planning team, will enable us to create long-term forecasts and compare the impact of demographic changes, various external healthcare initiatives and internal projects. The key benefits of having such a tool are:

- Internal benchmarking, standardisation and strategic horizon-scanning
- Contextualising predictions in terms of short-term vs. long-term forecasts (creating more accurate annual forecasts which can be easily reconciled to short term forecasts);
- Integrated risk and opportunity management (allowing better preparedness throughout the year of what to expect and plan for, including initiatives such as Demand Management).

This reference case is primarily being used in the first three stages of the strategy development: framing; diagnosing; and forecasting.

4. Overview of Strategy Development Key Milestones

Figure 2: high level overview of key milestones



4.1 The diagram above details the key milestones of the strategy development, including the core engagement sessions and the key stages at which Trust Board review and sign off will be requested. Further to the elements included in the diagram above, we will also be engaging with patients, through the Patients Forum, as well as working with LAS subject matter experts. We will also be arranging a number of one to one meetings with external stakeholders. Below is a brief description of some of these elements:

4.2 Staff Engagement: Tiered approach

4.2.1 In order to better engage with a broader range of our staff, we have now developed three tiers of staff engagement.

- Leadership Team – Directors, Deputy Directors, Assistant Directors and Heads of Service
- Senior Management – Middle Management, roughly Bands 8a – 8c (where not included in Tier 1)
- Management Group – Lower Management, including Group Station Managers, Clinical Team Leaders and all other band 6 or 7 managers

4.2.2 We will use these engagement sessions to develop and test the content of the strategy and to inform a broad range of staff about its content. By engaging in depth with staff across the breath of the organisation we will be able to achieve the necessary buy in to implement our ambition for implementation.

4.3 Staff Engagement: CEO Roadshows

4.3.1 Last year the roadshows engaged with roughly 1000 of our staff and will therefore be a crucial mechanism to engage a large number of staff this year with the development of the strategy. The roadshows will provide an opportunity for the CEO to outline his strategic

vision to our staff and we will design a 'quick-fire' interactive session to allow staff to provide feedback.

4.4 Staff Engagement: Thematic Engagement

4.4.1 In order to ensure our staff understand the need for change and what it means for them we are proposing a series of thematic engagement sessions for staff to participate in during the six week formal engagement period. This will allow staff to contribute ideas, shape how we deliver our proposed strategic themes and ultimately begin to take ownership of the Trusts Strategy.

4.5 Patient and Public Engagement

4.5.1 Patient and Public participation in the design of our strategy is critical to ensure we deliver a service that is responsive to patients needs. Working with our Patient & Public Involvement Team and Patients Forum we aim to design a Patient and Public Participation Event to share our emerging vision, discuss options for development and seek feedback. Importantly this session will focus on understanding the needs, hopes and wishes of our patients and the public.

4.6 External Stakeholder Engagement

4.6.1 The Strategy Toolkit identifies that we "may wish to involve them [external stakeholders] throughout to understand their priorities, validate your diagnosis and forecasts, and test the feasibility and likely impact of strategic initiatives. External stakeholders can help assess the coherence of your proposed strategy"

4.6.2 As part of this period of robust engagement we will be engaging with a variety of external stakeholders, either through one to one interviews or through the stakeholder summit. It is imperative that our strategy is aligned with the strategic intent of the five Sustainability & Transformation Partnerships (STP), the NHS system and the Emergency Services Sector. We have identified the following organisations as the key external stakeholders that we will look to engage with over the coming months:

- NHS Improvement
- NHS England
- Clinical Commissioning Groups
- Five London STPs
- Care Quality Commission
- Department of Health
- London Fire Brigade
- Police (Metropolitan Police, City of London Police & London Transport Police)
- Primary Care Providers
- Greater London Authority
- Mayor of London's Office
- NHS Providers (e.g. Acute & Mental Health)
- 3rd Sector providers
- 111 Providers

- Health Education England.

5. Trust Board Briefings

5.1 Over the course of the strategy development, we will provide formal updates to Trust Board on the following occasions:

Figure 3: Trust Board Deliverables

6. What we aim to achieve

6.1 By engaging in the process as outlined in this paper, we hope to achieve the following outcomes:

- A strategy that reflects the needs, hopes and wishes of our patients and the public
- A strategy that is robustly 'tested' with staff, patients and stakeholders to ensure that it is realistic and takes us in the direction we want to go in
- Staff who have been involved in the development of the strategy are 'bought in' and share a sense of ownership over it
- Fulfilment of the relevant CQC "well-led" KLOEs.

3rd October TB	31st October TB *Public*	28th November TB	12th December TB	30th January TB *Private*	End February TB *Public*
Part 1 – Proposed approach to continued strategy development, outlining: • Best practice guidance • CQC KLOE guidance • Development Plan • Approach to engagement • Key Milestones and deliverables **Part 2** – Emerging Strategic Vision: • McKinsey Report with supporting appendices	Launch of Strategic Visioning Document, including: • Strategic Outline • High level detail on strategic themes/initiatives • Reference Case • Highlights from engagement sessions • Emerging new ideas, issues or blockers • Final Engagement Plan	Through the CEO Report • Highlights from engagement sessions • Emerging new ideas, issues or blockers	Through the CEO Report • Highlights from engagement sessions • Emerging new ideas, issues or blockers	Draft final document and delivery plan	Final Document and delivery plan

7. Refreshing Supporting Organisational Strategies

7.1 The overarching LAS Strategy will be supported by a number of core 'daughter documents.' These daughter documents will be the more detailed strategies that sit beneath the overall strategy and will need to be refreshed or revised based on the overall strategy requirements.

7.2 Each of the daughter documents will require a different scale of refreshing or development. Each one will however require some work to ensure that it aligns with the new overall strategy. The table below outlines the current status of each of the key organisational strategies and the proposed approach to its refresh:

Figure 4: Daughter document proposed refresh approach

Strategy	Current Status	Proposed Refresh Approach
People & Organisational Development	Going to Trust Board for sign off on 3rd October 2017	P&OD strategy will be refreshed if necessary pending the outcome of the final draft of the LAS strategy. Any material changes will be proposed to Trust Board on the 30th January 2018
IM&T	Signed off by Trust Board January 2017	PA Consulting has carried out a refresh of the IM&T Strategy which incorporates the majority of the elements within the McKinsey work. This will continue to be refreshed throughout October, November & December to reflect the emerging strategic vision. Revised IM&T Strategy to be taken to Trust Board on the 30th January 2018
Fleet & Equipment	Signed off by Trust Board in March 2017	Refreshed throughout October, November & December to reflect the emerging strategic vision. Revised Fleet & Equipment to be taken to Trust Board in March 2018
Estates	No current Estates Strategy. Workshops have been held to identify estates priorities and options for change	Developed throughout October, November & December to reflect the emerging strategic vision. New Estates Strategy to be taken to Trust Board in April 2018
Clinical	Signed off by Trust Board January 2017	Refreshed throughout October, November & December to reflect the emerging strategic vision. Revised Clinical Strategy to be taken to Trust Board in March 2018

8. Requests for Trust Board

8.1 Trust Board are asked to:

1. Approve the engagement approach outlined in this paper
2. Approve the timeline for delivery outlined in this paper.

Angela Flaherty
Director of Strategy (Acting)

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Review of 17/18 Business Plan**			
Report Author(s):	**Key Leads from Quality, Finance, Workforce, Operations and Governance**			
Presented by:	**Lorraine Bewes, Director of Finance and Performance**			
History:	**Presentation to the Executive Leadership Team in correspondence**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides an update for the Trust Board on progress at the half year with delivery of the Business Plan deliverables that were agreed in May 2017.

Recommendation:

The Board is asked to note this report.

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

This report contains an overview of the progress, and risk to delivery, of the 67 objectives agreed to deliver the Trust's four organisational goals but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒

Reputation	☒
Other	☐

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

London Ambulance Service Business Plan

Six Month Update Report

1. Introduction

1.1 On 25 May 2017, Trust Board signed off the London Ambulance Service Business Plan 2017-19. The business plan was developed through extensive engagement with the Executive Leadership Team and introduced four new organisational goals:

- Patients receive safe, timely & effective care
- Staff are valued, respected & engaged
- Partners are supported to deliver change in London
- Efficiency & sustainability will drive us

1.2 Beneath these four goals, 67 objectives were agreed, all with delivery dates by the end of 2017/18. As part of the Business Plan, it was agreed that a six monthly status update would be presented to Trust Board.

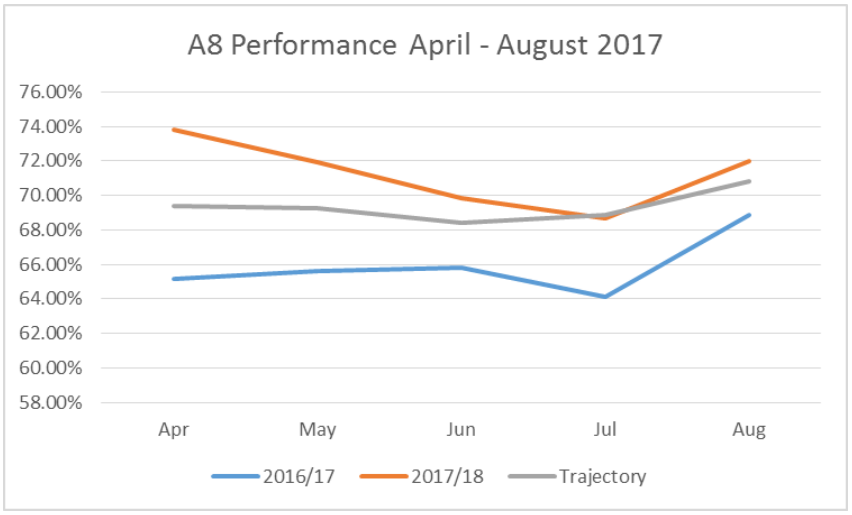
2. Summary of the first half of the year

2.1 Sadly, the start of 2017/18 for London was marred by three terror attacks, and one further major incident which saw the loss of over 80 lives. At this time the UK threat level was raised to 'CRITICAL'; which further placed additional requirements on the Trust. Over 1000 staff from all areas of the Trust were involved in some, or in some cases all, of these incidents. Our staff are to be commended for their professionalism and personal resilience during a very challenging time for the Trust, which also saw the need for enhanced staff welfare provision to be immediately available as Staff came to terms with the extremely challenging situations they were required to respond to. The Service received a large number of messages of thanks from The Royal Family, The Prime Minister, The Mayor of London, faith leaders and members of the public.

2.2 This period[1] has also seen a significant increase in the demand, especially for our most critically ill and injured patients. Compared to the same time last year, we have seen 25% more Red1 incidents and 5.5% more Category A incidents. Despite this significant increase in demand, our performance has exceeded that of last year and is also above our contractually agreed trajectory.

2.3 The chart below shows that 2017/18 performance has remained between 3.1% - 8.7% higher than 2016/17 performance for April – August 2017, with our overall performance being 1.9% above trajectory at 71.21%.

[1] At the time of writing this report only April – August data was available



2.4 The start of 2017/18 has also seen significant changes at leadership levels within the Trust. We have a new CEO as well as a number of new Directors in position. As a result of these changes, some of the strategies that were due for completion in Q1 and Q2 have not been finalised as they are continuing to be developed to reflect the priorities and vision of the new Executive Leadership Team.

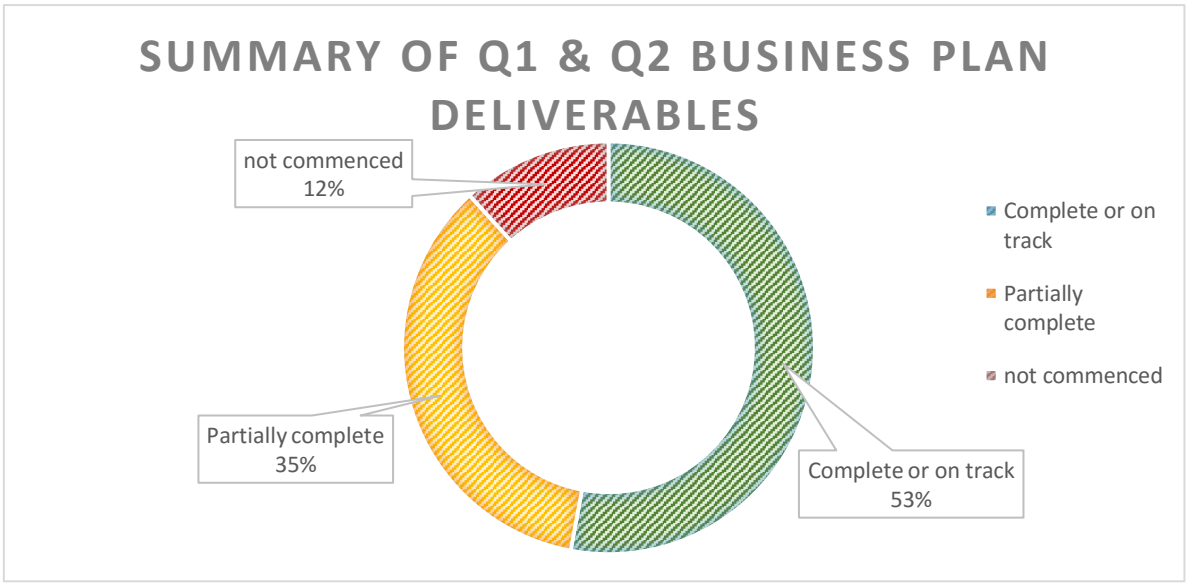
2.5 We also received our CQC report from our February 2017 inspection which rated LAS as 'requires improvement'. Whilst there is clearly further work to do in order to become a Good or Outstanding Trust, the report reflected the significant improvements that have taken place over the past year. Particularly pleasing was the CQC's acknowledgement of the outstanding care that is providing by our staff to their patients on a day to day basis. It was however confirmed that the Trust will not yet be removed from special measures which will be a primary aim of our next CQC inspection cycle.

2.6 A great deal of progress has been made against most of our Q1 & Q2 business plan deliverables, however not all have progressed as quickly as initially intended. The resource requirements of responding to and providing subsequent support relating to the major incidents, has meant that some of the business plan deliverables have become delayed. Mitigating actions are now in place to ensure that all business plan deliverables, apart from those recommended for withdrawal, are brought back on track within the second half of the year.

3. Summary of Deliverables

3.1 There are 17 deliverables that were due for delivery during the first half of 2017/18:

- 53% have been completed (9 deliverables)
- 35% have been partially completed (6 deliverables)
- 12% have not been commenced (2 deliverables)



3.2 Appendix 1 provides the detailed breakdown of progress against each deliverable, key progress made across Q1 & Q2 and any mitigating actions in place for overdue deliverables

4. Requests for Trust Board

4.1 Trust Board is asked to note the Business Plan six month update report

Appendix 1 – Detailed breakdown of progress against each deliverable due for delivery in Q1 & Q2 2017/18

GOAL 1 – PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

Ref	Deliverable	Lead Director	Delivery Date	RAG	Assurance provided by	Key Progress	Mitigating Actions
1.1	We will create a learning framework which involves patients in gaining feedback and service development	Trisha Bain	July 2017		Quality Assurance Committee	• Learning framework developed to align to Sign up to Safety and NHS quality frameworks, working with staff and Good Governance Institute	• Quality Improvement and Learning Strategy and associated plans to be presented to Trust Board in October • Mitigation has been through forums for assurance within clinical governance structure – QOG and QAC via key issue and progress reports, agendas
1.2	We will strengthen our clinical governance processes, supported by a restructured Quality Assurance Directorate	Trisha Bain	June 2017		Quality Assurance Committee	• Clinical governance structures agreed at Board in May – now implemented and evidence of minutes, key progress reports being used and escalations to QAC • Quality and Assurance directorate consultation ended August 2017 – recruitment to teams now taking place. Agreed business partner model for all functions in directorates	
1.7	Learning from feedback will be routinely incorporated into all education programmes	Fenella Wrigley	June 2017		Clinical Effectiveness & Standards Group	• Introduction of the Learning from Experience team	

						• Core Skill Refresher programme has been revised and is now case based, using real cases for teaching • Introduction of a quarterly learning from incidents magazine (*Insight*) • Patient Experience Department reporting to Quality Assurance Committee • Mortality and Morbidly Group being set up from October 2017 • Crews receive feedback directly from the medical director if they raise and incident which is considered at the serious incident group (but not declared) and on trauma cases where aspects of patient care require reflection	
1.15	We will introduce new annual leave arrangements to better match patient needs and demand across the year	Patricia Grealish	July 2017		People & Organisational Development Committee	• Delayed due to operational pressures.	Consultation to begin during September 2017 with a view to achieve a new policy to commence 1 April 2018

GOAL 2 - STAFF ARE VALUED, RESPECTED & ENGAGED

Ref	Deliverable	Lead Director	Delivery Date	RAG	Assurance provided by	Key Progress	Mitigating Actions
2.1	We will agree our new multidisciplinary skill mix model, supported by annual recruitment plans to deliver the changes required	Fenella Wrigley	September 2017		Workforce committee	• Implementation of nationally agreed pay band increase for paramedics with simultaneous introduction of a structured Newly Qualified Paramedic learning programme • ARP and integrated care model (through STPs) are both significant changes for the delivery of care by ambulance services – LAS is actively involved in preparing for implementation of both. • Expansion of MH nurses to provide parity of care for mental health patients • Agreed to roll out of APP Urgent Care – to provide care closer to home and avoid attendance at ED • Increased the consultant midwife hours to provide greater support in maternity cases and lead on related aspects of safer care. • Supporting an urgent care car from London Air Ambulance	To note that the roll out of the Ambulance Response Programme will require further significant changes to the ambulance care model and workforce skill mix which are being modelled.
2.3	We will implement new rest break and end of shift arrangements to support frontline staff	Paul Woodrow	July 2017		CEO performance review meeting	**Rest breaks** • Lengthy discussions with the Trade Unions took place during spring 2017 to try and seek agreement over the new rest break policy. However progress stalled over the summer due to the impact of the major incidents and the rise of the threat level to 'critical'	**Rest breaks** LAS has continued to focus on improving compliance with the existing rest break agreement. The impact to date is as follows: • Rest break allocation has improved from 8% in

						• Negotiations concluded in August when the Trade Unions made it clear that they could not recommend the policy to staff and would register a formal industrial relations dispute if it was imposed • The decision was taken to pause negotiations in order for the Trust to review its position. End of Shift • A successful end of shift trial was undertaken in South West London between 22 February and 4 May 2017. This gave staff who were operating three fast response units (FRUs) a 45 minute window of protected time at the end of their shift (during which the FRU was only available for critical cover) • Rest break allocation across the duration of the trial was high at 95%. Positive feedback was received from operational and EOC staff who participated in the trial while increased efficiencies have been observed at shift handover • An evaluation paper is being finalised for ELT consideration, which recommends that the full roll-out goes live in the South West sector in October 2017 • As a result of the trial's success, the FRU end of shift protection arrangements have been incorporated into the North Central	January to 38% being reported in the week commencing 4 September 2017 • Increased rest breaks has had a direct impact on the Category A 8 minute response standard particularly in the 05:00 – 06:00 and 17:00 – 18:00 hours (the handover period) • Trust Board has sustained its sight on rest breaks through the Quality Report which is provided to the Trust Board and the Quality Assurance Committee. This report has provided assurance to the Trust Board that there have been no serious incidents generated since February which occurred during the handover period. The Trust Board is also sighted on rest breaks through the Board Assurance Framework (BAF). • KPIs for rest breaks are captured in a new comprehensive dashboard which is reviewed at the

						dispatch model trial which went live on 17 August 2017. • Early signs from North Central are encouraging as the sector achieved 75.06% performance during the first week of the trial. A full and comprehensive analysis of the trial will be undertaken by November 2017.	CEO Performance Review meetings
2.4	By July 2017 we will introduce a new Occupational Health Service to support staff to keep staff healthy	Patricia Grealish	July 2017		People & Organisational Development Committee	• Completed and review of performance under the new arrangements now in place	
2.7	We will define our desired culture, introducing a behaviours framework and annual corporate management actions to set expectations and improve consistency	Patricia Grealish	September 2017		People & Organisational Development Committee	• Initial engagement has evolved a draft framework which was shared with ELT on 23 August 2017 • Further engagement work was carried out on 13 September with at the 'tier 1' staff engagement session	
2.10	We will further improve the quality of appraisals to ensure all staff support delivery of corporate objectives	Patricia Grealish	July 2017		People & Organisational Development Committee	• Focus on appraisals remains for completion and will form part of Performance Reviews with CEX going forward	• PDR appraisal skills training sessions to be launched from Nov 17 as part of the Management Essentials toolkit programme on the Leadership Development Pathway
2.13	We will put in place a clear Leadership Development Pathway across the Trust	Patricia Grealish	September 2017		People & Organisational Development Committee	• This forms part of the Part of the People & OD Strategy which will presented at Trust Board on 3 October 2017	
2.17	We will strengthen our Corporate & Operational Management	Patricia Grealish	September 2017		People & Organisational	• The Quality Directorate restructure consultation has been concluded and posts are currently being recruited to	Operational restructure revised timetable being finalised

	structures to improve support and accountability				Development Committee	• The Operational restructure revised timetable is now being finalised • Planning for the P&OD restructure is now underway	

GOAL 3 - PARTNERS ARE SUPPORTED TO DELIVER CHANGE IN LONDON

Ref	Deliverable	Lead Director	Delivery Date	RAG	Assurance provided by	Key Progress	Mitigating Actions

3.12	We will produce a Data Quality Framework to ensure that high Quality, accurate data is available and well managed throughout the Trust	Jill Patterson	May 2017		Audit Committee	• The Data Quality Assurance Framework was produced and presented to ELT on 18th May 2017 stating plans for governance, policies, best practices and data quality measures.
						• ELT reviewed the Framework and requested further detail on:
						  ○ RAG ratings
						  ○ Overall Structure
						  ○ Underpinning Finance
						• The revised Data Quality Assurance Framework was updated with the additions above and presented back to the Executive Leadership Team on 12th July 2017 where it was formally approved.
						• On Monday 4th September 2017 the updated Data Quality Assurance Framework was presented to the Audit Committee
						• Recruitment to the approved structure is now underway.	

GOAL 4 - EFFICIENCY AND SUSTAINABILITY WILL DRIVE US

Ref	Deliverable	Lead Director	Delivery Date	RAG	Assurance provided by	Key Progress	Mitigating Actions
4.3	We will design a rolling programme and process to ensure CIPs are identified and delivered for future years	Lorraine Bewes	June 2017		Finance & Investment & Committee	• This deliverable has been delayed due to the recruitment of a new Director of Finance and the priority being on the delivery of the 2017/18 CIPs • A paper outlining the process that will be implemented to identify CIP opportunities on an ongoing basis is going to FIC on 21st September 2017	We are recruiting a dedicated resource to support the CIP Programme. Graeme Dunne will also be focussed on CIP delivery.
4.4	We will agree a transformation methodology and structure to ensure transformation across the Trust	Angela Flaherty	September 2017		CEO performance review meeting	• The transformation of key organisational priorities is being monitored through the CEO performance review meetings • A Chief Exec's PMO office is also being set up to drive and closely monitor progress of these transformation activities	
4.14	We will launch our People & Organisational Development Strategy	Patricia Grealish	September 2017		People & Organisational Development Committee	• On track to present to Trust Board on 3 October	
4.15	We will launch our refreshed five Year Strategy	Angela Flaherty	September 2017		Trust Board	• A significant amount of work was undertaken with McKinsey & Co between May-July 2017. This work has included a number of workshops with ELT and Trust Board, the outcomes of which be presented to Trust Board on 3 October 2017. • The strategic intent, based on this McKinsey work, is being soft-launched with staff during	

						September and will be presented to Trust Board on 3 October • Further work will then be undertaken, engaging with staff, patients and stakeholders with the intention of publishing our final Strategy document in Q4 2017/18. • Trust Board will be asked to participate in a number of engagement sessions and will be kept updated on progress at each Trust Board meeting.	
4.16	We will put in place a programme to secure opportunities that arise from fleet and estates improvements	Lorraine Bewes	September 2017		Finance & Investment Committee	• We continue to look for opportunities to improve our service or generate efficiencies as a result of the changes that are taking place across our fleet and estates programmes of work • A huge amount of work has taken place to improve our fleet through the make ready programme resulting in less –out of service' time • Due to the development of a new Trust strategy, the Fleet & Estates strategies will need to be refreshed to support it accordingly.	We are recruiting a new Director of Assets who will take responsibility for both fleet and estates and will drive forward further improvements and efficiencies

Appendix 2 – deliverables due for delivery in Q3 & Q4

GOAL 1 – PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

Ref	Deliverable	Lead Director	Delivery Date	RAG	Comments (if not on track)
1.3	We will implement an annual plan of Clinical Education updates for all clinical supervisors	Fenella Wrigley	March 2018		
1.4	We will strengthen the patient voice through the delivery of an annual patient engagement work plan	Trisha Bain	March 2018		
1.5	We will ensure we have the right safe staffing levels in place, to fill our rosters to meet demand	Patricia Grealish	March 2018		
1.6	We will undertake and implement a Trust-wide review of rosters to better meet the needs of our patients	Paul Woodrow	March 2018		At the time this business plan was signed off, the intent was to review and implement the rosters against the current operating model. However, implementation of ARP has meant that the scoping work cannot begin until we go live in October 2017. The Trust-wide review of rosters will be completed by March 2018 but a new date for implementation will have to be agreed for 18/19..
1.8	We will deliver improvements in Infection Control and the management of safeguarding issues	Fenella Wrigley	March 2018		
1.9	We will deliver the second phase of medicine management improvement	Fenella Wrigley	March 2018		
1.10	We will support delivery of pan London care pathway redesign for: fallers; patients with mental health needs; urgent care referrals; and End of Life Care	Fenella Wrigley	March 2018		We are supporting delivery through engagement with STPs through demand management plans
1.11	We will improve our care for cardiac arrest, stroke and STEMI patients by reducing on-scene time	Fenella Wrigley	March 2018		

1.12	We will improve our performance for patients with low acuity needs by reducing the waiting time for treatment	Paul Woodrow	March 2018		Improvements have been made this year. However, reporting under ARP has identified that additional DCA cover is required. Current recruitment trajectories will not achieve these hours this financial year
1.13	We will improve our emergency control rooms and despatch processes	Paul Woodrow	March 2018		
1.14	We will deliver agreed CCG performance levels so that we have more consistent performance across London	Paul Woodrow	March 2018		

GOAL 2 - STAFF ARE VALUED, RESPECTED & ENGAGED

Ref	Deliverable	Lead Director	Delivery Date	RAG	Comments (if not on track)
2.2	We will establish a pipeline for our future Workforce, either via the LAS Academy, through University or other pipelines	Patricia Grealish	November 2017		Work is ongoing with partner and other UK universities. Options will also be explored with graduate providers from abroad including Australia. Apprenticeship programmes are being developed.
2.5	We will address the three top causes of sickness: Stress; muscular skeletal injuries and Mental Health	Patricia Grealish	November 2017		
2.6	We will improve staff engagement, creating time and space to listen and act on staff views and feedback	Angie Patton	December 2017		
2.8	We will deliver the actions outlined in our Workplace Race Equality Scheme action plan to improve the experience of BME staff and to make the Trust more representative of London's diversity	Patricia Grealish	March 2018		
2.9	We will complete our phase four actions to tackle bullying and harassment	Patricia Grealish	March 2018		
2.11	We will set new autonomy, accountability & decision making frameworks throughout the management tiers of the Trust	Patricia Grealish	October 2017		
2.12	We will design and implement new Talent Management arrangements to improve retention and succession planning	Patricia Grealish	March 2018		
2.14	We will roll out hand held devices, so that our frontline crews have better information to treat patients and join up care	Ross Fullerton	March 2018		Funding tbc
2.15	We will move to vehicle based equipment and drugs bags so that vehicles are consistently equipped	Lorraine Bewes	October 2017		
2.16	We will introduce a Business Partner model to ensure that Corporate Services are actively engaged and support frontline operations	Lorraine Bewes	October 2017		This deliverable is dependent on the restructures occurring across Corporate Services, particularly within P&OD. The planning is currently underway but will likely only be ready

					for execution in Q4 2017/18 going into 2018/19

GOAL 3 - PARTNERS ARE SUPPORTED TO DELIVER CHANGE IN LONDON

Ref	Deliverable	Lead Director	Delivery Date	RAG	Comments (if not on track)
3.1	We will work with health partners to improve referrals between 111 and 999 services	Fenella Wrigley	March 2018		
3.2	We will work with health partners to improve services to support frequent callers to 999	Trisha Bain	March 2018		
3.3	We will work with health partners to improve support required by Care Homes in London	Trisha Bain	March 2018		
3.4	We will work with health partners to improve referrals from healthcare professionals	Fenella Wrigley	March 2018		
3.5	We will review our conveyance rates & set targets to ensure patients are referred to the most appropriate setting of care	Fenella Wrigley	October 2017		
3.6	We will work with NHS Improvement & NHS England to reduce time lost through hospital handover delays	Fenella Wrigley	March 2018		
3.7	We will retain the South East London 111 contract	Fenella Wrigley	March 2018		
3.8	We will secure an additional 111 service in London	Angela Flaherty	December 2017		
3.9	We will begin to roll out access to special patient notes for crews on scene	Ross Fullerton	March 2018		
3.10	We will transform the way we run our 111 service, improving integration with 999	Paul Woodrow	March 2018		
3.11	We will undertake monthly analysis of patient and health data and use this to support STPs to improve London's health system	Jill Patterson	March 2018		
3.13	We will put in place a revised set of indicators specifically related to quality of care and patient engagement	Jill Patterson	October 2017		
3.14	We will review Value for Money opportunities with partners to define collaboration and procurement priorities for the Trust	Lorraine Bewes	December 2017		

3.15	We will maximise value for money through back office collaboration with NHS partners	Lorraine Bewes	March 2018		This deliverable is highly dependent on other parts of the wider NHS. We have currently not sufficiently engaged with STPs about this and a great deal of further work is required. We will complete the scope of available opportunities by March 2018, but delivery will be from 2018/19 onwards
3.16	We will review control room usage and future opportunities with Blue Light partners	Angela Flaherty	March 2018		
3.17	We will expand the co-responding pilot with blue light partners to reach our sickest patients quicker	Paul Woodrow	March 2018		

GOAL 4 - EFFICIENCY AND SUSTAINABILITY WILL DRIVE US

Ref	Deliverable	Lead Director	Delivery Date	RAG	Comments (if not on track)
4.1	We will achieve all targets in the financial plan	Lorraine Bewes	March 2018		This is on track, assuming that CQUIN and CIP risk mitigated through non recurrent contingencies.
4.2	We will deliver in full all the elements of the CIP programme: - Frontline efficiency: £7.5m - Corporate Pay: £1.4m - Non-pay: £4.1m - Income Generation: £2.0m - Other Opportunities: £2.8m	Lorraine Bewes	March 2018		As above, we will meet our financial targets, however we do not expect to meet our CIP targets and will need to use non recurrent contingencies.
4.5	We will transform how we operate and deliver care - Programme one of the transformation programme	Angela Flaherty	March 2018		
4.6	Programme two of the Transformation Programme will redesign the culture our organisation	Angela Flaherty	March 2018		
4.7	Transformation programme three will transform and simplify our business processes to improve organisational efficiency	Angela Flaherty	March 2018		
4.8	We will build IM&T Operating and Governance models and embed new IM&T management processes and tools to support a resilient organisation	Ross Fullerton	March 2018		
4.9	We will design and implement an IM&T assurance framework to provide assurance on IM&T performance and the resilience of services	Ross Fullerton	March 2018		
4.10	We will deliver our CAD resilience strategy and year 1 actions from the Resilience review focusing of the stability of the CAD environment	Ross Fullerton	March 2018		
4.11	We will deliver a linked programme of new system and enhancement initiatives to deliver digital enablers for the Business Plan	Ross Fullerton	March 2018		
4.12	We will deliver a linked programme of technology refreshes to ensure the Trust has a stable and sustainable technical infrastructure it can rely on	Ross Fullerton	March 2018		
4.13	We will outline our fleet requirements in a new 5 year Fleet Strategy and commence the implementation of our year one actions	Lorraine Bewes	March 2018		We have strategy but will need to do further work based on outcome of new Trust Strategy

4.17	We will define our Estates requirement for the next five years and commence the implementation of our year one actions	Lorraine Bewes	March 2018		Our estates requirements for the next five years will be based largely on our requirements from our new 5 year strategy. The full implications for our estate, based on this new strategy, will be known towards the end of 2017/18.
4.18	We will have piloted an electronic response vehicle to support the Mayor's pledge to clean up London's air	Lorraine Bewes	December 2017		

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	3 October 2017			
Document Title:	People and Organisational Development Strategy 2017-2020			
Report Author(s):	Patricia Grealish, Director of People and Organisational Development			
Presented by:	Patricia Grealish, Director of People and Organisational Development			
History:	LAS Business Plan 2017-18 Presented to the Executive Leadership Team on 20 September 2017 Presented to the People and Organisational Development Committee on 7 September 2017			
Status:	☐	Assurance	☐	Discussion
	☒	Decision	☐	Information

Background / Purpose:

This paper sets out the People and Organisational Development (P&OD) Strategy for the London Ambulance Service NHS Trust (LAS). It is intended to establish a framework and general direction and is informed by a number of different workstreams carried out in the last 12-18 months.

The strategy must remain dynamic and responsive to the changing needs of LAS and should be reviewed regularly (at least annually) to ensure that it captures any strategic developments and that priorities remain relevant and properly weighted in support of the general direction of travel. We are in the process of refreshing our 3-5 year strategy and therefore the P&OD Strategy will be subject to amendments.

In our 2017/18 Business Plan we set our sights on a clear vision to deliver our ultimate goal of making the LAS Great. The Business Plan details four organisational goals. These goals are interdependent and important in their own right but together they will ensure we deliver our vision. The P&OD Team will ensure that all we do is informed by and directly supports these goals. They will ensure we are working for the good of our patients and their families and carers, as well as our own people.

In setting out our P&OD Strategy we have taken into consideration the work and input of other Trusts, of our external partners and of our people through what they have told us directly, in focus groups, in 'tell the chief executive sessions', through engagement with the P&OD Team and through our Staff Survey.

There are a number of 'golden threads' that necessarily run through the separate strands of the People Strategy and these will include:

- **Continuous improvement.** We will demonstrate we are a learning organisation. For our people this will mean not only being technically or clinically competent but also the ability to continuously learn and improve for effectiveness and efficiency
- **Inclusion**. Organisations that are committed to effectively embedding 'difference' demonstrate the ability to deliver better decisions, better performance and better outcomes, in our case for our patients

- **Culture**. We must all commit to the values and behaviours that are required to succeed in a caring environment, ensuring that all that we do focuses on the needs of our patients and their families

In order to deliver the LAS' organisational goals we have developed **SEVEN** distinct and important people and organisational development strategic themes, bringing together the projects, work streams and approaches that we need to deliver on our commitments.

This Strategy is a guide to the direction and pace of change over the next few years as we aspire to achieve excellence in all we do. It is not intended to be, nor should it be, prescriptive or cover every eventuality or new development that may emerge over the coming years.

The key reference for our annual delivery plans will continue to be our Business Plan and Objectives, as well as feedback from external bodies – for example CQC, KPMG. The P&OD Team will organise itself so that it is aligned to the delivery of the Strategy. It will also define and work with a business partner model as other functions will move to do across the Trust.

Recommendation:

The Board is asked to approve the P&OD Strategy.

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

BAF Risk 7, 40 and 43 as stated for July 2017.

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

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

London Ambulance Service
NHS Trust

People and OD Strategy 2017-2020

Investing in our people to care for London

Patricia Grealish

18/09/2017

Contents

1. Foreword 2

2. Introduction 2

3. Background 3

Our Vision 3

Our Mission 3

Our Values 3

4. Who is the London Ambulance Service? 4

5. Implementation 5

6. People and Organisational Development Themes 8

Theme 1. Talent 9

Theme 2. Engagement 11

Theme 3. Healthy Workplace 12

Theme 4. Performance, Development and Growth 14

Theme 5. Leadership and Management 16

Theme 6. Inclusion 18

Theme 7. Rewarding and Recognising Excellence 20

7. How will we know we've been successful ? 22

8. Implementing the P&OD Strategy 23

9. How will we measure and monitor progress ? 24

10. Strategic Direction 2017 – 2019 25

1. Foreword

The London Ambulance Service's ambition is to deliver a world class ambulance service for the people of London. If there is one thing that I am absolutely certain about, it is that we can only realise this vision through our people. It is our people that will make the LAS 'great'; our people that will deliver outstanding care to Londoners and our people that will make LAS a great place to work. How they feel about working for the Trust, how new employees feel about coming to work for us and how engaged we all are in our work, are vital to us to achieving outstanding care for our patients.

I want to make sure we are enabled to do our best at all times, that we feel valued and recognised for going that extra mile and that we are all supported and empowered in the work that we do.

I want us to be a Trust that reflects London's rich and diverse society, creating opportunities for all of our people to develop their careers and achieve their potential. To achieve this we need to recruit and retain talent drawn from all sections of our community, develop our talent management and training capabilities and aspire to be the very best employer we can be in terms of staff health and welfare.

I want us to feel proud to come to work for the Service, recommend it as a place to work and as an organisation that we would recommend as providing great care for our patients. If we achieve this, we will make LAS a truly great organisation.

Chief Executive Officer
Garrett Emmerson

2. Introduction

The London Ambulance Service Trust faces unique challenges and is uniquely placed as the only pan-London Trust. We are rising to our challenges of providing an Urgent and Emergency Care service for Londoners in an environment of ever increasing demand. Our people vision is to make the LAS Great: a great place to work, a great place to gain experience and a great place to grow.

As an organisation our sole aim is to care for the people of London – saving lives, providing care for them and their relatives, and making sure they get the help they need.

We work hard, in sometimes heart-breaking and dangerous circumstances. But the people of London Ambulance Service have been recognised as being caring of those they look after and have shown this time and again.

Our people strategy is simple: 'investing in our people to care for London'. We will do this through the talent and dedication of our people who work together for a common purpose. We strongly believe that diversity and inclusivity in all its forms delivers greater impact in the work we do and enhances the services we deliver to Londoners. We will find new talent to meet our needs into the future and to enhance our culture; develop our people and; strive for effectiveness and efficiency to provide sustainable services within the London Healthcare System.

We are committed to ensuring that every single one of us is equipped to do the job and has equal opportunity to grow and progress.

Director of People and Organisational Development
Patricia Grealish

3. Background

The London Ambulance Service is the busiest ambulance service in the country, responding to over 1.8 million calls a year. We are the only pan-London health provider, providing urgent and emergency services for people in London. Commissioned by 32 CCGs and NHS England for our specialist services, we also provide patient transport, 111, and neonatal transport services. Demand for our services grows year on year. Both national and local issues affect everything we do.

In 2015 we published our 5 year strategy "Caring for the Capital" looking forward to 2020. This work set out our ambitions for the future of London Ambulance Service and for the first time spelt out our Purpose and our Core Values. In our 2017/19 Business Plan we set our sights on a clear vision to deliver our ultimate goal of making the LAS Great.

Our Vision

> To make the LAS great by delivering safe, high quality care that meets the needs of our patients and commissioners, and that makes our staff proud

Our Mission

> The London Ambulance Service is here to care for people in London: saving lives; providing care; and making sure patients get the help they need

Our Values

- **Clinical excellence**: Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.
- **Care**: Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.
- **Commitment**: Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; Learning and growing to deliver continual improvement.

In 2015 LAS was rated as inadequate by the CQC and was put into special measures. In 2017 we have achieved considerable success by moving forward across all the CQC indicators. Whilst we remain currently in 'special measures' there is recognition that considerable progress has been made and we will build on this over the next year.

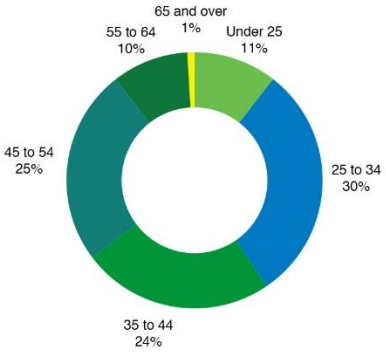
By 2019 we will set ourselves the target of being Good or Outstanding across all areas and as being rated as Outstanding overall.

4. Who is the London Ambulance Service?

Headcount

5,188

Age

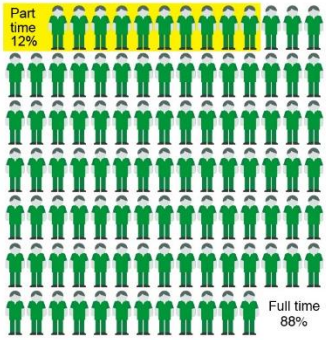


Gender

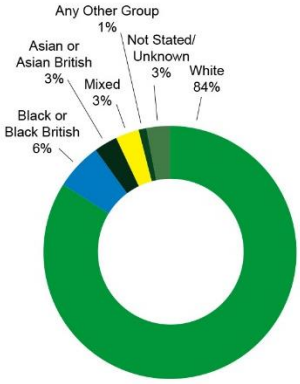
55%

45%

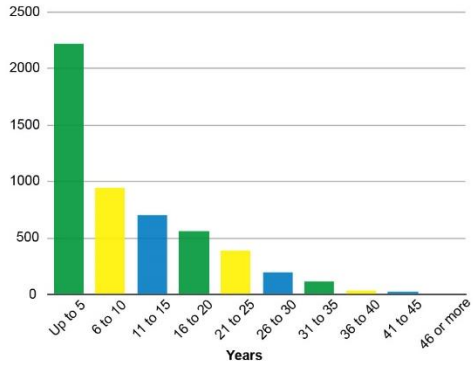
Full time vs Part time



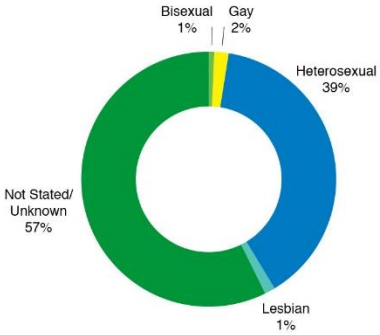
Ethnicity



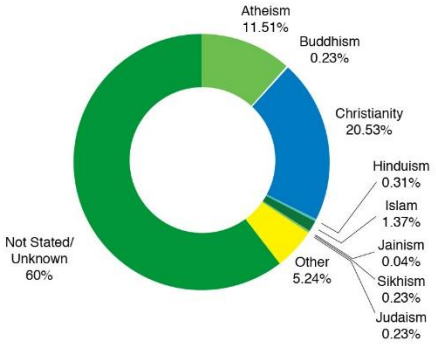
Length of service



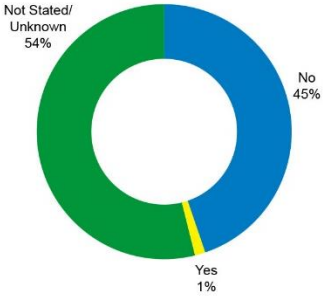
Sexual orientation



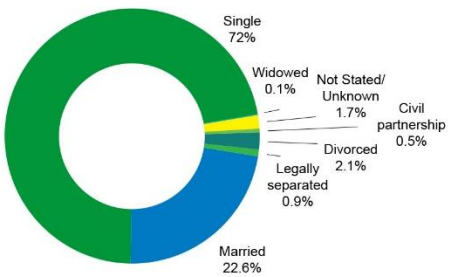
Religious belief



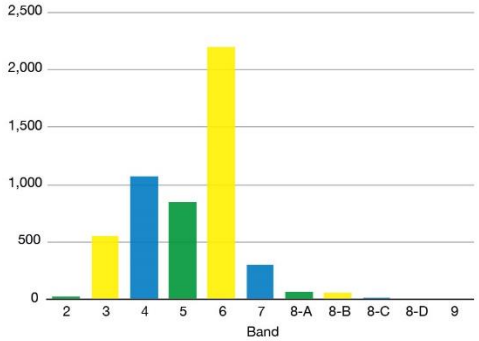
Disability



Marital status



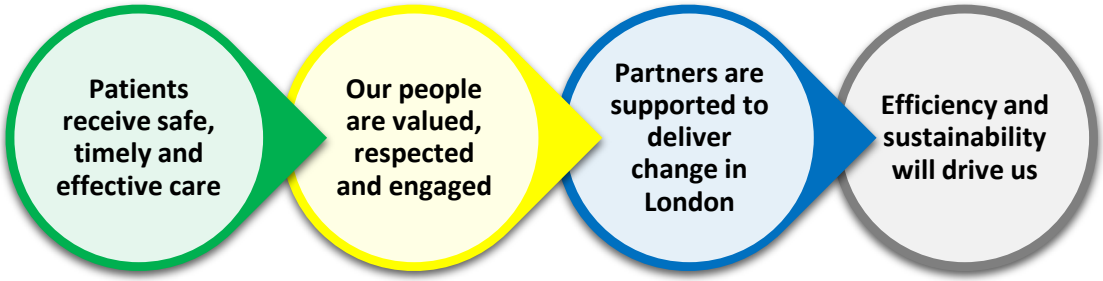
Agenda for Change



5. Implementation

In support of the Trust's Strategy we have developed a Business Plan that sets out clear actions across four organisational goals between now and 2019 – Patients, LAS People, LAS Partners and Organisational Efficiency and Sustainability

Making the London Ambulance Service a great place to work



Our Goals	Patients receive safe, timely and effective care	Our people are valued, respected and engaged	Partners are supported to deliver change in London	Efficiency and sustainability will drive us
Our objectives	To drive high quality and safe patient care	To ensure our workforce model meets future patient needs	To proactively work with London's five STPs to support delivery of the Five Year Forward View	To achieve financial targets and deliver a £17.8m Cost Improvement Programme
	To improve patient outcomes and enhance clinical excellence	To support the health and wellbeing of our people	To expand our reach into the London Integrated Urgent and Emergency Care system	To deliver a transformation programme to continue our improvement journey
	To achieve agreed performance, ambulance and regulatory standards	To develop our culture and improve diversity and inclusivity	To use data and system intelligence to improve patient care	To have stable and reliable IT platforms to enable 21st Century working
		To support and equip our Managers to lead well	To work with partners to improve patient care and value for money	To deliver the LAS Five Year Strategy and strategic plans for essential infrastructure
		To make it easier for our people to do their jobs		

The Trust's Business Plan details four organisational goals. These goals are interdependent and important in their own right but together they will ensure we deliver our Vision. The People & OD Team will ensure that all we do is informed by and directly supports these goals. They will ensure we are working for the good of our patients and their families and carers, as well as our own people.

In setting out our Strategy for People and Organisational Development we have taken into consideration the work and input of other Trusts, of our external partners and of our people through what they have told us directly, in focus groups, in 'tell the Chief Executive sessions', through engagement with the People & OD Team and through our Staff Survey.

Our work will not just focus on the short or medium term, but importantly seek to work with other organisations within the health and education sectors to tackle the future supply of paramedic skills. It will be focused on the development of our culture, of our management groups and on developing the professional behaviours and standards of the paramedic.

With our work on developing our Strategy for the future we know that there is an increasing demand for our services, and that we are supporting the needs of an ageing and ethnically diverse population with increasing numbers of our patients with complex health needs.

We know that we are working towards providing integrated urgent care services so that our people who have typically worked within a specific part of the business may be required to work across the LAS and health system boundaries. We understand that the future will see a decrease in 'dispatching and conveying, and an increasing focus on skills in 'hear and treat' and 'see and treat', extending the scope and practice of our Advanced Paramedics and allied healthcare practitioners. Last, but not least, technology will play an increasing and pivotal part in the work that we do and our people will need to be increasingly technology enabled and literate.

There are a number of 'golden threads' that necessarily run through the separate strands of the People Strategy and these will include:

- **Continuous improvement**. We will demonstrate we are a learning organisation. For our people this will mean not only being technically or clinically competent but also the ability to continuously learn and improve for effectiveness and efficiency
- **Inclusion**. Organisations that are committed to effectively embedding 'difference' demonstrate the ability to deliver better decisions, better performance and better outcomes, in our case for our patients
- **Culture**. We must all commit to the values and behaviours that are required to succeed in a caring environment, ensuring that all that we do focuses on the needs of our patients and their families

In order to deliver the London Ambulance organisational goals we have developed **SEVEN distinct and important people and organisational development strategic themes**, bringing together the projects, work streams and approaches that we need to deliver on our commitments.

The P & OD Strategy works with and supports the other key strategies of the Trust:

- Quality
- Clinical and Clinical Education
- IM&T
- Estates and Facilities
- Fleet
- Patient Experience
- Health and Safety

The following papers and documents have been considered, in addition to those internal strategies set out above:

CQC Report 2015 and February 2017

Deloitte, Well-Lead Governance Review, February 2017

Andrea Adams Review

WRES Report 2016

Bullying and Harassment. Report by Consultant, Cathe Gaskell, February 2017

Chief Executive Objectives

6. People and Organisational Development Themes

Each of the four London Ambulance organisational goals have been linked to a People and Organisational Development theme to ensure that the People & OD team always support the overall direction of LAS in all that we do. In the following pages we explore each of these themes in more detail, giving deliverables and outcomes and an explanation of what we are seeking to achieve.

- **Engagement**. Creating a working environment to inspire people to give their best
- **Healthy Workplace**. Placing health, wellbeing and mental resilience at the heart of our employees' experience of working at the LAS and encourage and inspire people to look after their health and wellbeing

- **Inclusion**. A diverse and inclusive LAS community that supports outstanding performance and celebrates difference
- **Rewarding and Recognising Excellence**. Reward and recognise excellent contribution which reflects the values of the London Ambulance Service and contributes to the accomplishment of our goals

- **Talent**. Known as a great place to work attracting diverse talent from the strongest pools
- **Performance, Development and Growth.** Creating capability for the future by motivating and engaging individuals to take responsibility for their own performance and development and to be resilient through change and challenge

- **Leadership and Management**. Instill confidence and capability in our people, leaders and managers to deliver innovative and creative solutions that enable the ambitions of the London Ambulance Service

Theme 1. Talent

Known as a great place to work attracting diverse talent from the strongest pools

Finding the right people to join London Ambulance Service is fundamental to our success. This means all people - paramedics, 111 and 999 call handlers, corporate officers, clinical and non-clinical specialists and managers – are equally important. We will work on the short and medium term supply needs and, importantly, will also seek to build relationships with health and education bodies to tackle the long term supply challenges for paramedic skills. It is not enough to find people. We also need to make sure we set every single one up for success during their time at LAS. This means we will have clear and effective on-boarding activities that support people finding their way around, doing their job well and ensuring they feel welcome and part of the team. This work has strong links to our focus on inclusion – we will not rest until the diversity of our people reflects the communities we serve.

- Dynamic workforce modelling and planning to support recruitment of our front line specifically but also other groups across LAS functions
- Our search for talent will include all the diverse roles that will be the future of the LAS clinical offering – no longer just paramedics but other health care professionals who will help us achieve our strategic vision: nurses, midwifes, mental health professionals
- We will work with our partners to ensure that we establish and maintain safe staffing levels aligned to the agreed operating model of LAS and changing dynamically to meet changing demands as the strategic vision of LAS is developed
- Clear definition of ‘front line’ to include all colleagues who deliver service to our patients: medical specialists, paramedics, emergency ambulance crew, emergency medical dispatcher, 111 call handler, 999 call handler, NETs, Bank Workers, Volunteers

- Recruitment events and activities that support the LAS Brand and seek to engage London communities in working for or supporting the LAS
- Ambassadors, who are Londoners, who can use their reach to positively connect across communities and cultures
- Talent and succession management planning to support the aspirations of our people and assure the service of the LAS
- Welcoming people to LAS and setting them up for success through thoughtful and thorough induction and on-boarding activities
- Introduce recruitment processes that ensure that we have a responsive end to end experience that supports managers and gives the very best candidate experience
- Maintain our vacancy rate at or below 10%
- Ensure best practice in the management of our temporary bank and volunteers workforce ensuring that they feel a part of the LAS team and that they are trained to the required standards
- We will ensure our leaders demonstrate integrity at all levels, at appointment and throughout their career at LAS. This means a robust and transparent approach to employment and capability checks such as DBS, Fit and Proper Person and Qualification checks
- Introduce a values based recruitment process to ensure that LAS people are recruited not only for their competencies but also for their values and attitude in support of the core values of LAS

Theme 2. Engagement

Creating a working environment to inspire people to give their best

We believe that to succeed we must work hard to listen to and act upon the experiences of our people as they work at LAS. This will mean we will challenge the way we communicate to ensure that we are speaking to all LAS people, keeping them informed of our work, standards and challenges across the organisation. We will engage proactively with our Trade Unions and different employee groups to ensure their views are taken into consideration as we shape the organisation for the future.

- LAS will review best practice in other organisations and roll out a method of engagement which best fits the organisation and patient needs
- Staff Surveys. Draw up action plans linked to what our people say of their experience of working for the LAS to inform what we do as an organisation to empower and engage them in their work
- Establish groups and events that support a 'you said, we did' cycle. Beyond surveys, we will meet face to face with all our people to ensure that everyone knows what we have done in response to their feedback
- Innovation Fair. We will hold an annual 'innovation' competition to celebrate the work of our people as they strive to make us more efficient, fit for the future and an exciting place to work
- Performance Conversations. Introducing 'days' / 'weeks' that are focused on setting objectives for the year ahead and ensuring that PDR appraisals work collectively to focus the whole organisation on achieving the LAS overarching objectives. We will set standards for our managers that demonstrate the importance in their roles of enabling these essential conversations on a regular basis, challenging them to be the role model for others to follow
- Establish a clear communications strategy that supports dynamic conversations with our people using different channels and approaches, recognising the challenge of talking with a dispersed workforce
- Agree and embed the revised partnership arrangements with our TU colleagues, ensuring that we meet regularly and work together to achieve the strategic aims of the LAS
- People Stories – regularly invite and listen to our people on the story of their LAS journey at P&OD Groups and Committees to ensure the voice of our people is reflected in the work that we do to make the LAS Great

Theme 3. Healthy Workplace

Placing wellbeing and mental resilience at the heart of our peoples' experience of working at the LAS and encourage and inspire people to look after their health and wellbeing. The Executive Leadership Team and Board of Directors of the London Ambulance Service are equally committed to ensuring the health, safety & wellbeing of all staff, patients, and members of the public who are affected by the activities of the Trust.

The LAS Strategy sets out the challenges facing the Healthcare system across the UK. These challenges include amongst others an ageing population, increasing instances of obesity, dementia and mental health problems, gaps in wealth and poverty and a growing population that is predicted to reach 10 million in London by 2029. It is in this context that this important work stream will bring focus to the overall health and wellbeing of LAS people – with particular emphasis on mental health. We want to ensure that LAS people have a single point of contact for all their 'wellbeing' needs and that it is available when and in a form that works for them. We will ensure that effective health, safety and wellbeing governance arrangements are implemented, with visible, active leadership from senior managers

- Healthy Workplace Charter. Working with our partners and blue light colleagues we will hold ourselves accountable to delivering support for the health and wellbeing of our people through an externally accredited programme. This will provide a framework of health and wellbeing services that promotes healthy working lives, and helps to reduce accidents and sickness absence and ensures support systems are available for staff following incidents or sickness
- Working with our Wellbeing partners and other colleagues across the NHS, we will look to source an 'App' to support different routes for timely conversations and support in times of challenge and stress

- Health Events. We will introduce events and activities to help our people focus on their health linking them to key health system campaigns to reinforce key themes
- Mental Health. We will develop proactive approaches to support the mental health and wellbeing of our people looking at assessments of roles and environments to identify stressors amongst other initiatives
- Adopting a preventative approach to reducing sickness absence and proactively managing cases of ill health to keep our people at work or facilitate a more timely return to work
- With decreasing skills available in key health roles it is important to look at all aspects of our workforce and consider its potential for contributing to our overall Workforce Planning and Modelling. We will establish lifelong career and development pathways that recognise the contribution that our people can make throughout their career at the LAS and seek ways to retain key experience so that it continues to add value even when full time front line roles are no longer viable
- Ensuring that all staff working for the LAS understand and are accountable for their responsibilities with regards to the health, safety and wellbeing of themselves and others
- Providing a framework that allows our people, especially those in operational roles, to receive the necessary training, skills, and knowledge required to safely and competently perform their role. The framework will also allow our people to maintain their skills and competence within designated refresher training cycle
- With increasing focus on pressures at work and at home we will have established a proactive approach to assessing the stressors affecting our people and will put in place a 'total health' approach to support our people to achieve their potential, feeling enabled to do a good job and working productively
- We will help more of our people stay in work for more of the time, or come back more quickly with the right support
- Working with our Quality and Clinical teams we will champion learning events, such as Schwartz rounds, and other methods of resilience training and development that support continuous improvement in support of better patient outcomes
- We will embed our approach to dealing with conflict at work ensuring that there are clear and transparent means for our people to speak up about their experiences. We will strengthen the use of courageous conversations and mediation as methods of early intervention to resolve issues between our people
- Undertaking regular surveys to assess our peoples' opinion to identify and improve the factors affecting their work

Theme 4. Performance, Development and Growth

Creating capability for the future by motivating and empowering individuals to take responsibility for their own performance and development and to be resilient through change and challenge. The role of our front line managers and supervisors is recognised as being central to the success of LAS and we will ensure we create the best management and development framework to support them and the people of LAS.

We believe that providing the right environment to give the best performance and being able to take opportunities to develop and grow will differentiate LAS into the future. We will develop a learning mind-set which ensures not only that we learn from our mistakes to ensure we deliver good patient outcomes but that every single employee is prepared to learn something new each day. We will continue to develop our performance and appraisal processes so that we have consistency across clinical and non-clinical employees and we will continue to shape our educational offering to support skills development and career progression for people across LAS. As we position the LAS and paramedics for the future we will establish a professional code for our front line paramedic workforce that enables them to take their position as a highly regarded healthcare professional.

- Working with our paramedic and front line teams, establish a 'professional code' that sits alongside and supports our behaviours framework
- Establish clear roles and accountability for supervision, ensuring that clear role descriptions demonstrate clear lines of responsibility and reporting
- Review and refresh the content and delivery of all Statutory and Mandatory training with over 85% delivered online, supported by a robust management information tool to ensure compliance and timely completion
- It is not sufficient to deliver training and development, we must ensure that it provides value and is effective in its aims. We will review all training processes to establish a means to ensure that we capture the effectiveness of training activities and that outcomes have been met
- Introduce an annual review of all training activities to ensure that we are responding to the changing needs of the organisation and that training offered is 'fit for purpose' and accessible to all groups as relevant
- In collaboration with our Medical Director, we will review clinical education delivery to ensure quality and effectiveness
- We will introduce a Learning and Development Framework that has something to offer all LAS people as they seek to develop their career and reach their personal goals. This Framework will cover stages of an individual's career at LAS: I Belong, I Learn, I Develop, I Lead, I Inspire
- PDR Appraisals - building on the work done so far, we will establish a dynamic performance conversation tool to support continuous improvement and growth ensuring that our people have time to talk and focus on both their work outcomes and personal development.
- We will continue to develop our management information capability to ensure timely and accurate information about the people for whom they are responsible
- We will establish and communicate a framework of professional standards to which the people at LAS adhere to enable transparency and assure our patients that we adhere to the highest professional standards

- We will review our standards, policies and procedures in relation to our Duty of Candour, ensuring we implement best practice through our Freedom to Speak Up Policy ensuring transparency and accessibility for all
- Through establishing clear role descriptions and accountabilities we will ensure that LAS people are empowered to take decisions at the appropriate level, ensuring robust governance but giving the ability to 'just do it'

Theme 5. Leadership and Management

Instill confidence and capability in our leaders and managers to deliver innovative and creative solutions that enable the ambitions of the LAS

We believe that ensuring clarity of organisational design with clear accountability for key deliverables and outcomes for LAS will support our aspiration to make the LAS a great place to work. We have been told by our people that a stable leadership team is important to them in their experience of working for LAS. If we are to achieve our ambitions we need excellent leadership. That means our leaders and managers need the courage and confidence to think differently, have the ability to take ownership and are empowered to act and, are open to learning and continuous improvement

- Within our Learning and Development Framework we will relaunch the Coaching programme and establish a Mentoring Programme to support managers at all levels
- We will review best practice and implement a Board Development programme that strengthens our position as a unitary board and enables the executive team to work effectively as a team and provides individual develop and support as required
- We will introduce Management Essentials, a management toolkit that will ensure that our managers are equipped to manage their business and their people
- We will establish a Leaders of Tomorrow programme that offers opportunities for our talented people to take part in challenging and stimulating learning programmes. The Leaders of Tomorrow Programme will be directly supported by our Executive Leadership Team and members of the Trust Board
- We will work with groups and teams across the LAS to establish our behaviours in support of developing our culture for the future and will ensure that these are reflected in our people processes to ensure that all our people are aligned in support of the culture and values of LAS
- Our Learning and Development Framework will include the latest in 360 feedback approaches to support development of our managers and leaders across the organisation
- We will establish a programme of Leadership Visits – to support the delivery of key management projects and provide stretching development opportunities
- We will draw on the talent of our LAS Leader community to address organisational challenges and prepare the Trust for the future. Working with the Strategy team we will ensure opportunities for secondment to key projects as part of the Leaders of Tomorrow and Learning and Development Framework.
- We will develop a clear management model and accountabilities to support a functional business partner approach


Chairman
Heather Lawrence
VIP
Awards 2017

Theme 6. Inclusion

A diverse and inclusive LAS community that drives performance and celebrates difference.

We believe that we must aim to attract, engage and retain the best talent – it is not negotiable. Our commitment to the principles of Diversity and Inclusion will inform all of our work with our people. We will provide particular focus on the Workforce Race Equality Standards which will help us embed inclusivity through LAS to create a truly remarkable place to work. However this is just one aspect of our work. Working closely alongside Engagement, we believe that taking positive action and challenging ourselves as individuals is essential to making an impact and achieving and maintaining progress. We will seek out best practice from other organisations in relation to their work across all protected characteristics and define and implement ways of working for the benefit of LAS

- Embedding a culture of inclusion will require us to develop accurate and timely intelligence about the experience of people from across the diversity spectrum. We will review the practices of other organisation and develop and implement clear reporting that will support our work
- As we articulate the 'behaviours' that will inform the LAS culture we will ensure commitment is given to behaviours which support a collaborative and inclusive way of working. We will hold our leaders and managers accountable for these behaviours
- We will continue to hold ourselves to account for the Workforce Race Equality and Disability Standards through developing action plans with inclusive engagement with our people and will demonstrate progress against all key indicators
- We will establish clear Equality Objectives across all nine protected characteristics which will form part of our continuing work on inclusion
- Groups. We will encourage special interest groups to form and feedback through 'tell the Chief Executive' and other open meetings and forum

- We will actively identify and engage with other influential groups to seek to improve our progress against key benchmarks / criteria
- We will actively engage with our Blue Light colleagues on the Inclusivity work stream of the Collaboration Project
- Patient Forum. We will establish ways of working with the Patient's Forum to ensure the voice of our patients and their families are reflected in the work that we do to make the LAS Great
- We will develop a communication plan that will encourage conversation and shape our understanding of the shifting understanding of inclusion beyond the obvious to meeting individual needs
- We will ensure we have an inclusive environment to work in at LAS putting in place programmes and support networks that focus on tackling bullying and harassment in all its forms and seeking to resolve disputes and differences in a proactive and positive way
- We will review and re-launch our training interventions to ensure that they reflect the values of LAS and are a constant reminder of our expectations and standards
- We will train our managers and leaders to ensure that they understand our approach to inclusion and are able to model diversity and inclusion
- Our LAS Emerging Leaders and 'I Lead' programmes will include modules on unconscious bias and inclusive leadership
- We will seek to work with a Diversity standard for London to share best practice and engage with other employers and communities

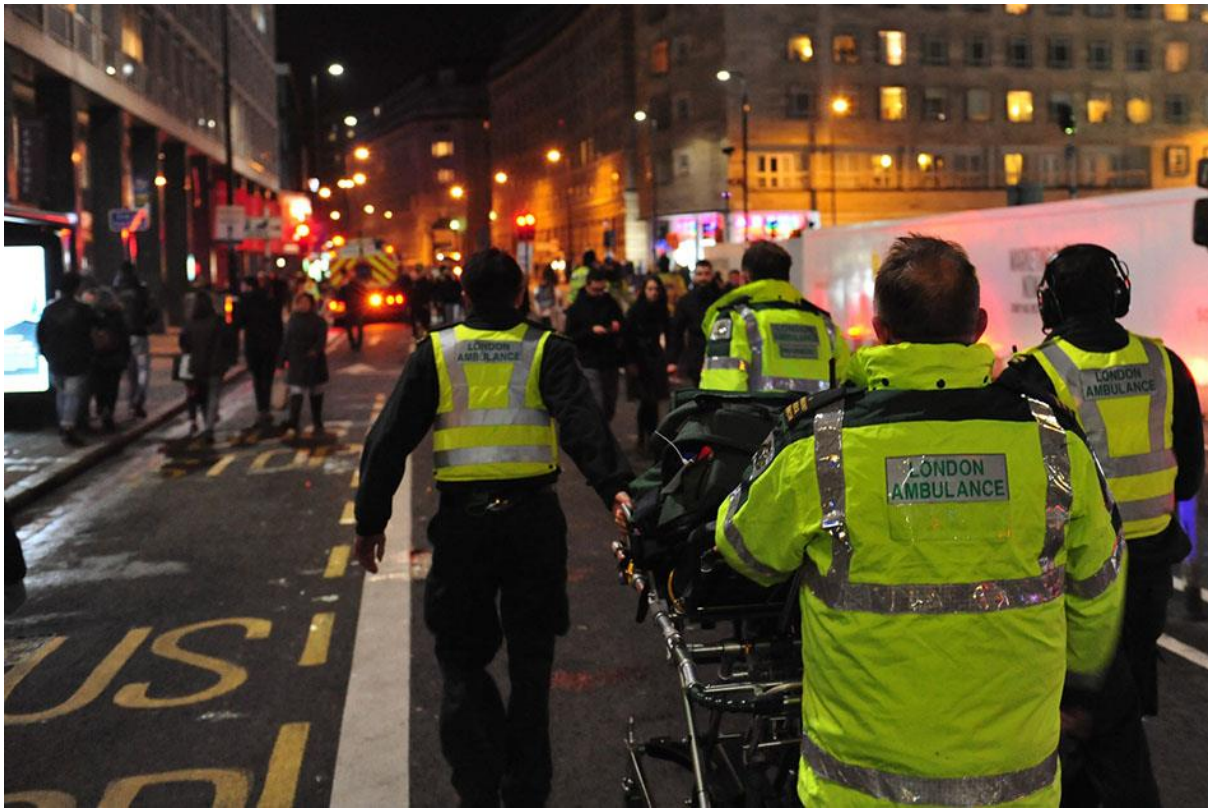
Theme 7. Rewarding and Recognising Excellence

Reward and recognise excellent contribution which reflects the values of the LAS and contributes to the accomplishment of our goals

Reward and recognition for us is not just about pay. It is about having planned recognition schemes that are active throughout the year and are supported by our leaders and managers. We believe our schemes should include peer to peer, instant, long service, and 'thank you' approaches. They should happen on the 'big stage' where appropriate but also more often, simply and immediately so that it recognises and rewards behaviours the mirror the LAS values

- We will seek out best practice in improvement methodologies, such as experience based design (a way of bringing patients and staff together in re-designing services), lean and six sigma
- Review and revitalise the Healthcare 'Total Reward Statement' approach, emphasising the wide range of benefits available working for the NHS and LAS in particular
- Introduce a 'Valour' recognition scheme - Above and beyond – working with other blue light organisations to learn from and introduce best practice
- We will review the VIP Awards scheme and test them against best practice looking at additional ways to recognise and celebrate achievements
- We will review and refresh the Chief Executive's Award programme
- We will introduce a 'thank you' programme that ensures LAS people know that they are appreciated every day for the care that they give and the work that they do
- We will seek to drive success through devolving accountability to managers for reward and recognition decisions within their areas

- We will develop an infographic as part of the Total Reward Statement, to clearly set out the different recognition processes at LAS and make these visible across the organisation – including all recognition schemes and education and learning opportunities
- We will establish a simple 'tool' to make it easy to give praise and recognition for a job well done
- We will review our approach to reward and recognition on an annual basis through pan-organisation focus groups
- We will introduce celebration of academic and development achievement, holding 'graduation' ceremonies to recognise the commitment to learning and professional development
- We will actively encourage our people to apply for external awards to gain recognition for the work that they do and to raise the profile of LAS
- We will actively seek out excellence in practice from other organisations – through buddying arrangements, secondments and visits
- We will seek external review of the work we do for our people to demonstrate our commitment to continuous learning and improvement and to celebrate the work that we do for LAS



7. How will we know we've been successful?

During the last 12 – 18 months, work has already begun to bring about change. In listening to our people, to our external partners and our patients and communities we know that we still have some way to go.

Most importantly, our 2017 CQC report demonstrated that we continue to give outstanding care of which we can be deeply proud.

During the remainder of 2017 and through 2018 people will see more change as we implement ways of working and work on setting out the behaviours that will drive the culture of LAS. We will have finalised the executive leadership team structure to ensure it is focused on our key deliverables and opportunities and we will be working to bring stability in that leadership team. We will have finalised and implemented a number of Directorate restructures so that those teams too are clear on who is accountable for key work strands and that we have clarity for all our people.

This will be done in a clear, open and transparent way that ensures we have the right people and skills in the right places and that our structure supports collaborative working across teams.

By 2017/18 workforce planning and modelling will be widely used and understood, using all of the skills we currently have, identifying and obtaining those we need, so that with good data and analytics we can make good decisions on the interventions needed for a proactive approach to working with and engaging our people.

Our leaders and managers will model our behaviours and be supported into developing into their management and leadership roles through learning and development activities as teams and as individuals. They will take responsibility for effective communication so that all of our people feel and describe being well informed about the work of LAS.

Engagement has improved and will continue to do so and we will seek to involve people in the improvement activities in their particular areas of work and working across teams to ensure that we do not waste any of the rich skills and experience of our people.

We will have clearly defined career paths for different roles within LAS and a well-managed succession planning process that seeks to identify and grow talent as well as ensure that we are resilient and managing for the unforeseen

Lastly and most importantly the people of LAS will feel proud to recommend LAS as a great place to work and as a great place to receive care and our vacancy and sickness rates will be falling.

All these things will have a positive impact on patient care, as we seek to ensure we are seen as a leader in our field and as Outstanding in the care and service we deliver. Other organisations will seek us out and ask us to share our work with them and we will be recognised nationally for best practice.

8. Implementing the P&OD Strategy

This Strategy is a guide to the direction and pace of change over the next few years as we aspire to achieve excellence in all we do. It is not intended to be, nor should it be, prescriptive or cover every eventuality or new development that may emerge over the coming years.

The key reference for our annual delivery plans will continue to be our Business Plan and Chief Executive Objectives, as well as feedback from external bodies – for example CQC, KPMG

The People & OD Team will organise itself so that it is aligned to the delivery of the Strategy. It will also define and work with a business partner model as other functions will move to do across the Trust.

We will have implemented a Business Partner model across our functional support portfolios. This means each directorate will have a dedicated individual through which services will be commissioned, delivery of day to day business as usual services will be routed and performance will be monitored.

We will report on a range of KPIs to the Trust Board as projects are implemented in support of the Strategy as well as continuing to report on business as usual delivery.

The Head of each function for the People & Organisational Development Team, will be responsible to the Director, through their individual objectives, for specific projects and associated KPIs

It is an essential part of any people strategy that managers and leaders share responsibility for modelling the right behaviours and creating the environment we all need to succeed. The People & Organisational Development team will support the development of our culture and provide the best tools, processes and structure to enable that to happen.

Each person at LAS also shares the responsibility to make the LAS a great place to work. Our responsibility as People & Organisational Development is to ensure that we provide clarity of structure, clarity of accountability for key functions and deliverables and, clarity about what people can do for themselves, what they can expect from managers and what they can expect from their corporate teams

Equally, People & Organisational Development have a responsibility to make sure that we are bringing solutions to meet the needs of our colleagues and our teams, working hard to remove barriers and blocks and set our sights on meeting expectations.

We will seek both formal and informal feedback on the work that we do and ensure that we listen and learn from what we are told. We will put in place service level agreements where this is relevant and will publish our results against our key performance indicators.

9. How will we measure and monitor progress?

The most powerful tool for understanding how people feel about working for LAS will be the Annual Staff Survey, which will be an 'all staff' survey. We will, in addition, introduce other 'check ins' during the year to regularly find out how people are feeling. For the first time in 2017 (Q3 Survey), the Trust has moved to a fully online survey after consulting with colleagues and other Trusts. We will set out a plan to seek to improve the level of participation for the survey so that we get a representative and broad view from across the organisation.

Other measures are equally as important and some are set out in our Business Plan with clear targets to aspire to as we focus on interventions that will support the engagement, wellbeing and growth of LAS people.

	Indicator	Baseline 16/17	National 16/17	2020
Partners are supported to deliver change in London	Vacancy Rates Trust Corporate Operational	5.10% 14% 7%	-	5%
	Length of time to hire (Corporate roles) Length of time to hire (Operational roles)	Tbc Tbc	Tbc Tbc	Tbc Tbc
	Turnover International Turnover	9% 10%	9.24% -	< 10% Tbc
	Stability	90.91%	90.54%	90%
Patients receive safe, timely and effective care	Staff recommendation of the organisation as a place to work or receive treatment	3.47	3.47 Average 3.57 Best	3.57
	Staff Survey Response Rates	42.2%	42%	Greater than 50%
	% of staff survey respondents (BME)	12%	14%	14%
	Absence Rates (long term and short term)	3.33% 1.83%	4.29%	3% 2%
	Improvement of 5% on Q15N (Bullying and Harassment)	32%	28%	27%
Partners are supported to deliver change in London	Appraisal completion	81.30%	86.7%	Greater than 85%
	Stat Man Training complete	69.95%	-	Greater than 85%
Efficiency and sustainability will drive us	Leadership – to be defined	We recognise that a stretching aspiration is important in this area and different options are currently under consideration		
Our people are valued, respected and engaged	No. of BME leavers	15.6%	-	11%
	No. of BME starters**	21.8%	-	27%
	Improvement of 5% on Q20 and 21 (discrimination and equal opportunities)	26% 73%	20% 70%	21% 78%

****Note:** whilst our aspiration is to reflect the make up of the population of our patients in terms of BME employees, we recognise that we have some way to go on this journey. We have set ourselves what we believe is a realistic but stretching target for this first year.

In addition we will want to hear from our regulators and auditors that people related risks are reducing.

10.Strategic Direction 2017 – 2019

Strategic Theme	Patients receive safe, timely and effective care	Our people are valued, respected and engaged	Partners are supported to deliver change in London	Efficiency and sustainability will drive us
People and Organisational Development Themes	**Engagement**. Creating a working environment to inspire people to give their best **Healthy Workplace**. Placing wellbeing and mental resilience at the heart of our employees' experience of working at the LAS and encourage and inspire people to look after their health and wellbeing	**Inclusion**. A diverse and inclusive LAS community that supports outstanding performance and celebrates difference **Rewarding and Recognising Excellence**. Reward and recognise excellent contribution which reflects the values of the London Ambulance Service and contributes to the accomplishment of our goals	**Talent**. Known as a great place to work attracting diverse talent from the strongest pools **Performance, Development and Growth.** Creating capability for the future by motivating and engaging individuals to take responsibility for their own performance and development and to be resilient through change and challenge	**Leadership and Management**. Instill confidence and capability in our people, leaders and managers to deliver innovative and creative solutions that enable the ambitions of the London Ambulance Service
Completed Activities 2016/17	• Introduced the first Wellbeing Strategy to the Trust Board for consideration • Procured a new OH contract	• Introduced a Diversity lead and established our first action plan against WRES	• Reorganised our recruitment team to reflect the needs of the organisation • Developed reporting tools to support workforce planning	• Recruited key people to fill positions within the Executive Leadership Team
Priorities for 2017/18	• Establish the PAM OH contract so that it is fully operational and supports managers and people • Develop and deliver a campaign to support communication and engagement across the LAS • Develop a communication plan for the P&OD Strategy and implement • Establish a pre-employment health assessment to support strong early engagement around health and expectations • Establish a framework for a Healthy Workplace, Step 1 • Review best practice in other organisations and roll out a method of engagement which best	• Review best practice in Inclusion and Diversity and make a commitment to working to achieve a recognised Diversity Standard for London • Review and relaunch recognition schemes, including a 'thank you' from the Executive Leadership Team • Run engagement sessions with local teams to support courageous conversations • Launch the WRES action plan for 2017/18 and put in place reporting against key deliverables • Establish targets for shortlists that ensure a diverse talent pool is considered for all posts across LAS	• Challenge our approach to recruitment across our front line roles, seeking best practice and transforming our ability to meet our needs now and in the future • Communicate the role of the Learning and Development team and provide a calendar of all available training throughout the year – across all forms of media (paper, social) • Develop and deliver a communication campaign to support recruitment activity to celebrate and enhance the LAS brand and to feed the long term pipeline for LAS frontline	• Articulate Organisational structure and clarity around ownership and deliverables • Introduce a People and OD Strategy and realign the People & OD team • Agreement of a People and OD Plan supporting Business Plan delivery • Establish a 'behaviours' framework in support of a well-lead organisation and to which all LAS people can aspire • Establish a Leadership Academy Programme and roll out • Introduce a structured approach for coaching and mentoring across Leaders of Tomorrow groups

Strategic Theme	Patients receive safe, timely and effective care	Our people are valued, respected and engaged	Partners are supported to deliver change in London	Efficiency and sustainability will drive us
	fits the organisation and patient needs Review our key people management policies and practices Establish a 'people management' toolkit for managers – mixed media (online, reference manuals, templates)	Develop a calendar of events that celebrates a diverse LAS community Develop accurate and timely intelligence about the experiences of people from across the diversity spectrum Implement a programme of 'lunch and learn' to support positive debate around all aspects of diversity	Review and update the Performance Review Process to ensure that effective performance conversations are held across LAS at least annually Design and roll out an on-boarding process for key roles Review Statutory and Mandatory training content and methods of delivery Establish our core training content within a I Belong, I Learn, I Develop, I Lead, I Inspire Framework Develop a partnership with an external provider to deliver Apprenticeships of all types	Develop and deliver a clear management model and accountabilities to support a functional business partner approach Implement a Board Development programme that strengthens our position as a unitary board and enables effective team working
Priorities for 2018/19	Improve our standing on the Healthy Workplace Framework, Step 2 Establish groups and events that support a 'you said, we did' cycle Introduce new reward and recognition schemes, such as an Innovation Fair	Review practices of other organisations and take on board learning from best practice examples Review, refresh and re-launch our training interventions	Design and roll out on-boarding process for all roles Continue to develop and evolve the performance framework to take it to an online platform Establish clear role descriptions that are standard across LAS, that provide clear accountabilities and ensure people are empowered to take decisions at the appropriate level, ensuring robust governance but giving the ability to take action	Build on our work to establish a Leaders of Tomorrow programme built on a model of using the skills and experience of people to support our learning Review best practice for leadership development from public and private organisations and update / refresh our approach
Priorities for 2018/19	Revisit engagement and healthy work place strategies in the light of the LAS strategy and implement new developments	Establish ourselves within a Diversity framework for London (GLA or similar) so that we can put ourselves forward for recognition of our achievements	Review our approach to feeding our Talent Pipeline looking to strengthen our candidate experience and take our work out into London's communities	Introduce a mentoring and coaching programme that supports our development interventions, including seeking out and taking secondment opportunities to support learning and experience

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Winter Plan 2017/18**			
Report Author(s):	**Kevin Bate, Deputy Director of Operations (Central Operations)**			
Presented by:	**Paul Woodrow, Director of Operations**			
History:	**Presented to the Executive Leadership Team on 23 August 2017**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Winter Plan 2017/18 provides the tactical options for the continuation of the London Ambulance Service NHS Trust's (LAS's) core service delivery during the 2017/18 winter period.

The aim of the plan is to ensure that those Londoners who need the LAS receive a timely service acknowledging the potential restrictions which may be caused by adverse weather or high demand throughout the service during winter.

Call history will be reviewed to help predict high demand across the months of November to February which in turn helps LAS to plan for staff cover to meet the predicted surges in core demand. The Winter Plan 2017/18 builds on earlier learning from the pressures experienced during previous winter periods.

As is the consistent theme across LAS plans, the Winter Plan 2017/18 sets out to maintain the optimum levels of service provided to service users across the capital by deploying, when and where necessary, innovative and different solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with requests for emergency ambulances are at the heart of this plan.

Recommendation:

The Board is asked to approve the Winter Plan 2017/18

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

BAF risk 37: There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒

Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☒
Other	☐

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

London Ambulance Service NHS Trust

Winter Plan 2017/18

Version No:	Date of Release:	No of Pages:	Completion Status:
1.0	07/09/17	49	**First Issue**
Written by: Staff Officer			Rommel Casaclang
Approved by: Deputy Director of Operations – Central Operations			Kevin Bate
Equality & Diversity Impact Assessment			Positive outcome
Risk Assessment			

Document Profile and Control

Purpose: Provides an overview of the arrangements in place for each operational area to maintain service provision during the winter period 2017/18 and the pressures experienced within

Sponsor Department: Central Operations

Author/Reviewer: R Casaclang/ K Bate/ P Woodrow

Amendment History			
Date	**Version**	**Author/Contributor**	**Amendment Details**
20/07/17	0.1	Winter Planning Group	First draft.
26/07/17	0.2	R Casaclang	Updated information.
07/08/2017	0.3	R Hutchings	Data from Business Intelligence included.
08/08/17	0.4	A Macarthur	Communications Campaigns included
12/08/17	0.5	K Bate	Reviewed & formatted
16/08/17	0.6	B Jordan	Feedback incorporated
17/08/17	0.7	R Casaclang	Formatting
22/08/17	0.8	B Jordan	Commentary relating to activity predictions clarified
25/08/17	0.9	K Bate	Pandemic preparedness, adverse weather, CAD outage review and primary care system requirements updated

Document Status: ISSUED

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Upon review the first version of a revised document is given the designation 1.1,
The second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Title	**Version**
LAS Adverse Weather Plan	2017
Adverse Weather Strategic Planning Framework v 0.21	2016
Resource Escalation Action Plan (REAP)	2016
London Resilience Forum (LRF) - Severe Weather and Natural Hazards Response Framework	2017
Public Health England Flu Plan Winter 2017/18	March 2017
Cold Weather Plan (NHS England)	2016
LAS Business Continuity Policy	TP028, 2016
Control Services Surge Management Plan	v2.1 2016
NHS England (London) Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy)	v8 2016
NHS Improvement Good practice guide: Focus on improving patient flow	July 2017

Table of Contents

1.0 Purpose 6
2.0 Introduction 7
3.0 Strategic Intention 7
4.0 Lessons Learned from Winter 2016/17 8
4.1 Computer Aided Dispatch (CAD) Failure 8
5.0 Ambulance Response Programme 10
6.0 Historical Activity and Demand during winter 11
7.0 Demand and Scenario Planning 13
7.1 Current Year 13
7.2 Daily Demand 14
7.3 Public Events in London 15
7.4 Alcohol Related Incidents 16
8.0 Demand Management Strategies 17
8.1 Daily Command and Co-ordination 17
8.2 Surge Escalation Plan 18
8.3 Resource Escalation Action Plan (REAP) 19
8.4 Primary & Community Care Partnership Working 19
8.5 Clinical Hub 20
8.6 NHS 111 20
8.7 Other Winter Initiatives 21
8.8 Communications 21
9.0 Staffing Capacity & Provision 22
9.1 Capacity Management Strategies 22
9.2 Health and Wellbeing for Staff 24
9.3 Seasonal Flu 24
9.4 Job Cycle Time 26
9.5 Hospital Turnaround Improvements 26
9.6 Significant and Major Incident Response 27
10.0 Adverse Weather 28
10.1 Weather Reports 28
10.2 Fleet 29
10.3 Grit and Shovels 29
10.4 The Cold Weather Plan 29
10.5 Operational Response 30
10.6 Manager Duties 30

10.7 Recovery 31
11.0 Fuel 31
12.0 Logistics 31
13.0 Business Continuity Plans 32
14.0 LAS Roles and Responsibilities 33
14.1 Winter Planning Group 33
15.0 Key Risks and Mitigations 34
Appendix 1 - Festive Period Event Calendar 36
Appendix 2 - Incidents conveyed to Hospital Nov 16 – March 17 38
Appendix 3 - Summary of cold weather actions for health and social care organisations and professionals, communities and individuals 39
Appendix 4 - LAS Adverse Weather Plan 43
Appendix 5 - LAS Control Services Surge Management Plan 44
Appendix 6 - LAS Resource Escalation Action Plan (REAP) 45
Appendix 7 - NHSE London ED Capacity Management, Redirect and Closure Plan 46
Appendix 8 - LAS Incident Response Plans 47
Appendix 9 - Report on the New Year's Day 2017 Computer Aided Dispatch system outage 48
Appendix 10 - New Year's Eve Event Plan 49

1.0 Purpose

1.0.1 This plan provides the tactical overview of the London Ambulance Service NHS Trust's (LAS) arrangements for maintaining effective and continued delivery of urgent and emergency care services during the 2017/18 winter period.

1.0.2 The aim of the plan is to ensure that the people within London who need the LAS receive a timely service acknowledging the potential restrictions which may be caused by adverse weather or high demand throughout the service during winter.

1.0.3 The LAS winter plan builds on earlier learning from the pressures experienced during previous winter periods.

1.0.4 As is the consistent theme across LAS plans, the winter plan sets out to maintain the optimum levels of service provided to service users across the capital by deploying, when and where necessary, innovative and different solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with requests for emergency ambulances are at the heart of this plan.

1.0.5 LAS Purpose and Values

- **Purpose:**
  - LAS is here to care for people in London: saving lives, providing care and making sure they get the help they need.

- **Values:**

Clinical Excellence:

- Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Care:

- Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

Commitment:

- Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

2.0 Introduction

2.0.1 The winter period historically causes increased pressure within the health system for various reasons such as seasonal flu, increased falls and respiratory illnesses which lead to increased admissions to hospitals. As well as the increases in demand resulting from these factors, this period also encompasses a number of significant public and social events (such as New Year's Eve) which impact on LAS in terms of road access, large variations in population numbers and alcohol related incidents.

2.0.2 As well as being prepared for the variation in activity caused by the winter period, in line with the Civil Contingencies Act 2004 (CCA), the International Standard for Business Continuity ISO 22301 and the Department of Health Emergency Preparedness Guidelines, the Trust is required to make sufficient preparations in order to be able to maintain critical functions through periods of disruption.

2.0.3 Other contingencies that are in place all year round to assist with surge demand will continue to be used when required.

2.0.4 This plan reflects the live and continuous nature of the Trust's planning for the winter period. As a result, this plan will be updated regularly to ensure that it provides an accurate reflection of the Trust's preparedness at any given time.

3.0 Strategic Intention

3.0.1 To deliver a clinically safe service to patients.

3.0.2 Meeting the Trust's locally agreed performance trajectory over winter.

3.0.3 To continue to provide safe and effective response and management of major and significant incidents during the winter period.

3.0.4 To react to and manage the challenges faced throughout the winter period, e.g. weather changes and flu.

3.0.5 To protect the health and well-being of staff during one of the busiest periods of the year.

3.0.6 To work in partnership with colleagues across the wider health community to mitigate or minimise the impact of identified risks to service delivery throughout winter.

3.0.7 To maintain public and key stakeholder confidence and protect the reputation of the Trust.

3.0.8 To create a comprehensive communication plan for audiences internally, externally, and to the wider public which supports the delivery of the operational plans across the winter period

4.0 Lessons Learned from Winter 2016/17

4.0.1 A review of the plans implemented during winter 2016/17 was undertaken which identified the following lessons:

4.0.2 A strategic performance cell was introduced to support the Incident & Delivery Managers with the management of system capacity issues and delayed handover of care at hospitals. The cell operated for 16 hours a day and added capacity during this peak demand period. This will be implemented again during 2017/18.

4.0.3 The process that LAS uses to coordinate separate tactical command structures dealing with concurrent events under a single strategic command team needed further clarification and so was reviewed and communicated within the command team.

4.1 Computer Aided Dispatch (CAD) Failure

4.1.1 LAS experienced the failure of its computer aided dispatch system (CAD) during New Year's Day which resulted in the use of paper systems within the Emergency Operations Centre (EOC) during the busiest period of the year and which resulted in delays to providing a response to some patients. A robust investigation of this outage was undertaken and an action plan was developed to address the issues identified.

4.1.2 As a consequence of this system failure, and to ensure lessons were properly learned, an executive group was formed, involving LAS, commissioners, NHS England and NHS Improvement. It commissioned four pieces of work:

- Review 1: An examination of the impact of the CAD failure on patients and their care.
- Review 2: An independent review of the IT system, carried out by PA Consulting, to look at why it failed, the steps that were taken to fix the problem and the IT systems, and what expertise and support LAS has available.
- Review 3: An assessment of the business continuity and system resilience, led by the Emergency Preparedness, Resilience and Response Lead for NHS England (London).

- Review 4: By nature of their complexity, the NHS has to plan for when CAD systems fail. A fourth review, looking at the response of the NHS more widely to CAD system outages, was undertaken by NHS England to identify what additional learning could have taken place after previous outages.

4.1.3 An independent review by PA Consulting into LAS's IT and business continuity produced 12 recommendations, of which 6 are already complete and the remainder are on track for completion prior to winter 2017.

4.1.4 Additional investment and improved governance structures were recommended. Since the incident, LAS has appointed a chief information officer and a non-executive director with an extensive background in IT has joined the Board.

4.1.5 Following recommendations from NHS England relating to business continuity and system resilience, all operational contingency plans have been reviewed and modified.

4.1.6 NHS England has trained a further 40 LAS staff as loggists so that the method of record keeping for any similar event is improved. Changes to the incident report books used by LAS are also being made so they meet best practice guidelines.

4.1.7 All recommendations and actions from the various reviews are being overseen by the Trust executive team and the Trust Board.

4.1.8 The reviews found that the computer system that is used by LAS to respond to 999 calls is fit for purpose.

4.1.9 Although the specific cause of the outage has been rectified and cannot now happen again, the EOC staffing contingency plans for this New Year's Eve will include consideration for the increased staff required for technical outages at peak periods.

4.1.10 Additional assurance and technical resourcing plan is being implemented in preparation for New Year's Eve.

4.1.11 Any changes to CAD are being assured by NHS Digital and the Chief Information Officer for NHS England.

5.0 Ambulance Response Programme

5.0.1 The measurement of response times to emergency calls has been used as an indicator for ambulance services quality in England since 1974, with the current standards being introduced in 1996 to reflect the differences in urgency and clinical need of the calls received.

5.0.2 Since February 2015, ambulance services in England have been engaged in an NHS England led trial of a new operating model, under an initiative known as the Ambulance Response Programme (ARP). ARP has been developed using the most comprehensive study about ambulance services completed anywhere in the world. More than 10 million patients have been studied, and there have been no adverse incidents or patient safety concerns identified with its implementation in operational practise. This work has also independently evaluated by Sheffield University's School of Health and Related Research (ScHARR).

5.0.3 The development of ARP focussed on four main areas:

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

5.0.4 Pre Triage Sieve (PTS) and Nature of Call (NOC) involve asking callers a series of four brief questions before entering the triage tool (MPDS). Ambulance services within the trial (including LAS itself) are capturing as many as 75% of Category 1 patients through this process, saving on average around 50 seconds when dispatching a resource. This process offers assurance that a high proportion of the most seriously ill patients are being identified and responded to at the earliest opportunity.

5.0.5 The review of clinical code sets was led by the National Ambulance Services Medical Directors group (NASMeD) under the governance of ARP. The code set was reviewed and approved by the Emergency Call Prioritisation Advisory Group (ECPAG) which comprises a broad range of regulators, stakeholders and clinical experts. The code set comprises four categories:

Identifier	Basic definition	Response time standard
Category 1	Immediately life threatening	7 minute mean response time (15 minutes 90th centile response time)
Category 2	Potentially serious condition	18 minutes mean response time (40 minutes 90th centile response time)
Category 3	Urgent problem	120 minutes 90th centile response time
Category 4	Urgent problem likely requiring transport or hear and treat	180 minutes 90th centile response time

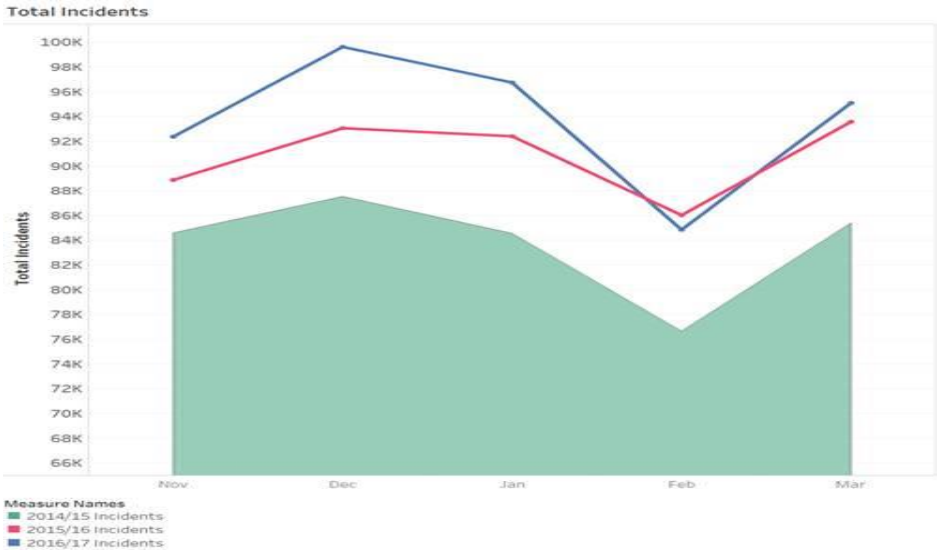
5.0.6 For LAS, in practical terms, the new standards will mean that the number of calls requiring a rapid response will likely fall from around 1500+ (for Red 1 and Red 2 within 8 minutes) per day to around 250 (Category 1 within a 7 minute mean) per day.

5.0.7 The Ambulance Quality Indicators (AQIs) were introduced in 2011 for all ambulance services in England, and comprise a series of standards, indicators and measures to look at the quality of care provided for the patient as well as the speed of response to patients. A new set of AQIs has been developed to assist with the governance of the new national operating model whilst also allowing for local flexibility. The latest version of the AQIs was received in early August.

5.0.8 The Department of Health announced in mid-July that it will require all English ambulance trusts to introduce ARP as soon as possible. Due to the nature of the technical changes required to introduce the new operating model, there is no opportunity for a period of dual reporting on the existing and new performance regimes. LAS has therefore agreed with NHS England that ARP will be implemented on the night of 3 October 2017 into 4 October 2017.

6.0 Historical Activity and Demand during winter

6.0.1 The graph on the following page demonstrates the levels of Category A incidents (those that are classified as life threatening) over the last three years spanning the winter period. In 2016/17 the Trust experienced higher Category A demand during the months of November, December and January in comparison to the two previous years.



6.0.2 The graph below shows the total number of incidents over the last three years between November and March. There are similarities between Category A and total incidents during the winter period, with total incidents in 2016/17 remaining above the previous two years' activity between November to January. There was however a marginal decrease in February followed by a small increase in March.

7.0 Demand and Scenario Planning

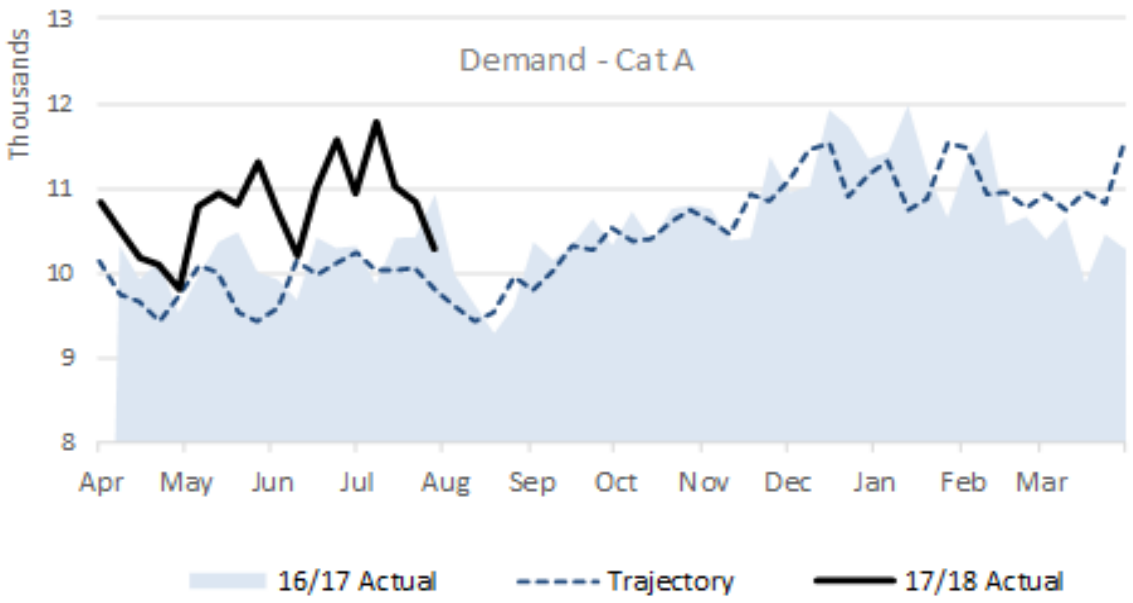
7.1 Current Year

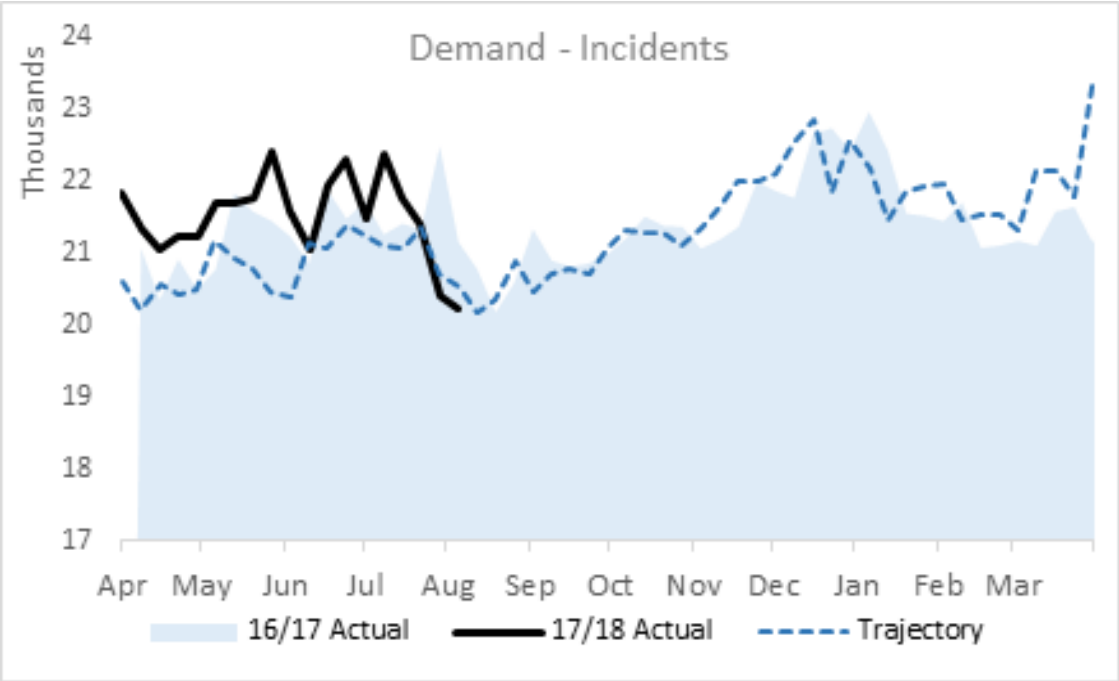
7.1.1 Although the implementation of the revised standards will improve the service provided to patients, it does pose some difficulties in developing activity and performance plans as part of the winter planning process. This is because no previous evidence or data exists on how many calls of each category LAS will be required to respond to and so anticipated levels of demand are based on mathematical modelling only.

7.1.2 LAS has commissioned work to better predict the distribution and volume of the new categories of call. This work is scheduled to be completed in September however results of earlier modelling has identified that the incidents responded to by LAS between April and October 2016 correlated to the following distribution among the new categories;

- Category 1 – 7.1% of responded incidents
- Category 2 – 53.8% of responded incidents
- Category 3 – 26.6% of responded incidents
- Category 4 – 12.6% of responded incidents

7.1.3 As identified in the graphs below (from the tri-partite pack, week ending 6 August 2017), weekly demand volumes continue to remain significantly above that of last year and above the trajectory with current Category A demand following the seasonal trends displayed last year, with some exceptions.





7.1.4 The year-to-date growth on 2016/17 is currently calculated to be +1.2% for all incidents and +5.5% for Category A incidents.

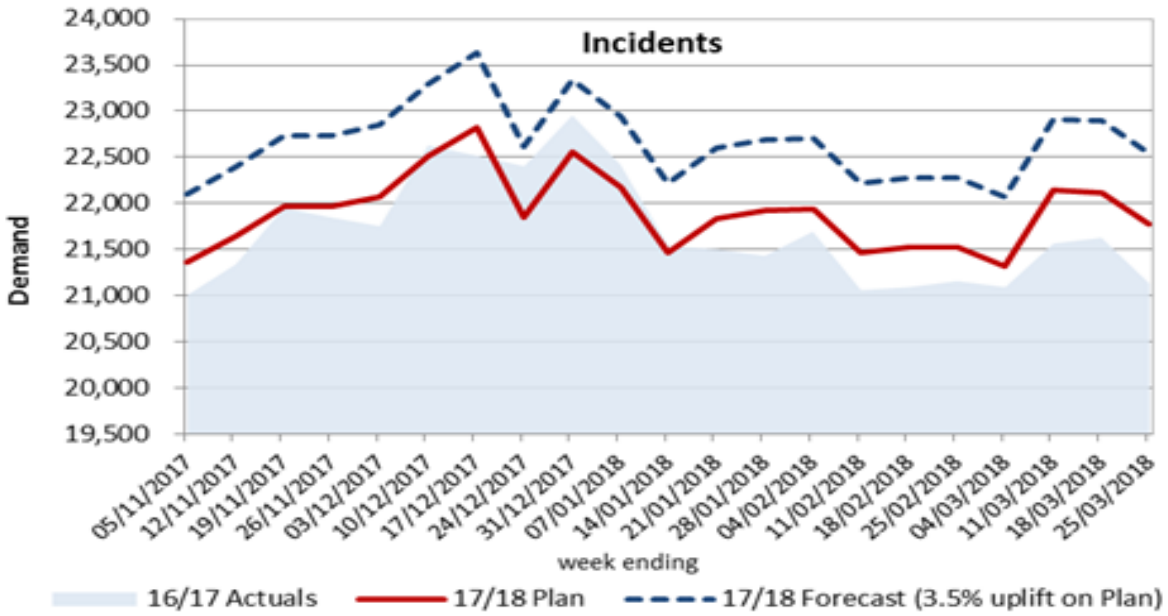
7.1.5 Although current analysis identifies a trend in demand variation, due to a combination of the dynamic nature of emergency demand and the potential variations as a result of the ARP, a separate detailed plan of hourly resource provision during the peak periods of December/January is being developed and will be issued as a separate addendum to this report.

7.2 Daily Demand

7.2.1 The locally agreed contracted trajectories are set at a weekly level. To obtain daily forecasts, these strategic plans will be split based on the expected weekday proportions. An average winter weekly-to-weekday split (calculated from 2016/17 data) will be used for all weeks in the shown winter period, except for:

- Christmas week
- New Year's week
- The first week of January 2017

7.2.2 It should also be noted that last year, Christmas Day and New Year's Day fell on a Sunday whilst this year those days will fall on a Monday. The split of weekly totals down to daily predictions will therefore be manually adjusted over the two and a half week festive period to accommodate an approximate change in volume that may come from the holidays falling on different weekdays.



7.2.3 As previously identified, separate demand forecasting is being undertaken to assist in the development of hourly resource and staffing plans at peak periods and to assist in providing the wider health community with intelligence of predicted ambulance arrival volumes and distributions at hospital accident and emergency centres. This plan will be published at the end of September.

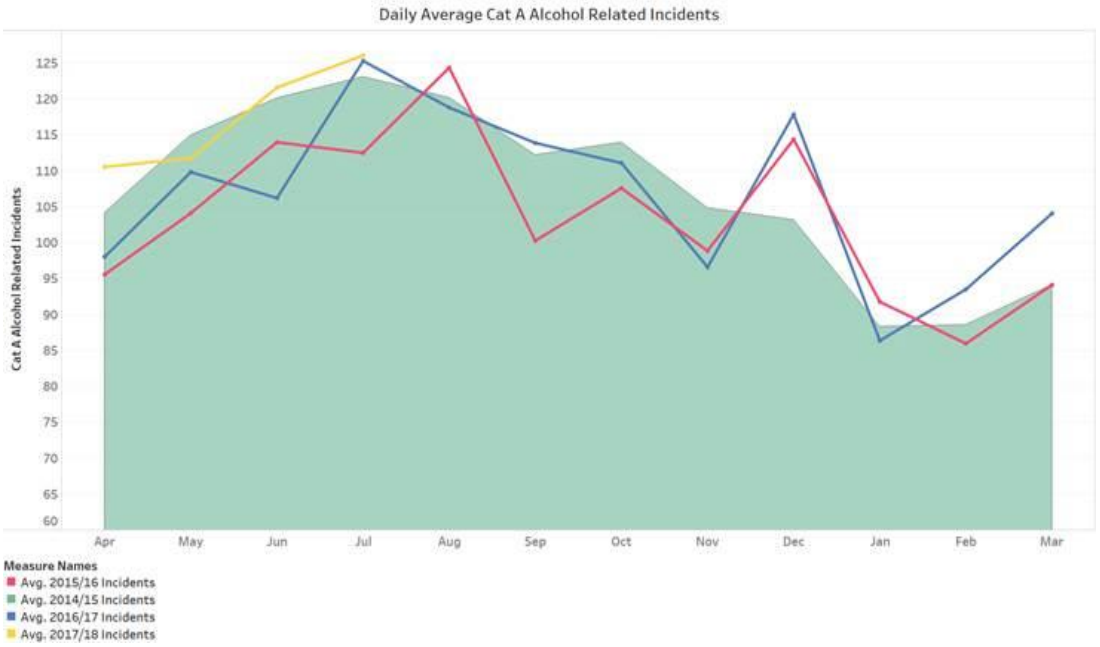
7.3 Public Events in London

7.3.1 London will host a number of public events over the winter period. Remembrance Sunday (November), the Lord Mayor's Show (November), New Year's Eve and the New Year Day Parade are just a few of the well-known events that take place.

7.3.2 Although Emergency Planning and Resilience Officers (EPROs) are developing individual plans for these events, the scope, scale and resource implications are considered as part of the overarching winter planning work.

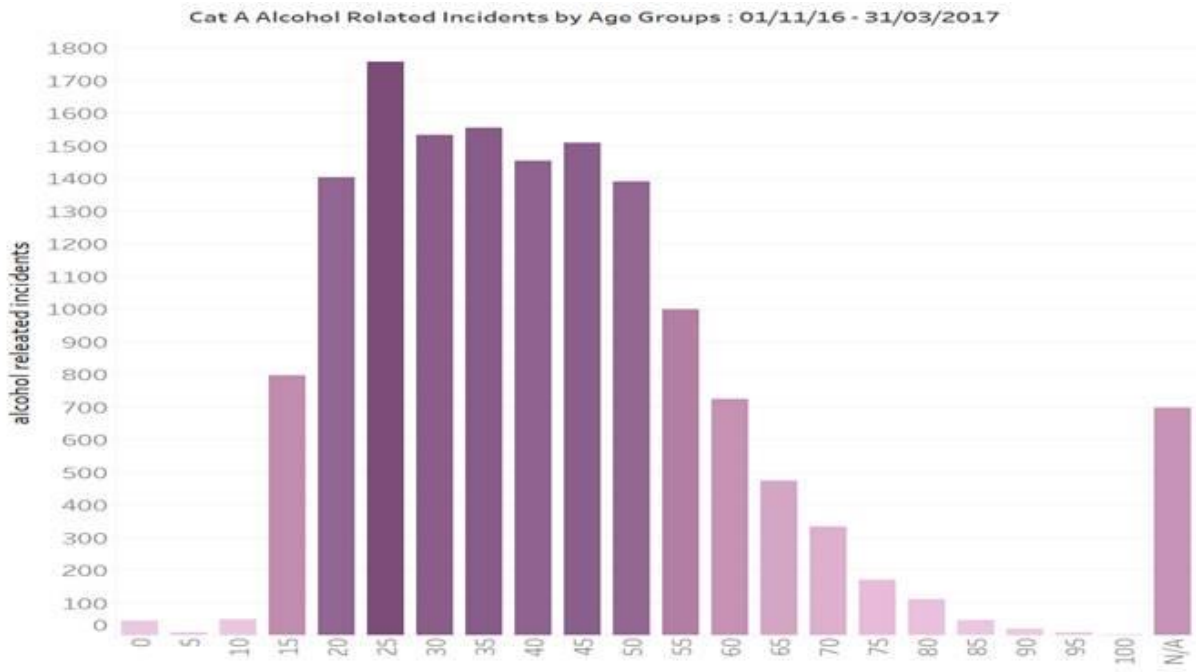
7.4 Alcohol Related Incidents

7.4.1 The graph below shows the daily average number of Category A alcohol incidents which the LAS has attended by month and across the financial year. It displays that the highest peak occurs between July and August with a secondary peak in December. While the peak is not as pronounced it does demonstrate a marked increase which presents a risk to the service during the winter period.



7.4.2 LAS is developing an alcohol communications campaign for the winter period as a means of raising awareness of the impact of alcohol related incidents. Previous campaigns such as *Eat, Drink and Be Safe* (which was a joint agency public awareness campaign) are credited with helping to reduce the number of alcohol related calls during New Year's Eve/New Year's Day by up to 12.5%.

7.4.3 The chart on the next page shows the number of alcohol related Category A incidents by age group, between November 2016 to March 2017. This shows that the age group between 25 and 29 make up the largest proportion of the service's alcohol related incidents over this time period.



7.4.4 A proactive alcohol awareness campaign will be run in the lead up to December to support two key operational objectives during winter: demand management and staff safety. Our aim will be to encourage Christmas party-goers to take personal responsibility for their alcohol consumption, along with educating the public on what to do if they come across someone drunk and in need of help. The campaign is likely to be online, capitalising on our ever-growing social media presence and online media to reach our target audience of 18-50 year olds (with a specific audience of 21-30 year olds, who make up our most frequent alcohol related callers).

8.0 Demand Management Strategies

8.1 Daily Command and Co-ordination

8.1.1 The LAS operates with a 24 hour, 7 day a week command structure in place, with a Silver (Tactical) Officer on duty 24/7 managing core delivery for the LAS. Over the winter period, the Trust will maintain the strategic, tactical and operational command structure, in line with London Emergency Services Liaison Panel Manuel / Joint Emergency Services Interoperability Principles.

8.1.2 Normal command and control procedures will apply during the winter period. A Gold (Strategic) Officer will assume the position of the Trust's Strategic Commander on call and co-ordinate the Trust's actions during a major incident. The on-duty Incident Delivery Manager (IDM) will act as the Trust Silver (Tactical) Commander and will be based at Waterloo Headquarters or Devon's Road, Bow. If required, the on-call Silver (Tactical) Manager will be

recalled to take over the command of specific incidents to allow the IDM to return to managing business as usual.

8.1.3 Teleconferences will be held every four hours during the winter period to monitor the level of demand, resource availability and consider any mitigating actions. These conferences will be called by the on duty Incident and Delivery Manager.

8.1.4 To further enhance the capacity of the command structure to respond proactively to demand and/or capacity issues, additional support will be implemented during the December period in the form of a strategic performance cell which will actively monitor organisational performance and take all steps necessary to resolve or mitigate performance inhibitors or escalate concerns within the wider NHS. This cell will operate 06:30 – 22:30 over seven days.

8.1.5 Increased operational management support will also be implemented during the peak winter periods to assist in the management of any delayed handovers and to provide appropriate welfare monitoring for staff during what will be a period of increased activity. These extra managers will operate across the full 24 hour period.

8.2 Surge Escalation Plan

8.2.1 The surge escalation plan provides a demand management framework for Control Services to use in periods of high pressure. Implementation of this plan releases additional vehicles from responding to lower acuity calls to allow peaks in demand to be managed in a manner which continues to enable the sickest patients to be responded to in the quickest way and provides the safest possible management of all patients.

8.2.2 There are five levels of the surge plan: green; red; purple; blue and black. As escalation levels rise more patients get an alternative response or no response at all. All decisions made during a surge management conference call are recorded at the time of invoking the matrix level for reference at any time in the future.

8.3 Resource Escalation Action Plan (REAP)

8.3.1 All ambulance service providers (as Category 1 responders) must ensure that they embrace best practice national guidance. The REAP plan provides a consistent and co-ordinated approach to the management of ambulance trusts during times of pressure/excessive demand.

8.3.2 In the current REAP structure, there are four levels of escalation which aim to aid ambulance services to integrate into the wider NHS surge/escalation framework. These levels are used to determine what actions are necessary to protect core services and supply the best possible level of service with the resources available. REAP is reported nationally as well as utilised within the Trust to guide escalation planning.

8.3.3 REAP is designed to 'be informed' by any disruptive challenges and 'to inform' internally and to the wider NHS/other partner agencies of the pressures facing the organisation. The considerations and actions contained within 'the REAP' are designed to assist in protecting staff, patients and the organisation and should be viewed as guidance in challenging situations. REAP triggers are formally reviewed on a weekly basis at LAS's Service Delivery Group meetings and are escalated as appropriate.

8.4 Primary & Community Care Partnership Working

8.4.1 Sectors will liaise with local networks and stakeholders to ensure appropriate management plans are implemented for patients who frequently access the health system via the ambulance service.

8.4.2 The review of local directories of services will also be required due to the protracted festive period and potential impact on accessing community based services by both patients and ambulance clinicians at the scene of an incident.

8.4.3 The numbers of patients referred to alternative care pathways (ACP) during the winter period last year is identified in the table below. Any reduction in the accessibility to such pathways will have a significant impact on ambulance availability due to increased job cycle time from arranging access to remaining pathways or because of an increased number of patients being transported to hospital due to alternative pathways not being available.

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Patient not conveyed	15,518	17,481	16,508	14,175	15,844
Patient referred and not conveyed	4,940	5,594	5,927	4,824	5,032
Other patients not conveyed	4,842	5,430	4,909	4,361	4,848
Patient conveyed to urgent ACP	3,433	3,723	3,386	3,335	3,640
Patient conveyed to acute ACP	1,769	1,804	1,869	1,761	2,011
Other conveyance	3,062	3,059	2,840	2,773	3,399
Total incidents	92,427	99,694	96,806	84,905	95,161
Percentage not conveyed	16.79%	17.53%	17.05%	16.7%	16.65%
Percentage referred and not conveyed	5.34%	5.61%	6.12%	5.68%	5.29%
Percentage other patients not conveyed	5.24%	5.45%	5.07%	5.14%	5.09%
Percentage conveyed to urgent ACP	3.71%	3.73%	3.5%	3.93%	3.83%
Percentage conveyed to acute ACP	1.91%	1.81%	1.93%	2.07%	2.11%
Percentage other conveyance	3.31%	3.07%	2.93%	3.27%	3.57%

8.4.4 Sectors will be liaising with local emergency/urgent care networks and Sustainability and Transformation Partnerships (STP) to ensure appropriate contingency plans are being implemented across winter and especially during the peak festive/public holiday period to ensure access to primary care and alternative care pathways.

8.5 Clinical Hub

8.5.1 The clinical hub is a key component of the hear and treat, hear and refer and clinical advice process provided within the EOC and so staffing is closely monitored to ensure sufficient capacity.

8.5.2 At times of increased demand, Clinical Team Leaders within Operations and the Medical Directorate staff will be utilised to supplement the staff of the Clinical Hub to further support crews and EOC staff.

8.6 NHS 111

8.6.1 Additional capacity in the LAS operated 111 will be reviewed and agreed with the commissioners with particular attention given to increasing clinical advisors. LAS 111 will maintain a high level of enhanced assessment to minimise the numbers of calls passed for ambulance response.

8.6.2 Our South East London (SEL) 111 service will maintain a separate plan with staffing levels and demand predictions as set with SEL commissioners.

8.7 Other Winter Initiatives

8.7.1 Following a successful trial last winter, Cycle Response Units will be strategically placed at major transport hubs during peak commuter periods to better facilitate access to any patients becoming unwell on the rail network.

8.7.2 LAS will review the Cycle Joint Response Unit that operated in collaboration with the City of London Police last winter. Where appropriate, the Trust will reintroduce such schemes to assist in providing assessment and referral services within that geographical area.

8.7.3 LAS will work in collaboration with local government to identify areas where the use of alcohol recovery centres would help to reduce ambulance requests for people suffering from the effects of alcohol.

8.8 Communications

8.8.1 Winter communications (October 2017 to March 2018)

The LAS will be running a proactive winter campaign to support two key operational objectives; keeping well during cold weather and choosing the most appropriate NHS service. Our aim is to ensure that members of the public stay well over winter and receive the right treatment they need. We will share our key messages proactively using our social media channels, press releases and our website. We will also have reactive media lines ready to respond robustly to any winter issues, performance issues, hospital handover delays and severe weather. We will include winter messages in our communication to stakeholders, such as in our stakeholder bulletin.

LAS will support and contribute to NHS England and Public Health England on their campaigns for winter 2017 and will support their messaging where appropriate. We will continue to explore further opportunities to help manage operational demand through our media, campaigns and social media while continuing to support staff winter wellbeing initiatives.

8.8.2 Promoting NHS 111 to influence call demand (November 2017 to March 2018)

We are working with our colleagues in fleet & logistics to promote NHS 111 on all new ambulances and cars as they are rolled out. With assistance from funding received from NHS England, new graphics have been added to ambulances which will signpost Londoners to NHS 111 when it is not an emergency. Car stickers are also being provided to all LAS staff to display in their cars to further support this initiative.

LAS will support any NHS England campaigns for a more proactive promotion of NHS 111 as an alternative to 999. We will use our own internal and external channels to secure further opportunities to advise patients of other healthcare options to try to influence demand this winter.

9.0 Staffing Capacity & Provision

9.0.1 LAS cover staffing requirements in one of four ways: staff on core rosters; staff on overtime; bank staff; and through the use of private and voluntary ambulance provision.

9.0.2 Current staffing levels are being reviewed on a regular basis as a means of directing resources to periods of anticipated high demand. In addition, specific staffing profiles are being developed in response to specific event plans such as New Year's Eve.

9.0.3 Due to the nature of roster provision, the detailed hourly staffing provision for the festive period will be developed as previously identified in section 7.2.3.

9.1 Capacity Management Strategies

The following initiatives are being utilised as a means of maximising resource levels:

9.1.1 Overtime

LAS will construct specific overtime incentives which are targeted to where additional capacity is required. Provision in line with the Trust's patterns of spend in 2016/17 will be included within the financial plan for this period of time.

9.1.2 Training

All non-essential training will be suspended for December to ensure staff can be focused on core service delivery requirements.

9.1.3 Clinical Team Leaders

Clinical Team Leaders will be 100% patient-facing or deployed to the Clinical Hub during peak periods in December and January.

9.1.4 Bank Staff Arrangements

The availability of those currently registered on the bank will be reviewed and collated in order to maximise availability.

9.1.5 Emergency and Community First Responders

These teams make an important contribution to service provision and will be reviewed to ensure their availability is maximised. Volunteers are also very responsive to the provision of additional capacity when there are short periods of high demand (e.g. NYE and the Friday before Christmas).

9.1.6 Contracted Ambulance Providers

These services already contribute to core resource levels at the current time however the level and time of provision is being reviewed to ensure it meets projected activity requirements wherever possible.

9.1.7 Non-Emergency Transport Service (NETS)

The feasibility and affordability of extending the hours of operation of this service in peak periods is being reviewed in line with post ARP modelling for the festive period and where appropriate, will be modified to redistribute demand and maximise emergency vehicle availability.

The use of the NETS vehicles to assist in multi patient journeys will also be considered as part of any surge management plans.

9.1.8 Taxi Service Transport

The current taxi service is used to convey patients to hospital and usage is reviewed as part of the demand and surge management plans. This method of transport is also used for the movement of single staff between locations.

9.1.9 Mutual Aid (NHS Ambulance Services)

Mutual aid planning is co-ordinated through the National Ambulance Co-ordination Centre (NACC) which feeds into NHS England and the other statutory bodies. Normal mutual aid for cross boundary work exists on a daily basis and will continue through the winter months.

9.1.10 Mutual Aid Voluntary Ambulance Services

In the event of a major incident, both the British Red Cross and St John Ambulance will supply resources to assist with supporting core fleet response.

9.1.11 Specialist Capability

The LAS maintains two Hazardous Area Response Teams (HART) within its operational area. The HART personnel and assets are subject to a national service specification and are required at all times to be available to respond for significant and major incidents. However, following direct instruction from the Strategic Commander (Trust Gold), the teams may be deployed to provide additional capacity in order that the Trust can ensure safe service.

The Trust also provides specific capability in order to respond to chemical incidents or mass casualty events including staff specially trained to operate in support of police armed response incidents. These capabilities are provided as part of the normal service specification and will be monitored to ensure appropriate levels of cover are maintained.

9.2 Health and Wellbeing for Staff

9.2.1 One of the LAS strategic objectives of LAS winter planning is to protect the health and well-being of staff; the methods employed are listed below.

- The Staff Counselling Service provides a confidential and independent facility for work-related or personal problems;

- The Employee Assistance Programme (EAP) is a free confidential advice, support and practical information telephone and online service that allows staff and managers to access support with any personal or work-related difficulties, such as:
  - Conflict in family or work relationships
  - Childcare and eldercare issues
  - Consumer problems
  - Budgeting and debt management
  - Bullying and Harassment concerns

9.2.2 The Occupational Health Services provider works in partnership with the LAS in providing expertise to ensure a safe, healthy working environment.

9.2.3 The London Ambulance Service Staff Benevolent Fund was established to support members faced with temporary hardship.

9.2.4 Other services include:
- Trauma Risk Management (TRiM)
- Consultations
- Mediation
- Wellbeing Training in Stress Management; Nutrition and Sleeping Smart; Mental Health; PTSD and TRiM Strategy training for Managers.

9.3 Seasonal Flu

9.3.1 Influenza (flu) is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care as a result, and on the wider health and social care system that supports people in at risk groups. There is usually one period of high Influenza activity during a season which, from its emergence, will take around three weeks to peak and another three weeks to decline. In the UK this commonly occurs between December and February.

9.3.2 The annual national immunisation programme helps to reduce unplanned hospital admissions and pressure on A&E and is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter.

9.3.3 Influenza affects the London Ambulance Service by increasing demand from the public and NHS partners and by lowering the capacity to deal with that demand, especially if frontline staff become ill.

9.3.4 It is not only frontline operational work that is affected by flu, but also Control Services and Support Services staff throughout the Trust whose critical functions maintain frontline operations. These work areas can be severely affected by decreased staff numbers.

9.3.5 There are three main strategies employed to stop the spread of flu and mitigate the effects; Infection Prevention & Control, vaccination and Business Continuity Planning.

9.3.6 The LAS Seasonal Flu Vaccination Programme 2017 will support the national flu programme through;

- Actively offering flu vaccination to all staff, especially those directly involved in patient care
- Aiming to vaccinate at least 70% of healthcare workers with direct patient contact
- Improving uptake for those in other staff groups, particularly for those in Control Services
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS and sharing this information with staff and managers.

9.3.7 A staff communications campaign we will run activity across all our internal channels – including payslip leaflets, posters, and regular posts on our intranet, staff bulletin and staff Facebook page. An “arms race” league table concerning vaccination uptake rates will help to foster some healthy competition between operational areas and these league tables will be circulated to all staff in our daily communication updates.

9.4 Job Cycle Time

9.4.1 A revised Job Cycle Time (JCT) Improvement Programme proposal has been developed detailing a refreshed project portfolio and is pending approval. There are three categories of initiatives being considered:

- 'Pattern of the working day' - comprising existing live projects (end of shift arrangements and rest breaks)

- 'Clinical protocols and administration' – opportunities to reduce time taken for administrative processes, embed protocols for ten clinical conditions, review a more efficient standard approach to clinical patient assessment to assist rapid decision making and optimisation of the benefits from using the new Clinical Information System Overview (CISO) tool

- 'Process changes' – opportunities to improve hospital handover, handover to green and further reduce MAR

9.4.2 Planning is also underway for engagement events to describe the tangible benefits for patient care and for staff of achieving a 7 minute JCT reduction, essential to win the 'hearts and minds' of staff leading to behaviour change.

9.5 Hospital Turnaround Improvements

9.5.1 Improving patient flow is a key requirement of the NHS for winter 2017/18 and LAS recognises the importance of engaging with A&E Delivery Boards to ensure that there is region-wide, joined up effective patient care, particularly over the winter period. LAS ensure that there is senior representation at A&E Delivery Board meetings and on other local surge hub teleconferences/meetings.

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

9.5.3 To assist acute trusts in planning for ambulance attendance, activity and demand forecasting data will be shared in advance of the peak festive periods.

9.5.4 During 2016/17, the amount of time spent by LAS crews waiting longer than 15 minutes to handover their patient at a hospital equated to over 74,000 hours.

9.5.5 Although December 2016 saw a 5.8% increase in the numbers of patients conveyed to hospitals by LAS, it resulted in a 30% increase in the numbers of hours lost by LAS crews waiting to handover their patient.

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Conveyances*	50,114	49,842	52,735	51,304	44,820	50,251
Arrive at Hospital to Patient Handover - Total >15 Min Breaches	30063	30402	33818	33451	27767	30586
Arrive at Hospital to Patient Handover - Total Hours Lost > 15 Mins	5,848.1	6,548.6	8,532.7	9,111.8	5,832.9	6,008.8

9.5.6 An improvement programme is being undertaken by LAS in collaboration with the wider health community to identify and resolve ambulance handover delays as part of the work being supported by NHS Improvement under the Emergency Care Improvement Programme (ECIP).

9.5.7 Although not directly part of the winter planning process, hospital handover delays are increased during the winter period and so any improvements in this area will assist in improving capacity to respond to emergency calls within the community during the LAS's busiest period.

9.5.8 The Trust does and will continue to refer to the published NHS England (London) surge management framework when dealing with divert requests from acute trusts as per NHS England (London) Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy).

9.5.9 The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15 minute handover target.

9.5.10 Capacity at London emergency departments will be closely monitored, and where appropriate, extra ambulance stretchers will be deployed to assist with the early release of ambulance clinicians and vehicles. This will be authorised by the Trust Strategic Commander (Trust Gold).

9.6 Significant and Major Incident Response

9.6.1 The Trust will continue to react and respond to a major incident as required throughout the winter period; as per the NHS definition of a major incident: "*Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special service arrangements to be implemented by hospitals, ambulance trusts or primary care organisations*".

9.6.2 In the event of the Trust declaring a 'Major or Significant Incident', the Trust's incident response processes and protocols will be followed as per the Trust's Incident Response Guidelines.

9.6.3 The Trust will deploy Mass Casualty Vehicles, Equipment Support Units, Special Operations Response Teams and Command Vehicles as per the predetermined attendance stated in the Incident Response Guidelines.

9.6.4 Public health threats are always present. Whether caused by natural, accidental, or intentional means, these threats can lead to a surge in demand. The LAS has two Hazardous Area Response Teams (HART) based in East and West London.

9.6.5 The UK threat level is currently at 'severe' for international terrorism and 'substantial' for domestic terrorism. These levels are monitored and the Trust will change its method of operation in response to any increase or reduction in those assessments.

9.6.6 There is no specific intelligence to suggest that there will be an imminent attack, however as the capital city, London remains a potential target and the LAS emergency preparedness remains in a standby state to be activated as per the incident response arrangements.

10.0 Adverse Weather

10.0.1 The LAS have a detailed plan for maintaining service delivery should adverse weather occur. The full details of these plans are contained within the LAS adverse weather plan (Appendix 3).

10.0.2 An abridged version of the activities of this plan are as follows:

10.1 Weather Reports

10.1.1 Daily weather reports are received by the Emergency Planning and Resilience Officers (EPROs) via the Meteorological Office. Long range forecasts are also monitored by this department during the winter period and feed into the Trust's normal forecasting and planning group activities.

10.1.2 Current weather reports from the Meteorological Office extend for only 30 days; at this time there is no indication or intelligence of any specific adverse weather event relating to the festive period.

10.2 Fleet

10.2.1 Operational vehicles are fitted with tyres suitable for winter conditions all year round so no specific initiative is required to deal with adverse weather. Vehicle servicing schedules and out of hours repair/support plans have been developed by the Fleet Department to ensure the maximum availability of response vehicles during the winter period.

10.3 Grit and Shovels

10.3.1 Local managers will ensure that all LAS buildings have an adequate stock and supply chain of gritting salt and appropriate tools for spreading it such as snow shovels.

10.3.2 Waterloo Headquarters and Bow have sufficient salt and shovels in order to clear any snow and/or spread salt well in advance of any predicted adverse weather. This is co-ordinated through headquarters' security.

10.4 The Cold Weather Plan

10.4.1 In 2016, Public Health England issued The Cold Weather Plan for England: Protecting Health and Reducing Harm from Cold. This plan is designed to prepare for; alert people to; and prevent; the major avoidable effects on health during periods of severe cold weather in England. The Plan has five levels:

Cold Weather Plan levels	
Level 0	Long-term planning - All year
Level 1	Winter preparedness programme - 1 November–31 March
Level 2	Severe winter weather is forecast – alert and readiness Mean temperatures of 2°C and/or widespread ice and heavy snow are predicted within 48hrs with 60% confidence
Level 3	Response to severe winter weather – Severe weather action Severe weather is occurring: Mean temperatures of 2°C and/or widespread ice and heavy snow
Level 4	Major incident – Emergency response Central government will declare a level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health

10.4.2 Levels 2 / 3 of the plan are triggered according to the probability of threshold conditions being met. For London this means: "*Average temperature of 2°C or less for at least 48 hours, or the Met Office anticipate issuing a warning for heavy snow or widespread ice*".

10.5 Operational Response

10.5.1 Should adverse weather occur, all managers will make themselves available to assist in leading the delivery of operations. Non-operational managers will assist by ensuring their departments/areas of work are able to function to the best of their ability during times of adverse weather.

10.5.2 Given the possibility of adverse weather affecting transport systems, managers will liaise with their staff members to request that they consider alternative ways of getting to and from work. This includes car sharing, establishing clear routes to and from their place of work and identifying frequently affected roads/areas.

10.6 Manager Duties

10.6.1 There will be daily checks of the on-call rota (via the x-drive) to ensure the correct information is held by EOC.

10.6.2 Where snow has been forecast, a teleconference will be arranged to ensure the Snow Operational Plan is implemented. The teleconference is to be attended by the designated managers for the relevant departments dialling in. When snow does fall, the Gold (strategic) on-call officer will convene a teleconference at the earliest opportunity during the working week. This will be at a time nominated by the Gold Officer on-call unless otherwise advised. This meeting will review plan compliance, current and planned levels of operational staffing (and numbers of any staff attending muster points) and any deficiencies in Control Services staffing and current demand.

10.6.3 The Resource Centre will ensure that all staff data is up to date, including home location and normal mode of transport. They will consider registering staff with 4x4 vehicles that are willing to provide a 'car pool' function during adverse winter weather.

10.6.4 Staff that are seconded to other departments, or are undertaking training, should be requested by the Head of EOC to be returned to core EOC duties during the period of adverse weather that is affecting LAS core response.

10.6.5 Each directorate is required to have a business continuity plan which reflects scenarios involving reduced staff capacity, reduced or restricted access to premises and functionality disruption.

10.6.6 LAS managers should ensure that local plans at sector, group and station level are reviewed and updated if necessary. Estates should assure Group Station Managers that central heating and water pipes are prepared for winter weather and that adequate supplies of grit are ordered in time for use during cold weather.

10.7 Recovery

10.7.1 Staff and management teams will be kept appraised of weather forecasts and other important information in order to maintain a level of resilience and to not become complacent if alert levels are lowered. A lowering of the alert levels should be communicated in the same manner as any escalation of alert levels. Actions at the revised level should be taken and where appropriate, staff transport plans (and other similar plans) should be stood down and prepared for use in the near future.

11.0 Fuel

11.0.1 The Trust continues to manage its in-house supply of diesel fuel and has an extensive supply held in secure locations across London. This fuel is held in case public access to fuel supplies is disrupted for any reason. The amount of fuel held is in line with Department of Health guidelines for emergency services which is to hold 20 days' supply.

11.0.2 Fuel is purchased at the point of sale with BP agency cards which can also be used at Texaco filling stations. Senior operational managers within the Trust have a purchasing card (company credit card) and, should BP or Texaco filling stations not be able to supply fuel for a period of time, fuel can be purchased from other suppliers' forecourts using these cards.

11.0.3 A number of "supercharged" fuel cards are held centrally which permit the purchase of fuel from any forecourt. These cards are used when other normal methods of purchasing fuel are not available.

12.0 Logistics

12.0.1 Procurement arrangements for the goods/products used across the Trust – particularly business critical items – are, in the main, relatively generic. These include obvious products such as vehicle fuel, medical gas, electricity supply (for 999 call centre operations) and vehicle parts such as tyres and brake components, all of which can significantly impact on the ability of LAS to continue to operate effectively.

12.0.2 The LAS has identified its critical supply chains in the following areas to ensure the provision of service during periods of high demand is maintained:

- Continuous supply of ambulance medicines/drugs
- Continuous supply of medical consumables
- Maintain continuity of medical gas supplies
- Maintain continuity of supplies of critical vehicle maintenance parts
- Vehicle maintenance and repair staff and facilities
- Vehicle fuel supplies
- Utility supplies (electricity, gas and water)
- Adequate levels of procurement, fleet and logistics staff to ensure the ability to process purchase orders through to delivery.

13.0 Business Continuity Plans

13.0.1 LAS is finalising a business continuity plan which aims to provide a detailed, trust-wide, coordinated plan, compliant with business continuity (BC) requirements (as set out within the NHS England EPRR Assurance Process) to ensure LAS can respond to any business continuity incident and maintain critical services, and where possible, business as usual.

13.0.2 The plan applies to all services provided by, and any services managed by, LAS. Contractors are referred to in the plan but have their own local plans which have been reviewed and assessed as compliant by the Trust.

13.0.3 The plan will be implemented in response to BC incidents and not major incidents however, in some circumstances, a major incident may trigger a business continuity incident and vice versa – it will be the responsibility of the Trust On-Call Strategic Commander (GOLD) to identify if this is the case and ensure that the appropriate plan is invoked.

13.0.4 While the actual response will be governed by the type and impact of the incident, the plan provides guidelines so that all parties concerned can be clear with regards to their role and appropriate response.

13.0.5 Each area of the Trust has undertaken a business continuity impact assessment during 2017 and plans are being updated accordingly. Although plans relating to seasonal flu, adverse weather, response escalation and surge management are already referenced within this document, separate plans also exist in relation to

- Computer Aided Dispatch (CAD) failure (policies OP66, OP68, OP04)
- Pandemic Influenza
- Viral Haemorrhagic Fever
- Middle East Respiratory Syndrome
- Lockdown
- Fuel disruption

14.0 LAS Roles and Responsibilities

14.0.1 The Director of Operations has overall executive responsibility for winter preparedness and service delivery.

14.0.2 The Deputy Director of Operations (Central Operations) is responsible for leading and managing the arrangements for winter planning across all service lines.

14.1 Winter Planning Group

14.1.1 The winter planning group reports to the Operations Board and is established with representatives from all areas of LAS to ensure that the Trust is prepared for the annual rise in activity and demand during the winter period, is aware of the operational gaps in advance and has mitigated the organisation's risks to maintaining patient safety as far as possible.

14.1.2 Membership

- Strategic Lead (Chair)
- Clinical Lead
- Fleet and Logistics representative
- EOC representative
- Incident & Delivery representative
- Nominated officer from the operational sectors
- Finance representative
- Estates representative
- Resourcing Manager
- Practice Learning Manager
- EPRR or Business Continuity Co-ordinator
- Patient Transport Services/NETS
- 111 representative
- Business Intelligence representative
- Administration support/Staff Officer

14.1.3 Meetings

The winter planning group will meet monthly from June and weekly from November. A New Year's Eve specific command group will also be established to oversee the operational planning of this event. This group links into the overarching winter preparedness programme.

15.0 Key Risks and Mitigations

15.0.1 Main risks have been identified in relation to winter. The table below summarises these, together with how the LAS is mitigating against them:

Risk	Mitigation
Demand increasing	activity modelling by external specialists being undertaken Hear and Treat capacity being reviewed Clinical HUB capacity being reviewed CCGs charged with reducing demand by 5% across London Review of HCP and 111 growth and actions being reviewed to address Management of frequent callers across winter being reviewed Alcohol recovery centres to be considered Reviewing how we can use surge buses and NETs vehicles and staff differently Review sector and local issues and identify systems actions to target these Surge management tools
Staffing levels on key dates	Overtime incentive payments are being developed PAS/VAS provision being sourced Consider the creation of a winter relief roster to target capacity on key dates Active management of long and short term sickness Flu vaccinations Continue to recruit and train staff Bank staff being sourced
Loss of capacity due to delays in handovers at hospital	Trolley bed deployment across Trusts will be considered HALOs and cohorting being actively considered Review wheelchair availability at hospitals Share expected activity levels with hospitals so that they can review as part of their winter plans Rapid Handover Escalation Policy being drafted, where the authority for initiation is delegated by the Gold (Strategic) level.

Fleet being out of service	Head of Fleet reviewing out of service and drawing up a plan to minimise out of service across Winter Operational vehicles fitted with tyres suitable for winter conditions all year round. Vehicle servicing schedules and out of hours repair/support plans have been developed by the Fleet Department to ensure the maximum availability of response vehicles during the winter period Management of in-house supply of diesel fuel and extensive supply held in secure locations across London
Control Room staffing shortages	Review number of corporate staff trained in control room and seek to deploy Explore setting up additional Clinical Hub in Croydon Reviewing operating model to see if we are losing time in EOC to enhance capacity Management of long and short terms sickness Continue to recruit and train Overtime incentives to be reviewed
Loss of key IT systems	Specific CAD outage action plan developed All Trust areas reviewing business continuity plans

Appendix 1 - Festive Period Event Calendar

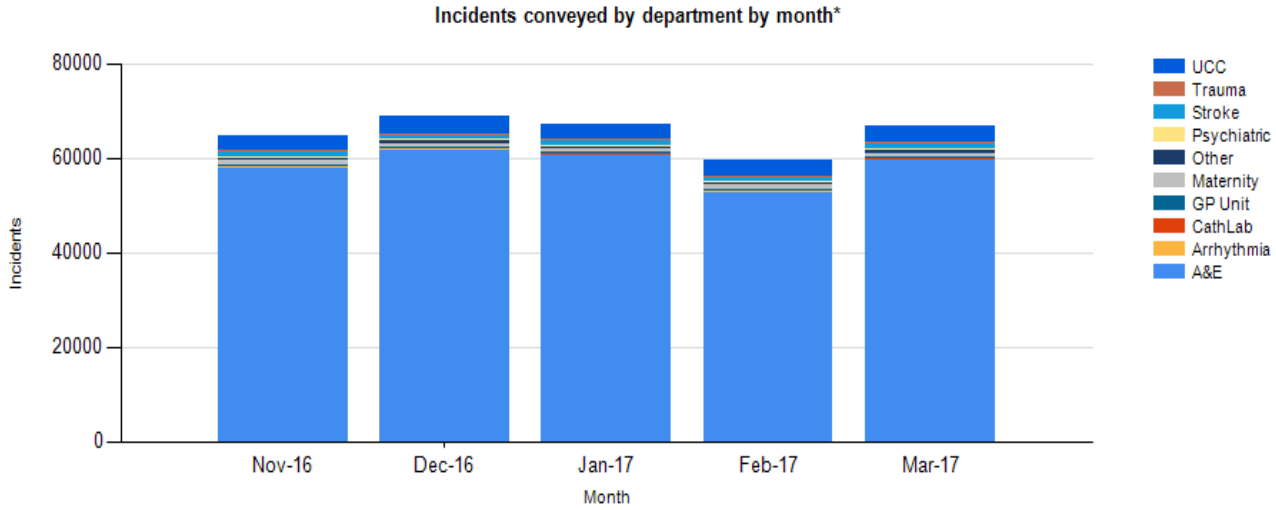
	Sporting Events	Pre-Planned Events
04 Nov	Barbarians v New Zealand Brentford v Leeds Chelsea v Man Utd Millwall v Burton Spurs v Crystal Palace West Ham v Liverpool	
11 Nov	England v Argentina	Lord Mayors Show Lord Mayors Show Fireworks
12 Nov		Remembrance Sunday
18 Nov	Arsenal v Spurs Charlton v MK Dons Crystal Palace v Everton England v Australia Fulham v Derby Leyton Orient v Dover QPR v Aston Villa	30th Anniversary Kings Cross Fire
21 Nov	Brentford v Burton Charlton v Rochdale Leyton Orient v Chester Millwall v Hull	
25 Nov	Crystal Palace v Stoke England v Samoa England Women v Canada Fulham v Millwall QPR v Brentford Spurs v West Brom West Ham v Leicester	
29 Nov	Arsenal v Huddersfield Chelsea v Swansea	
02 Dec	Arsenal v Man Utd Brentford v Fulham Chelsea v Newcastle Millwall v Sheff Utd	
03 Dec	Harlequins v Saracens	
07 Dec	Varsity Match	
09 Dec	Charlton v Portsmouth Crystal Palace v Bournemouth Fulham v Birmingham Leyton Orient v Sutton	

	QPR v Leeds Spurs v Stoke West Ham v Chelsea
12 Dec	Crystal Palace v Watford
13 Dec	Spurs v Brighton West Ham v Arsenal
16 Dec	Arsenal v Newcastle Brentford v Barnsley Chelsea v Southampton Millwall v Middlesbrough
23 Dec	Arsenal v Liverpool Charlton v Blackpool Fulham v Barnsley QPR v Bristol City West Ham v Newcastle
26 Dec	Brentford v Aston Villa Chelsea v Brighton Crystal Palace v Arsenal Leyton Orient v Dag & Red Millwall v Wolves Spurs v Southampton
29 Dec	Millwall v QPR
30 Dec	Brentford v Sheffield Weds Chelsea v Stoke Crystal Palace v Man City Harlequins v Northampton Leyton Orient v Bromley Saracens v Worcester Spurs v West Ham
31 Dec	New Year's Eve event
01 Jan	New Year's Day parade

In addition there are large numbers of visitors expected in the shopping areas of central London as well as to the several Christmas markets at locations including the Southbank and at Leicester Square.

There are planned to be a number of temporary ice skating rinks across London throughout December and January. Sites include: Somerset House, the Natural History Museum, Hampton Court and the Tower of London.

Appendix 2 – Incidents conveyed to Hospital Nov 16 – March 17



Conveyances by month by Hospital

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Barnet	1,839	1,925	1,838	1,669	1,915	9,186
Charing Cross	1,718	1,955	1,853	1,579	1,829	8,934
Chelsea & Westminster	1,716	1,748	1,747	1,502	1,723	8,436
Croydon University (Mayday)	2,864	3,007	3,012	2,573	2,858	14,314
Ealing	1,719	1,917	1,896	1,581	1,687	8,800
Hillingdon	2,371	2,489	2,427	2,216	2,480	11,983
Homerton	1,527	1,641	1,620	1,407	1,639	7,834
King Georges, Ilford	1,404	1,520	1,617	1,307	1,474	7,322
Kings College	3,029	3,205	3,026	2,725	3,152	15,137
Kingston	2,083	2,125	2,069	1,819	2,015	10,111
Lewisham	2,109	2,296	2,275	1,975	2,345	11,000
Newham	2,519	2,593	2,581	2,287	2,523	12,503
North Middlesex	2,944	3,179	3,002	2,735	3,095	14,955
Northwick Park	3,418	3,669	3,438	3,075	3,628	17,228
Princess Royal, Farnborough	2,504	2,645	2,648	2,402	2,611	12,810
Queen Elizabeth II, Woolwich	3,168	3,389	3,225	2,784	3,033	15,599
Queens, Romford - A&E	3,752	4,191	4,090	3,545	4,050	19,628
Royal Free	1,877	1,924	1,966	1,687	1,849	9,303
Royal London (Whitechapel)	2,868	3,027	2,956	2,658	3,020	14,529
St Georges, Tooting	3,179	3,335	3,361	2,971	3,378	16,224
St Helier	1,613	1,714	1,658	1,432	1,662	8,079
St Marys, W2	2,638	2,806	2,737	2,445	2,750	13,376
St Thomas'	3,210	3,390	3,149	2,888	3,093	15,730
University College	2,394	2,389	2,241	2,175	2,413	11,612
West Middlesex	2,318	2,527	2,550	2,144	2,491	12,030
Whipps Cross	2,330	2,348	2,253	2,168	2,480	11,579
Whittington	1,713	1,778	1,938	1,641	1,720	8,790

Appendix 3 – Summary of cold weather actions for health and social care organisations and professionals, communities and individuals

	Level 0	Level 1	Level 2	Level 3	Level 4
	Year-round planning *All year*	Winter preparedness and action *1 November to 31 March*	Severe winter weather forecast – Alert and readiness *Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60'% confidence.*	Severe weather action *Mean temperatures of 2°C and/or widespread ice and heavy snow.*	Major incident – Emergency response
Commissioners of health and social care	1) Take strategic approach to reduction of EWDs and fuel poverty. 2) Ensure winter plans reduce health inequalities. 3) Work with partners and staff on risk reduction awareness (eg flu vaccinations, signposting for winter warmth initiatives.	1) Communicate alerts and messages to staff/public media. 2) Ensure partners are aware of alert system and actions. 3) Identify which organisations are most vulnerable to cold weather and agree winter surge plans.	1) Continue level 1 actions. 2) Ensure partners can access advice and make best use of available capacity. 3) Activate business continuity arrangements as required.	1) Continue level 2 actions. 2) Ensure key partners are taking appropriate action. 3) Work with partners to ensure access to critical services.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
Provider organisations	1) Ensure organisation can identify and support most vulnerable. 2) Plan for joined up support with partner organisations. 3) Work with partners and staff on risk reduction awareness (eg flu vaccinations, signposting for winter warmth initiatives.	1) Ensure cold weather alerts are going to right staff and actions agreed and implemented. 2) Ensure staff in all settings are considering room temperature. 3) Ensure data sharing and referral arrangements in place.	1) Continue level 1 actions. 2) Ensure carers receiving support and advice. 3) Activate business continuity arrangements as required; plan for surge in demand.	1) Continue level 2. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Implement local plans to ensure vulnerable people contacted.	
Frontline staff – care facilities and community	1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have flu vaccinations.	1) Identify vulnerable clients on caseload; ensure care plans incorporate cold risk reduction. 2) Check room temperatures and ensure referral as appropriate. 3) Signpost clients to other services using 'Keep Warm Keep Well' booklet.	1) Continue level 1 actions. 2) Consider prioritising those most vulnerable and provide advice as appropriate. 3) Check room temperatures and ensure urgent referral as appropriate.	1) Continue level 2 actions. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Prioritise those most vulnerable.	

GPs and their staff	1) Be aware of emergency planning measures relevant to general practice. 2) Ensure staff aware of local services to improve warmth in the home including the identification of vulnerable individuals 3) Signpost appropriate patients to other services when they present for other reasons.	1) Consider using a cold weather scenario as a table top exercise to test business continuity arrangements. 2) Be aware of systems to refer patients to appropriate services from other agencies. 3) When making home visits, be aware of the room temperature.	1) Continue level 1 actions. 2) Take advantage of clinical contacts to reinforce public health messages about cold weather and cold homes on health. 3) When prioritising visits, consider vulnerability to cold as a factor in decision making.	1) Continue level 2 actions. 2) Expect surge in demand near future. 3) Ensure staff aware of cold weather risks and can advise appropriately.	
	Level 0	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Community and voluntary sector	1) Engage with local statutory partners to agree how CVS can contribute to local community resilience arrangements. 2) Develop a community emergency plan to identify and support vulnerable neighbours. 3) Agree arrangements with other community groups to maximise service for and contact with vulnerable people.	1) Test community emergency plans to ensure that roles, responsibilities and actions are clear. 2) Set up rotas of volunteers to keep the community safe in cold weather and check on vulnerable people. 3) Actively engage with vulnerable people and support them to seek help.	1) Activate the community emergency plan. 2) Activate the business continuity plan. 3) Continue to actively engage vulnerable people known to be at risk and check on welfare regularly.	1) Continue level 2 actions. 2) Ensure volunteers are appropriately supported. 3) Contact vulnerable people to ensure they are safe and well and support them to seek help if necessary.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
National level	1) OO will lead on coordinating cross-government work; individual government departments will work with partners on winter preparations. 2) DH PHE and NHS England will look to improve the CWP and the monitoring and analysis of winter related illness and deaths. 3) PHE and NHS England will issue general advice to the public and professionals and work closely with other government departments and other national organisations that produce winter warmth advice.	1) Cold Weather Alerts will be sent by the Met office to the agreed list of organisations and Category 1 responders. 2) PHE and NHS England will make advice available to the public and professionals. 3) NHS England will continue to hold health services to account for action and PHE will routinely monitor syndromic, influenza, Norovirus and mortality surveillance data.	1) Continue level 1 actions. 2) DH will ensure that other government departments, particularly DCLG RED, are aware of the change in alert level and brief ministers as appropriate. 3) Government departments should cascade the information through their own partner networks and frontline communication systems.	1) Continue level 2 actions. 2) NHS England will muster mutual aid when requested by local services. 3) Met Office will continue to monitor and forecast temperatures in each area, including the probability of other regions exceeding the level 3 threshold.	

Individuals	1) Seek good advice about improving the energy efficiency of your home and staying warm in winter; have all gas solid fuel and oil burning appliances services by an appropriately registered engineer. 2) Check your entitlements and benefits; seek income maximisation advice and other services. 3) Get a flu jab if you are in a risk group (September/October)	1) If you are receiving social care or health services ask your GP, key worker or other contact about staying healthy in winter and services available to you. 2) Check room temperatures – especially those rooms where disabled or vulnerable people spend most of their time. 3) Look out for vulnerable neighbours and help them prepare for winter.	1) Continue to have regular contact with vulnerable people and neighbours you know to be at risk in cold weather. 2) Stay tuned into the weather forecast; ensure you are stocked with food and medications in advance. 3) Take the weather into account when planning your activity over the following days.	1) Continue level 2 actions. 2) Dress warmly; take warm food/drinks regularly; keep active. If you have to go out, take appropriate precautions. 3) Check on those you know are at risk.	Follow key public health and weather alert messages as broadcast on the media.

Appendix 4 – LAS Adverse Weather Plan

Appendix 5 – LAS Control Services Surge Management Plan

Appendix 6 – LAS Resource Escalation Action Plan (REAP)

Appendix 7 – NHSE London ED Capacity Management, Redirect and Closure Plan

Appendix 8 – LAS Incident Response Plans

https://thepulseweb.lond-amb.nhs.uk/operational/emergency-preparedness-eprr/planning-for-significant-and-major-incidents/major-incident-response-procedures/

Copies of this document are available by request, it can be found internally on the LAS Pulse.

Appendix 9 – Report on the New Year's Day 2017 Computer Aided Dispatch system outage

Appendix 10 - New Year's Eve Event Plan

Due to the multiagency approach to planning NYE, the full plan will not be ready for distribution until early December 2017; however, current planning activities are underway.

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Quality Improvement Plan and CQC preparation**			
Report Author(s):	**Dr Patricia Bain, Chief Quality Officer**			
Presented by:	**Dr Patricia Bain, Chief Quality Officer**			
History:	**Presented to the Executive Leadership Team in correspondence** **Presented to the Quality Assurance Committee on 26 September 2017**			
Status:	☒	**Assurance**	☒	**Discussion**
	☒	**Decision**	☒	**Information**

Background / Purpose:

The purpose of the presentations is to provide an update on the current actions in preparation for the next Well-led inspection, provide the Board with the overarching quality improvement plan and the current status of the plan (appendix 1).

Information in relation to Well Led Key Lines of Enquiry (KLOEs) and a gap analysis of the London Ambulance Service NHS Trust has been provided to Board members separately, for information.

Recommendation:

The Board is asked to approve the Quality Improvement Plan and to note the other supporting information provided.

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

Failure to plan appropriately for the next Well-led inspection will could have an adverse impact on the likelihood of the Trust being removed from special measures.

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

and Well-led	
Reputation	☒
Other	☐

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

London Ambulance Service
NHS Trust

Trust Board CQC Update and approach going forward

Tuesday 3rd October 2017

Dr. Trisha Bain, Chief Quality Officer

Special Measures

- The Trust was placed into special measures with an overall rating of ‘Inadequate’ highlighting significant concerns in both well led and safe in 2015
- The Trust was issued with a Section 29a Warning Notice; and ordered to make improvements to patient safety and management of medicines
- Following a period of intense work by the Trust, the subsequent Warning Notice inspection in August 2016 saw the Section 29a Warning Notice removed
- A fully comprehensive inspection was undertaken in February 2017, which saw the Trust move from Inadequate to Requires Improvement overall
- The Trust increased in every domain, with safe and well led being rated as ‘Requires Improvement’
- A further inspection focusing on the well led domain is scheduled for early 2018; the new inspection process allows the Trust to start providing information, attendance of CQC managers at meetings/Board – currently developing actions.
- The presentation sets out our approach to our aim of being removed from the special measures regime.

Lessons from QIP 2016-17

Lesson Learned	Suggested Actions
There was inconsistency across stations and departments √ Actioned CQO	• Develop a set of corporate management actions so that responsibility and expectation is clear and known so that actions become part of the way we do things in LAS • CQO implementation of Health Assure system so that managers audit their stations/services and take action to implement will provide this • Quality Assurance programme being planned – October to December and on-going post inspection ***Currently being implemented***
Internally run service audits are essential to understand how things are being experience of actually happening on the ground **√ Actioned CQO**	• Put in place an annual plan of service audits across Trust made up of staff from across Directorates • Implementation of Health Assure system so that managers audit their individual services and take action to improve • Review the internal KPMG lead audit programme and widen their reach into the quality of what they audit e.g risk registers – KMPG audit said we were green; CQC said the quality of risk registers locally was often poor ***Deep dives programme in place as part of KPMG audit plan √***
Policies were often out of date or inaccurate and the process for upkeep was ineffective **√ Action for Dir CG**	• Define what is a policy, guidance and procedure • Undertaken a review of Trust policies to identify core set that are needed and which should be deleted or changed into guidance notes or procedures • Review of PMAG to be undertaken to identify purpose, membership & processes ***Interim support currently undertaking focused piece of work on policy development and key policies***
Need to improve the quality of written submissions across the Trust **Action in CQO/Dir CG**	• Senior managers should take responsibility for the standard of information and data submitted. • Data and information should be checked and signed off by Senior Managers as being of being the right content and quality • Implement corporate templates for agendas, minutes, action logs & risk registers ***Meeting with QGAMS, ADOs Corporate staff PIR process agreed, standard templates 13th October***

Reporting views – supported by Audit Apps and automatic downloads to system

CQC Quality Report

CQC Quality Report

CQC Quality Report - (August 2016)

Page 1 of 1
Displaying items 1 to 1 of 1

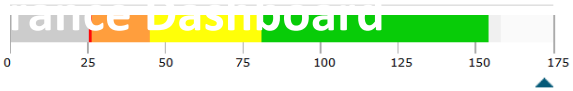
CQC Quality Reviews - Overall

Not Assessed	0
Inadequate	1
Requires Improvement	21
Good	128
Outstanding	15
Not Applicable	0
TOTAL	165

Children and Young People	0	0	1	16	3	0
Critical care	0	0	6	19	0	0
End of life care	0	0	0	4	1	0
Maternity and gynaecology	0	0	3	10	2	0
Medical care	0	0	2	30	3	0
Outpatients and diagnostic imaging	0	0	1	19	0	0
Surgery	0	1	5	16	3	0
Urgent and emergency services	0	0	3	14	3	0
TOTAL	**0**	**1**	**21**	**128**	**15**	**0**

Navigate to the "2. CQC Assurance (Trust)" Dashboard

NICE Guidance



Clinical Guidelines	6	0	6	8	8	1
Diagnostics Guidance	0	0	1	1	3	1
Highly Specialised Technology Guidance	0	0	0	0	1	0
Interventional Procedures Guidance	5	0	1	7	17	0
Medical Technologies Guidance	1	0	0	0	2	0
NICE Guidelines	5	0	5	5	16	0
Public Health Guidance	0	0	0	0	1	0
Technology Appraisals	8	1	6	15	25	2
TOTAL	**25**	**1**	**19**	**36**	**73**	**4**

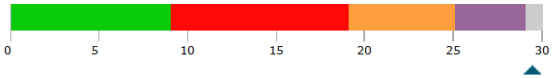
Navigate to the "NICE Guidance 2016 (by Release Date)" Saved View

NICE Quality Standards

Not Assessed	14
Not Implemented	3
Partially Implemented - Moderate Concern	32
Partially Implemented - Minimal Concern	28
Fully Implemented	76
Not Applicable	0
TOTAL	153

Navigate to the "NICE - Quality Standards." Saved View

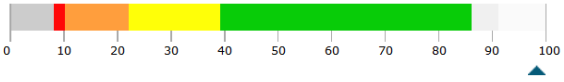
Clinical Audit Status



Core Project	4	1	1	2	3	0
Non Core Project	5	4	4	4	1	1
TOTAL	**9**	**5**	**5**	**6**	**4**	**1**

Navigate to the "Clinical Audit" Saved View

CAS Alerts



Action	4	2	8	12	37	5
Class 1: Immediate	2	0	1	1	2	0
Class 2: Action within 48 hours	1	0	2	2	2	0
Class 4: For Information	1	0	1	0	2	0
Immediate Action	0	0	0	2	4	0
TOTAL	**8**	**2**	**12**	**17**	**47**	**5**

Navigate to the "CAS Alerts (2016)" Saved View

Procedural Documents Tracking

No Status	0
Awaiting Assessment	1
3 months until Review Date	1
Under Review	2
Awaiting Committee Sign off	1
Awaiting EMB Sign off	1
Approved	11
Archived	0
Withdrawn	2
TOTAL	19

Plan & Manual	0	0	0	0	0	1	0	0	
Policy	0	1	1	2	1	0	7	0	2
Process & Procedure	0	0	0	0	0	0	1	0	0
Standard Operating Procedure	0	0	0	0	0	1	2	0	0
TOTAL	**0**	**1**	**1**	**2**	**1**	**1**	**11**	**0**	**2**

Navigate to the "Procedural Documents" Saved View

Lessons from QIP continued

Lesson Learned	Suggested Actions
We were not able to get certain information from Datix as expected and risks were not always agreed or known **√ Actioned CQO**	• Review of Datix configuration, in particular ensuring hierarchies are correct and that responsibility for reviewing and approval risks sits at the appropriate level • Themes and trends identified through Datix, across Directorates ,should be produced on a quarterly basis • Risk registers produced exported from Datix need to be improved so that they are readily available in a usable and printable format to reduce inefficiency *Datix review almost complete, risk registers structure under reviewand risk management strategy (Oct 31st Board)*
Silo working was evident and needs to be improved **√** Action Dir P&OD	• Review membership of key groups to make sure all business critical functions are represented where relevant • Identify whether a Senior Leadership Team meeting/forum should be re-established to identify and overcome barriers to progress/activities *New meetings structure for all levels of staff – roll out from October 2017*
When delivering targeted actions owners did not always think about all the steps and decision making processes required to achieve the deadline, this lead to delay **Action for Dir Transformation and Strategy/CEX**	• each objective/plan has a project plan and/or detailed timeline to ensure all necessary steps have been thought about in advance • Identify a toolkit of core project/programme management documents to be made available on The Pulse • Development programmes should incorporate this learning to ensure there is a culture of completion, ownership and perseverance within LAS • Line managers should ensure in one to one meetings that actions are delivered and staff supported to overcome barriers – not stop when they meet barriers **Part of development of central PMO**
Structure Charts are not routinely kept up to date **Actioned DCG/DO&PD**	• **Identify whether structure charts can be automatically kept up to date as part of the ESR programme People and OD to own upkeep of structure charts and the process by which they are updated** *Review of structure charts undertaken - recruitment of committee secretaries to ensure on-going review/updates*

London Ambulance Service
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Programme Management Approach

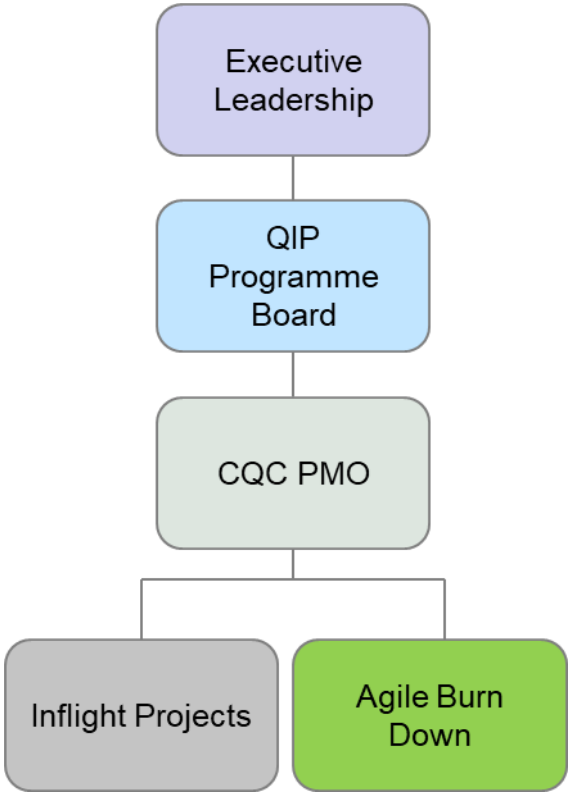
Well Led KLOE – Definition and Assessment Criteria

Well Led			
By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture			
Outstanding	**Good**	**Requires Improvement**	**Inadequate**
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.

Our Approach

- We have reviewed all of the current Trust action plans and completed a gap analysis against the newly defined KLOE's for both Well Led and Safe
- We have compiled a single plan for the Trust, combining all quality deliverables within the 2017/18 Business Plan, Well Led analysis and CQC Action Plan into a Quality Improvement Plan
- This new Improvement Plan will incorporate both impact and progression KPIs, all within a clear reporting framework via the newly created Programme Board, the first meeting of which is 5th October
- Developing a proposed framework to ensure the Trust is prepared and ready for the next CQC inspection
- In addition to the other structural, systems and process changes currently being implemented by the CQO, ensure that the Trust has sustainable quality improvement and assurance mechanisms

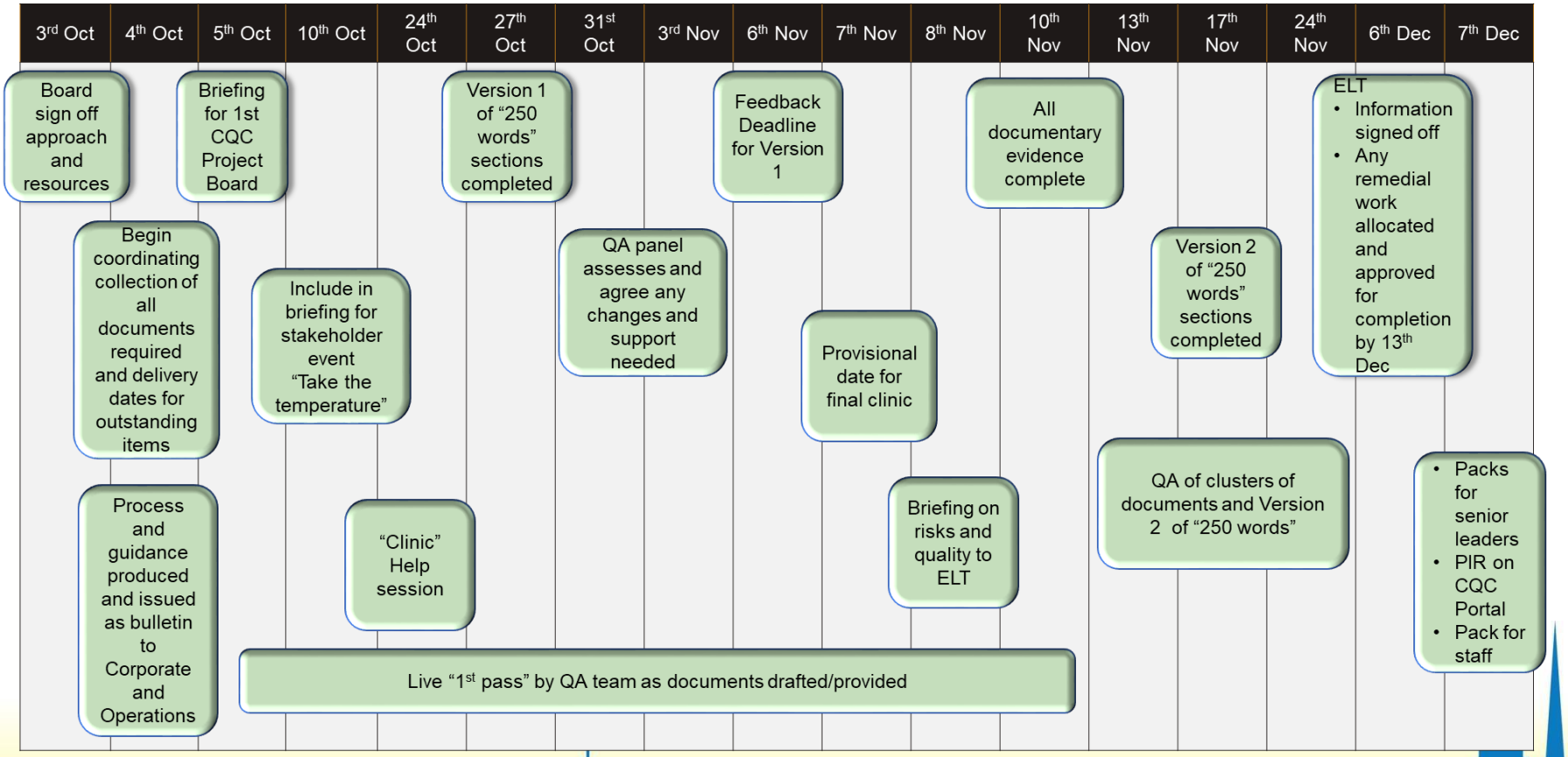
QIP Programme Board



Membership

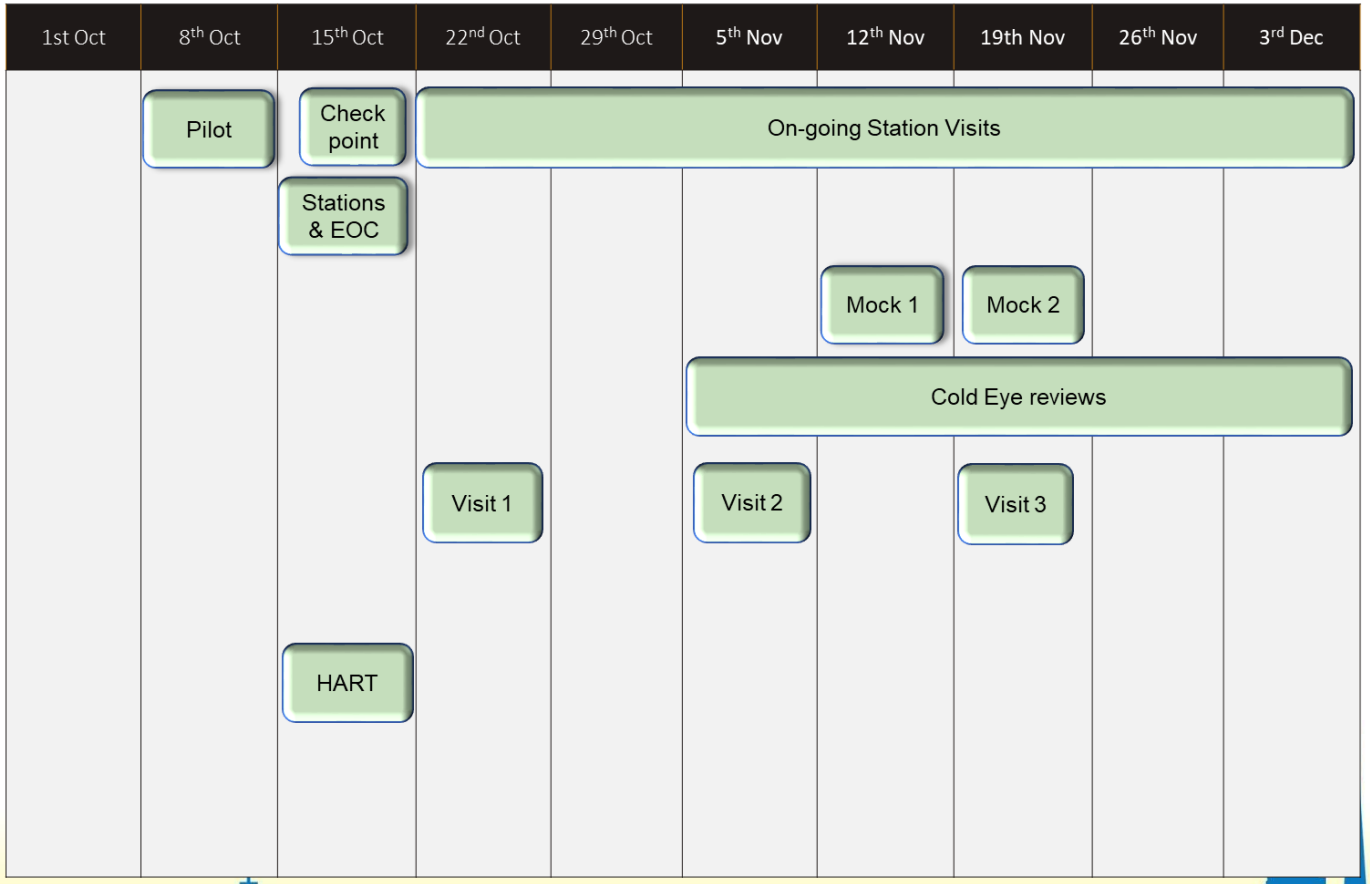
- CQC PMO Team
- Director of Finance
- Chief Quality Officer
- Director of Corporate Governance
- Director of Operations
- Chief Executive Officer
- Director of People and OD
- Improvement Director
- Medical Director

PIR Schedule



Quality Assurance Visits - Schedule

QA Visits
CE Roadshows
Mock Inspections
Exec/ Non-Exec 'Cold Eye' Reviews
Night Owl visits (provisional)
'Sit down with Director' sessions
'HART'



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Overview of the Agile Process and roles

Overview of Agile Key Roles

ROLES

Product owner
Accountable for 'business' decisions - empowered

Scrum master
Accountable for pace and clearing blockages

Team members
Accountable for delivery and expertise

Stakeholders
Informed and 'show cased'

ARTIFACTS

Product backlog
The tasks we must get done before end of November

Sprint Goal
The desired outcome of the week

Sprint Backlog
The tasks we must get done this week

Blocks List
A list of issues that need to be cleared

Increments
What have we achieved in terms of the product backlog

MEETINGS

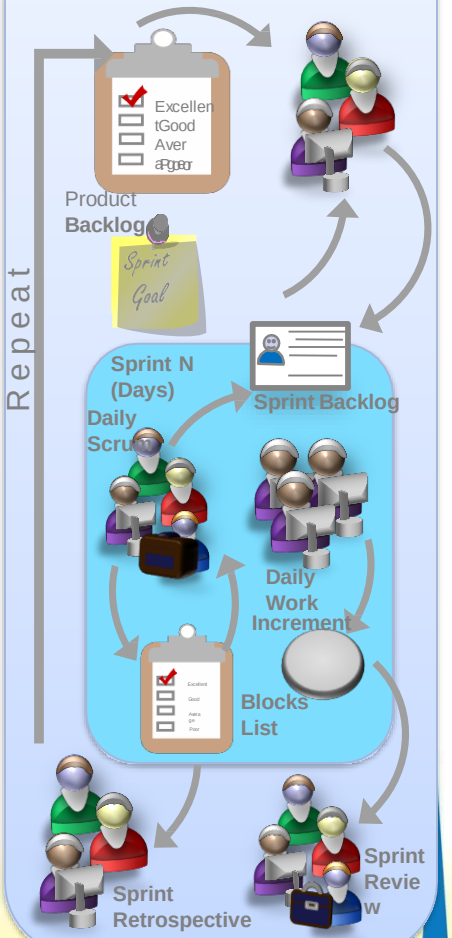
Sprint Planning
The initial meeting to agree the backlog and timings

Daily Scrum
A 15 - 20 minute meeting at a set time to talk progress and blockers.

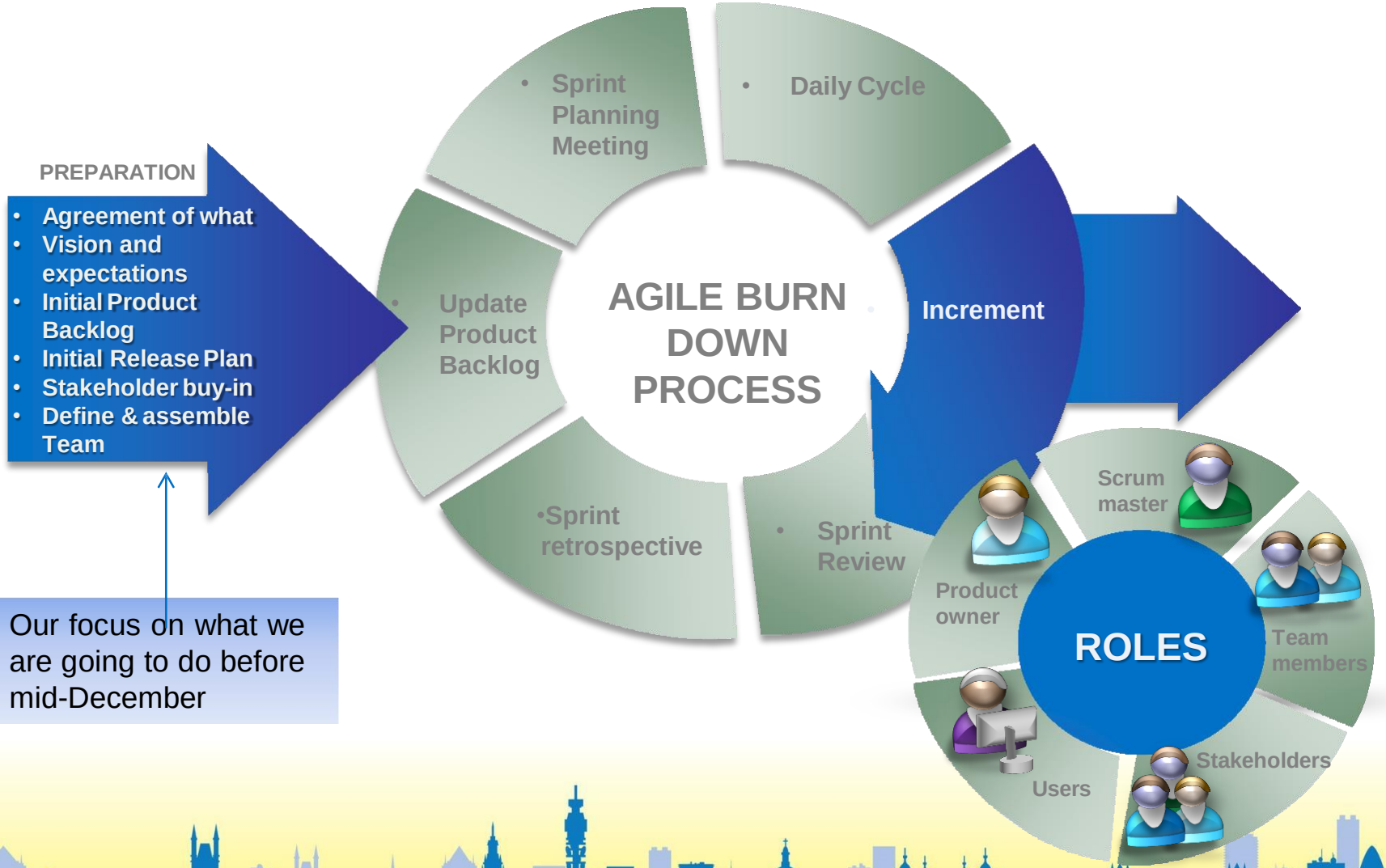
Sprint Review
A look back at what has been achieved, did it meet expectations

Sprint Retrospective
A review at the end of the 'release'

PROCESS

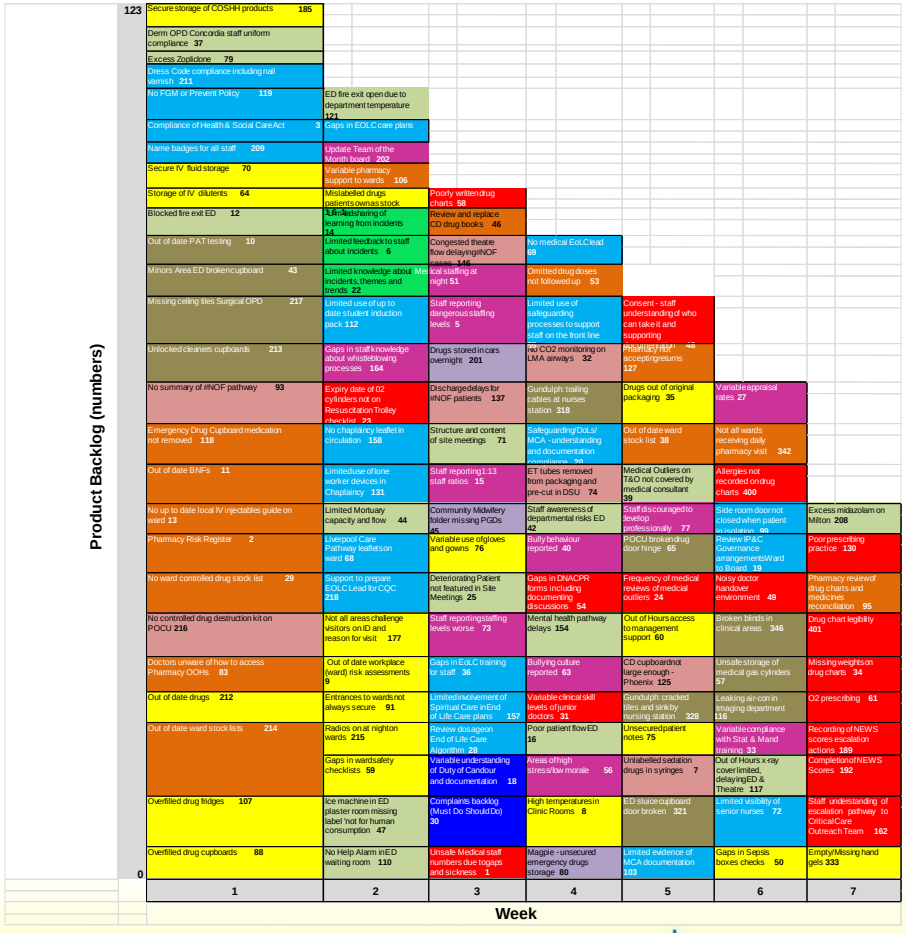


Overview of Agile Process and roles



Our focus on what we are going to do before mid-December

Agile Burn Down Chart illustration only



Burndown against agreed targets

- Task/time tracked daily/weekly

Variations

- Managed via daily stand ups
- Retrospective reviews ensure quality

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Current Status

Patients Receive Safe, Timely and Effective Care

Current Status	Previous Status
A	A

Summary Actions: 7	
Actions: 29	
Completed	10
On track	17
Amber	2

- Rest break allocation has improved from 8% in January to an average of 38% week commencing 4th September.
- There has been an agreed pause in negotiations with the TUs on new rest break policy however the Trust is still committed to finding a solution by the end of Q3 2017
- People & OD - Wellbeing Matters strategy will be presented at 3rd October Board
- Roadshows planned for October to all Staff led by CEO
- Pulse Survey Launched 4th September

KPI	July	August
MAST compliance %	69%	71%
Sickness Absence rate	5.40%	5.20%

KEY

Red = **Will miss/has missed due date**

Amber = **At risk of missing due date, but recoverable**

Green = **On Target**

Staff are Valued, Respected and Engaged

Current Status	Previous Status
G	G

Summary Actions: 5	
Actions: 20	
Completed	11
On track	9
Amber	0

- The Datix Risk Management System has been reviewed, initial redesign and reconfiguration taking place on 1 October 2017 across LAS for Incidents.
- Risk management training for all operational managers e-learning package to launch early 2018
- Risk Management learning framework draft developed. Session with QGAMs, operational staff Medical Directorate 3rd week in October to finalise.
- Datix web training e-learning platform tool 1st October Trust Wide
- Datix training activity being presented at October RIB
- LIN reportable controlled drugs incidents – 0
- Non LIN reportable controlled drugs incidents – 31 (includes errors identified as documentation only

KPI	July	August
Percentage of Incidents reported within 4 days of incident occurring	95%	88%
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	100%	100%
Potential Serious Incidents ref erred to SI Group	12	37
Serious Incidents declared in-month	4	6
Serious Incidents breaching 60 days	0	1
Serious Incidents breaching 40 days	0	1

KEY
Red = Will miss/has missed due date
Amber = At risk of missing due date, but recoverable
Green = On Target

Efficiency and Sustainability Will Drive Us

Current Status	Previous Status
A	A

Summary Actions: 2	
Actions: 7	
Completed	0
On track	6
Amber	1

- The Trust anticipates that the introduction of the Ambulance Response Programme (ARP) –assurance documents to be completed by the 20th October, goes live on 31st October 2017 – will help to deliver phase 3.
- Early modelling indicates that over 80% of incidents will not require a rest break to be interrupted
- Intelligence from Trusts already operating ARP shows they are consistently delivering high levels of rest breaks due to a reduction in the number of incidents requiring an 8-minute response
- The FRU end of shift protection arrangements have been incorporated into the North Central Dispatch Model trial, this went live on the 17th August and is currently being closely monitored. Roll-out within the South West Sector is planned for October 2017.
- Scoping of an end of shift arrangement for Double Crewed Ambulances (DCAs) will begin in late September.
- Winter Plan agreed at ELT 30th August

KPI	July	August
Overall JCT (time) (mins)	80.9	80.4
Average Arrived at Hospital to Patient Handover (mins)	19.1	19.3
Average Patient Handover to Green (mins)	18.1	18.1

KEY
Red = Will miss/has missed due date
Amber = At risk of missing due date, but recoverable
Green = On Target

Next Steps

- Delivery:
  - CQC PMO Team will meet with each Director/Product owner to confirm and agree:
  - deliverables and due dates for inclusion in Burndown in agile process
  - agree product definition/detail
- Preparation:
  - Product Owners trained in Agile Process
  - Appoint and train Scrum Master
  - Define CQC Countdown plan pre and post
- Assurance:
  - Commence PIR evidence gathering – based on known model
  - Commence evidence review of completed items
  - Agile implementation of Health Assure on-going

London Ambulance Service

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Quality Improvement Plan

KEY	
Red	= Will miss/has missed due date
Amber	= At risk of missing due date, but recoverable
Green	= On Target
Blue	= Complete

Organisation ID: RRU01
CQC Ref:INS1-2918947652

27th September, 2017

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

EXEC LEAD: Patricia Grealish

Proposed action	#Ref	Actions	Director Responsible	Owner	Due date	Jul-17	Aug-17	Sep-17	Comments	Evidence	Impact	Risks	KPI	Source
MUST DO: (1) Mast training compliance: Governance : Owner Patricia Grealish Director of People and Organisational Development														
Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such information must be more efficient. Enhancing Governance	1.01	Update all MAST training material/information contained in induction materials and messaging to reinforce and ensure individuals understand their responsibility for completion	Patricia Grealish	Jane Thomas	30/09/2017					1.Training Material Updated 2.All MAST information updated on HR system 3. Individual training records updated		Harm to patients Perceived lack of effective governance	MAST compliance %	Chris Randall
	1.02	A communication plan will be designed and implemented to embed the process, responsibilities and accountabilities for MAST compliance across all management groups	Patricia Grealish	Jane Thomas	31/08/2017					1. Communication plan and materials			Yes/No	Owner
	1.03	Ensure that the full extent of bank workers and their use at LAS is investigated and a report brought to ELT to discuss next steps.	Patricia Grealish	Lindsay Koppenhol/ Gill Heuchan	31/08/2017				Work is underway to review the data that the trust currently holds on bank workers. Once this has been completed, a training needs gap analysis will be undertaken and a capacity plan generated. This will be shared with Clinical Education and the LAS e-learning team	1. Report on use of Bank workers 2. Training records for Bank staff updated			Bank shifts as % of total shifts	tbc
	1.04	Clearly define and implement a process to ensure that all bank workers can evidence compliance with LAS MAST training	Patricia Grealish	Lindsay Koppenhol	31/07/2017				The core training policy is currently being reviewed to ensure it supports managers in this task especially in terms of tolerance, risk to the trust regarding non-compliance and consequence. In order to support the delivery and maintenance of statutory and mandatory compliance for bank workers the relevant policies will be	1. Revised process to allow Bank workers to evidence MAST training			Bank MAST compliance %	tbc
	1.05	Complete implementation of enhanced ESR Project so records are available on demand for managers at individual, team, sector and function level	Patricia Grealish	Chris Randall	01/08/2017					1. ESR system live and rolled out			Yes/No	Owner
	1.06	Ensure that MAST compliance data is incorporated into the workforce report for the Board, split into corporate and clinical staff groups	Patricia Grealish	Jill Patterson	31/08/2017					1. Updated Workforce report			Yes/No	Owner
MAST Training (2) : Setting and Maintaining standards														
Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such information must be more efficient.	1.07	Carry out a review of the content of MAST training for clinical staff to include the method of delivery and skills of trainers	Patricia Grealish	Tina Ivanov	31/08/2017					1. MAST training for clinical staff approved scope and quality 2. List of trainers and their skills for MAST training 3. Training methodology		Harm to patients Perceived lack of effective governance	Yes/No	Owner
	1.08	All managers to have an objective requiring them to ensure their teams are compliant for all accessible MAST training	Patricia Grealish	Jane Thomas/ Julia Smyth	31/08/2017				Standard objectives drafted and sent out with a request to all staff cascade across Directorates	1. Appraisal forms for Managers			Yes/No	Owner
	1.09	Agree compliance target and dates for clinical staff to recognise the Block training nature of their core skills refresher programme	Patricia Grealish	Tina Ivanov	31/08/2017					1. Approved MAST training schedule by staff member/group			CSR Compliance %	tbc
	1.10	Carry out review to agree consequences of non-compliance with MAST requirements and to investigate options to require new employees to complete training period between offer and starting work with LAS	Patricia Grealish	Jane Thomas/ Julia Smyth/ Chris Randall	31/08/2017					1. Report to the Workforce Committee on the consequences of non compliance with MAST 2. Validated set of options for training of all new staff between offer and starting work with LAS			Yes/No	Owner
	1.11	The ELT will require all corporate staff to be compliant in current MAST modules which are currently accessible, by 31 August 2017. This focus will be supported by the communication plan.	Patricia Grealish	Executive Leadership Team	31/08/2017					1. Training records for all corporate staff			Yes/No	Owner
	1.12	The ELT will require all corporate staff to be compliant in new MAST modules accessible on ESR by 31 November 2017. Evidence of progress will then be submitted to CQC to lift the requirement notice.	Patricia Grealish	Julia Smyth	30/11/2017					1. Training records for all corporate staff			Yes/No	Owner
Sickness and Absence: Owner Patricia Grealish														
To continue working with staff to address the issues related to rosters, rest breaks, sickness and absence, Actions should demonstrate a fair and consistent approach to managing the demands of the service along with health and safety of staff	1.13	Complete implementation of agreed approach in relation to Rest Breaks	Paul Woodrow Patricia Grealish	**SC**/ Lindsay Koppenhol	31/12/2017				Rest break allocation has improved from 8% in January to an average of 38% week commencing 4th September. There has been an agreed pause in negotiations with the TUs on new rest break policy however the Trust is still committed to finding a solution by the end of Q3 2017	1. Revised Rest Break policy 2. Communicate Plan to all impacted staff		Staffing levels unsafe Wellbeing of staff Risk of industrial action Unable to meet patient demand	Yes/No	Owner
	1.14	Launch of People & OD - Wellbeing Matters strategy theme introducing proactive approach to health and wellbeing	Patricia Grealish	Gill Heuchan Fatima Fernandes	31/12/2017				This forms part of the People and OD strategy which will be presented at 3rd October Board	1. People and OD strategy 2. Board approval 3. P&OD Implementation Plan specifically Well Being Matters 4. Pulse surveys of staff awareness			Yes/No	Owner
	1.15	Ensure the introduction of the Workforce Dashboard to time which will give managers dynamic information about their people, including vacancy rates, sickness rates and appraisal	Patricia Grealish	Chris Randall	01/08/2017					1. Revised Workforce Dashboard/Report			Yes/No	Owner
	1.16	Review the Trust Policy on Sickness Absence in light of 1.14 above and implement any recommendations	Patricia Grealish	Alex Bass/ **CH**	31/12/2017					1. Revised Sickness Absence Policy			Sickness Absence rate	Chris Randall
Leadership development														
Review the leadership and management styles of key staff with responsibility for managing emergency and urgent care ambulance crews. In addition identify further opportunities for the executive team to increase their engagement with staff, to ensure strategy and vision is embed in culture and that the views of staff are heard.	1.17	Launch of People & OD, Leadership and Management Theme, central to which is the development and communication of management behaviours	Patricia Grealish	Jane Thomas/ Julia Smyth	31/12/2017				This forms part of the People and OD strategy which will be presented at 3rd October Board	"1. People and OD strategy 2. Board approval 3. P&OD Implementation Plan specifically Leadership and Management theme		Failiure to tackle bullying culture Disengaged workforce Unable to deliver trust strategy & vision Lack of trust between staff & management	Yes/No	Owner
	1.18	Develop and deliver behaviours and professional standards frameworks, learning from NHS Leadership Academy GMC and NMC. Ensure that role descriptions and objectives set out the imoortance of role modelling values and behaviours.	Patricia Grealish	Tina Ivanov/ Jane Thomas/ Julia Smyth/ Bryony Sloper	31/12/2017				This forms part of the People and OD strategy which will be presented at 3rd October Board	1. Set of professional standards 2. Updated role descriptions			Yes/No	Owner
	1.19	Design and deliver key communication and engagement activities, including 'town halls', management group away days and ,road shows to support face to face communication with people across LAS. Explore the value of standardised	Patricia Grealish	Angie Patton/ Alex Bass	31/10/2017				Roadshows planned for October to all Staff led by CEO.	1. Communication and Staff Engagement Plans 2. Agreed process for staff engagement such as 'Listening into Action'			Yes/No	Owner
	1.20	Launch of People & OD, Engagement strategy theme, central to which is developing communication and engagement plans to support staff survey and see 2.20 below	Patricia Grealish	Lindsay Koppenhol/ Alex Bass	04/10/2017				This forms part of the People and OD strategy which will be presented at 3rd October Board	"1. People and OD strategy 2. Board approval 3. P&OD Implementation Plan specifically Engagement theme 4. Pulse surveys of staff awareness"			Yes/No	Owner
	1.21	Launch of People & OD, Engagement strategy theme, central to which (in addition to 2.19 above) is core management development interventions to support working proactively with TUs and communicating directly with our people	Patricia Grealish	Patricia Grealish (new lead yet to be appointed)	31/12/2017				This forms part of the People and OD strategy which will be presented at 3rd October Board	"1. People and OD strategy 2. Board approval 3. P&OD Implementation Plan specifically Engagement theme 4. Pulse surveys of staff awareness"			Yes/No	Owner
	1.22	Undertake a Pulse Survey in January 2018 and an independent deep dive in Q1 18/19 to test the impact of leadership development, changing working practices and engagement activities on staff experience	Patricia Grealish	Angie Patton/ Patricia Bain	30/06/2018				Survey Launched 4th September	1. Pulse Survey results 2. Deep dive notes of meeting and actions			Yes/No	Owner
Bullying and Harassment and BME; Owner Patricia Grealish														
Continue to build on the programme of work to improve the culture around perceived bullying and harassment. Push forward with the measures it has identified and already established to increase a more diverse and representative workforce with greater numbers of black and ethnic minority staff.	1.23	To commission Consultant to complete Phase 4 of the work commenced in 2016/17	Patricia Grealish	Patricia Grealish	31/07/2017					1. Programme deliverables 2. Pulse surveys Staff survey results		Disengaged workforce Bullying culture No improvement in diversity Non representative workforce	Yes/No	Owner
	1.24	To procure the services of an independent Mediator to support our approach for informal resolution and courageous conversations	Patricia Grealish	Cathe Gaskell	30/11/2017					1. Appoint an independent mediator			Yes/No	Owner
	1.25	To develop and launch the WRES Action Plan for 2017/18	Patricia Grealish	Melissa Berry	03/10/2017					1. WRES Action Plan 2. Comminication plan 3. Increased diversity within the workforce - Workforce report			Yes/No	Owner
Allocation of resources : Owner Paul Woodrow														
Allocate ambulance personnel appropriately taking into account individual qualifications, experience and capabilities	1.26	A review will be undertaken of the Trust's allocation of ambulance personnel to vehicle resource against the Trust's skill mix matrix to determine levels of compliance.	Paul Woodrow	Brian Jordan	30/09/2017					1. Report on ambulance staff allocation and compliance to skill mix matrix		Safe staffing Staff wellbeing Inability to meet demand	Yes/No	Owner
	1.27	The Trust's skill mix matrix will be reviewed on an annual basis to ensure it remains fit for purpose and clinically appropriate.	Paul Woodrow Fenella Wrigley	Brian Jordan	30/03/2018					1. Evidence of review at Workforce Committee 2.Internal Audits 3. Executive Leadership Team review			Yes/No	Owner
Shift Patterns : Owner Paul Woodrow														
Ensure enough time is factored into shift patterns for ambulance crews to undertake their daily vehicle checks within their allocated shift pattern	1.28	The outcome of 4.01 and 4.02 will be considered as part of the Trust's roster review.	Paul Woodrow	Gill Heuchan	This date needs to follow the dates given for					1. Revised Shift rota's		Unsafe vehicles, risk of accidents Safety of patients & public	Yes/No	Owner
	1.29	The outcome of 4.01 and 4.02 will be considered as part of the Trust's roster review.	Paul Woodrow	Gill Heuchan	This date needs to follow the dates given for					1. Revised Shift rota's			Yes/No	Owner

STAFF ARE VALUED, RESPECTED & ENGAGED			EXEC LEAD: Patricia Bain, Fenella Wrigley											
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Owner**	**Due date**	**Jul-17**	**Aug-17**	**Sep-17**	**Comments**	**Evidence**	**Impact**	**Risks**	**KPI**	**Source**
Risk Management - Patricia Bain Philippa Harding														
Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly. Ensure staff report all incidents including low harm and near miss incidents and are encouraged to do so. Improve and Evidence how we learn from incidents, risks, feedback and external inquiries.	2.01	Undertake a baseline review of all local risk registers and complete a gap analysis	Patricia Bain	Fatima Fernandes	01/09/2017				Complete	1. Updated local risk registers 2. Completed gap analysis		Inability of organisation to share learning Lack of assurance at board level Reputation damage with regulators & commissioners Suspension of license Repetition of SI's	Yes/No	Owner
	2.02	Undertake regular monitoring / audit of risk registers and the Datix system to encourage proactive learning and risk mitigation. Undertake a Q3 deep dive to test the impact of changes on quality of risks being reported and effectiveness of the risk management approach	Patricia Bain	Nathan Coleman	ongoing				Complete	1. Records of regular audit of risk registers 2. Records of egular audit of Datix system 3. Records of deep dives to test impact of changes on quality and effectiveness			Yes/No	Owner
	2.03	Update and publish revised Risk Management Policy	Patricia Bain	Fatima Fernandes	30/09/2017				Due to complete 31st October	1. updated Risk Management Policy			Yes/No	Owner
	2.04	Complete a strategic risk review of the Trust risk register and align local risk register to BAF	Patricia Bain	Philippa Harding	01/08/2017				Due to be presented to 3rd October Board	1. Evidence of Strategic Risk review of Trust risk register 2. Local risk registers alignedto Board Assurance framework			Yes/No	Owner
	2.05	Raise awareness of incident reporting across the Trust through various mechanisms that include automatic feedback loops from Datix when an incident is reported. Ensure the Integrated Performance Report tracks the number of low harm and no harm incidents reported as well as total incidents reported	Patricia Bain	Amanda Mansfield	30/09/2017				The Datix Risk Management System has been reviewed with an initial redesign and reconfiguration taking place on 1 October 2017 across LAS for Incidents. These improvements and future enhancements (to be made in Q3) will see the incident reporting process more robust and far more intuitive for staff, with a detailed feedback mechanism providing information to assist the learning and sharing relating to all clinical and non-clinical incidents. An e-learning package is being developed for all staff as part of mandatory training which will raise awareness of incident reporting, investigations and the sharing of lessons (to be launch in early 2018).	1. Evidence of communicaion regarding incident reporting importance and process across the Trust 2. Enhanced incident reporting process 3. e-learning package on incident reporting			SI's	Quality Report
	2.06	Roll out updated risk management training for all operational managers for cascading to all staff, raising awareness of risk management processes	Patricia Bain	Nathan Coleman	01/10/2017				e-learning package to launch early 2018	1. e-learning package 2. Mandatory training plan for all Operational managers 3. Training records updated 4. Record of training cascaded to all staff 5. Underpin improtance with a communications and awareness plan			Risk Mgt Training %	Quality Report
	2.07	Redesign the investigation process to accelerate learning that includes training for core staff	Patricia Bain	Jon Fletcher	01/07/2017				Complete	1. Redesigned investigation process			Yes/No	Owner
	2.08	Develop a reporting and learning framework that includes events, communication at all levels in the Trust	Patricia Bain	Jo Cutting	01/09/2017				Learning framework draft developed working with operational and corporate staff. Session with QGAMs, operational staff Medical Directorate 3rd week in October to finalise . To be presented with Quality Improvement and Learning strategy at October Board.	1. Learning Framework 2. Evidence of implementation of the Learning Framework			Yes/No	Owner
	2.09	Develop the Datix system to ensure it captures and can report risks and incidents in a way that supports proactive learning	Patricia Bain	Nathan Coleman	ongoing				The Datix Risk Management System has been reviewed with an initial redesign and reconfiguration taking place on 1 October 2017 across LAS for Incidents, further activity is planned to review additional enhancement on within the Incidents, Risks and Patient Experience module in Q3 which will support proactive learning.	1. Revised Datix system configuration 2. Amended Datix system 3. Evidence of Monitoring effectiveness of the changes			Yes/No	Owner
Improving incident reporting - Sandra Adams														
Review and improve Trust incident reporting data Address under reporting of incidents including the perceived pressure in some departments not to report some incidents	2.10	Review incident reporting awareness tools	Patricia Bain	Kirstie Smith	01/08/2017					1. Review of incident awareness tools 2. Recommend revisions/gap analysis		Lack of timely & accurate information Lack of board level assurance Bullying culture	Yes/No	Owner
	2.11	Develop DatixWeb training and implementation plan for roll out	Patricia Bain	Nathan Coleman	ongoing				e-learning platform tool 1st October Trust Wide	1. Training Needs Analysis (TNA) 2. Training materials 3. Training schedule 4. Training records			Yes/No	Owner
	2.12	Design a plan for staff communication to ensure they understand the Trust updated incident management processes, following the implementation of DatixWeb	Patricia Bain	Nathan Coleman	01/09/2017				On-going activity being presented at October RIB	1. Communication Plan 2. Evidence of monitoring effectiveness of changes			Yes/No	Owner
Improving safety: Fenella Wrigley														
Ensure ongoing robust plans to tackle handover delays	2.13	Continue to implement system wide hand over project	Fenella Wrigley	Steven Russell	31/03/2018					1. Project deliverables 2. Evidence of monitorig of effectveiness		Impact on patient safety Inability to meet demand Impact on acute hospitals	Yes/No	Owner
	2.14	Monitor Monthly at ROG	Fenella Wrigley	Steven Russell	monthly					1. Standardised Monthly reporting pack 2. Evidence of monitoring effectivness			Yes/No	Owner
Improve the oversight and management of infection prevention and control practices. This includes ensuring consistent standards of cleanliness in the ambulance stations vehicles and staff adherence to hand hygiene practices	2.15	Recruit to IPC agreed Resource	Fenella Wrigley	Eng-Choo Hitchcock	30/08/2017					1. Budget and Establishment approval 2. Advertised role 3. Appointment			Yes/No	Owner
	2.16	Continue to develop and implement Perfect Ward app	Fenella Wrigley	Eng-Choo Hitchcock	ongoing					1. Perfrect Ward app in use			Roll Out Completion %	Owner
	2.17	Increase IPC Audit at stations and A&E	Fenella Wrigley	Eng-Choo Hitchcock	ongoing					1. Audit programme and results 2. Evidence of monitoring effectiveness			Yes/No	Owner
Ensure continued monitoring and improvements are made in medicines management so that safety procedures are embedded in everyday practice and sustained by staff	2.18	2nd phase of medicines management improvements to be implemented	Fenella Wrigley	Timothy Edwards	end 2017/18				LIN reportable controlled drugs incidents - 0 Non LIN reportable controlled drugs incidents – 31 (includes errors identified as documentation only)	1. Evidence of communications 2. Evidence of montioring effectiveness			tbc	Quality Report
	2.19	Continue development and roll-out of Perfect Ward App	Fenella Wrigley	Eng-Choo Hitchcock	end 2017/18					1. Perfrect Ward app in use			Roll Out Completion %	Owner
	2.20	On-going auditing of estate to ensure drugs stored securely	Fenella Wrigley	Timothy Edwards	end 2017/18					1. Established audit/review programme(s) 2. Evidence of monitoring effectiveness			Audits completed / delinquent %	Owner

EFFICIENCY & SUSTAINABILITY WILL DRIVE US			EXEC LEAD: Paul Woodrow											
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Owner**	**Due date**	**Jul-17**	**Aug-17**	**Sep-17**	**Comments**	**Evidence**	**Impact**	**Risks**	**KPI**	**Source**
Fleet / Vehicle Preparation - Lorraine Bewes														
Ensure performance targets are met for high priority patients	4.01	Implement the Ambulance Response Programme in line with national guidelines and timescales	Paul Woodrow	**SC**	04/10/2017				Testing of Paramount software successful with technical issues resolved. Extra week of testing has delayed ARP go live date. Assurance documents will be completed by 20th Oct ARP implementation date will be overnight on 31st Oct	1. Programme implementation plans		Risk to patient safety Impact to staff wellbeing Impact to operational performance Impact to financial performance	Yes/No	Owner
	4.02	Finalise and implement the new system for rest breaks	Paul Woodrow	**SC**	30/09/2018				The Trust anticipates that the introduction of the Ambulance Response Programme (ARP) – which goes live on 31st October 2017 – will help to deliver phase 3. Early modelling indicates that over 80% of incidents will not require a rest break to be interrupted. Intelligence from Trusts already operating ARP also shows that these Trusts are consistently delivering high levels of rest breaks due to a reduction in the number of incidents requiring an 8 minute response.	1. Evidence of montoring impact of ARP implementation on rest breaks 2. Revised policy and process forRest Breaks			Yes/No	Owner
	4.03	Reduce job cycle time (JCT) to 78 minutes	Paul Woodrow	**SC**	30/03/2018				An evaluation paper has been finalised for Executive Leadership Team consideration with recommendations regarding roll-out of the FRU end of shift protection arrangements The FRU end of shift protection arrangements have been incorporated into the North Central Dispatch Model trial, this went live on the 17th August and is currently being closely monitored. Roll-out within the South West Sector is now planned for October 2017 to allow for staff engagement and data analysis of the North Central trial. Scoping of an end of shift arrangement for Double Crewed Ambulances (DCAs) will begin in late September.	1. Revised JCT processes 2. Evidence of monitoring JCT improvement			JCT time	IPR
	4.04	Undertake robust planning for winter 2017/18	Paul Woodrow	Kevin Bates	01/09/2017				Winter Plan agreed at ELT 30th August	1. Winter plans 2017/18			Yes/No	Owner
	4.05	Reduce delays in hospital handovers	Paul Woodrow	Peter McKenna	30/11/2017					1. Evidence of improvement in handover times			Hospital Handover delays	IPR
	4.06	Produce robust workforce demand and capacity model	Patricia Grealish	Chris Randall	03/10/2017					1. Workforce demand and capacity model			Yes/No	Owner
Further improve the provision and monitoring of essential equipment availability for staff at the start of their shift	4.07	Understand the types of equipment in short supply and root cause. Address supply chain and distribution issues and ensure a robust audit process is in place to monitor impact	Lorraine Bewes	Justin Wand	30/11/2017					1. System for equipment logging 2. Evidence of ontioring usage		Impacting patient safety & responsiveness	Yes/No	Owner

WELL-LED			EXEC LEAD:											
Proposed action	**#Ref**	**Actions**	**Director Responsible**	**Owner**	**Due date**	**Jul-17**	**Aug-17**	**Sep-17**	**Comments**	**Evidence**	**Impact**	**Risks**	**KPI**	**Source**
Is there leadership capacity and capability to deliver high quality sustainable care - Garrett Emmerson & Patricia Grealish														
W1.1 Do leaders have the skills, knowledge, experience and integrity that they need - both when they are appointed and on an ongoing basis ?	W0	Complete recruitment to remaining Executive team vacancies	Garrett Emmerson	Garrett Emmerson	31/10/17 - garrett to sense check									
	W1	Specify and commission a programme of Board and Executive development once the Executive recruitment is in place	Garrett Emmerson	Garrett Emmerson	31/12/2017									
	W2	Ensure Board meetings include some time for reflection on how effective they are and identify areas for improvement and there is an agreed timescale in place for re-looking at the dates of Board sub-committees to improve the flow of information to Board	Philippa Harding	Philippa Harding	31/08/2017									
	W3	Ensure all Executive and Non Executive Directors (including secondees) have a personnel file which is compliant with the Trust Fit and Proper Person Policy	Patricia Grealish	Patricia Grealish	31/10/2017 needs to match W0 date set by GE									
W1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions to address them ?	W4	Ensure the actions relating to CQC February inspection and the well led gap analysis are reflected in Executives objectives and cascaded to their teams	Garrett Emmerson	Garrett Emmerson	31/08/2017									
	W5	Get consensus amongst the Executive on the top corporate risks to ensure alignment with the Business plan objectives and current strategic issues. Propose refreshed BAF to Board.	Garrett Emmerson	Philippa Harding	31/10/2017									
	W6	Director of Operations to chair the weekly Service Delivery Group	Paul Woodrow	Paul Woodrow	31/08/2017									
	W7	Explore with Mike Davidge the potential for information for improvement support into the performance function	Garrett Emmerson	Garrett Emmerson	31/08/2017									
	W8	Strengthen visibility of the Business Continuity work programme amongst the Executive Team and ensure the Board receives an assurance report before end October	Philippa Harding	Sarah Rosenhurst-Banks	31/10/2017									
	W9	Ensure the loop is closed on a number of areas where the Board has asked for further assurance - workforce resilience including safe staffing (PG), mandatory training compliance (PG), the impact of CIPs on quality (LB) and the impact of demand on patient quality and safety (FW,TB)	Philippa Harding	Philippa Harding	31/10/2017									
	W10	Agree an Executive lead responsible for maintaining a register of external reviews and ensuring they are reported to Board. This includes the Health and Safety Review (July 2017) and the NARU assurance review (Dec 2017)	Philippa Harding	Philippa Harding	01/08/2017									
	W11	Agree a definition of 'key business cases' to submit in the PIR and collate the information needed for the return	Lorraine Bewes	Lorraine Bewes	30/11/2017									
	W12	Ensure that there is a programmed local staff survey in June each year reported up to Board through the Workforce Committee to provide leaders with a more live sense of staff morale, views of leadership and engagement and assess the effectiveness of the action plan developed in response to the national staff survey released in January each year.	Patricia Grealish	Angie Patton, Tracey Watts	31/03/2017									
	W13	Undertake a specific pre CQC staff survey and / or mock focus groups before re-inspection and share findings with the Board and senior Corporate and Operational leaders. This should include questions on appraisal quality and quality of management support. Take advice from the equalities lead on	Patricia Grealish	Angie Patton, Tracey Watts	31/01/2018									
	W14	Ensure all Executive Directors, the NEDs on the Quality Committee and the Trust Chair have a good understanding of the 17/18 financial and CIP plans and how they are supporting the quality agenda in the trust	Lorraine Bewes	Lorraine Bewes	31/10/2017									
W1.3 Are leaders visible & approachable ?	W15	Reinstate a formal programme of diarised Executive and Non Executive visits to services and a mechanism for collecting and reporting data to the Programme Board, ready for the PIR	Patricia Grealish	Angie Patton	01/09/2017									
	W16	Ensure there is a clearly articulated written approach to staff engagement and collated evidence of those activities, ready for the PIR	Patricia Grealish	Angie Patton	31/11/2017									
W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership and is there a leadership strategy or	W17	Cross check the draft People and OD strategy and the implementation plan to ensure the KLOEs are explicitly addressed. This includes a clear statement the trust will use values based recruitment.	Patricia Grealish	**SH**	31/08/2017									
	W18	Brief ELT on progress of the leadership development programme and agree the staff groups to be covered in each wave, including which staff could have training before Operations restructure is completed	Patricia Grealish	Julia Smyth Jane Thomas	30/09/2017									

development programem which includes effective selection, development, deployment and support processes and succession planning	W19	Finalise the 'key people' risk assessment and mitigations document	Patricia Grealish	Patricia Grealish	31/08/2017									
	W20	Ensure the consultation documents and proposed structure diagrams for the Operational restructure have been shared with the wider Executive team for comment	Paul Woodrow	Brian Jordan	03/08/2017									
Is there a clear vision and credible startegy to deliver high quality sustainable care to people who use services and robust plans to deliver - Garret Emmerson, Karen Broughton & Angela Flaherty														
W2.1 Is there a clear vision and set of values with quality and sustainability as the top priorities	W21	Complete the quality strategy and implement a communications plan to share it with staff and partners	Patricia Bain		31/08/2017									
W2.2 Is there a robust, realistic strategy for achieving the prioties and delivering good quality, sustainable care	W22	Complete the refresh of the trust over-arching strategy and ensure the staff roadshows clarify the timetable and opportunities for staff engagement	Garrett Emmerson	Angela Flaherty, Angie Patton	Garrett to suggest									
W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services and external partners	W23	Ensure that evidence is being collated on who has been involved in developing the overarching strategy and how, ready for the PIR	Garrett Emmerson	Angie Patton	30/11/2017									
W2.5 Is the strategy aligned to local plans in the wider health and social care economy and how have services been planned to meet the needs of the local population ?	W24	Ensure there is a clearly articulated reference case for the over-arching strategy which can be supplied to CQC as evidence	Garrett Emmerson	Angela Flaherty	30/11/2017									
W2.6 Is progress against the strategy and local plans monitored and reviewed and is there evidence to show this ?	W25	Provide quarterly progress updates on clinical strategy implementation to Board and a mechanism for communicating progress to staff	Fenella Wrigley	Fenella Wrigley	30/09/2017									
	W26	Programme quarterly updates to Board for other significant approved Trust strategies	Philippa Harding	Angela Flaherty	30/09/2017									
Is there a culture of high quality sustainable care - Fenella Wrigley & Trisha Bain														
W3.4 Is action taken to address behaviour and performance that is inconsistent with the vision and values regardless of seniority ?	W27	Collate the learning from the NE London intensive support programme as an exemplar for changing culture and agree what the model should be the trust will use across London	Paul Woodrow	Peter McKenna	30/11/2017									
	W28	Refresh the Management of Change Policy	Patricia Grealish		Patricia to advise									
W3.5 Does the culture encourage openness and honesty at all levels of the organisation including with people who use services in response to incidents ? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution and is appropriate learning and action taken as a result of concerns raised ?	W29	Ensure the private part of the board receives a quarterly report on Whistleblowing and the work of the Speak up Guardian. Implement a mechanism for collating the information needed on whistleblowing for the PIR.	Patricia Bain	Margaret Luce	31/10/2017									
W3.8 Are equality and diversity promoted within and beyond the organisation ? Do all staff, including those with a protected characteristics under the Equalities Act feel they are treated equitably ?	W30	Ensure the gap analysis on equalities and diversity has visibility within the organisation and progress is monitored quarterly at board sub-committee level	Patricia Grealish	Melissa Berry	30/09/2017									
W3.7 Is there a strong emphasis on the safety and well being of staff ?	W31	Ensure the Health and safety external review is presented to Board and assurance to QAG includes progress updates	Patricia Bain	**AA**	31/10/2017									
Are there clear responsibilities, roles and systems of accountability to support good governance and management - Garrett Emmerson and Lorraine Bewes														
W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality sustainable services ? Are	W32	Ensure there are up to date organisational structure charts and visual representations of the governance arrangements, including Board to floor assurance on quality and safety	Patricia Grealish, Philippa Harding		30/11/2017									
	W33	Confirm the timetable for business partnering arrangements to be in place and the shape of the HR and Finance support	Lorraine Bewes, Patricia Grealish	Angela Flaherty	30/09/2017									
W4.2 Are arrangements with third party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care	W34	Request a rapid review of third party provider monitoring, with particular emphasis on quality oversight	Lorraine Bewes		30/11/2017									
W4.3 Do all levels of governance and management function effectively and interact with each other appropriately ?	W35	Introduce standardised agendas and action logs for local risk and governance meetings and ensure these are Quality checked	Patricia Bain	QGAMS	31/10/2017									
	W36	Implement minute taking training for admin staff taking minutes at Board, ELT, and sub-committees to improve the quality of evidence recording and ensure there are core templates for ppaers, action plans, minutes and action logs	Philippa Harding	Jacqui Galetta	01/11/2017									
Are there clear and effective processes for managing risks, issues and performance - Trisha Bain and Philippa Harding														
W5.4 Are there robust arrangements for recording and managing risks, issues and mitigating actions ? Is there alignment between the recorded risks and what staff	W37	Agree a process for risks identified through the Operational and Corporate performance meetings to feed through to the corporate risk register and the BAF	Garrett Emmerson	Philippa Harding	Garrett to suggest									

	W38	Re-instate the quality assurance visits to core services to identify risks and ensure actions are being taken. Set out the reporting lines for intelligence from the visits	Patricia Bain	Terence Joe	31/10/2017									
	W39	Ensure papers for ELT, Board and sub-committees have a properly completed cover sheet to highlight their implications for risk and the risk appetite	Philippa Harding	Philippa Harding	30/09/2017									
	W40	Review how the metrics being measured through the IPR could be used to inform the BAF paper at Board eg by prompting discussion of new risks, the scoring, completion dates or list of mitigating actions	Philippa Harding, Jill Patterson	Jill Patterson	31/10/2017									
W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored ? Are there examples of where financial pressures have compromsied care ?	W41	Review the current QIA process in use and ensure there is a mechanism in place to assure FIPC of any risks to quality relating to the CIP	Lorraine Bewes		30/11/2017									
Is appropriate and accurate information being effectively processed, challenged and acted upon - Jill Patterson and Ross Fullerton														
W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant ? What action is taken when issues are identified	W42	Finalise the data quality strategy and business case. Sign off the priorities for improvement in data quality and the reporting lines for progress against the strategy	Jill Patterson	Oliver Waring	31/08/2017									
W6.6 Are there effective arrangements in place to ensure that data or notifcations are submitted to external bodies as required	W43	Ensure that the Trust is submitting data correctly to STEIS and NRLS	Patricia Bain, Fenella Wrigley		31/08/2017									
W6.7 Are there robust arrangements (including external and internal validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Are lessons learned when there are data security breaches ?	W44	Consider bringing forward the annual information governance assessment to Q3 so the results and action plan are available at the point of reinspection. Ensure there is evidence collated to demonstrate learning from IG breaches	Philippa Harding	Steven Moore, **OS**	31/10/2017									
Is there leadership capacity and capability to deliver high quality sustainable care - Garrett Emmerson & Patricia Grealish														
W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include people in a range of equality groups ?	W45	Develop a clear narrative on the approach and mechanisms for staff engagement. Assess whether there is value in introducing some standard tools eg listening into action sessions	Patricia Grealish	?	30/09/2017									
W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of the challenges within the system and the needs of the relevant population and to deliver services to meet those needs	W46	Clarify the mechanism for recording and sharing local engagement activity led by SEMs and CIOs	Patricia Grealish	Angie Patton	31/08/2017									
Are there robust systems and processes for learning, continuous improvement and innovation - Angela Flaherty and Trisha Bain														
W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes ?	W47	Clarify which, if any, accreditation and peer review schemes the trust is part of to enable this section of the PIR to be completed	Fenella Wrigley	?	30/11/2017									
W8.2 Are there standardised improvement tools and methods and do staff have the skills to use them ?	W48	Confirm a provider and specification for board to floor leadership for improvement / quality improvement training and commission the work (75k available from special measures which needs to be spent)	Angela Flaherty		31/08/2017									
W8.3 How effective is participation in and learning from internal and external reviews including those related to mortality ? Is learning shared effectively and used to make improvements ?	W49	Collate evidence from internal audit deep dives, SIG and the new mortality meetings. Have a clear statement of the mechanisms outside Insight magazine which are being used to share learning	Patricia Bain	QGAMS, AD Patient Safety	31/12/2017									
W8.5 Are there system in place to support improvement and innovation work including objectives and rewards for staff, data systems and process for evaluating and sharing the results of improvement work ?	W50	Set out clearly the infrastructure available to support quality improvement including the links between the Service Improvement Team in Operations and Corporate transformation team	Angela Flaherty	**SC**	31/10/2017									
	W51	Collate information on awards the trust has been nominated for or received in the preceding 12 months ready for PIR	Patricia Grealish	Angie Patton	30/11/2017									

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Computer Aided Dispatch (CAD) – Action Plan update**			
Report Author(s):	**Ross Fullerton, Chief Information Officer**			
Presented by:	**Ross Fullerton, Chief Information Officer**			
History:	**Presented to the Executive Leadership Team in correspondence**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The report into the outage of the Trust's Computer Aided Dispatch (CAD) system published on 27 June 2017 identified a series of actions to be completed by London Ambulance Service NHS Trust (LAS), NHS England and the National Ambulance Resilience Unit (NARU).

Progress against the actions is reported into the Trust's regular Executive Leadership Team (ELT) meetings, to the Trust Board and to stakeholders such as the Regional Oversight Group.

A total of 32 actions were due to be completed by the end of August 2017. These actions have all been completed successfully and reviewed by the Director of Operations and the Chief Information Officer for completeness.

A further 6 actions are scheduled to complete in September 2017 and at the time of writing are on course to complete.

A detailed action tracker can be found as an appendix to this document.

In recognition that the Trust Board seeks additional assurance that the actions have been addressed sufficiently it is proposed that a review of the status of the actions is undertaken by internal audit for report to the Board in early 2018.

Recommendation:

The Board is asked to receive this update on progress against the CAD action plan as assurance that work continues to address the issues highlighted as result of the CAD outage.

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

Failure to address the issues highlighted in the report into the outage of the Trust's CAD could result in further CAD resilience failures.

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

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

CAD Action Plan Update

Appendix A – Action Status sorted by Due Date

Review	ID	Recommendation in report	Owner	Due date	Priority	Status	Progress against timeline
RCA	R13	Empty the Recycle Bin	Chief Information Officer	Feb-17	High	Complete	
RCA	R14	Disable the Recycle Bin functionality	Chief Information Officer	Feb-17	High	Complete	
RCA	R15	Perform an OP66 on 21st and 22nd February to allow the above.	Chief Information Officer	Feb-17	High	Complete	
RCA	R18	Plan regular maintenance slots, at least an average of 2.5 a year to cover all five operational shifts every two years (NB, current approach is to perform five per year which is generally unsustainable).	Chief Information Officer	Feb-17	High	Complete	Planned schedule for system maintenance developed and agreed.
RCA	R8	LAS and Northrop Grumman must determine a detailed monitoring regime required to monitor all system resources. The overall systems management regime must be defined at lower level of detail than at present and the needs of LAS set out contractually.	Chief Information Officer	Feb-17	High	Complete	Detailed monitoring in place
RCA	R9	System maintenance must be conducted regularly.	Chief Information Officer	Feb-17	High	Complete	Replaced by Review 2 action IT1
RCA	R10	Whenever a system outage occurs there should be full checklist of data files, thresholds, and parameters etc. that are validated before a return to service. Whilst there is an existing process this should be reviewed, with NG, Oracle and other suppliers for completeness.	Chief Information Officer	Mar-17	High	Complete	
RCA	R17	Review all system thresholds with Oracle and NG and amend those requiring it.	Chief Information Officer	Mar-17	High	Complete	
RCA	R16	Update the CAD system with recent patches.	Chief Information Officer	Apr-17	High	Complete	Whilst the system has been updated there continues to be patches released from Microsoft. This will be managed on an ongoing basis.
Review 1	R1	Regular refresher training must take place for EOC and operational crews (including NETS) to ensure they are familiar with the process when EOC is working on paper - EOC depend on information from crews.	Head of Control Services	May-17	High	Complete	Part of CSR for control room staff and a video published on the Pulse.
Review 1	R2	Laminated cards to be provided as an aide-memoire to EOC staff to ensure they are clear on the minimum fields that must be completed on the CRF . This was a recommendation following a previous CAD outage and has been proved effective and should continue	Head of Control Services	May-17	High	Complete	
Review 1	R3	The watch management team on duty at the time of the fall-back should be responsible for auditing the quality of CRFs being completed to provide real-time feedback and therefore real time improvement. This process was instigated for the pre-planned CAD takedown on 21st February and evidence of CRF completion compliance was witnessed by the Medical Director	Head of Control Services	May-17	High	Complete	

CAD Action Plan Update

Review 1	R5	When operational resources are dispatched to a call, the unique identifier should also be included and used as their CAD number on the PRF. This will enable correlation of paperwork after the incident.	Head of Control Services	May-17	High	Complete	
Review 1	R6	Cancellation times should be recorded on CRFs so that delays can be correctly reviewed	Head of Control Services	May-17	High	Complete	
Review 1	R7	Planning for periods of unprecedented or sustained demand should include adequate clinical support and leadership	Head of Clinical Hub	May-17	High	Complete	
RCA	R11	The relationship between LAS and Oracle through Northrop Grumman must be reviewed alongside the implementation of other recommendations.	Chief Information Officer	Jun-17	High	Complete	
RCA	R21	Mid to long term, address gaps in problem management – RCA[2], capturing lessons learnt, updating procedures and maintaining known errors database.	Chief Information Officer	Jun-17	High	Complete - superseded	Superseded by Review 2 action IT5.
Review 1	R4	The CRF unique identifier should be added to the call log instead of adding a CAD number after the event. This will prevent calls being tied up incorrectly and would reduce the amount of work/manual entering required following a fall-back test of system failure	Head of Control Services	Jun-17	High	Complete - in testing	Solution developed and in testing.
Review 2	IT1	Schedule and perform regular maintenance and health checks across the entire CAD solution.	Chief Information Officer	Jun-17	High	Complete	
Review 2	IT3	Strengthen resilience across practices throughout the Trust through a single accountable owner for IM&T on the Trust Board	LAS Chair	Jun-17	High	Complete	Chief executive to lead IM&T at Trust Board, supported by Chief Information Officer (non-Board role).
Review 2	IT2	Define, agree and publish EOC service resilience levels.	Head of Control Services and Chief Information Officer	Jul-17	High	Complete	Draft complete; final review and assurance likely to complete in August. Review scheduled Ross & Pauline C this week. Review complete; further work required to simplify document. Due end Sept.
Review 2	IT4	Review the size of the CAD technical team to ensure that the right capacity and capability are in place to meet service levels.	Chief Information Officer	Jul-17	High	Complete	Subject to final agreement of EOC service levels
RCA	R12	The relationship between LAS IM&T[1] and NG and LAS IM&T and other system suppliers must be reviewed and improved such that LAS has key information regarding the systems that deliver services to LAS.	Chief Information Officer	Jul-17	High	Complete	On schedule to complete July 2017
RCA	R22	Review the concerns expressed in this report on shift change and roster deployment	Director of Operations and CIO	Jul-17	High	Complete	System reporting demonstrates there is no system performance issue during shift handover.
Review 3	E10	Business continuity and resilience is a trust-wide holistic activity and should be re-aligned as part of wider corporate governance processes.	Head of Business Continuity	Jul-17	Medium	Complete	Trust wide review has been completed. Papers scheduled for board in September.

CAD Action Plan Update

Review 3	E4	Investigate options for staff to multi-skill and assess the benefit of that multi skilling to provide wider support to EOC	Head of Control Services	Jul-17	Medium	Complete	Complete. Not possible due to licensing restrictions; alternative of training non-EOC staff in non-EMD activities has been completed as an alternative.
Review 3	E5	Reiterate and ensure clarity of understanding of the role of runners at both sites	Head of Control Services	Jul-17	High	Complete	Roles clarified and communicated. To be included in re-write of OP66
Review 3	E6	Roles for non-EOC trained personnel should be clearly defined within the contingency arrangements	Head of Control Services	Jul-17	Low	Complete	Work completed and will be incorporated into rewrite of OP66.
Review 4	H1	All logs and records are completed using best practice for incident logging, including writing out in full, on first use, before the use of acronyms and initials to ensure clarity and that language is clear and local jargon and non-standard terms are avoided.	NHS England	Jul-17	Medium	Completed - this will be monitored through future NHS01 meetings	NHS01 group to agree a common process for logging on call issues. NHS01 group to agree common terminology for on call logs. Initial NHS01 meeting held on 5 April and it was agreed that acronyms would not be used in call logs unless explained first. List of agreed acronyms has been added to the on call log template to ensure consistency. Ongoing NHS01 meetings will ensure that there is continued consistency around logging and terminology.
Review 4	H2	To ensure that there is a clear process for the management of reported CAD outages for first on call including when to escalate, who to escalate to, other parties to inform and expected actions. This involves commissioner oversight of Serious Incidents (SIs) generated as a result of CAD outages.	NHS England	Jul-17	Medium	Completed - awaiting sign off	NHS01 group to develop an algorithm /flowchart for the management of reported CAD outages. Draft algorithm /flowchart has been developed which outlines who needs to be contacted and what actions are expected at each stage of the outage, eg when a teleconference should be held with partners.
Review 2	IT6	Undertake non-pressurised simulations to ensure staff are familiar with critical incident management processes.	Head of Control Services and Chief Information Officer	Aug-17	High	Complete	Succesful paper working in February, April, August plus planned OP66 events in October and December. No IT changes planned in December OP66.
Review 2	IT7	Explore what a fully managed CommandPoint system would entail, cost and whether that would meet defined service levels.	Chief Information Officer	Aug-17	Low	Complete	Complete. LAS CAD comprises CommandPoint and several 10+ other systems. Fully managed CP service would not include the other systems and therefore has minimal impact on service risk. A clearer set of processes and governance (as per other actions) is appropriate.
Review 2	IT5	Review and improve the technical operating model to meet agreed service levels with a particular focus on service management, change management, release management, technical architecture and supplier management.	Chief Information Officer	Sep-17	High	In progress	Changes to the IM&T operating model have been deferred until after the ARP implementation.
Review 2	IT8	Improve monitoring of the CAD landscape to improve communication between IM&T and EOC functions	Head of Control Services and Chief Information Officer	Sep-17	Medium	In progress	Initial monitoring improvements in place with further enhancements to monitoring and communication planned to complete September 2017

CAD Action Plan Update

Review 2	IT9	Review and improve critical incident management process for the whole of the EOC service including all functions	Head of Control Services and EPRR	Sep-17	High	In progress	On schedule to complete Sep 2017
Review 3	E7	All revised contingency plans are subjected to a rigorous testing and exercise programme supported by structured training for all levels of staff including Golds.	EPRR/Head of Business Continuity	Sep-17	High	In progress	Training and exercise plan being reviewed to address all recommendations; will be tested in December 2017
Review 3	E8	Preparation and planning for high impact events such as New Year Eve and Notting Hill Carnival should, where possible, include planned takedowns of CAD as part of the risk management process.	EPRR/Head of Control Services	Sep-17	High	Complete	The planned schedule for OP66 exercising includes key dates. All watches will have been through an OP66 exercise this calendar year.
Review 3	E9	Escalation processes for alerting partners and commissioners about CAD and other LAS system outages should be reviewed.	Head of Control services	Sep-17	Medium	Complete	The escalation process for alerting partners was revised and used successfully for the 26/27 April. It will be written into the revised OP66 procedure.
RCA	R20	Update the Oracle version to current (or one below as a default)	Chief Information Officer	Nov-17	Medium	In progress	Currently running Oracle 12.1.0.2.0 client; server will be updated on new infrastructure in Spring 2018
Review 3	E13	EOC staff training records need to be reviewed and consolidated in one place prior to being integrated into service wide processes.	Head of Control services	Nov-17	High	In progress	CS Practice Learning Manager in progress of confirming format of data and how this can be linked to the OLM system in ESR and be flagged as a competency in GRS.
Review 3	E14	An action plan needs to be developed to address the log keeping issues highlighted as part of this report	LAS EPRR	Nov-17	High	In progress	NHS E currently reviewing LAS logs to provide best practice guidance. Loggist course being run by NHSE in June to increase capacity.
Review 3	E15	Escalation procedures for call management by other agencies including NHS trusts need to be reviewed and protocols agree to ensure calls can be sent back to the affected trust in a timely and appropriate manner.	NARU	Nov-17	Medium	In progress	A national review is in progress to go to the 10 ambulance Trusts, through the National Director of Operations Group (NDOG). This is due to conclude in November 2017.
Review 3	E16	Escalation, notification and management processes within and beyond NHS England (London) need to be improved.	NHSE EPRR	Nov-17	High	In progress	An algorithm/flowchart has been developed for NHS01s to use which outlines what actions need to be taken following notification from LAS of a IT/CAD issue. It outlines who needs to be contacted internally and externally and what actions are expected at each stage of an outage, eg when a teleconference should be held with partners and who should be involved (NHS Improvement, national EPRR team). The flowchart is undergoing consultation with the NHS01s group before it is formally signed off.
Review 3	E17	There should be a national resilience exercise to test mutual aid arrangements which should include BT	NARU/NHSE EPRR	Nov-17	Medium	In progress	By July 2017 the business as usual process for testing mutual aid agreements will be agreed. The first practice exercise will run before winter 2017.

CAD Action Plan Update

Review 3	E3	Investigate options for other technical solutions to be activated when main CAD goes down 1) locally within LAS and 2) more widely	Chief Information Officer	Nov-17	High	In progress	LAS and Northrup Grumman developing options to scope and review. Meeting held with SCAS to explore options 04/09/17. Recommendation to create MS Office based alternative for basic form completion.
Review 4	H3	To determine timescales and/or triggers for outages when further reporting and possible further investigation/root cause analysis is undertaken and identification of any impacts. Trend analysis of CAD outages to be undertaken.	NHS England	Nov-17	Medium	In progress	Across the country the national EPRR team are assessing all CAD systems for ambulance trusts to determine triggers for outages and any possible root causes. This will complete in November 2017
Review 2	IT11	Annually review the current and future service requirements ensuring they are aligned to Trust and NHS strategic direction	Chief Information Officer	Nov-17	Medium	Complete	Quarterly reviews scheduled
RCA	R19	Update the CAD servers to a modern, supported platform that replaces the existing Itanium servers	Chief Information Officer	Nov-17	Medium	Complete - superseded	Superseded by Review 2 action IT10.
Review 3	E12	The training regime for all staff groups including competency training as part of the promotion process should be revised to better equip staff to deal with CAD outages.	Head of Control Services	Nov-17	Low	Complete	The programme has been reviewed and is now included in this year's CSR (3) delivery, and will be included in assessment centres for promotion.
Review 4	H4	As part of the regional assurance done by organisations which have an oversight and assurance role of London's Ambulance Service, monitoring of the risks associated with CAD outages should be strengthened for winter periods where peak demand is expected.	NHS England	Nov-17	High	Completed	The winter assurance process led by NHS England has been updated to ensure that risks associated with the CAD system at LAS are incorporated.
Review 2	IT12	Engage a full time CIO at industry standard remunerate rates	LAS Chief Executive	Jan-18	High	Complete	
Review 3	E1	A complete revision to be undertaken of all contingency arrangements related to CAD outages and revise contingency policy OP66 and OP68.	LAS Business Continuity Lead	Mar-18	High	In progress	An earlier deliverable of 30/9/2017 has been set. The lessons learnt and actions have been consolidated into a single work plan. 41% of these actions or recommendations have been completed.
Review 3	E11	OP066/068 training lesson plans and learner outcomes need to be updated to accurately reflect changes in operational procedures.	Head of Control Services	Mar-18	Medium	In progress	Work has been done by the training team to ensure that the lesson plans and learner outcomes align with the current version of OP66 / 68 in use.
Review 3	E2	Articulate clearly within OP066, OP068 the command and control structure	LAS Business Continuity Lead and Head of Control Services	Mar-18	High	In progress	The use of Silver and functional bronzes now forms part of the plan, and was used for the 21st Feb 2017 OP66 and was used again during the planned outage 26/27 April. Will be written into the new version of OP66 or it's replacement.
Review 2	IT10	Increase resilience, capacity and redundancy of CAD system architecture	Chief Information Officer	May-18	Low	In progress	Options appraisal in progress; due Aug 2017

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**3 October 2017**			
Document Title:	**Scheme of Delegation Adjustments**			
Report Author(s):	**Graeme Dunn, Financial Management Consultant**			
Presented by:	**Lorraine Bewes, Director of Finance and Performance**			
History:	**Presented to the Audit Committee on 4 September 2017**			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

Since the revision of the Standing Financial Instructions and Scheme of Delegation in late 2016, a number of minor adjustments have been identified that would clarify the application of the Scheme of Delegation, facilitate business operations and reflect the separation of the Scheme of Delegation from the Standing Orders.

These adjustments were reviewed by the Audit Committee on 4 September and recommended to the Trust Board for approval.

The attached summarises those changes and the reasoning behind them.

Recommendation:

The Board is asked to approve the changes to the Scheme of Delegation.

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

This paper links to risk 214 Financial Balance. These changes will facilitate improved understanding of the Scheme of Delegation, and assist in the smooth running of business functions and improve compliance.

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

and Well-led	
Reputation	☒
Other	☐

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

Approval of Adjustments to Scheme of Delegation

Background

1. The Scheme of Delegation (SoD) was last reviewed in November 2016 and since that review, a number of minor adjustments have been identified that would clarify the application of the Scheme of Delegation, facilitate business operations and reflect the separation of the Scheme of Delegation from the Standing Orders.

2. The following summarises the suggested changes, along with the reasons for those changes being incorporated, and a copy of the revised Scheme of Delegation is included as an Appendix.

Principal Changes

3. The following table details the changes to the Scheme of Delegation suggested and the reason for suggesting the change.

SoD Section	Change Description	Reason for Change
1	Inserted references to Scheme of Delegation	Scheme of Delegation is now a separate document and not contained within the Standing Orders, thus this clarifies who has the authority to approve changes.
3.1	Amended to clarify what is included in responsibility delegated.	Previously unclear whether this included actions such as closing bank accounts.
3.2	Amended to clarify what is included in responsibility delegated.	Previously unclear who had authority to close a bank account.
6.1.3	Adding a delegation for budget transfers at a lower level than Director for small transfers.	The management of some expenses centrally (such as mobile phones) necessitates regular small budget transfers which would otherwise need to be approved by a Director which is not considered an appropriate use of time.
6.2.2	Adding a delegation for approval of non-material restructures, and adding a description of a material restructure.	To clarify who has the authority to approve a minor restructure, and what constitutes a material restructure.
6.3.2	Added new standard delegation levels and amended numbering.	Gap between £5k and £25k too large, and Director of Operations has requirement to approve higher value items.
6.4	Removed reference to £250k in excess of budget, and amended to simply state approving additional budget, added new level for approval by Finance Director only with reporting to ELT.	Amended to clarify wording (previously seemed to allow expenditure up to £250k over budget before gaining approval), to stop all changes requiring Chief Executive approval, and to ensure ELT visibility

		over changes.
6.6.1	Added new standard delegation levels and amended numbering.	Gap between £5k and £25k too large, and Director of Operations has requirement to approve higher value items.
6.7	Removed reference to £250k in excess of budget, and amended to simply state approving additional budget, added new level for approval by Finance Director only with reporting to ELT, and adjusted to require both Chief Executive and Finance Director for changes over £250k.	Amended to clarify wording (previously seemed to allow expenditure up to £250k over budget before gaining approval), to stop all changes requiring Chief Executive approval, to ensure consistency between pay and non-pay treatment and to ensure ELT visibility over changes.
7.1	Added specific approval levels for clarity and consistency with other sections.	Amended to clarify limits and ensure consistency with other approval limits.
18	Clarifying that NHSI approval is now required for consultancy appointments over £50k including irrecoverable VAT and expenses as opposed to the approval limit which is excluding VAT	NHSI rules changed/clarified to measure including VAT
20	Amended to incorporate proposals other than tenders	Costings for Proposals for the provision of goods or services not covered elsewhere and need to be incorporated.
26	Removed reference to disposal by "sale" and added net book value less cost of disposal	Changed to incorporate disposals not by sale and to specify the cost to be measured.

London Ambulance Service NHS Trust

Scheme of Delegation and Financial Limits

Please Note: Where a particular officer or director mentioned in this scheme of delegation has a formally appointed deputy, that deputy is able to exercise the authority given to that officer when the officer is absent from the Trust's premises for longer than one day or as otherwise agreed in writing between the deputy and the officer and notified to the Finance Director

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
1	**Standing Orders, Scheme of Delegation & Standing Financial Instructions**		
1.1	Approving Standing Orders, Scheme of Delegation and Standing Financial Instructions	Trust Board	
1.2	Approving suspensions of Standing Orders	Trust Board with review by Audit Committee	
1.3	Monitoring compliance with Standing Orders, Scheme of Delegation and Standing Financial Instructions.	Audit Committee	
1.4	Final Authority on Interpretation of Standing Orders, Scheme of Delegation and Standing Financial Instructions	Chairman	
1.5	Exercising the powers the board has retained for itself in an emergency	Chairman and Chief Executive having consulted at least two NEDs	
1.6	Creation and Submission of Standing Orders for Authorisation	Chief Executive	
1.7	Creation and Submission of Standing Financial Instructions and Scheme of Delegation for Authorisation	Finance Director	
2	**Audit Arrangements**		
2.1	Approving Internal and External Audit Arrangements	Trust Board following advice from Audit Committee	
2.2	Deciding on action in response to the external auditors' management letter	Trust Board	
2.3	Receiving the minutes of the Audit Committee	Trust Board	
2.4	Submitting External Auditor's management letter to the Trust Board	Chief Executive	
2.5	Following though the implementation of all recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office.	Chief Executive	
2.6	Managing arrangements for the provision of external audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Finance Director	
2.7	Managing arrangements for the provision of internal audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Director of Corporate Governance	
2.8	Monitoring and ensuring compliance with directions set out in the NHS Standard Contract (National Commissioning Contract) on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Finance Director	
2.9	Monitoring reliance placed upon the internal audit function of the Trust's Shared Financial Services function by either internal or external audit.	Finance Director	
2.10	Approving the appointment of external auditors to provide non-external audit services in line with Trust Policy	Audit Committee	
3	**Banking**		
3.1	Approving Banking Arrangements (such as approving changes to commercial banking service providers and contracts for tendered services)	Trust Board	
3.2	Managing banking arrangements (including but not limited to opening and closing accounts with current banking providers) and advising on the provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.	Finance Director or Deputy	
3.3	Reviewing banking arrangements at regular intervals	Finance Director	
4	**Financial Strategy and Performance**		
4.1	Setting overall policy and strategy for the financial performance of the Trust within the requirements of the Secretary of State or Regulatory Authority	Trust Board	
4.2	Responsible for the performance of the Trust subject to accountability to the Trust Board	Chief Executive	
4.3	Delegation of responsibility for budgets to Directors and agreement to virement	Chief Executive	
4.4	Overall Financial Control and implementation of Trust Financial Policies	Finance Director	
4.5	Advising the Chief Executive and Directors on budgets allocated and spending against budgets	Finance Director	
5	**Financial Plan, Operating Plan, Annual Report and Accounts**		

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
5.1	Receiving and deciding on reports submitted by the Chief Executive and/or Finance Director	Trust Board	
5.2	Approving the financial plan submitted by the Director of Finance	Trust Board following review by Finance and Investment Committee	
5.3	Approving the operating plan submitted by the Director of Transformation and Strategy	Trust Board	
5.4	Approving Annual Report and Accounts	Trust Board	
5.5	Reviewing the Annual Financial Statements prior to submission to the Trust Board	Audit Committee	
5.6	Compiling and submitting annual financial and operating plan to the Trust Board	Chief Executive	
5.7	Approving financial reports for submission to the Trust Board	Chief Executive	
5.8	Compiling and submitting Annual Report for the Trust to the Trust Board	Chief Executive	
5.9	Approving budget for submission	Chief Executive	
5.10	Preparing and submitting financial plan and reports to the Chief Exec for approval prior to submission to the Trust Board	Finance Director	
5.11	Devising and maintaining systems of budgetary controls	Finance Director	
5.12	Monitoring financial performance and reporting to the Trust Board	Finance Director	
5.13	Submitting Financial Statements and Accounts to the Trust Board	Finance Director	
5.14	Preparing and submitting operating plan to the Trust Board	Director of Transformation and Strategy	
6	**Delegation of the management of budgets and approval to spend funds (revenue & capital)**		5
6.1	Budgetary control		
6.1.1	Delegation of the management of individual budgets if included within the Trust approved Plan and agreed at the commencement of the financial year	Director	
6.1.2	Movements from reserves:		
	Up to £500,000	Finance Director	
	Over £500,000	Chief Executive Officer (if previously approved by the Finance Director)	
6.1.3	Virements:		
	Pay expenditure up to delegated limit under section 6.3.2 of this schedule, or non-pay expenditure up to delegated limit under section 6.6.1 of this schedule, and not between pay and non-pay	Delegated budget holder who reports to Director for the business area	
	Up to £50,000 and not between pay and non-pay	Director	
	Above £50,000, or below £50,000 and between pay and non-pay	Finance Director or Chief Executive	
6.2	**Staff and Agency Staff Appointments and Regrading**		11
6.2.1	Approval of, and signing contracts for new staff appointments and regrading if within budgeted establishment:		
	Up to £90,000 basic salary (excluding on-costs)	Director	
	Above £90,000 (excluding on-costs)	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)	
6.2.2	Approval of Staff Restructures:		
	Minor restructures (those which do not exceed available budget and which do not propose redundancies)	Director	
	Material Staff Restructures (those which exceed available budget or which propose redundancies)	Executive Leadership Team (ELT) approval	
6.2.3	Approval of appointments and amendments of charges in relation to agency staff if within budget (and in accordance with regulatory authority requirements):		
	Within regulatory authority price limits (non-VSM)	Director	

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
	Above regulatory authority price limits (non-VSM)	Finance Director within Trust Board approved process on exceptional patient safety grounds only	
	VSM Posts	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)	
6.2.4	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director	
6.3	**Other Pay Expenditure**		11
6.3.1	Approval of schemes of incentives or incentivised overtime or other pay expenditure within budget	Finance Director and Director of Operations	
6.3.2	Approval of other pay expenditure and claims within budget (e.g. approving overtime worked, incentives due and approving staff or agency staff timesheets)		
	Up to £2,500	Budget Holder Level 1	
	Up to £5,000	Budget Holder Level 2	
	Up to £10,000	Budget Holder Level 3	
	Up to £25,000	Budget Holder Level 4	
	Up to £50,000	Budget Holder Level 5	
	Up to £100,000	Budget Holder Level 6	
	Up to £150,000	Director of Operations	
	Up to £500,000	Finance Director	
	Up to £1,000,000	Chief Executive	
	Up to £2,000,000	Chief Executive or Finance Director with ELT approval	
	Up to £5,000,000	Chief Executive or Finance Director with FIC approval (after ELT review)	
	Over £5,000,000	Chief Executive or Finance Director with Trust Board approval (after FIC review)	
6.3.3	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director	
6.4	Approving additional pay expenditure budget:		11
	Up to £250,000 cumulative in financial year	Finance Director and reported to ELT	
	Up to £500,000 cumulative in financial year	Chief Executive and Finance Director and reported to ELT and Audit Committee	
	Over £500,000 cumulative in financial year	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with SFI 11	
6.5	**Credit notes**		8
6.5.1	Reimbursing income previously invoiced (correcting an error):		
	Up to £25,000	Head of Financial Services	
	Up to £100,000	Deputy Finance Director	
	Up to £250,000	Finance Director	
	Over £250,000	Audit Committee	
6.5.2	Where cancelling and re-raising invoice (e.g. incorrect organisation, additional information requested on invoice):		
	Up to £100,000	Head of Financial Services or Deputy Head of Financial Services	
	Up to £250,000	Deputy Finance Director	
	Up to £500,000	Finance Director	
	Over £500,000	Audit Committee	
6.5.3	All credit notes must be reported to the Audit Committee on a quarterly basis	Head of Financial Services	
6.6	**Non-Pay Expenditure**		12
6.6.1	Authorisation of non-pay expenditure (revenue and capital, including leases and service contracts valued over the term of the agreement but excluding business rates and NHS Litigation Authority expenditure) within budget or for capital, within the capital plan:		
	Up to £2,500	Budget Holder Level 1	

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
	Up to £5,000	Budget Holder Level 2	
	Up to £10,000	Budget Holder Level 3	
	Up to £25,000	Budget Holder Level 4	
	Up to £50,000	Budget Holder Level 5	
	Up to £100,000	Budget Holder Level 6	
	Up to £150,000	Director of Operations	
	Up to £500,000	Finance Director	
	Up to £1,000,000	Chief Executive	
	Up to £2,000,000	Chief Executive or Finance Director with ELT approval	
	Up to £5,000,000	Chief Executive or Finance Director with FIC approval (after ELT review)	
	Over £5,000,000	Chief Executive or Finance Director with Trust Board approval (after FIC review)	
6.6.2	Authorisation of business rates and NHS Litigation Authority expenditure within budget		
	Up to £5,000,000	Chief Executive or Finance Director	
6.7	Authorisation of non-pay expenditure in excess of budget:		12
	Up to £250,000 cumulative in financial year	Finance Director and reported to ELT	
	Up to £500,000 cumulative in financial year	Chief Executive and Finance Director and reported to ELT and Audit Committee	
	Over £500,000 cumulative in financial year	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with the process set out in SFI 12	
6.8	Approval of routine expenses claims		12
	Up to £5,000	Budget Holder following Line Manager confirmation	
	Over £5,000	Deputy Finance Director	
7	**Approval of business cases, gating templates and other requests for budget**		11 and 12
7.1	Revenue funding in excess of allocated budget:		
	Up to £250,000	Finance Director and reported to ELT	
	Up to £500,000	Chief Executive and Finance Director and reported to ELT and Audit Committee	
	Over £500,000	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with SFI 11	
7.2	Capital:		
	Up to £1,000,000	ELT	
	Up to £2,000,000	Finance and Investment Committee (FIC)	
	Up to £5,000,000	Trust Board approval following review by FIC	
	Over £5,000,000	Regulatory Authority following Trust Board Review	
8	**Operation of all detailed financial matters**		
	Establishment and management of bank accounts	Finance Director or Deputy	8
	Payroll	Director of Workforce	11
	Purchase ledger/creditor payments	Finance Director or Deputy	8
	Petty cash	Finance Director or Deputy	7, 12
	Debtors	Finance Director or Deputy	8
	Treasury Management	Finance Director or Deputy	7
	Asset Register	Finance Director or Deputy	15
	Inventory Management	Directors and Direct Reports to Directors	16
9	**Income systems**		8
	System design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash	Finance Director or Deputy Finance Director	
10	**Funding contracts, Contracts for the Provision of Services and Service Level Agreements:**		10
	Below £100,000	Relevant Director and Deputy Finance Director	
	Up to £500,000	Finance Director	
	Up to £2,000,000	Finance Director and Chief Executive	
	Up to £5,000,000	FIC following ELT review	

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
	More than £5 000 000	Trust Board following FIC review	
	Routine mid term variations to any of the above if contract baseline value not changed by more than 5%	Finance Director	
11	**Annual capital programme and capital expenditure proposals**		5
11.1	Approval of Annual Capital Plan as part of the Integrated Financial Plan before the start of the financial year.	Trust Board following review by Finance and Investment Committee	
11.2	Capital Project Budget Variation		
	Total budget spend of each capital scheme may be varied by 10% or £100,000, whichever is the smaller, subject to capital programme remaining within budget.	Finance Director	
	Total budget spend of each capital scheme may be varied by 20% or £500,000, whichever is the smaller, subject to capital programme remaining within budget.	Executive Leadership Team or as delegated through Finance and Investment Committee	
	If any individual variation in project value results in a breach of approval limits as set out in 2 above, re-approval in line with section 2 is required		
12	**Arrangements for the management of land, buildings and other assets and equipment belonging to or leased by the Trust**		15
	Physical management and maintenance of assets	Directors responsible for assets	
	Land and buildings	Director responsible for Estates	
	Vehicles	Director responsible for Fleet	
	Equipment	Directors and Direct Reports to Directors responsible for equipment assets	
	Asset register, depreciation and PDC	Finance Director	
13	**Management and control of stock and equipment**		16
	Central Consumables Stores and Pharmaceuticals Stocks	Director responsible for Logistics	
	Vehicle Parts, Oil and Lubricants	Director responsible for Fleet	
	IM&T Equipment	Chief Information Officer	
	Station Consumables, equipment and specialised equipment stores and fuel stocks	Director of Operations and Director responsible for Logistics	
	Other stocks	Directors and Direct Reports	
14	**Recording, monitoring and approval of payments under the losses and special payments regulations including theft and fraud**		17
	All losses and special payments reported through to Audit Committee on a quarterly basis	Finance Director	
	Monitoring and approval of losses and special payments	Finance Director	
	Accounting for losses and special payments	Finance Director, Deputy Director and Head of Financial Services	
	General administration	Directors and Direct Reports	
	Cash losses and bad debts		
	Note: These write-offs, once agreed, will impact on individual budgets - there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the Trust, whether or not invoiced - it does not include adjustments relating to invoices raised in error.		
	Up to £10,000	Finance Director or Deputy	
	Over £10,000	Chief Executive and Finance Director or Deputy	
	Losses of equipment and property		
	Up to £50,000	Finance Director	
	Up to £250,000	Chief Executive	
	Over £250,000	Audit Committee or Trust Board	

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
	Claims net of recovery from NHSLA		
	Up to £100,000	Finance Director or Chief Executive	
	Up to £500,000	Executive Leadership Team	
	Over £500,000	Audit Committee or Trust Board	
	Staff grievance settlements other than in response to a formal process	As for losses of equipment and property	
	Complaints	As for losses of equipment and property	
15	**Disposal of deceased patients' property**		19
	Property of value up to £5,000		
	Cash up to £100 and all valuables may be relatives who sign an indemnity form	Deputy Finance Director	
	Cash over £100 may be released by cheque together with all valuables to relatives who sign indemnity form	Deputy Finance Director	
	Property of value over £5,000		
	Cash over £100 may be released by cheque together with all valuables on production of probate or letters of administration	Finance Director	
16	**Management of Patients' monies**	Finance Director	19
17	**Insurance arrangements**		23
	Approval of Insurance Arrangements	Finance Director with approval of Trust Board (Finance Director to obtain quotes for insurance cover, and to present an annual report to the Audit Committee, Chief Executive to report to Trust Board on potentialinsurable risks and associated costs)	
18	**Appointment of Consultancy Firms**		9, 12
	Up to £50,000 excluding VAT over the period of the contract	Directors with NHSI approval for contracts exceeding £50k including irrecoverable VAT and expenses	
	Up to £250,000 excluding VAT over the period of the contract	Chief Executive or Finance Director with report to Trust Board over £100k	
	Over £250,000 excluding VAT over the period of the contract	Chief Executive with report to, and approval of Trust Board	
	All appointments of consultancy firms must be in line with regulatory authority approval requirements at the point of appointment, and relevant procurement requirements as per SFI 9 and 12		
19	**Legal Obligations**		12
	Payment of compensation payments etc under legal obligation:		
	Up to £100,000	Chief Executive	
	Over £100,000	Trust Board	
	Quarterly Report on payments to the Trust Board	Director of Corporate Governance and/or Director of Workforce	
20	**Approving Financial Information/Costings for Tenders and Proposals for the Provision of Goods or Services, and signing Tenders Submitted By The Trust**		10
	Approving arrangements for the submission of tenders	Trust Board	
	Signing general tenders submitted by the Trust:		
	Up to £500,000 per annum	Finance Director	
	Over £500,000 per annum	Chief Executive and Finance Director	
21	**Charitable Funds**		20
21.1	Approving the composition and terms of reference for the Charitable Funds Committee and approving the Annual Report and Accounts for funds held on trust to be submitted to the Charity Commission	Trust Board	
21.2	Setting overall policy on investment and presenting annual progress reports on the update of the Trust's charitable funds.	Charitable Funds Committee	
21.3	Monitoring the effective administration of charitable funds, including management and accounting arrangements	Finance Director	

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
21.4	Approving the appointment of the Financial Adviser to the Charitable Funds Committee	Finance Director	
21.5	Approval of Transactions:		
	Up to £5,000	Head of Financial Services	
	Up to £25,000	Finance Director	
	Over £25,000	Finance Director with approval of the Charitable Funds Committee	
22	**Ex-gratia Payments**		17
22.1	Making Ex-Gratia Payments in respect of liability claims where legal advice has indicated a case can be made for LAS liability which would need to be contested in court or tribunal.		
	Up to £500,000	Approval by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000	
	Over £500,000	Approval by Trust Board following recommendation by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000	
22.2	Making other ex-gratia payments, including where legal advice has not been obtained		
	Up to £500	Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report)	
	Up to £3,000	Finance Director upon recommendation from Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority for all cases over £1,000)	
	Over £3,000	Chief Executive or Director of Finance (Finance Director must be informed and must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority)	
23	**Tribunal Payments**		17
	Making payments resulting from a tribunal not under legal obligation:		
	Up to £50,000	Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel for Tribunal claims over £10,000. Formal reporting and approval for all payments.	
	Over £50,000	Trust Board to approve following recommendation by Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel. Formal reporting and approval for all payments.	
24	**Payment of Claims arising under Property Expenses Scheme**		17
	Up to £20,000	Finance Director with Chief Executive review following report from Head of Estates	
	Over £20,000	Chief Executive and Finance Director following report from Head of Estates (Trust Board to be informed)	
25	**Payment of Personal injury and other liability claims outside the NHSLA indemnity schemes and commercial insurance**		17
	Up to £50,000 which are not under legal obligation and are not novel, contentious, or repercussive	Chief Executive and Finance Director following recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services.	
	Over £50,000 which are not under legal obligation and are not novel, contentious, or repercussive	Chairman following review by Chief Executive and Finance Director based on recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services.	
	Claims which are under legal obligation and are novel, contentious, or repercussive	Chief Executive and Finance Director following Regulatory Authority approval	
26	**Disposals of Trust Property**		17

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
	Approval of disposals of Trust property with a net book value less cost of disposal of:		
	Up to £25,000	Deputy Director of Finance following consideration of formal proposal	
	Up to £100,000	Finance Director following consideration of formal proposal	
	Up to £250,000	Finance Director and another Executive Director following consideration of formal proposal	
	Up to £1,000,000	Chief Executive, Finance Director and another Executive Director following consideration of Combined Business Case	
	Over £1,000,000	Trust Board following consideration of Full Business Case	
	Approval of Gifts of Trust property with a value of:		
	Up to £5,000	Chief Executive	
	Up to £300,000	Trust Board	
	Over £300,000	Trust Board following Regulatory Authority Approval	
27	**Dismissals**		
27.1	Approving arrangements for the discipline and dismissal of staff	Trust Board	
27.2	Nomination of a panel to hear appeals against dismissal brought by the Chief Executive or Executive Trust Board Directors	Trust Board	
27.3	Authority to dismiss the Chief Executive and Executive Directors	Chairman	
27.4	Nomination of a panel to hear appeals against dismissal brought by Directors who are not members of the Board.	Chairman	
27.5	Dismissal of staff below Director level	Chief Executive, Director or Director's Deputy	
27.6	Nomination of a panel of Directors to hear appeals against dismissal by staff below Director level	Chief Executive	
27.7	Ensuring that appropriate processes are completed to ensure salary and other payments cease as appropriate following dismissal.	Directors	
27.8	Advising panels dealing with dismissals and appeals	Director of Workforce	
28	**Remuneration and Terms of Service for the Chief Executive, Directors and Other Senior Officers**		
28.1	Decides the Directors' remuneration and terms of service	Trust Board on recommendation from Nominations and Remuneration Committee	
28.2	Decides performance related payments to the Chief Executive	Trust Board	
28.3	Reporting in writing to the Trust Board the basis of its recommendations in relation to remuneration, terms of service and performance related payments	Nominations and Remuneration Committee with advice from the Director of Workforce	
28.4	Recommending performance related payments for the Chief Executive.	Chairman	
28.5	Deciding performance related pay awards for Directors and all staff on performance related pay.	Chief Executive	
28.6	Recommending performance related payments to their staff to the Chief Executive.	Directors	
28.7	Advising on remuneration and terms of service	Director of Workforce	
29	**Human Resources Policy and Disputes**		
29.1	Approving all human resources policies	Trust Board (Chief Exec to determine submissions to Trust Board following advice from Director of Workforce)	
29.2	Approving premature retirement for the Chief Executive and all Directors	Trust Board	
29.3	Approving premature retirement for staff up to Director level	Chief Executive	
29.4	Settling disputes in line with the agreed disputes procedure	Chief Executive	
29.5	Preparing options and draft policy in conjunction with Directors	Director of Workforce	
29.6	Advising on human resources policy matters	Director of Workforce	
30	**Human Resources Arbitration**		
30.1	Approving arbitration submissions	Trust Board	
30.2	Determining and approving submissions to the Trust Board when appropriate	Chief Executive	
30.3	Advising on arbitration matters	Director of Workforce	

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
31	**Human Resources Disciplinary Matters**		
31.1	Receiving reports and hearing appeals on disciplinary action relating to the Chief Executive and/or Directors	Nominations and Remuneration Committee	
31.2	Initiating action on disciplinary matters relating to the Chief Executive and/or Directors.	Chairman	
31.3	Determining and approving submissions to the Trust Board when appropriate	Chief Executive	
31.4	Advising on disciplinary matters	Director of Workforce	
32	**Management and Control of Computer Systems and Facilities**		
32.1	Approving the overall corporate IT Policy on procurement and control of systems and facilities on the recommendation of the Chief Information Officer	Trust Board	
32.2	Co-ordinating IT Policy on behalf of the Trust and being the responsible officer for control and security of hardware, software and data	Chief Information Officer	
32.3	Compliance with the Data Protection Act, Use of Computers Act and other legislation in their Directorates	Directors	
32.4	Operation and compliance with legislation for all telecommunications and radio systems	Chief Information Officer	
32.5	Ensuring that risks to the Trust from IT are identified and considered, and that disaster recovery plans are in place	Chief Information Officer	
32.6	Ensuring that where computer systems have an impact on corporate financial systems: • System acquisition, development and maintenance are in line with corporate polices; • Data assembled for processing by finance system is adequate, accurate, complete and timely and that a management trail exists; • That the Finance Director and staff have access to such data; and • That such computer reviews are being carried out as are considered necessary.	Finance Director	
33	**Contracts for Computer Services with Other Health Bodies or Outside Agencies**		
33.1	Ensuring that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and that the contract ensures rights of access for audit purposes	Chief Information Officer	
33.2	Periodically seeking assurances that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications	Finance Director	
34	**Data Protection**		
34.1	Approving policy on Data Protection	Trust Board	
34.2	Notification under the Data Protection Act and the implementation of the Board's Data Protection Policy	Director of Corporate Governance	
34.3	Advising the Board on Data notification	Director of Corporate Governance	
34.4	Ensuring compliance with the Data Protection Act and the Board's Data Protection Policy in Directorates	Directors	
35	**Health and Safety Arrangements**		
35.1	Approving overall policy on Health and Safety at work.	Trust Board	
35.2	Ensuring an effective overall Health and Safety system within the Trust and compliance with legislative requirements	Chief Executive	
35.3	Ensuring the effective implementation of the Human Resources aspects of Trust Health & Safety policy and advising the Chief Executive of requirements	Director of Workforce	
35.4	Ensuring the effective implementation of clinical aspects of Trust Health and Safety policy and advising the Chief Executive of requirements	Director of Operations	

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
35.5	Ensuring the effective implementation of the Health and Safety Policy in individual Directorates	Directors	
36	**Complaints Against the Trust**		
36.1	Approves the Trust's Complaints Procedure	Trust Board	
36.2	Receiving reports regarding complaints about any aspect of service.	Trust Board	
36.3	Management of complaints within the Trust and ensuring complaints receive written responses in line with regulations	Chief Executive	
36.4	Supporting the Chief Executive in the management of complaints within the Trust and signing written responses to complaints	Directors	
37	**Executive and Non-Executive Directors Issues (Visits, Hospitality etc)**		
37.1	Approving overall policy on hospitality and visits.	Trust Board	
37.2	Advising the relevant Regulatory Authority on the performance of Non-Executive board members	Chairman	
37.3	Ensuring Directors are aware of guidelines	Chief Executive	
37.4	Ensuring compliance with Guidelines	Directors	
37.5	Developing policies and guidelines on behalf of the Chief Executive	Director of Corporate Governance	
38	**Freedom of Information**		
38.1	Approving Freedom of Information Policy	Trust Board	
38.2	Receiving an annual report on the implementation of the Freedom of Information policy	Trust Board	
38.3	Ensuring the Trust is compliant with current Freedom of Information legislation	Director of Corporate Governance	
38.4	Publishing and maintaining a Freedom of Information scheme	Director of Corporate Governance	
39	**Risk Management**		
39.1	Approving and Monitoring the risk management programme	Trust Board	
39.2	Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activity both clinical and non-clinical that support the achievement of the organisation's objectives	Audit Committee	
39.3	Deciding whether the Trust will use the risk pooling scheme administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed), and reviewing decisions to self-insure annually	Trust Board	
39.4	Ensuring that where NHSLA risk pooling schemes are used, the arrangements entered into are appropriate and complementary to the risk management programme, and that documented procedures cover these arrangements	Director of Corporate Governance	
39.5	Ensuring that where the Board decides not to use NHSLA risk pooling schemes, they are informed of the nature and extent of the risks that are self-insured as a result of this decision, and that formal documented procedures are drawn up for the management of any claims arising from 3rd parties and payments in respect of losses that will not be reimbursed	Finance Director	
40	**Signing and Sealing of Documents**		
40.1	Receiving a report of all sealings	Trust Board	
40.2	Affixing the seal	Chairman and the Chief Executive or another Executive Director in accordance with standing orders	
40.3	Approving and signing all documents which will be used in legal procedures	Chairman, Chief Executive and an Executive Director	
40.4	Keeping the common seal of the Trust in a secure place in accordance with arrangements approved by the Trust	Trust Secretary	
40.5	Keeping a register of sealings	Trust Secretary	
41	**Tendering Procedures - General**		
41.1	Approving standing orders regarding tendering	Trust Board	

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
41.2	Approves exceptions to Standing Orders regarding Competitive Tendering	Trust Board	
41.3	Receiving reports regarding all waiving of competitive tendering	Audit Committee	
41.4	Ensuring compliance with Standing Orders	Chief Executive	
41.5	Authorising exceptions to Standing Orders in an urgent situation	Chief Executive following consultation with the Chairman or Deputy Chairman under Standing Order 41	
41.6	Where EU procurement regulations have been satisfied, waiving the requirement for competitive tendering for goods and services up to £200,000	Chief Executive in conjunction with Finance Director	
41.7	Where insufficient tenders are received, authorising the originating Directors to approach known firms with a view to procuring the goods or services required	Chief Executive	
41.8	Ensuring that at least 3 competing quotations from comparable firms are received for appropriate contracts (unless NHS Supplies is used)	Directors	
41.9	Authorising all tenders and waivers and ensuring satisfaction with the financial competence of all tendering organisations	Finance Director	
42	**Tendering Procedures - Limits**		
42.1	Ensuring that proper tendering arrangements are in place	Audit Committee	
42.2	Ensuring that competitive tenders are received for non-estate purchases above £25,000 and estate purchases over £100,000	Chief Executive	
	Ensuring that competing quotations are received for non-estates purchases between £3,000 and £25,000 and for Estates purchases between £3,000 and £100,000 except where ordered through NHS Supplies	Directors	
43	**Tendering Procedures - Receipt and Opening Tender Submissions**		
43.1	Nominating officers, including the Trust Secretary to open tenders	Chief Executive	
43.2	Accepting late tenders, despatched in good time but delayed through no fault of the tenderers	Chief Executive	
43.3	Accepting late tenders other than those that are despatched in good time but delayed through no fault of the tenderers	Chief Executive in conjunction with Finance Director	
43.4	Being present at the opening of tenders of value:		
	Up to £1m	Senior Manager responsible for the procurement and the Trust Secretary	
	Over £1m	Senior Manager responsible for the procurement, Executive Director responsible for the originating department, and the Trust Secretary	
43.5	Advising the Board by way of a report on both tenders invited and received and, in due course, tender amounts after their analysis is complete	Trust Secretary	
44	**Tendering Procedures - Post Tendering**		
44.1	Authorising post tender negotiations	Chief Executive or Finance Director	
44.2	Requesting in writing that post tender negotiations take place	Directors	
44.3	Keeping a record of the reasons for post tender negotiations and their outcome	Directors	
45	**Tendering Procedures - Approvals**		
45.1	Deciding where a tender other than the lowest (if payment is to be made by the Trust), or other than the highest (where payment is to be received by the Trust), shall be accepted	Chief Executive (with report to the Trust Board)	
45.2	Approving non-competitive tenders	Chief Executive (subject to report to the Trust Board)	
46	**Education and Training**		
46.1	Approving Trust policy on education and training	Trust Board	
46.2	Submitting policy on education and training to the Trust Board	Chief Executive	
46.3	Developing and updating the Trust policy on education and training	Medical Director	
46.4	Development of vocational/technical training	Medical Director in conjunction with Directors	

London Ambulance Service NHS
NHS Trust

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
1	**Standing Orders, Scheme of Delegation & Standing Financial Instructions**			Inserted references to Scheme of Delegation	Scheme of Delegation is now a separate document and not contained within the Standing Orders, thus this clarifies who has the authority to approve changes.
1.1	Approving Standing Orders, Scheme of Delegation and Standing Financial Instructions	Trust Board			
1.2	Approving suspensions of Standing Orders	Trust Board with review by Audit Committee			
1.3	Monitoring compliance with Standing Orders, Scheme of Delegation and Standing Financial Instructions.	Audit Committee			
1.4	Final Authority on Interpretation of Standing Orders, Scheme of Delegation and Standing Financial Instructions	Chairman			
1.5	Exercising the powers the board has retained for itself in an emergency	Chairman and Chief Executive having consulted at least two NEDs			
1.6	Creation and Submission of Standing Orders for Authorisation	Chief Executive			
1.7	Creation and Submission of Standing Financial Instructions and Scheme of Delegation for Authorisation	Finance Director			
2	**Audit Arrangements**				
2.1	Approving Internal and External Audit Arrangements	Trust Board following advice from Audit Committee			
2.2	Deciding on action in response to the external auditors' management letter	Trust Board			
2.3	Receiving the minutes of the Audit Committee	Trust Board			
2.4	Submitting External Auditor's management letter to the Trust Board	Chief Executive			
2.5	Following though the implementation of all recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office.	Chief Executive			
2.6	Managing arrangements for the provision of external audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Finance Director			
2.7	Managing arrangements for the provision of internal audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Director of Corporate Governance			
2.8	Monitoring and ensuring compliance with directions set out in the NHS Standard Contract (National Commissioning Contract) on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Finance Director			
2.9	Monitoring reliance placed upon the internal audit function of the Trust's Shared Financial Services function by either internal or external audit.	Finance Director			

London Ambulance Service NHS
NHS Trust

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
2.10	Approving the appointment of external auditors to provide non-external audit services in line with Trust Policy	Audit Committee			
3	**Banking**				
3.1	Approving Banking Arrangements (such as approving changes to commercial banking service providers and contracts for tendered services)	Trust Board		Amended to clarify what is included in responsibility delegated.	Previously unclear whether this included actions such as closing bank accounts.
3.2	Managing banking arrangements (including but not limited to opening and closing accounts with current banking providers) and advising on the provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.	Finance Director or Deputy		Amended to clarify what is included in responsibility delegated.	Previously unclear who had authority to close a bank account.
3.3	Reviewing banking arrangements at regular intervals	Finance Director			
4	**Financial Strategy and Performance**				
4.1	Setting overall policy and strategy for the financial performance of the Trust within the requirements of the Secretary of State or Regulatory Authority	Trust Board			
4.2	Responsible for the performance of the Trust subject to accountability to the Trust Board	Chief Executive			
4.3	Delegation of responsibility for budgets to Directors and agreement to virement	Chief Executive			
4.4	Overall Financial Control and implementation of Trust Financial Policies	Finance Director			
4.5	Advising the Chief Executive and Directors on budgets allocated and spending against budgets	Finance Director			
5	**Financial Plan, Operating Plan, Annual Report and Accounts**				
5.1	Receiving and deciding on reports submitted by the Chief Executive and/or Finance Director	Trust Board			
5.2	Approving the financial plan submitted by the Director of Finance	Trust Board following review by Finance and Investment Committee			
5.3	Approving the operating plan submitted by the Director of Transformation and Strategy	Trust Board			
5.4	Approving Annual Report and Accounts	Trust Board			
5.5	Reviewing the Annual Financial Statements prior to submission to the Trust Board	Audit Committee			
5.6	Compiling and submitting annual financial and operating plan to the Trust Board	Chief Executive			
5.7	Approving financial reports for submission to the Trust Board	Chief Executive			
5.8	Compiling and submitting Annual Report for the Trust to the Trust Board	Chief Executive			
5.9	Approving budget for submission	Chief Executive			

London Ambulance Service NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
5.10	Preparing and submitting financial plan and reports to the Chief Exec for approval prior to submission to the Trust Board	Finance Director			
5.11	Devising and maintaining systems of budgetary controls	Finance Director			
5.12	Monitoring financial performance and reporting to the Trust Board	Finance Director			
5.13	Submitting Financial Statements and Accounts to the Trust Board	Finance Director			
5.14	Preparing and submitting operating plan to the Trust Board	Director of Transformation and Strategy			
6	**Delegation of the management of budgets and approval to spend funds (revenue & capital)**		5		
6.1	Budgetary control				
6.1.1	Delegation of the management of individual budgets if included within the Trust approved Plan and agreed at the commencement of the financial year	Director			
6.1.2	Movements from reserves:				
	Up to £500,000	Finance Director			
	Over £500,000	Chief Executive Officer (if previously approved by the Finance Director)			
6.1.3	Virements:				
	Pay expenditure up to delegated limit under section 6.3.2 of this schedule, or non-pay expenditure up to delegated limit under section 6.6.1 of this schedule, and not between pay and non-pay	Delegated budget holder who reports to Director for the business area		Adding a delegation for budget transfers at a lower level than Director for small transfers.	The management of some expenses centrally (such as mobile phones) necessitates regular small budget transfers which would otherwise need to be approved by a Director which is not considered an appropriate use of time.
	Up to £50,000 and not between pay and non-pay	Director			
	Above £50,000, or below £50,000 and between pay and non-pay	Finance Director or Chief Executive			
6.2	**Staff and Agency Staff Appointments and Regrading**		11		
6.2.1	Approval of, and signing contracts for new staff appointments and regrading if within budgeted establishment:				
	Up to £90,000 basic salary (excluding on-costs)	Director			
	Above £90,000 (excluding on-costs)	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)			

London Ambulance Service NHS
NHS Trust

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
6.2.2	Approval of Staff Restructures:				
	Minor restructures (those which do not exceed available budget and which do not propose redundancies)	Director		Adding a delegation for approval of non-material restructures.	To clarify who has the authority to approve a minor restructure.
	Material Staff Restructures (those which exceed available budget or which propose redundancies)	Executive Leadership Team (ELT) approval		Adding a description as to what a material restructure is.	To clarify what a material restructure is.
6.2.3	Approval of appointments and amendments of charges in relation to agency staff if within budget (and in accordance with regulatory authority requirements):				
	Within regulatory authority price limits (non-VSM)	Director			
	Above regulatory authority price limits (non-VSM)	Finance Director within Trust Board approved process on exceptional patient safety grounds only			
	VSM Posts	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)			
6.2.4	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director			
6.3	**Other Pay Expenditure**		11		
6.3.1	Approval of schemes of incentives or incentivised overtime or other pay expenditure within budget	Finance Director and Director of Operations			
6.3.2	Approval of other pay expenditure and claims within budget (e.g. approving overtime worked, incentives due and approving staff or agency staff timesheets)				
	Up to £2,500	Budget Holder Level 1			
	Up to £5,000	Budget Holder Level 2			
	Up to £10,000	Budget Holder Level 3		Added new standard delegation level	Gap between £5k and £25k too large.
	Up to £25,000	Budget Holder Level 4		Delegation level numbering amended	
	Up to £50,000	Budget Holder Level 5		Delegation level numbering amended	
	Up to £100,000	Budget Holder Level 6		Delegation level numbering amended	
	Up to £150,000	Director of Operations		Added new standard delegation level for Director of Operations	Director of Operations has need to approve higher value items
	Up to £500,000	Finance Director			
	Up to £1,000,000	Chief Executive			
	Up to £2,000,000	Chief Executive or Finance Director with ELT approval			
	Up to £5,000,000	Chief Executive or Finance Director with FIC approval (after ELT review)			
	Over £5,000,000	Chief Executive or Finance Director with Trust Board approval (after FIC review)			
6.3.3	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director			

London Ambulance Service NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
6.4	Approving additional pay expenditure budget:		11	Removed reference to £250k in excess of budget, and amended to simply state approving additional budget	Amended to clarify wording - previously seemed to allow expenditure up to £250k over budget before gaining approval
	Up to £250,000 cumulative in financial year	Finance Director and reported to ELT		Added new level for approval by Finance Director only with reporting to ELT	Inappropriate to have all budget change requests requiring Chief Executive approval
	Up to £500,000 cumulative in financial year	Chief Executive and Finance Director and reported to ELT and Audit Committee		Added reporting to ELT	ELT should be sighted on items being reported to Audit Committee
	Over £500,000 cumulative in financial year	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with SFI 11		Added cumulative in financial year	Amended for consistency with other levels
6.5	**Credit notes**		8		
6.5.1	Reimbursing income previously invoiced (correcting an error):				
	Up to £25,000	Head of Financial Services			
	Up to £100,000	Deputy Finance Director			
	Up to £250,000	Finance Director			
	Over £250,000	Audit Committee			
6.5.2	Where cancelling and re-raising invoice (e.g. incorrect organisation, additional information requested on invoice):				
	Up to £100,000	Head of Financial Services or Deputy Head of Financial Services			
	Up to £250,000	Deputy Finance Director			
	Up to £500,000	Finance Director			
	Over £500,000	Audit Committee			
6.5.3	All credit notes must be reported to the Audit Committee on a quarterly basis	Head of Financial Services			
6.6	**Non-Pay Expenditure**		12		
6.6.1	Authorisation of non-pay expenditure (revenue and capital, including leases and service contracts valued over the term of the agreement but excluding business rates and NHS Litigation Authority expenditure) within budget or for capital, within the capital plan:				
	Up to £2,500	Budget Holder Level 1			
	Up to £5,000	Budget Holder Level 2			
	Up to £10,000	Budget Holder Level 3		Added new standard delegation level	Gap between £5k and £25k too large.
	Up to £25,000	Budget Holder Level 4		Delegation level numbering amended	
	Up to £50,000	Budget Holder Level 5		Delegation level numbering amended	

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
	Up to £100,000	Budget Holder Level 6		Delegation level numbering amended	
	Up to £150,000	Director of Operations		Added new standard delegation level for Director of Operations	Director of Operations has need to approve higher value items
	Up to £500,000	Finance Director			
	Up to £1,000,000	Chief Executive			
	Up to £2,000,000	Chief Executive or Finance Director with ELT approval			
	Up to £5,000,000	Chief Executive or Finance Director with FIC approval (after ELT review)			
	Over £5,000,000	Chief Executive or Finance Director with Trust Board approval (after FIC review)			
6.6.2	Authorisation of business rates and NHS Litigation Authority expenditure within budget				
	Up to £5,000,000	Chief Executive or Finance Director			
6.7	Authorisation of non-pay expenditure in excess of budget:		12	Removed reference to £250k in excess of budget, and amended to simply state approving additional budget	Amended to clarify wording - previously seemed to allow expenditure up to £250k over budget before gaining approval
	Up to £250,000 cumulative in financial year	Finance Director and reported to ELT		Added new level for approval by Finance Director only with reporting to ELT	Inappropriate to have all budget change requests requiring Chief Executive approval
	Up to £500,000 cumulative in financial year	Chief Executive and Finance Director and reported to ELT and Audit Committee		Amended to replace "or" with "and" as per pay expenditure equivalent, and added reporting to ELT and Audit Committee	Amended for consistency with pay expenditure equivalent
	Over £500,000 cumulative in financial year	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with the process set out in SFI 12		Added cumulative in financial year	Amended for consistency with other levels
6.8	Approval of routine expenses claims		12		
	Up to £5,000	Budget Holder following Line Manager confirmation			
	Over £5,000	Deputy Finance Director			
7	**Approval of business cases, gating templates and other requests for budget**		11 and 12		
7.1	Revenue funding in excess of allocated budget:				
	Up to £250,000	Finance Director and reported to ELT		Added specific approval levels for clarity and consistency with other sections	Amended to clarify limits and ensure consistency with other approval limits
	Up to £500,000	Chief Executive and Finance Director and reported to ELT and Audit Committee			
	Over £500,000	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with SFI 11			
7.2	Capital:				
	Up to £1,000,000	ELT			
	Up to £2,000,000	Finance and Investment Committee (FIC)			
	Up to £5,000,000	Trust Board approval following review by FIC			
	Over £5,000,000	Regulatory Authority following Trust Board Review			

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
8	**Operation of all detailed financial matters**				
	Establishment and management of bank accounts	Finance Director or Deputy	8		
	Payroll	Director of Workforce	11		
	Purchase ledger/creditor payments	Finance Director or Deputy	8		
	Petty cash	Finance Director or Deputy	7, 12		
	Debtors	Finance Director or Deputy	8		
	Treasury Management	Finance Director or Deputy	7		
	Asset Register	Finance Director or Deputy	15		
	Inventory Management	Directors and Direct Reports to Directors	16		
9	**Income systems**		8		
	System design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash	Finance Director or Deputy Finance Director			
10	**Funding contracts, Contracts for the Provision of Services and Service Level Agreements:**		10		
	Below £100,000	Relevant Director and Deputy Finance Director			
	Up to £500,000	Finance Director			
	Up to £2,000,000	Finance Director and Chief Executive			
	Up to £5,000,000	FIC following ELT review			
	More than £5 000 000	Trust Board following FIC review			
	Routine mid term variations to any of the above if contract baseline value not changed by more than 5%	Finance Director			
11	**Annual capital programme and capital expenditure proposals**		5		
11.1	Approval of Annual Capital Plan as part of the Integrated Financial Plan before the start of the financial year.	Trust Board following review by Finance and Investment Committee			
11.2	Capital Project Budget Variation				
	Total budget spend of each capital scheme may be varied by 10% or £100,000, whichever is the smaller, subject to capital programme remaining within budget.	Finance Director			
	Total budget spend of each capital scheme may be varied by 20% or £500,000, whichever is the smaller, subject to capital programme remaining within budget.	Executive Leadership Team or as delegated through Finance and Investment Committee			

Scheme of Delegation and Financial Limits

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	If any individual variation in project value results in a breach of approval limits as set out in 2 above, re-approval in line with section 2 is required				
12	**Arrangements for the management of land, buildings and other assets and equipment belonging to or leased by the Trust**		15		
	Physical management and maintenance of assets	Directors responsible for assets			
	Land and buildings	Director responsible for Estates			
	Vehicles	Director responsible for Fleet			
	Equipment	Directors and Direct Reports to Directors responsible for equipment assets			
	Asset register, depreciation and PDC	Finance Director			
13	**Management and control of stock and equipment**		16		
	Central Consumables Stores and Pharmaceuticals Stocks	Director responsible for Logistics			
	Vehicle Parts, Oil and Lubricants	Director responsible for Fleet			
	IM&T Equipment	Chief Information Officer			
	Station Consumables, equipment and specialised equipment stores and fuel stocks	Director of Operations and Director responsible for Logistics			
	Other stocks	Directors and Direct Reports			
14	**Recording, monitoring and approval of payments under the losses and special payments regulations including theft and fraud**		17		
	All losses and special payments reported through to Audit Committee on a quarterly basis	Finance Director			
	Monitoring and approval of losses and special payments	Finance Director			
	Accounting for losses and special payments	Finance Director, Deputy Director and Head of Financial Services			
	General administration	Directors and Direct Reports			
	Cash losses and bad debts				

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
	Note: These write-offs, once agreed, will impact on individual budgets - there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the Trust, whether or not invoiced - it does not include adjustments relating to invoices raised in error.				
	Up to £10,000	Finance Director or Deputy			
	Over £10,000	Chief Executive and Finance Director or Deputy			
	Losses of equipment and property				
	Up to £50,000	Finance Director			
	Up to £250,000	Chief Executive			
	Over £250,000	Audit Committee or Trust Board			
	Claims net of recovery from NHSLA				
	Up to £100,000	Finance Director or Chief Executive			
	Up to £500,000	Executive Leadership Team			
	Over £500,000	Audit Committee or Trust Board			
	Staff grievance settlements other than in response to a formal process	As for losses of equipment and property			
	Complaints	As for losses of equipment and property			
15	**Disposal of deceased patients' property**		19		
	Property of value up to £5,000				
	Cash up to £100 and all valuables may be relatives who sign an indemnity form	Deputy Finance Director			
	Cash over £100 may be released by cheque together with all valuables to relatives who sign indemnity form	Deputy Finance Director			
	Property of value over £5,000				
	Cash over £100 may be released by cheque together with all valuables on production of probate or letters of administration	Finance Director			
16	**Management of Patients' monies**	Finance Director	19		
17	**Insurance arrangements**		23		
	Approval of Insurance Arrangements	Finance Director with approval of Trust Board (Finance Director to obtain quotes for insurance cover, and to present an annual report to the Audit Committee, Chief Executive to report to Trust Board on potentialinsurable risks and associated costs)			

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
18	**Appointment of Consultancy Firms**		9, 12		
	Up to £50,000 excluding VAT over the period of the contract	Directors with NHSI approval for contracts exceeding £50k including irrecoverable VAT and expenses		Clarifying that NHSI approval is now required for consultancy appointments over £50k including irrecoverable VAT and expenses as opposed to the approval limit which is excluding VAT	NHSI rules changed/clarified to measure including VAT
	Up to £250,000 excluding VAT over the period of the contract	Chief Executive or Finance Director with report to Trust Board over £100k			
	Over £250,000 excluding VAT over the period of the contract	Chief Executive with report to, and approval of Trust Board			
	All appointments of consultancy firms must be in line with regulatory authority approval requirements at the point of appointment, and relevant procurement requirements as per SFI 9 and 12				
19	**Legal Obligations**		12		
	Payment of compensation payments etc under legal obligation:				
	Up to £100,000	Chief Executive			
	Over £100,000	Trust Board			
	Quarterly Report on payments to the Trust Board	Director of Corporate Governance and/or Director of Workforce			
20	**Approving Financial Information/Costings for Tenders and Proposals for the Provision of Goods or Services, and signing Tenders Submitted By The Trust**		10	Amended to incorporate proposals other than tenders	Costings for Proposals for the provision of goods or services not covered elsewhere and need to be incorporated.
	Approving arrangements for the submission of tenders	Trust Board			
	Signing general tenders submitted by the Trust:				
	Up to £500,000 per annum	Finance Director			
	Over £500,000 per annum	Chief Executive and Finance Director			
21	**Charitable Funds**		20		
21.1	Approving the composition and terms of reference for the Charitable Funds Committee and approving the Annual Report and Accounts for funds held on trust to be submitted to the Charity Commission	Trust Board			
21.2	Setting overall policy on investment and presenting annual progress reports on the update of the Trust's charitable funds.	Charitable Funds Committee			
21.3	Monitoring the effective administration of charitable funds, including management and accounting arrangements	Finance Director			
21.4	Approving the appointment of the Financial Adviser to the Charitable Funds Committee	Finance Director			

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
21.5	Approval of Transactions:				
	Up to £5,000	Head of Financial Services			
	Up to £25,000	Finance Director			
	Over £25,000	Finance Director with approval of the Charitable Funds Committee			
22	**Ex-gratia Payments**		17		
22.1	Making Ex-Gratia Payments in respect of liability claims where legal advice has indicated a case can be made for LAS liability which would need to be contested in court or tribunal.				
	Up to £500,000	Approval by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000			
	Over £500,000	Approval by Trust Board following recommendation by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000			
22.2	Making other ex-gratia payments, including where legal advice has not been obtained				
	Up to £500	Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report)			
	Up to £3,000	Finance Director upon recommendation from Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority for all cases over £1,000)			
	Over £3,000	Chief Executive or Director of Finance (Finance Director must be informed and must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority)			
23	**Tribunal Payments**		17		
	Making payments resulting from a tribunal not under legal obligation:				
	Up to £50,000	Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel for Tribunal claims over £10,000. Formal reporting and approval for all payments.			

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
	Over £50,000	Trust Board to approve following recommendation by Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel. Formal reporting and approval for all payments.			
24	**Payment of Claims arising under Property Expenses Scheme**		17		
	Up to £20,000	Finance Director with Chief Executive review following report from Head of Estates			
	Over £20,000	Chief Executive and Finance Director following report from Head of Estates (Trust Board to be informed)			
25	**Payment of Personal injury and other liability claims outside the NHSLA indemnity schemes and commercial insurance**		17		
	Up to £50,000 which are not under legal obligation and are not novel, contentious, or repercussive	Chief Executive and Finance Director following recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services.			
	Over £50,000 which are not under legal obligation and are not novel, contentious, or repercussive	Chairman following review by Chief Executive and Finance Director based on recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services.			
	Claims which are under legal obligation and are novel, contentious, or repercussive	Chief Executive and Finance Director following Regulatory Authority approval			
26	**Disposals of Trust Property**		17		
	Approval of disposals of Trust property with a net book value less cost of disposal of:			Removed reference to disposal by "sale" and added net book value less cost of disposal	Changed to incorporate disposals not by sale and to specify the cost to be measured.
	Up to £25,000	Deputy Director of Finance following consideration of formal proposal			
	Up to £100,000	Finance Director following consideration of formal proposal			
	Up to £250,000	Finance Director and another Executive Director following consideration of formal proposal			
	Up to £1,000,000	Chief Executive, Finance Director and another Executive Director following consideration of Combined Business Case			
	Over £1,000,000	Trust Board following consideration of Full Business Case			
	Approval of Gifts of Trust property with a value of:				
	Up to £5,000	Chief Executive			
	Up to £300,000	Trust Board			
	Over £300,000	Trust Board following Regulatory Authority Approval			
27	**Dismissals**				

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
27.1	Approving arrangements for the discipline and dismissal of staff	Trust Board			
27.2	Nomination of a panel to hear appeals against dismissal brought by the Chief Executive or Executive Trust Board Directors	Trust Board			
27.3	Authority to dismiss the Chief Executive and Executive Directors	Chairman			
27.4	Nomination of a panel to hear appeals against dismissal brought by Directors who are not members of the Board.	Chairman			
27.5	Dismissal of staff below Director level	Chief Executive, Director or Director's Deputy			
27.6	Nomination of a panel of Directors to hear appeals against dismissal by staff below Director level	Chief Executive			
27.7	Ensuring that appropriate processes are completed to ensure salary and other payments cease as appropriate following dismissal.	Directors			
27.8	Advising panels dealing with dismissals and appeals	Director of Workforce			
28	**Remuneration and Terms of Service for the Chief Executive, Directors and Other Senior Officers**				
28.1	Decides the Directors' remuneration and terms of service	Trust Board on recommendation from Nominations and Remuneration Committee			
28.2	Decides performance related payments to the Chief Executive	Trust Board			
28.3	Reporting in writing to the Trust Board the basis of its recommendations in relation to remuneration, terms of service and performance related payments	Nominations and Remuneration Committee with advice from the Director of Workforce			
28.4	Recommending performance related payments for the Chief Executive.	Chairman			
28.5	Deciding performance related pay awards for Directors and all staff on performance related pay.	Chief Executive			
28.6	Recommending performance related payments to their staff to the Chief Executive.	Directors			
28.7	Advising on remuneration and terms of service	Director of Workforce			
29	**Human Resources Policy and Disputes**				
29.1	Approving all human resources policies	Trust Board (Chief Exec to determine submissions to Trust Board following advice from Director of Workforce)			
29.2	Approving premature retirement for the Chief Executive and all Directors	Trust Board			
29.3	Approving premature retirement for staff up to Director level	Chief Executive			
29.4	Settling disputes in line with the agreed disputes procedure	Chief Executive			

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
29.5	Preparing options and draft policy in conjunction with Directors	Director of Workforce			
29.6	Advising on human resources policy matters	Director of Workforce			
30	**Human Resources Arbitration**				
30.1	Approving arbitration submissions	Trust Board			
30.2	Determining and approving submissions to the Trust Board when appropriate	Chief Executive			
30.3	Advising on arbitration matters	Director of Workforce			
31	**Human Resources Disciplinary Matters**				
31.1	Receiving reports and hearing appeals on disciplinary action relating to the Chief Executive and/or Directors	Nominations and Remuneration Committee			
31.2	Initiating action on disciplinary matters relating to the Chief Executive and/or Directors.	Chairman			
31.3	Determining and approving submissions to the Trust Board when appropriate	Chief Executive			
31.4	Advising on disciplinary matters	Director of Workforce			
32	**Management and Control of Computer Systems and Facilities**				
32.1	Approving the overall corporate IT Policy on procurement and control of systems and facilities on the recommendation of the Chief Information Officer	Trust Board			
32.2	Co-ordinating IT Policy on behalf of the Trust and being the responsible officer for control and security of hardware, software and data	Chief Information Officer			
32.3	Compliance with the Data Protection Act, Use of Computers Act and other legislation in their Directorates	Directors			
32.4	Operation and compliance with legislation for all telecommunications and radio systems	Chief Information Officer			
32.5	Ensuring that risks to the Trust from IT are identified and considered, and that disaster recovery plans are in place	Chief Information Officer			

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
32.6	Ensuring that where computer systems have an impact on corporate financial systems: • System acquisition, development and maintenance are in line with corporate polices; • Data assembled for processing by finance system is adequate, accurate, complete and timely and that a management trail exists; • That the Finance Director and staff have access to such data; and • That such computer reviews are being carried out as are considered necessary.	Finance Director			
33	**Contracts for Computer Services with Other Health Bodies or Outside Agencies**				
33.1	Ensuring that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and that the contract ensures rights of access for audit purposes	Chief Information Officer			
33.2	Periodically seeking assurances that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications	Finance Director			
34	**Data Protection**				
34.1	Approving policy on Data Protection	Trust Board			
34.2	Notification under the Data Protection Act and the implementation of the Board's Data Protection Policy	Director of Corporate Governance			
34.3	Advising the Board on Data notification	Director of Corporate Governance			
34.4	Ensuring compliance with the Data Protection Act and the Board's Data Protection Policy in Directorates	Directors			
35	**Health and Safety Arrangements**				
35.1	Approving overall policy on Health and Safety at work.	Trust Board			
35.2	Ensuring an effective overall Health and Safety system within the Trust and compliance with legislative requirements	Chief Executive			
35.3	Ensuring the effective implementation of the Human Resources aspects of Trust Health & Safety policy and advising the Chief Executive of requirements	Director of Workforce			

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
35.4	Ensuring the effective implementation of clinical aspects of Trust Health and Safety policy and advising the Chief Executive of requirements	Director of Operations			
35.5	Ensuring the effective implementation of the Health and Safety Policy in individual Directorates	Directors			
36	**Complaints Against the Trust**				
36.1	Approves the Trust's Complaints Procedure	Trust Board			
36.2	Receiving reports regarding complaints about any aspect of service.	Trust Board			
36.3	Management of complaints within the Trust and ensuring complaints receive written responses in line with regulations	Chief Executive			
36.4	Supporting the Chief Executive in the management of complaints within the Trust and signing written responses to complaints	Directors			
37	**Executive and Non-Executive Directors Issues (Visits, Hospitality etc)**				
37.1	Approving overall policy on hospitality and visits.	Trust Board			
37.2	Advising the relevant Regulatory Authority on the performance of Non-Executive board members	Chairman			
37.3	Ensuring Directors are aware of guidelines	Chief Executive			
37.4	Ensuring compliance with Guidelines	Directors			
37.5	Developing policies and guidelines on behalf of the Chief Executive	Director of Corporate Governance			
38	**Freedom of Information**				
38.1	Approving Freedom of Information Policy	Trust Board			
38.2	Receiving an annual report on the implementation of the Freedom of Information policy	Trust Board			
38.3	Ensuring the Trust is compliant with current Freedom of Information legislation	Director of Corporate Governance			
38.4	Publishing and maintaining a Freedom of Information scheme	Director of Corporate Governance			
39	**Risk Management**				
39.1	Approving and Monitoring the risk management programme	Trust Board			

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
39.2	Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activity both clinical and non-clinical that support the achievement of the organisation's objectives	Audit Committee			
39.3	Deciding whether the Trust will use the risk pooling scheme administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed), and reviewing decisions to self-insure annually	Trust Board			
39.4	Ensuring that where NHSLA risk pooling schemes are used, the arrangements entered into are appropriate and complementary to the risk management programme, and that documented procedures cover these arrangements	Director of Corporate Governance			
39.5	Ensuring that where the Board decides not to use NHSLA risk pooling schemes, they are informed of the nature and extent of the risks that are self-insured as a result of this decision, and that formal documented procedures are drawn up for the management of any claims arising from 3rd parties and payments in respect of losses that will not be reimbursed	Finance Director			
40	**Signing and Sealing of Documents**				
40.1	Receiving a report of all sealings	Trust Board			
40.2	Affixing the seal	Chairman and the Chief Executive or another Executive Director in accordance with standing orders			
40.3	Approving and signing all documents which will be used in legal procedures	Chairman, Chief Executive and an Executive Director			
40.4	Keeping the common seal of the Trust in a secure place in accordance with arrangements approved by the Trust	Trust Secretary			
40.5	Keeping a register of sealings	Trust Secretary			
41	**Tendering Procedures - General**				
41.1	Approving standing orders regarding tendering	Trust Board			
41.2	Approves exceptions to Standing Orders regarding Competitive Tendering	Trust Board			
41.3	Receiving reports regarding all waiving of competitive tendering	Audit Committee			
41.4	Ensuring compliance with Standing Orders	Chief Executive			
41.5	Authorising exceptions to Standing Orders in an urgent situation	Chief Executive following consultation with the Chairman or Deputy Chairman under Standing Order 41			
41.6	Where EU procurement regulations have been satisfied, waiving the requirement for competitive tendering for goods and services up to £200,000	Chief Executive in conjunction with Finance Director			

London Ambulance Service NHS
NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
41.7	Where insufficient tenders are received, authorising the originating Directors to approach known firms with a view to procuring the goods or services required	Chief Executive			
41.8	Ensuring that at least 3 competing quotations from comparable firms are received for appropriate contracts (unless NHS Supplies is used)	Directors			
41.9	Authorising all tenders and waivers and ensuring satisfaction with the financial competence of all tendering organisations	Finance Director			
42	**Tendering Procedures - Limits**				
42.1	Ensuring that proper tendering arrangements are in place	Audit Committee			
42.2	Ensuring that competitive tenders are received for non-estate purchases above £25,000 and estate purchases over £100,000	Chief Executive			
	Ensuring that competing quotations are received for non-estates purchases between £3,000 and £25,000 and for Estates purchases between £3,000 and £100,000 except where ordered through NHS Supplies	Directors			
43	**Tendering Procedures - Receipt and Opening Tender Submissions**				
43.1	Nominating officers, including the Trust Secretary to open tenders	Chief Executive			
43.2	Accepting late tenders, despatched in good time but delayed through no fault of the tenderers	Chief Executive			
43.3	Accepting late tenders other than those that are despatched in good time but delayed through no fault of the tenderers	Chief Executive in conjunction with Finance Director			
43.4	Being present at the opening of tenders of value:				
	Up to £1m	Senior Manager responsible for the procurement and the Trust Secretary			
	Over £1m	Senior Manager responsible for the procurement, Executive Director responsible for the originating department, and the Trust Secretary			
43.5	Advising the Board by way of a report on both tenders invited and received and, in due course, tender amounts after their analysis is complete	Trust Secretary			
44	**Tendering Procedures - Post Tendering**				
44.1	Authorising post tender negotiations	Chief Executive or Finance Director			
44.2	Requesting in writing that post tender negotiations take place	Directors			
44.3	Keeping a record of the reasons for post tender negotiations and their outcome	Directors			

London Ambulance Service NHS Trust

Scheme of Delegation and Financial Limits

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Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference	Change Description	Change Reasoning
45	**Tendering Procedures - Approvals**				
45.1	Deciding where a tender other than the lowest (if payment is to be made by the Trust), or other than the highest (where payment is to be received by the Trust), shall be accepted	Chief Executive (with report to the Trust Board)			
45.2	Approving non-competitive tenders	Chief Executive (subject to report to the Trust Board)			
46	**Education and Training**				
46.1	Approving Trust policy on education and training	Trust Board			
46.2	Submitting policy on education and training to the Trust Board	Chief Executive			
46.3	Developing and updating the Trust policy on education and training	Medical Director			
46.4	Development of vocational/technical training	Medical Director in conjunction with Directors			

London Ambulance Service
NHS Trust

Quality Report

September 2017

All data pertains to August 2017 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

Section	Slide
Exceptions	3-4
Safety	5
Patient Safety	6
Safety (Infection Control)	7-10
Medicines Management	11
Safeguarding	12-13
Effectiveness (Clinical Measures)	14
Effectiveness (Ambulance Clinical Quality Indicators)	15-16
Clinical Audit Performance	17
Caring	18
Mental Health	19-20
Patient and Public Involvement	19
Maternity	22-24
Safety (Health & Safety)	25-26
Statutory & Mandatory Training	27
Sector Heat Map: Quality Data	28
Learning from Incidents	29-30
Learning from Inquests and Claims	31
Learning From Complaints	32-33
Quality CQUINs	34
Quality Risk Register	35

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

Executive Summary: Exception Report (Positive)

Safety

- Daily reviews of all patient safety incidents graded no harm, low harm and moderate harm are being conducted centrally
- Administration of adrenaline 1:1000 in wrong dose or via wrong route

Controlled drugs management

- Non-controlled drugs incidents
- The incident classification will be updated from 1st October and validated by the NRLS.
- OWR Hand Hygiene compliance successfully exceeded the Trust Target of 90%

Actions & Assurance

- Any incidents that are considered to be incorrectly graded are being referred to the SIG meeting for review
- Reduction in incidents to one (this is also only a possible excessive dose) – incidents are being fed back individually
- No LIN reportable CD incidents
- Reduction in incidents from previous month, overall downwards trend.
- It was identified that incidents from the 111 Datix system were not being sent to the NRLS and this will be corrected as part of the changes made to the system.
- Hand Hygiene audits will remain ongoing.

Effectiveness

- New Serious Incident Policy has been approved. The policy includes the new SI process and a number of SOPs to ensure a uniformed approach to all SI investigations
- New Terms of Reference for the Serious Incident Group meeting have been approved

Actions & Assurance

- Compliance with the new process will be monitored by the Quality, Governance and Assurance Team
- Changes to the Datix SI module have been drafted to reflect the changes in the SI investigation process

Caring

Actions & Assurance

Executive Summary: Exception Report (Improvement Required)

Safety

- The report of the independent review conducted to assess the level of the Trust's compliance with statutory Health and Safety requirements has been received. The report highlights significant gaps in health and safety compliance across the Trust. The report was presented and agreed by the ELT on 23rd August 2017.

- There are currently 91 remaining actions, many of which are duplicates relating to closed SI investigations. Of the 91 actions:
    - 17 = 6 months or over
    - 19 = 3 to 6 months over
    - 10 = 3 months over
    - 11 = 2 months over
    - 34 = less than 1 month over
- The governance team are working closely with operational leaders and those who have a delegated responsibility to ensure actions from learning are implemented promptly.

- Increase in breakages of injectable morphine
- Administration of drugs in breach of PGD indications

Actions & Assurance

- An action plan has been developed to address the gaps highlighted by the Health and Safety Review Report. The action plan will be closely scrutinised and monitored via monthly reports to the ELT as well as quarterly reports to the Corporate Health and Safety Committee.

- Weekly reminder emails are being sent to those responsible and non-compliance is escalated to the Chief Quality Officer
- Improvement to the current Datix system to provide action compliance dashboards for all directorate/sectors
- Improved reporting of overdue actions and the SI investigations they concern

- Progression of secure drugs rooms to provide bespoke area for medicines preparation
- Further PGD training programme for APP staff

Effectiveness

- There remains a risk that SI reports will breach the required deadline despite the support of the Quality, Governance and Assurance Team. Main themes that are being communicated from Lead Investigators is their individual capacity to take on an investigation. An additional concern regarding the lack of communication from Lead Investigators has been highlighted from the Quality, Governance and Assurance Team.

Actions & Assurance

- New escalation process is being developed with Senior Managers for the Trust.
    - Operations escalation will be via the ADO for the sector in the first instance following by escalation to the DDO for Operations.
    - Control Services escalation will be via the relevant General Manager followed by escalation to the DDO for Control Services

Caring

Actions & Assurance

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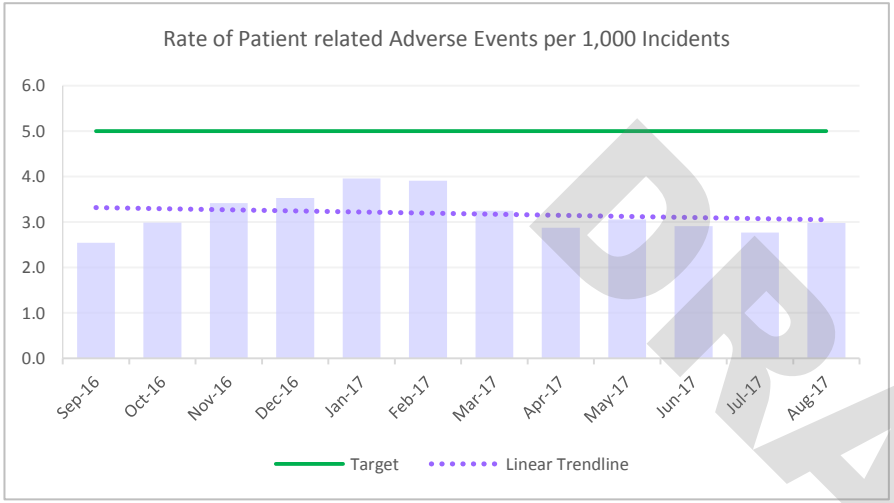
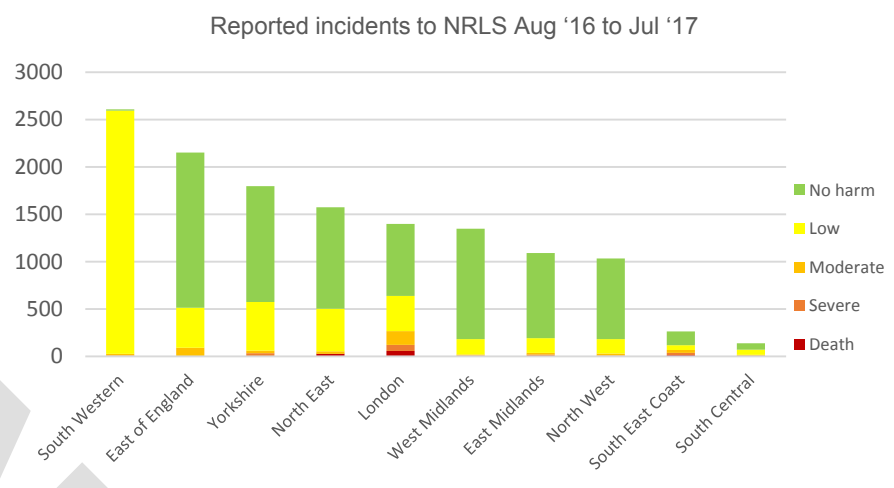
Patient Safety

Measures	Target / Range	RAG	YTD 17/18	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	G	76%	76.2%	87.2%	90.2%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	R	2.9	2.9	2.8	3.0	↑					
Patient related Adverse Events - **NONE**			1100	226	210	214	↑					
Patient related Adverse Events - **LOW**			116	19	23	25	↑					
Patient related Adverse Events - **MODERATE**			72	13	15	17	↑					
Patient related Adverse Events - **SEVERE**			37	6	10	7	↓					
Patient related Adverse Events - **DEATH**			40	6	5	11	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.3	3.0	3.5	3.2	↓					
Staff related Adverse Events - **NONE**			823	145	181	158	↓					
Staff related Adverse Events - **LOW**			684	123	148	126	↓					
Staff related Adverse Events - **MODERATE**			24	5	1	13	↑					
Staff related Adverse Events - **SEVERE**			1	1	0	0	↔					
Controlled Drugs - Non LIN Reportable Incidents	0	R	134	28	31	35	↑					
Controlled Drugs - LIN Reportable Incidents	0	G	1	1	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G		90%	95%	88%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			148	24	12	37	↑					
Serious Incidents declared in-month			27	3	4	6	↑					
Serious Incidents breaching 60 days	0	R	22	5	0	1	↑					
Serious Incidents breaching 40 days	0	R	22	5	0	1	↑					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events	0%	R	5%	6%	8%	3%	↓					
Needle Stick Injuries as % of Staff Adverse Events	0%	R	1%	2%	2%	2%	↑					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	2	0	0	0	↔			LQ25	✓	
Safeguarding Referrals as % of total LAS attended incidents			2%	2.2%	1.9%							
Safeguarding Training (Level One)	90%	R	88%	88.0%	87.8%							
Safeguarding Training (Level Two)	90%	R	76%	76.1%	75.6%							
Safeguarding Training (Specific - Trust Board)	90%	R	32%	31.8%	31.8%							
Safeguarding Training (Specific - Bank)	90%											
Safeguarding Training (Specific - Operational)	90%	G	91%	90.5%	90.1%							
Total Inquests where LAS asked to give evidence - In-Month			33	4	9	10	↑					
Total Inquests where LAS asked to give evidence - Year to Date			84	14	23	33	↑					
Missing Equipment Incidents as % of all reported incidents			3%	3%	2%	2%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			11%	16%	9%	9%	↓					
Number of NRLS uploads In-Month	1	G	5	1	1	1	↔			LQ21		

Patient Safety

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





Actions and Assurance

- The Quality, Governance and Assurance Team is working with the Datix Leads to improve the feedback mechanism to staff who have reported incidents.
- Once an incident has been reviewed, investigated and closed the system will automatically send an email to the reporter updating them on the findings of the investigation and any actions that have been assigned as a result.
- The feedback mechanism is schedules to go live on the 1st October 2017.
- Communication will be sent Trust wide informing them of the change in process.

National Reporting and Benchmarking

- NRLS data from August 2017 is not yet available at the time of this report, however the breakdown for August for the LAS is as follows, along with the change from July:
  - No harm 234 (+30) 78.3%
  - Low harm 24 (-2) 8.0%
  - Moderate harm 23 (+10) 7.7%
  - Severe harm 6 (-6) 2.0%
  - Death 12 (+9) 4.0%
- Only 63 of the above 299 incidents have been quality checked (as of 6th September) and therefore the numbers may change between now and the next report
- However all no harm, low harm and moderate harm incidents are reviewed daily by the Governance team to identify any potential serious incidents

Safety (Infection Control)

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

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

Monthly OWR Hand Hygiene 2017-2018 (Trust target: 90%)

	Apr		May		Jun		Jul		Aug	
Compliance/ submission	%	Sub	%	Sub	%	Sub	%	Sub	%	Sub
TRUST Overall	69.8	61	84.8	120	76.2	101	87	128	90.2	124
North East	97.4	13	90.6	35	60.9	27	57	27	95.3	35
North Central	100*	0*	100*	14*	48.9	8	89	8	100	32
North West	56	19	73.8	39	92	17	95	17	100	24
South East	33.3	14	95.8	21	95.8	27	95	27	62	9
South West	62.5	15	62.5	26	83.6	22	100	22	93.8	24
Others	-	-	-	-	-	-	-	-		
TPAPs	-	-	-	-	-	-	-	-		

- 4/5 Sectors are compliant with the 90% target set this month. Overall Trust compliance 90.2%.
- OWR submissions this month has increased, apart from SE Sector, with Greenwich Station not submitting any OWR for August.
- External peer review of IPC services took place in July & August; preliminary results & recommendations for improvement in the following areas – Cleaning, Hand Hygiene, PPE, Waste disposal, Deep Clean, Workshops, Third party providers, Occupational Health, including link between the Trust and the provider.

Actions

- Feedback to Sectors re the need for better overall performance in Hand Hygiene compliance.
- Highlight to SE Sector management the need to submit OWRs and for them to share the results locally to gain engagement.
- Management oversight at Deptford and Greenwich to ensure timely data submission.
- Management to use IPC Champions to assist in improvement in this area.
- Hand Hygiene training supplies (disclosing cream and UV lights) – funding source to be identified.
- Reinstate Hand Hygiene training at Trust Induction.
- IPC to continue to monitor performance and drill down for reasons for low compliance.
- IPC to incorporate interim recommendations from the external peer review into the IPC Work Plan.

Assurance

- Oversight: Monitoring established
  - OWR being undertaken each year for all front facing staff and reported monthly to IPC
  - Monthly Monitoring By IPC Team and performance recorded and shared via the Monthly Scorecard, and via the Chief Quality Officer through Quality Reports
  - Quality Operational and Strategic IPC meetings
- Learning from Others – Peer review request by LAS IPC Team and completed in August by EMAS. Interim Summary recommendations provided to inform Work Plan; close working with National Ambulance Trust IPC Leads to ensure best practice.
- IPC initiated a meeting with University Leads to understand their training content and methodology to build on their training when new staff joins the LAS – building on skills and knowledge.
- Local support via established IPC Champion network.
- Operations – leading on enhancing the OWR database to ensure robust data capture.
- DIPC support for reinstatement of Hand Hygiene Training at Trust Induction sessions.
- Audit programme agreed to include monitoring of practice at A&Es.

Safety (Infection Control)

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

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

IPC Training Compliance 2017- 2018 (Trust Target: 90%)					
TRUST Overall	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Level 1 *	87.8%	88.18%	87.96%	88.5%	91.56%
Level 2 *	87 %	84.92%	82.3%	78.28%	78.15%
Level 1 (No: trained)	4471/5093	4491/5093	4493/5108	4510/5096	4634/5061
Level 2 (No: trained)	3383/3887	3288/3872	3200/3888	3039/3882	3018/3862
Bank staff	-	-	-	-	-
TPAPs	-	-	-	-	-
CFRs/ERs	-	-	-	-	-
CFRs - no data					
ERs %	100%	100%	100%	100%	100%
ERs (Active) Numbers trained	134/134	140/140	138/138	150/150	162/162%

Robust data is being provided via the monthly Training Dashboard for LAS employees

- Overall compliance for LAS employees are as follow:
  - Level 1 for non-patient facing staff has achieved 91.56% against the Trust target of 90% in August.
  - Level 2 for clinicians/patient-facing staff has dipped in August 78.15%
- ERs consistently achieved 100% for all their active responders.
- No robust data is available from Third Party Ambulance Providers (TPAP), Bank staff or CFRs

Actions

- All staff will be able to access their own Compliance and Competency Matrix in MY ESR Portal from mid-September to identify their training gaps including IPC. This will enable timely completion of their training modules online.
- Local Managers to ensure that IPC training has been undertaken during one-ones and Appraisals
- IPC team to support services with bespoke packages to address their specific needs – e.g. Logistics from October 2017
- IPC team to clarify with TPAP managers re IPC requirements for monthly reporting
- IPC team to complete IPC online packages by September
- Reinstate hand hygiene training at Trust Induction

Assurance

- Oversight: Monitoring established - monthly monitoring by IPC team, quarterly ICDG
- MY ESR Portal – Compliance and Competency Matrix from Mid-September
- Online training available for IPC Level 1 and since been enhanced for 2017
- IPC approved training packages for new recruits (taught by Education Clinical Tutors)

Safety (Infection Control)

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

Actions

- 6 weekly deep clean – No action
- Premises cleaning:
  - Local management were informed to monitor and address; results to be shared locally and improvement to be made with the assistance of IPC Champions
  - IPC to monitor for improvement; oversight at IPC meetings

Assurance

- Oversight for both - Monthly monitoring by IPC Team; Quarterly ICDG and IPCC; Monitoring also by Estates and Logistics
- 6 weekly deep clean - Hub VP services completed rollout August providing better supervision and quality control of outputs; consistently exceeds targets
- Premises cleaning – station, estates and contractor undertake audits and results routinely provided to IPC team and shared at ICDG meetings for oversight and scrutiny

6-Weekly Vehicle Deep Clean 2017-2018 (Trust target: 90%)

	Apr	May	Jun	Jul	Aug*
TRUST Overall	97%	97%	94.8%	94.3%	96.8%
North East	95%	95%	97.8%	96.2%	96%
North Central	99%	99%	82.5%	91.2%	97%
North West	99%	99%	98%	98%	98%
South East	99%	98%	98.3%	95.5%	97%
South West	97%	97%	94%	94%	96%
Others	93%	93%	98.3%	91%	-
TPAPs	-	-	-		-

Monthly Premises Cleaning 2017-2018 (Trust target: 90%)

	Apr	May	Jun	Jul	Aug
TRUST Overall	96%	96.4%	96.7%	98.2%	78.65%
North East	92%	93%	95%	96%	97.3%
North Central	99%	99%	96%	100%	66.7%
North West	96%	95.4%	97%	98%	98%
South East	97%	97%	97%	98%	33%
South West	96%	98.5%	98.5%	99%	98.25%
Others	-	-	-	-	-
TPAPs	-	-	-	-	-

6-Weekly Deep Clean : Reporting changed from Station Groups to Hub Bases in August. The compliance with the schedule consistently exceeds the target set at 90%. ATP swabbing to provide assurance of the quality of the clean continues to be undertaken quarterly and data will be analysed from Q4.

Premises cleaning: Performance unusually has dipped this month. Partial submission form NC and SE has impacted on the overall scores.

Safety (Infection Control)

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

Sharps & Splash Incidents	Q1'17	Q2'17		Q3'17	Q4'17	YTD Total
Contact with sharps (includes needle stick)	0	1				1
Exposure to bodily fluids	43	28				71
Incident involving broken ampoule or vial	11	8				19
Lancets injury (clean)	2	0				2
Lancets injury (contaminated)	3	0				3
Needle stick injury - Cannula (clean)	0	1				1
Needle stick injury - Cannula (contaminated)	10	6				16
Needle stick injury - IM (clean)	0	2				2
Needle stick injury - IM (contaminated)	3	1				4
Needle stick injury - sub-cutaneous (clean)	0	0				0
Needle stick injury - sub-cutaneous (contaminated)	2	0				2
Razor injury (clean)	6	2				8
Razor injury (contaminated)	1	0				1
Bit by a person	4	4				8
YTD Total:	85	53		0	0	138

Figures to August 2017 (in Q2) – Trust total only. No sector data were submitted to the IPC team this month

There has been an overall increase in numbers of incident for August (24).
Of these:

- Exposure to body fluids +8
- Contaminated cannula +4
- Human bites +4
- Broken Vials +3

- No change in numbers for contaminated IM, S/C, lancet, Razor injuries

All incidents reported via Datix were reviewed by the IPC and H&S Teams

Actions

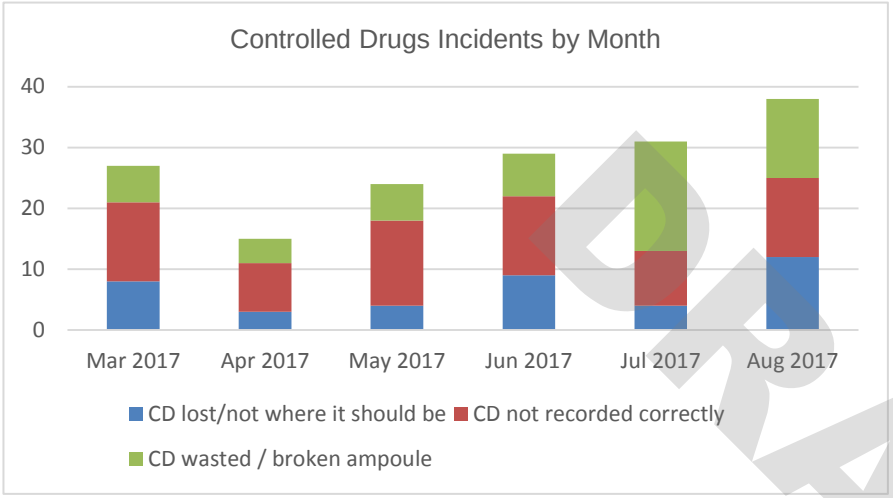
- Continue oversight by IPC and H&S team – review each incident for lessons and share across the Trust
- Collaborative working to be established between the Trust IPC, H&S Team and PAM OHS and the contract manager
- Sector data to be submitted to IPC team so that we can target improvement measures according
- Ensure robust data on vaccination status of staff is kept at OHS and data easily accessible to provide assurance to the Trust; data submission to IPC team to inform BHH CCG report
- Continue to work with Education to ensure that IPC measures are incorporated in to practical skills sessions

Assurance

- Datix incidents reviewed by IPC and H&S teams
- Lessons shared via Medical Bulletins, training content updates
- Provision of IPC advisory service; Pulse IPC page with video clips
- PAM OHS Protocol shared by Workforce; OHS service established July
- Quarterly reporting on vaccination status to BHH CCG to commence
- Oversight by IPC team; ICDG and IPCC meetings

Medicines Management

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



Summary

- No LIN reportable controlled drugs incidents in August 2017
- Total of 35 non-reportable controlled drugs including the following
  - Morphine retained whilst off-duty and subsequently returned (n=10)
  - Administrative errors in CD register (n=12)
  - Ampoules broken at scene (n=2) or at station (n=8)
  - Drug discarded due to drawing up error (n=1) and out of date (n=1)
  - Morphine Ampoule found on drugs room floor (n=1)
- Total of seven other drugs incidents including the following
  - Incorrect dose of intramuscular adrenaline in anaphylaxis (n=1)
  - Inappropriate use of dexamethasone in anaphylaxis (n=1)
  - Administration outside PGD guidance of Calcium Chloride (n=1) and Magnesium sulphate (n=1)
  - Incorrect dose of oral paracetamol given (n=2)

Actions

- Secure drugs rooms on pilot sites (Ilford & Bromley) now active with evaluation to follow. In addition, the installation of secure drugs rooms should reduce the incidence of ampoule breakages at stations due to appropriate flooring and work surfaces.
- CSR e-learning materials for medicines management including adrenaline administration and cross check procedures nearing completion
- Awaiting secondment arrangements for interim pharmacist.
- Additional PGD and pharmacology training schedule for critical care and urgent care APPs

Assurance

- Reduction in inappropriate dose/route administration of adrenaline 1:1000
- No LIN reportable controlled drugs issues during August 2017
- Further reduction in non-controlled drugs incidents from 13 during preceding month to 7 this month

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

Safeguarding referrals and concerns raised

Month	Adult Concerns	Adult welfare	Adult total	Children referrals	Total referrals
May 2017	366	680	1046	753	1799
June 2017	385	708	1093	787	1880
July 2017	379	656	1035	735	1770
Aug 2017	366	666	1032	622	1654

Numbers remain stable apart from the drop in child referrals that is consistent with summer holiday period as seen in previous years.

Level Three Safeguarding training

- The Trust has begun to deliver a full days level three safeguarding training to staff identified as requiring the training.
- Feedback from those attending has been very positive.
- Reports on numbers is via the Trust MAST reporting. Currently level 1 and 2 refresher are awaiting the Trust new e learning platform to be launched which is expected in the next month

FGM and mandatory reporting

The Trust received clarification from NHSE on reporting process regarding mandatory reporting of direct disclosures of FGM from Girls <18yrs and witnessed FGM.

The Trust issued a Quality Bulletin to all staff to inform them of their duty. Whilst the duty only applies to registered professionals the Trust has applied this to all clinicians.

Dementia work

The Trust has been working with the Alzheimer's society to introduce dementia friends into the Trust.

The safeguarding Adult specialist has been trained as a Dementia Champion and will be providing dementia awareness training to staff in the coming months to introduce a number of dementia friends across the Trust. The first sessions on becoming a Dementia Friend is 25th September where there are five sessions throughout the day with availability for up to 25 staff per session.

A couple of members of staff were also successful in gaining places on the Dementia Care Leadership and Quality Improvement Course which is being run by UCL Partners (Academic Health Science partnership which start on the 7th September and continues into the new year.

This is a Tier 3 training course. The objectives are:

- To enhance knowledge of best practice and effective communication in the care of people with Dementia
- To develop a better understanding of the needs of people with dementia and their carer's and consider how they can be addressed
- To focus on the practicalities of supporting people with dementia, particularly in challenging situations involving distress, pain and delirium
- To consider how to lead and improve dementia care practice
- To gain an understanding of Quality Improvement methodology
- To share information, experiences and ideas and learn from each other
- To support participants in implementing and managing change.

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

Child Death		
	Number	Outcome
Number of Child Death Reviewed	17	
No further action	10	
Referred for SI consideration	3	1 not declared 1 declared 1 pending SIG decision
Referred for clinical opinion	2	1 complete no concerns 1 outstanding
Referred other	2 (consultant midwife)	1 completed no concerns 1 outstanding
All staff receive a letter following a child death where they have (ROLE) recognized life extinct to offer them safeguarding supervision and to remain them of welfare and counselling support available.		

- The Trust has enhanced it's process for reviewing child death to ensure appropriate quality review of incidents.
- All Child deaths are reviewed by the safeguarding team weekly
- Where there are questions on clinical practice these are sent to Medical Directorate for a clinical opinion.
- Where there are concerns with treatment provided or delays in treatment that may have impacted on the outcome these are sent for SI consideration.
- The chart above provides details on the numbers reviewed and or referred.

Effectiveness (Clinical Measures)

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

Measures	Target / Range	RAG	YTD 17/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	36%	28%	28%	31%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	56%	64%	59%	49%	51%		↑			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	70%	74%	65%	70%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	65%	R	67%	70%	67%	68%	63%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	97%	98%	97%		↓			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:34	00:34		↓					
Survival to Discharge (AQI)			10%	10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	38%					↑					
STEMI- On scene duration (CARU continual audit)				00:41	00:43	00:40	00:42		↑					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	87%	83%	83%	88%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	0.03%	0.18%	0.59%	1.72%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98%	98%	98%		↔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	92%	92%	92%	91%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96%			↑		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		98%		97%		↓			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	6%	28%	51%	79%	89%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)	85%											LQ11	✓	

Actions

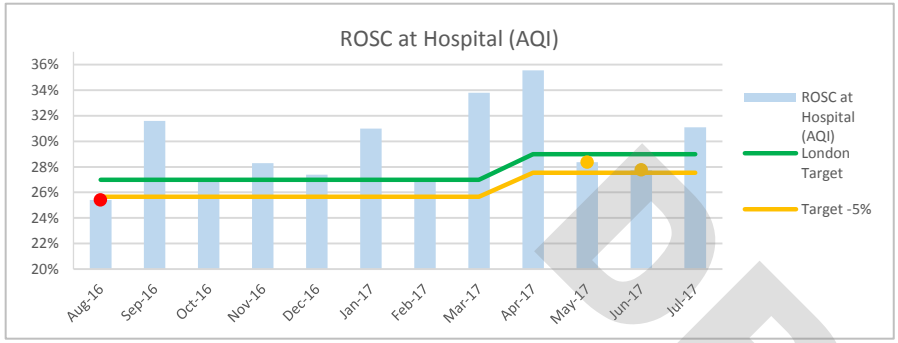
- As part of the Service's work on Job Cycle Time, the Clinical Audit Team reviewed all aspects of care in the CPIs with the Deputy Medical Director and specialty leads. The proposed changes will be discussed with the Medical Directorate and frontline staff at a workshop on the 14th September.
- The Non-Traumatic Cardiac Arrest for APPs went live in August 2017. On the whole, compliance was high, and completion (47%) is expected to improve as CPI audits become in embedded in the APP role.

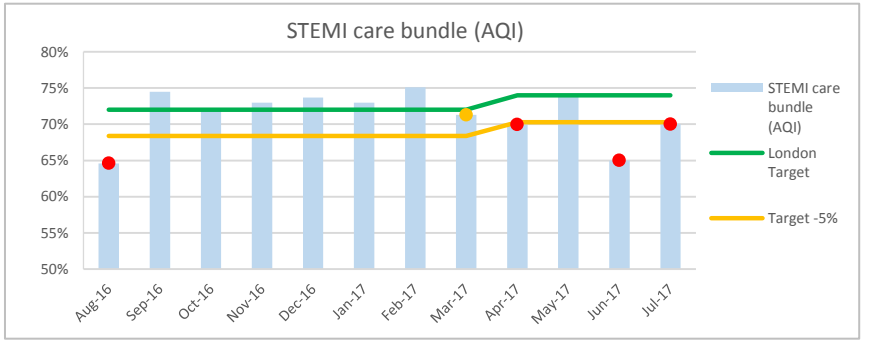
Assurance

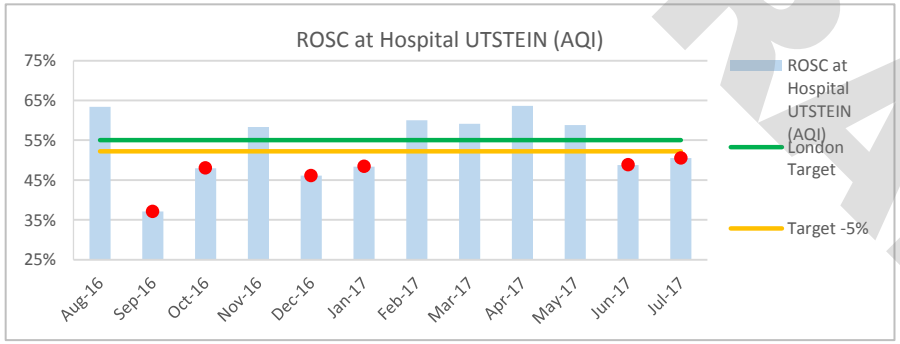
- Lower completion in June was largely due to a reduction in the number of staff on alternative duties and decreased Team Leader availability. In order to assist stations with low CPI completion, CARU continue to arrange help from staff on alternative duties at other complexes where completion is high.
- All the above measures have been communicated widely across the Trust and to Complexes via our monthly reports for discussion at the appropriate local forums.

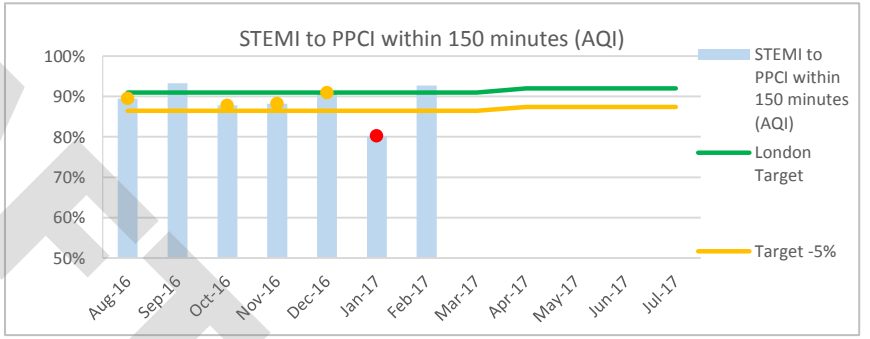
Effectiveness (Clinical AQIs)

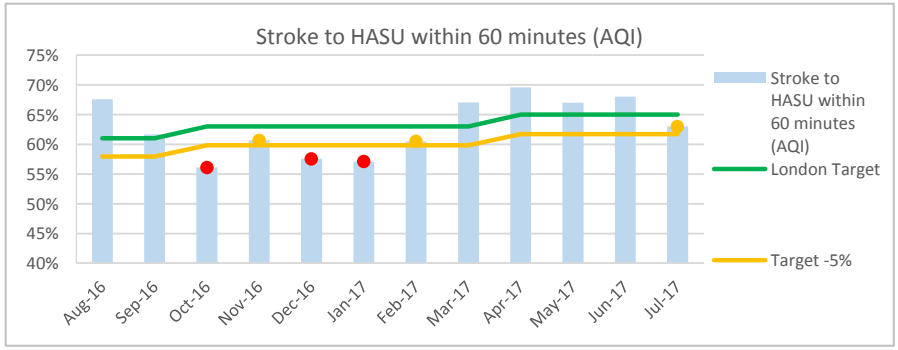
Owner: Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

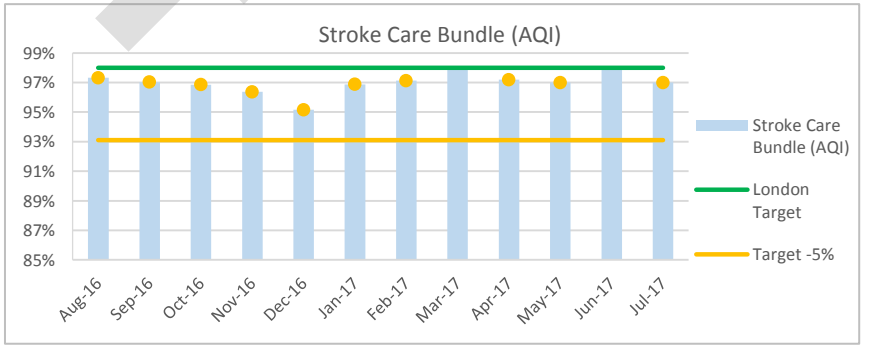








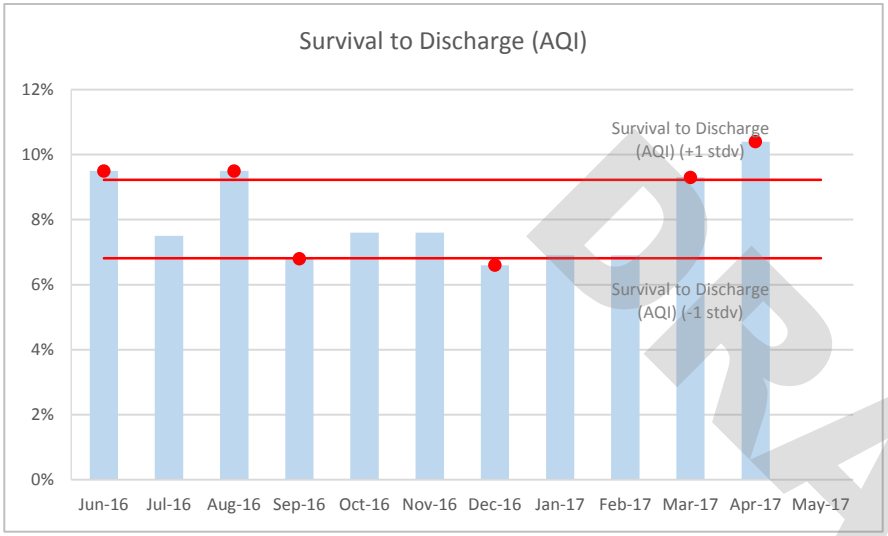


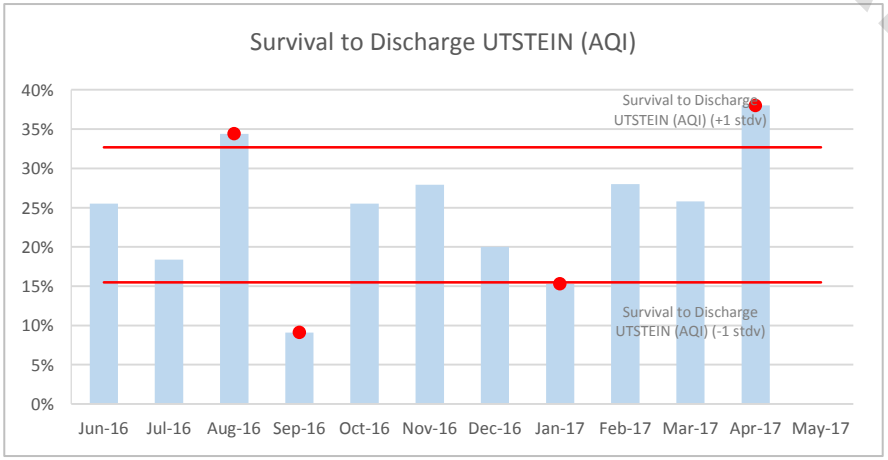


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Effectiveness (Clinical AQIs)

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





AQI: Actions

- Final survival figures have been submitted to NHS England and the LAS cardiac arrest survival rate will be released in our Cardiac Arrest Annual Report due for publication in Q3.
- There was a slight increase in the number of patients for whom we achieved ROSC. However, we do expect variation month to month due to attending patients with varying chances of survival.
- Compliance to the STEMI care bundle increased this month (+5%). However, the Trust still needs to consider how to improve analgesia administration.
- The proportion of patients who arrive at a HASU within 60 minutes fell this month. A reminder for staff to spend minimal time on scene has been included in this month's stroke infographic.

AQI: Assurance

- To improve compliance to the STEMI care bundle, a reminder to consider analgesia for all patients was included as an infographic within the STEMI care pack, that was circulated widely across the Trust. The infographic is available for Team Leaders to print and display on station.
- The importance of documenting a full FAST has been highlighted in the infographic that went to all complexes.

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

Clinical Audit Performance

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

Clinical Audit: Progress

We recently released a clinical audit on the care provided to patients whose PRF was coded as 'psychiatric problems – undiagnosed'. We found that:

- Only 63% of clinicians (n=126) used the 'psychiatric problem - undiagnosed' code correctly. The remaining 37% of patients (n=74) had a diagnosed mental health condition on their PRF, were experiencing an exacerbation of symptoms, and should have been coded as 'psychiatric problem – diagnosed' for inclusion in the Mental Health CPI
- On the whole, good practice was identified in history taking (97%) and the physical assessment of the patient (88%)
- Compliance was mixed when assessing patients' expressed thoughts (87%), behaviour (85%), appearance (62%) and communication (59%)

As a result of the audit, our recommendations include:

- Exploring the feasibility of including suspected psychiatric problems in the CPIs, by alternating each month with patients who have a diagnosed psychiatric condition
- Recording a Q&A session with our Mental Health Nurses
- Reviewing the wording of the illness code, to be 'suspected' or 'possible' psychiatric problems

Research Actions & Outcomes

Paramedic-2: 84 patients were recruited in August; 1,976 since the beginning of the study (contractual target =1,600).
RIGHT-2: 80 patients have been recruited since the beginning of the study (contractual target =180). Recruitment rates increased greatly in August (+58%).
ARREST: the Chief Investigator has submitted the updated trial protocol for regulatory approval. A decision is expected by mid-October.

Actions

Good progress is being made against our clinical audit work plan:

- The final draft of a clinical audit on the administration of analgesia for adult patients is currently with CARSG for review
- We are working on 13 further audit projects, three of which are in final draft (Hypovalaemic Shock, Ondansetron, Management of Overdose) and will be shared with CARSG over the coming weeks
- We are also facilitating 3 members of frontline staff to undertake their own clinical audits
- 5 clinical audits are yet to commence

We are currently collating the key findings and areas in need of improvement identified in our recent clinical audit on pain management, together with our results from a staff survey. These will be shared with the Clinical Tutor developing the upcoming CSR session on pain management.

Assurance

Two clinical audit actions were completed in July:

- The findings of the adrenaline clinical audit were shared with the medicines management group
- CARU surveyed frontline clinicians on their attitudes and understanding of paediatric pain management.

In addition, medicines-related audit findings were collated and shared with the Clinical Tutor developing the medicines management CSR session.

Continuous Re-contact Clinical Audit: 27 members of staff received feedback as a result of the audit in August 2017 (11 constructive and 16 positive).

Caring

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

Measures	Target / Range	RAG	YTD 17/18	Jun-17	Jul-17	Aug-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	100%	100%	100%	⇔			LQ27	
Friends and Family Test Response Rate			1.8	0.1	0.2	0.1	↓			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	⇔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	48	8	8	23	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.79	0.8	0.8	0.9	↑			LQ29c	
Positive Feedback Compliments			450	88	93	54	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	9.9%	6.6%	7.9%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.1%	1.8%	2.2%	↑				
Mental Health related Incidents as percentage of all calls			5%	5.7%	4.7%	5.3%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.4%	↑				
Rate of Frequent Callers per 1,000 Calls			2.90	2.8	2.7	3.0	↑				
CMC records viewed			11				⇔			LQ30	

Actions

Assurance

Mental Health

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

London Ambulance Service NHS

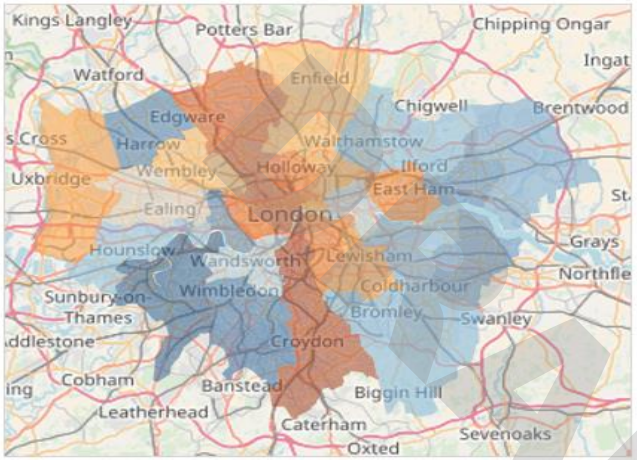
Mental Health Dashboard - August 2017

Business Intelligence

Mental Health Trusts by CCG

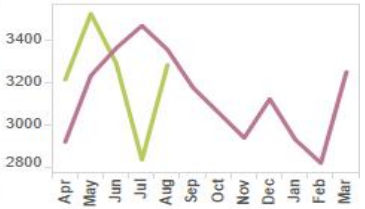
Camden and Islington NHS Foundation Trust	NHS Camden CCG
	NHS Islington CCG
Barnet, Enfield and Haringey Mental Health NHS Trust	NHS Barnet CCG
	NHS Enfield CCG
	NHS Haringey CCG
Central and North West London NHS Foundation Trust	NHS Brent CCG
	NHS Central London (W
	NHS Harrow CCG
	NHS Hillingdon CCG
	NHS West London (K&
East London NHS Foundation Trust	NHS City and Hackney
	NHS Newham CCG
	NHS Tower Hamlets CC
NELFT NHS Foundation Trust	NHS Barking and Dage
	NHS Havering CCG
	NHS Redbridge CCG
	NHS Waltham Forest C
Oxleas NHS Foundation Trust	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
South London and Maudsley NHS Foundation Trust	NHS Croydon CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
South West London and St Georges Mental Health NHS Trust	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
West London Mental Health NHS Trust	NHS Ealing CCG
	NHS Hammersmith and
	NHS Hounslow CCG

CCG Map - August 2017 Totals

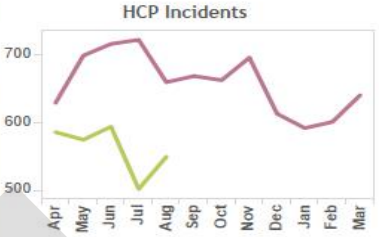


Total Calls

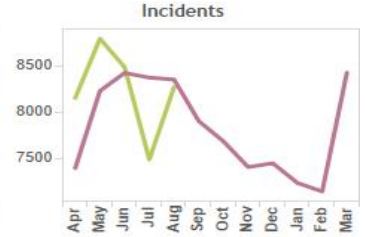
MPS Calls



HCP Incidents

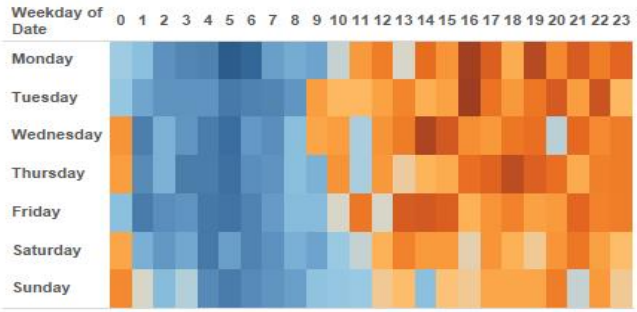


Incidents

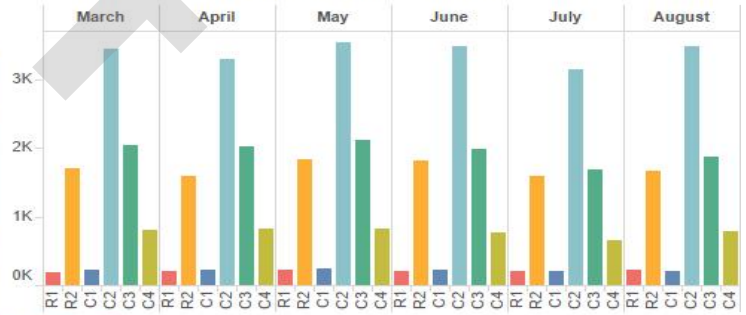


FY 2017
FY 2018

Average Incidents by Hour/Day of Week - August 2017



Incidents by Doh Subcategory



Mental Health

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

London Ambulance Service NHS

Mental Health Dashboard - August 2017

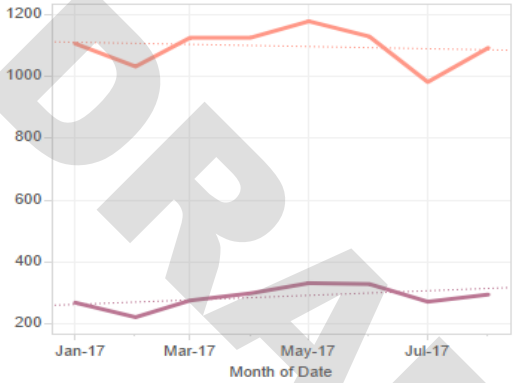
Business Intelligence
BusinessIntelligenceRequests@lond-amb.nhs.uk

South London and Maudsley NHS Foundation Trust

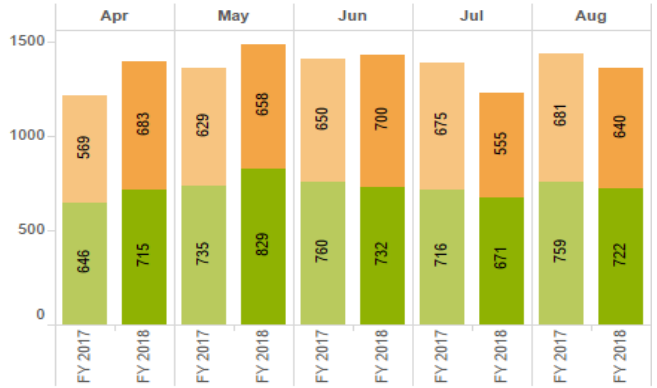
NHS Croydon CCG | NHS Lambeth CCG | NHS Lewisham CCG | NHS Southwark CCG

Heat Map - August 2017

Cat A & C Incidents



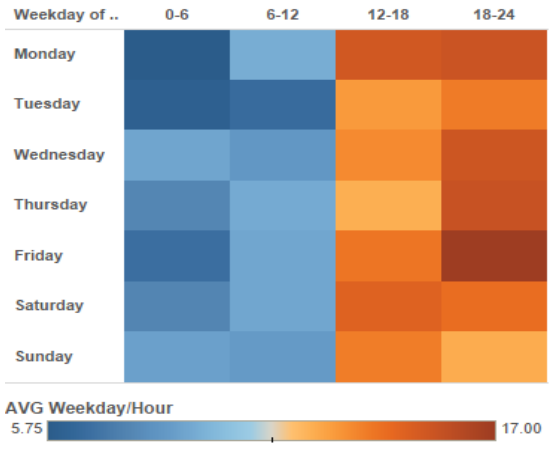
Gender



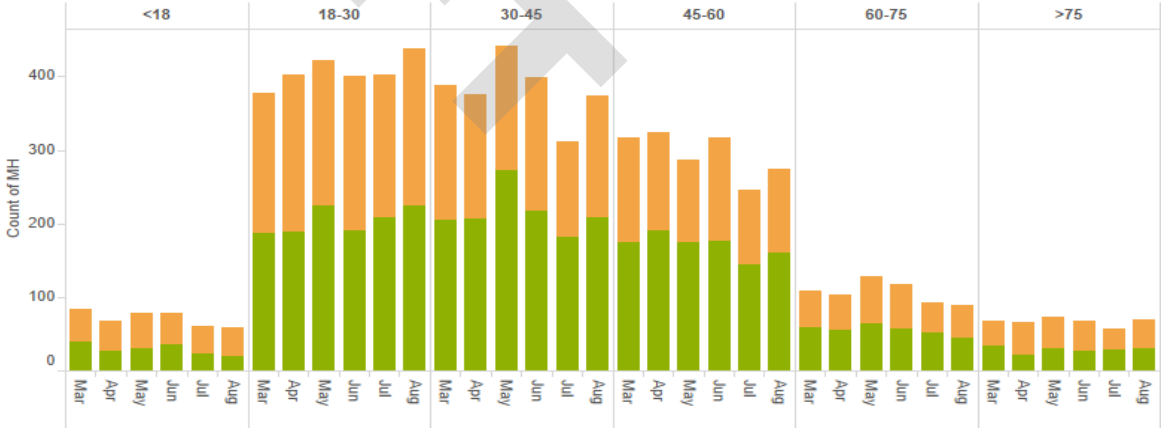
A | C

FY 2017, F | FY 2017, M | FY 2018, F | FY 2018, M

Average Incidents Group by Hour and Day of Week August 2017



Gender/Age Group



Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Patient & Public Engagement

Events on database	Events attended	Interested staff
23	12	1178

Rainham Library, Young at Heart Group – Tuesday 1st August

"Anja did very well and had great feed back. Everyone said she was a good speaker and that they learned a lot from her. She would be welcome to come back should you wish to come and talk again. Over all I'm very pleased with her performance. "

Charing Cross Day Nursery – Wednesday 2nd August

They absolutely loved having Diarmuid come in. Staff said that Diarmuid was great with the children, approachable and friendly .The children were very comfortable around him, which allows the children to get the full potential out of their learning. Thank you so much once again."

Please note the number of visits is lower due to the summer holidays

Key Updates

- The Public Education Staff Development Programme (PESDP) will take place in October for 12 members of staff from across the Service who have an interest in public education.
- Members of the team are developing new presentations on acid attacks and legal highs.
- One of the Public Education Officers has taken the lead on the Service's involvement in Safe Drive, Stay Alive. This is a multi-agency project aimed at reducing the numbers of young people killed and seriously injured on London's roads.

Staff Awards

The Trust Mental Health nursing team have been shortlisted in the Emergency and Critical Care category of the Nursing Times Awards 2017. The team were introduced in the service following feedback from staff and patients, to take calls directly from emergency call handlers and to provide support to frontline clinicians when attending complicated mental health calls.

Nursing Times Awards 2017

Two paramedics successfully completed the 100 mile Prudential RideLondon raising over £450 for the Chief Executive charity, Charlie Chaplin Adventure Playground.

Staff Recognition

A letter from the Chairman of the Football Association thanking the service for its response to the Grenfell tragedy and to staff for their hard work providing care to Londoners every day. In total over 50 letters of thanks were received in August and these were forwarded to 122 members of staff.

One of the Trust Clinical Tutors has featured in a new television advert to say 'thank you'. The video is part of a BT campaign asking colleagues to say thank you to someone who has made a difference to their career.

One of the Trust HART team supervisors set sail from Liverpool to Uruguay on the first leg of the Clipper Round the World yacht race in August in support of Ellenor, a charity that provides hospice care for people of all ages and their families.

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Patient Story – August 2017

- Positive incident report – Shoulder Dystocia - Seamless Maternity Care
  - Emergency Medical Dispatchers, Allocators, Advanced Paramedic Practitioner, Ambulance Clinicians managed a complex birth – Shoulder Dystocia
  - Managed Birth, resuscitation of the newborn baby and managed mother experiencing a post partum haemorrhage
  - Communicated effectively to receiving unit
  - Hand over to receiving clinicians acknowledged
  - All staff provided with feedback
  - Feedback from the Maternity Services

Collaboration

- North West London (NWL) – Local Maternity System (Better Births Delivery Transformation) – Engagement with LAS commencing in November 2017
- Two LMS now engaged – NEL and NWL
- University College Hospital, London – Leading with LAS to deliver Joint Maternity Training model through the NEL sector with Maternity Education Lead, Clinical Team Leader and Quality Assurance and Governance Manager – 3 sessions to be delivered over 5 months with evaluation of model
- LAS approached to share Pre Hospital Action and Screening Card with German Paramedic
- LAS staff survey on experiences of use of the Maternity Pre Hospital Screening and Action Tool

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

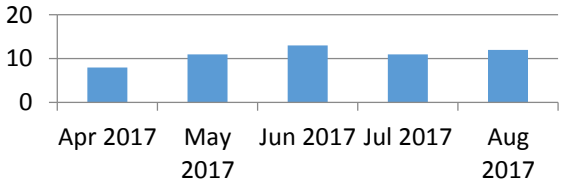
Maternity Performance 2017

CCG Name	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Grand Total
NHS Barking and Dagenham CC	39	32	35	29	36	32	41	41	37	30	28	21	28	24	28	24	26	19	550
NHS Barnet CCG	34	15	21	24	19	19	20	23	23	32	11	15	18	11	21	19	21	17	363
NHS Bexley CCG	14	9	3	14	16	10	20	3	11	13	12	8	9	17	10	11	15	9	204
NHS Brent CCG	41	34	32	27	41	29	32	28	30	25	32	28	23	19	39	32	38	34	564
NHS Bromley CCG	14	10	16	12	29	19	19	13	9	13	18	16	18	9	13	11	14	18	271
NHS Camden CCG	9	7	10	15	22	15	12	18	14	12	17	13	17	21	18	11	20	11	262
NHS Central London (Westmins	9	9	12	10	12	10	16	19	13	9	11	10	9	9	4	14	11	12	199
NHS City and Hackney CCG	24	21	17	30	29	40	28	28	21	17	19	22	17	14	17	10	24	22	400
NHS Croydon CCG	36	32	35	40	38	32	42	28	31	43	33	31	37	37	38	33	34	31	631
NHS Ealing CCG	27	18	29	27	29	30	26	21	28	24	22	29	28	20	17	22	19	22	438
NHS Enfield CCG	33	28	35	29	35	28	31	28	34	30	15	24	15	22	25	28	31	25	496
NHS Greenwich CCG	29	19	27	20	30	29	28	24	23	25	15	23	28	29	22	22	19	29	441
NHS Hammersmith and Fulham	13	7	3	14	13	13	19	11	9	14	9	8	5	7	12	6	12	9	184
NHS Haringey CCG	22	23	30	27	31	27	30	24	26	22	27	20	10	16	24	14	21	25	419
NHS Harrow CCG	18	15	13	13	20	13	12	12	13	16	11	6	15	15	14	19	16	13	254
NHS Havering CCG	21	12	15	18	11	18	10	21	10	9	7	9	11	4	8	10	13	5	212
NHS Hillingdon CCG	21	19	13	20	18	18	14	15	22	18	19	23	17	10	15	8	32	20	322
NHS Hounslow CCG	18	14	17	27	18	18	18	20	22	26	10	23	12	14	24	16	15	14	326
NHS Islington CCG	19	22	14	17	17	17	25	17	13	18	15	14	18	12	19	12	17	13	299
NHS Kingston CCG	8	4	6	12	3	3	5	6	3	2	6	4	4	7	7	4	5	2	91
NHS Lambeth CCG	31	33	34	33	27	38	31	36	25	27	40	20	21	34	36	32	42	36	576
NHS Lewisham CCG	34	37	34	33	31	30	32	38	28	32	32	30	26	33	17	32	33	28	560
NHS Merton CCG	11	11	12	16	9	9	9	13	14	16	15	10	14	16	21	5	15	11	227
NHS Newham CCG	66	47	43	57	57	51	43	42	57	49	63	53	39	33	34	43	32	45	854
NHS Redbridge CCG	34	22	27	33	33	34	21	22	25	23	15	36	28	18	26	26	24	33	480
NHS Richmond CCG	8	3	5	5	6	8	2	5	7	2	2	3	3	7	4	4	4	3	81
NHS Southwark CCG	26	28	54	42	41	40	42	43	42	37	43	34	36	40	33	23	31	35	670
NHS Sutton CCG	7	3	3	6	11	13	10	2	9	11	10	6	5	5	11	9	1	7	129
NHS Tower Hamlets CCG	38	21	32	28	37	46	33	39	27	42	34	21	34	29	35	29	33	26	584
NHS Waltham Forest CCG	35	25	21	22	22	20	37	21	31	31	20	21	10	18	23	22	22	23	424
NHS Wandsworth CCG	18	16	19	15	23	19	20	14	22	22	15	15	18	17	18	13	12	12	308
NHS West London (Kensington	7	10	7	13	8	5	5	16	9	8	11	4	4	12	14	6	11	4	154
Grand Total	**764**	**606**	**674**	**728**	**772**	**733**	**733**	**691**	**688**	**698**	**637**	**600**	**577**	**579**	**647**	**570**	**663**	**613**	**11973**

Maternity Incidents – Key Facts

- January – December 2016 – Total "999" calls received where "Maternity/Pregnancy/Childbirth" related in Medical Priority Dispatch Protocol – 9505
- Average monthly "Maternity/Pregnancy/Childbirth" = 792 (range 676-864
- Average Datix incident with maternity identified per month = 11
- 0.1% current maternity activity involves a Datix incident report

Incidents by Reported (Month and year)



Maternity Risk Themes – Key Facts

- Local Maternity Unit declining to accept pregnant woman (2)
- Delay to hand over of woman to midwife (2)

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Key Maternity Risks

- Gaps in maternity training due to capacity within Maternity Education Leads
- Strategic overview of maternity education requires review in anticipating service expansion of Urgent and Emergency Care capability to include midwives
- Pan London Communication of impact of Ambulance Response Programme to the acute sector maternity units.
- Existing system of requesting a midwife to attend at request of LAS to a birth imminent requires review to monitor clarity around standards of reasonable service delivery
- Resource availability to support Implementation of introduction of Midwives into the London Ambulance Service - Project Management Support.
- Equipment to assess newborn temperature reliably is under review
- Foil blizzard cribs for newborn removed (latex identified within material) awaiting review of replacement)

Actions

- Review of JD/Person Specification for Lead Midwife for Practice Development and Education - 1 Whole Time Equivalent (WTE) October 2017
- Review and familiarise the new ARP response profiles and share with Pan London Maternity Heads of Midwifery – October 2017
- Presentation at CQRG – October – discuss the existing system and it contractual monitoring of midwives attending at birth imminent LAS requests – October 2017
- Identify resource within Trust Project Management Support resource – October 2017
- Equipment review of neonatal thermometers to be presented Equipment Group – September 2017
- New blizzard foil crib to be reviewed by team of midwives and neonatologists at Northwick Park Hospital to review acceptability – October 2017

Assurance

1. Daily monitoring and feedback from Maternity related Datix to identify and monitor ongoing risk
2. Staff awareness of Datix incident reporting communicated
3. All maternity education requests being overseen by Senior Maternity Education Lead
4. Review of existing content of LAS-Live e-learning to ensure fit for purpose
5. Maternity packs currently contain newborn towels and thermometers

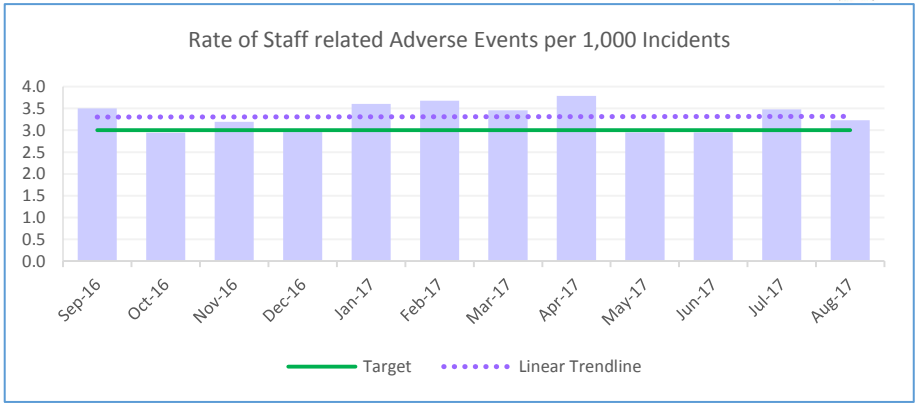
Safety (Health and Safety)

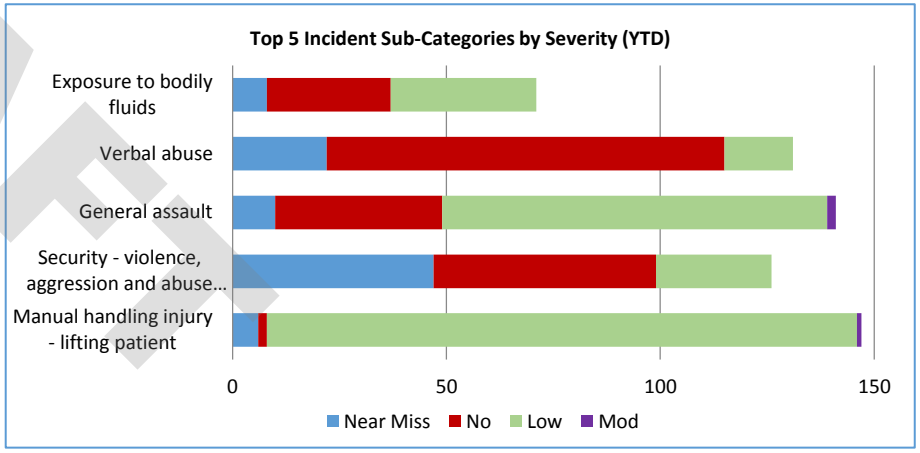
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Trust H&S incidents	Q1'17	July-17	Aug -17
Incidents affecting Patient(s)	2	0	0
Incidents affecting LAS Staff	776	281	227
Incidents affecting Visitors, contractors or the public	24	6	2
Incidents affecting the Trust	38	21	2
YTD Total:	840	308	231

H&S Incidents by Result – Aug 2017	**Near Miss**	**No Harm**	**Harm**
Incidents affecting Patient(s)	0	0	0
Incidents affecting LAS Staff	35	59	133
Incidents affecting Visitors, contractors or the public	0	2	0
Incidents affecting the Trust	0	2	0

Top 5 H&S Incidents by Sub-category	**2017 YTD**
Manual handling injury - lifting patient	147
General assault	141
Verbal abuse	131
Security - violence, aggression and abuse - Other	126
Exposure to bodily fluids	71





- There was a slight increase in the number of incidents reported for Q1 and July 2017 compared to the data previously presented in the July Quality Report. This is due to the recent upload of incidents that were reported through paper incident forms – LA277 and LA52. It has been agreed that all paper reporting forms will be withdrawn by 1st October 2017 following changes to the Trust's Datix System.
- There was a slight decrease in the number of health and safety related incidents reported in August 2017 compared to Q1 and July 2017. The top 5 incident categories however remain the same.
- Report and action plan of the independent review of Trust-wide Health & Safety arrangements and compliance presented to the ELT on 23rd August 2017. The report was accepted and will be presented to the Board in October 2017. The full action plan will be monitored by the Corporate Health and Safety Committee.

Safety (Health and Safety)

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

RIDDOR

RIDDOR Incidents	Apr-17	May-17	June-17	July-17	Aug 17
RIDDOR reportable incidents	10	4	18	10	29

29 incidents were reported as RIDDORs in August 2017. A total of 71 incidents have been reported YTD. A breakdown of the incidents reported in August is provided below:

- Over 7-day injuries – 25
- Major Injury – 3 (Fractures)
- Death – 1 (incident reported at the request of the HSE as part of investigation into death of staff member in 2016).

MHRA/CAS Alerts Management

Alert Date	2017
Total alerts received	62
Total MHRA Alerts Received	8
Total CAS Alerts Received	54
Total CAS Alerts Acknowledged within 2 days	43
Total alerts assessed as relevant to LAS	2
Total (relevant) alerts closed	1
Total outstanding (relevant) alerts	1
Total assessed 'not relevant'	59
Total under assessment	1

Actions:

Security:
Security related incidents accounted for 49% of H&S incidents reported in August and 16% of harm (low/moderate) incidents. Actions taken to address these incidents includes:

- Lone working arrangements under review to enable the implementation of robust measures to mitigate risks.
- Review of Datix security incident categories /descriptors to be completed by 1st October. This will enable better analysis of incidents reported.
- Contact established with the Head of the Met Police Prosecution Unit who has agreed to support LAS with the follow-up of incidents, and ensure that appropriate actions are taken by the Met Police when assault incidents are reported.
- Established direct link with Unison (National Officer, Health Group) to explore joint working to help address the issue of assaults against staff.

Manual handling:

- 16% of H&S incidents reported in August related to 'Manual handling injuries'
- Contributory factors identified include: sudden patient movements, carry/track chairs faults, lifting/assisting patients onto trolleys or to stand.

Actions:

- Agreement received from ELT regarding the provision of practical training to clinical educators in December 2017. Practical Manual handling refresher training to be incorporated into CSR from April 2018.
- Increase in number of track/chair related incidents highlighted. 139 incidents reported between 01/04/17 to 31/08/17. Recommendations from independent review submitted to Manual Handling Implementation group. Full report to be tabled at 13/09/2017 Corporate H&S Committee Meeting.
- Risk assessments completed for all high-risk manual handling activities - task and finish group to be put together to review and agree risk assessments.

Infection Control:

- 71 incidents relating to 'Exposure to bodily fluids' have been reported in 2017/18. Contributory factors include: Non adherence to IPC Practices & wearing of appropriate PPE supplied to staff.

Assurances:

- Quarterly monitoring reports are produced for the Corporate Health, Safety & Security Committee.
- Monitoring of incidents by Corporate Infection Control and Prevention Committee.

Sector Heat Map: Quality Data

CQC		Key Performance Indicator	NW	NC	NE	SW	SE	Other	LAS Target	LAS Ranges	SPC RANGES Lower Limit	SPC RANGES Lower Limit +5%	SPC RANGES Upper Limit -5%	SPC RANGES Upper Limit
SAFETY		Hand Hygiene OWR compliance	100%	100%	95%	94%	62%		90%					
		Rate of Patient related Adverse Events per 1,000 Incidents	2.5	2.5	2.9	1.6	3.2		5					
		Rate of Staff related Adverse Events per 1,000 Incidents	2.9	2.3	4.4	3.2	3.3		3					
		Controlled Drugs - LIN Reportable Incidents	0	0	0	0	0		0					
		Percentage of Incidents reported within 4 days of incident occurring	94%	92%	97%	100%	100%		85%					
		Potential Serious Incidents referred to SI Group	2	1	2	2	3				1.3	2.3	3.3	4.3
		Serious Incidents declared in-month	0	0	0	0	0		0					
		Serious Incidents breaching 60 days YTD	0	0	0	0	0		0					
		Serious Incidents breaching 40 days YTD	0	0	0	0	0		0					
		Medication Errors as % of Patient Adverse Events	0.0%	3.1%	6.0%	9.5%	3.4%		0%					
		Needle Stick Injuries as % of Staff Adverse Events	3%	3%	3%	0%	0%		0%					
		Missing Equipment Incidents as % of all reported incidents	1%	3%	3%	1%	2%							
		Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	7%	8%	10%	5%	14%							
	*	Safeguarding Training (Level Two) YTD	83%	80%	77%	84%	88%		90%					
		Percentage of staff completing Core Skills Refresher 2017.1 (cumulative)	90%	93%	86%	86%	93%		85%					
EFFECTIVENESS	*	ROSC at Hospital (AQI)	25.0%	28.9%	30.8%	51.2%	27.3%				28%	29%		29%
	*	STEMI care bundle (AQI)	63.8%	73.0%	68.4%	75.0%	71.8%				62%	64%		65%
	*	Stroke to HASU within 60 minutes (AQI)	69.6%	49.3%	63.9%	64.6%	63.7%		65%					
	*	Stroke Care Bundle (AQI)	99.2%	98.0%	96.3%	97.0%	97.4%		98%					
	**	Survival to Discharge (AQI)	-	-	-	-	-							
	*	CPI - Completion Rate (% of CPI audits undertaken)	82%	98%	91%	86%	90%				75%	94%		95%
	*	CPI - Percentage of Staff receiving ONE Feedback Session YTD	37.2%	25.6%	26.5%	31.8%	25.7%							
	*	Documented Care - Cardiac Arrest Compliance (CPI audit)	97%	97%	98%	98%	98%		95%		75%	95%		95%
	*	Documented Care - Discharged at Scene Compliance (CPI audit)	98%	98%	97%	98%	97%		95%		75%	95%		95%
	*	Documented Care - Mental Health Compliance (CPI audit)	92%	92%	87%	94%	91%		95%		75%	95%		95%
	*	Documented Care - Severe Sepsis Compliance (CPI audit)	96%	97%	98%	97%	97%		95%		75%	95%		95%
	*	Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-		95%		75%	95%		95%
	*	Documented Care - Glycaemic Emergencies Compliance (CPI audit)	98%	97%	97%	98%	97%		95%		75%	95%		95%
CARING		Rate of Complaints per 1,000 Incidents	0.3	0.5	0.7	0.4	0.2							
		Mental Health Related Incidents	8%	9%	8%	8%	9%							
		Mental Health Related HCP Incidents	0%	1%	0%	1%	0%							
		Rate of Frequent Callers per 1,000 Calls	5.8	6.5	5.6	4.4	4.0							

* data shown refers to Jul-17

** data not available by sector yet

Learning from Incidents

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

Learning from Incidents

- Due to the number of overdue actions relating to closed SI investigations the Quality, Governance and Assurance Team have been working with the Datix Leads to include action compliance dashboards which will be accessible to all Senior Managers within each directorate and ELT. Future reports will be run on a monthly basis which will display all actions and the SI investigation they relate to.
- A maternity related 'improving patient care' poster has been distributed to all operational stations to disseminate to front line staff.

- A Maternity Patient Safety bulletin has been issued following a recent SI investigation which found issues regarding:
  - The application of the maternity tool
  - The clinical handover to the receiving hospital
- The Trust has started the process of re-introducing oramorph to areas which have had it temporarily withdrawn
- New 'tamper evident seals' for the oramorph bottles are now being implemented Trust wide

Incidents

SI update	Incidents reviewed In August	SIs declared In August	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	36	8	17	8 (+2 RCA)	6	1	1
Trend on previous week	↑	↑	↑	↑	↓	↓	↓

Serious Incidents & Incidents

Serious Incident Policy has been approved by ELT ready for circulation. This Policy includes the new SI investigation process and timeline.

Additional SOPs have been produced to ensure a uniformed approach to key elements of the investigation process such as:

- Multidisciplinary team meetings
- Completion of the SI report
- SI milestones
- Escalation of concerns

The Governance Team is currently updating the Duty of Candour Policy to reflect best practice and national guidance.

New Terms of Reference for the Serious Incident Group have been approved.

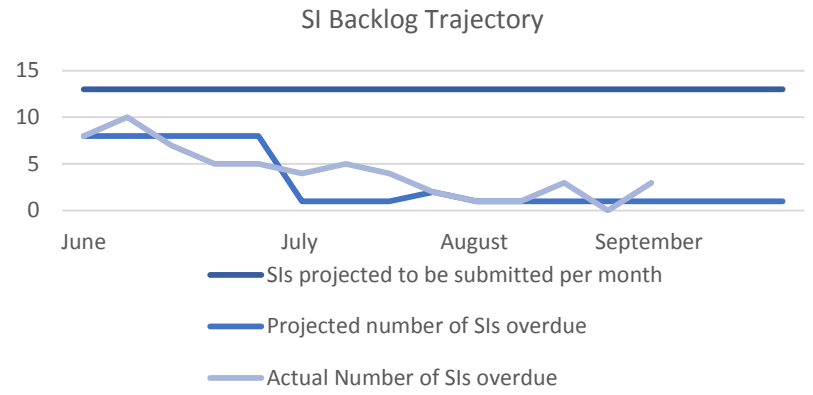
Learning from Incidents

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

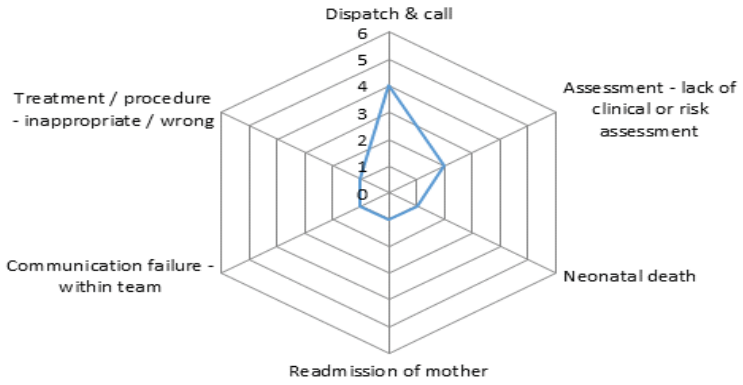
Overdue Serious Incidents Investigations

ELT	STEIS ref	No of days overdue	Due Date	Update
ELT group	2017/13483	**16**	18.08.2017	11.09.17 – report back with the Governance Team for comments post ELT review

SI Trajectory



SIs under investigation as of 10/08/2017



Actions

SI action plan update:

- There are currently 91 remaining actions, many of which are duplicates relating to closed SI investigations.
- Quality, Governance and Assurance Team sending weekly reminders to responsible individuals
- Incomplete actions being escalated to Chief Quality Officer
- Review of Datix to ensure action compliance
- Of the 91 remaining actions:
  - 17 = 6 months or over
  - 19 = 3 to 6 months over
  - 10 = 3 months over
  - 11 = 2 months over
  - 34 = less than 1 month over

Learning From Deaths, Inquests and Claims

Owner: Nicola Foad | Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

Inquests – figures and learning

- In August LAS staff were requested to attend Inquests to give oral evidence on 10 occasions, up from 9 the month before.
- The reasons for LAS' attendance to provide oral evidence ranged from providing background for the Coroner with regard to the removal of an obstruction from the airway to answering questions about a delay in transferring a patient to another hospital, this Inquest is yet to conclude.
- No Prevention of Future Death (PFD) Reports were received.

Claims – figures and learning

- NHS Resolution (NHSR) prepare quarterly reports on the numbers of claims received, and to reflect their reporting cycle details of the claims received in August will be reported in the next Quality Report, as part of the NHSR Q2 figures. As at the end of Quarter 1 2017/2018 NHSR had 40 claims against LAS open under their Clinical Negligence Scheme for Trusts and 75 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- Members of the Legal Services team attended a seminar where the Safety and Learning Lead from NHSR gave a presentation on 'learning from tragedy '. A video has been made by another Ambulance Service, along with the family of the patient and a charity to raise awareness of their experience and the learning identified. A copy of this video has been shared with the Deputy Director for Clinical Education for her to consider whether there is also learning for LAS and whether the video would aid this.

Claims – learning

- In August a risk management recommendation was made by Panel solicitors further to a trial. Panel Solicitors identified that:
  "(i) the judge was concerned regarding the lack of training covered in regard to lifting of bags within the manual handling training. We would suggest incorporating some training on lifting bags within the current manual handling training being presented. It would be useful to train paramedics in how to carry their bags in a way so as to minimise the risk of injury as far as possible.
  (ii) the judge was concerned in regard to the Trust's reliance on the intranet for circulating policies. We would suggest enforcing the point to employees to ensure that they have read and considered the policies on the intranet. And maybe this could also be something that could be incorporated in training."

Actions

Completed:

Safe hold training – The Medical Directorate have discussed our safe hold training with NASMeD in light of recommendation referenced in July's Quality Report.

PRF continuation sheets – Medical Directorate confirmed that guidance is provided within the guidance notes for completion of a PRF.

Learning from tragedy – video shared with Deputy Director for Clinical Education

Ongoing:

Response to PFD dated 12 May 2017 to be shared with the Quality Oversight Group on 24 October 2017

NHS Resolution Scorecard – analysis received but further identification of learning and trends to be undertaken and reported within LAS.

Risk Management Recommendations – Legal Services to discuss the recommendations made and identify any appropriate actions.

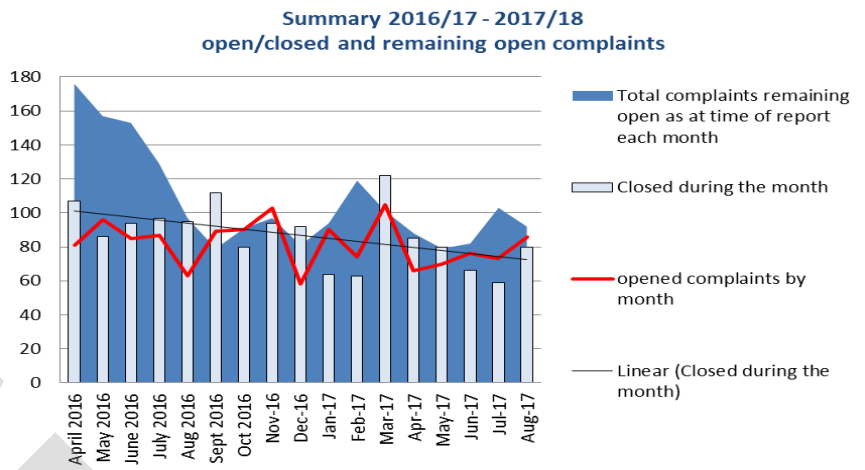
Learning from Complaints

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

Top 5 Key complaint themes Sept 2016 to August 2017

Complaints by subject 2015/17	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Total
Delay	35	29	37	19	36	16	27	21	17	16	14	26	293
Conduct	16	25	22	15	26	27	36	16	19	24	19	19	264
Road handling	14	11	8	8	7	9	16	12	11	13	14	10	133
Treatment	8	14	6	1	3	3	5	1	2	5	1	7	56
Non-convey	0	4	1	1	1	3	4	3	0	4	12	0	33
Total these	73	83	74	44	73	58	88	53	49	62	60	62	779
Overall totals	89	90	103	58	90	74	105	66	70	76	73	86	980

Complaint summary April 2016 to August 2017



Actions

- 86 complaints were received during August. Those where the chief complaint related to the delay in attending increased by 87% over July, despite calls attended being lower than July.
- We have added and incident time field to Datix from which we are aiming to prepare data in the future to determine the exact time of each complaint (where appropriate).
- There was an increase in overdue complaints (up to 23). Of these 57% (13) were delayed at Executive Office awaiting sign off and the remainder (10) were awaiting further information.
- We have also added an 'outcome code' by each subject code so that where there is more than one subject, we can record the outcome for each subject. For example a complaint may relate to delay/conduct and treatment but only one of those aspects may be upheld

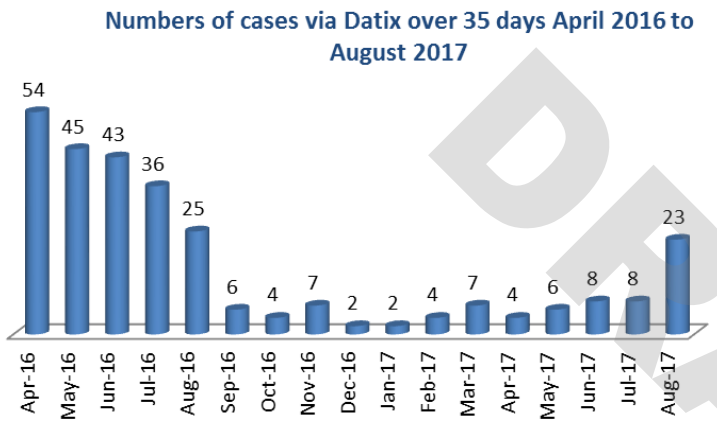
Assurance and learning

- Currently 82 in time complaints remain open.
- 12 complaints, that were closed during August have been upheld, these include:
- A complaint was received where aspects of the care the ambulance staff provided to a maternity patient fell short of the practice standards we expect. The crew have been invited to meet with our Consultant Midwife and a CTL to review the care provided and the areas of practice where their care fell short.
- A complaint was received from the family of a patient who waited a considerable amount of time for an ambulance after she had a seizure. There were some technical shortcomings in the management of the 999 call and extensive feedback will be offered to the call handler concerned with their performance monitored for a period to be decided by their line manager.

Learning from Complaints

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

Performance against 35 day response target



Assurance and learning

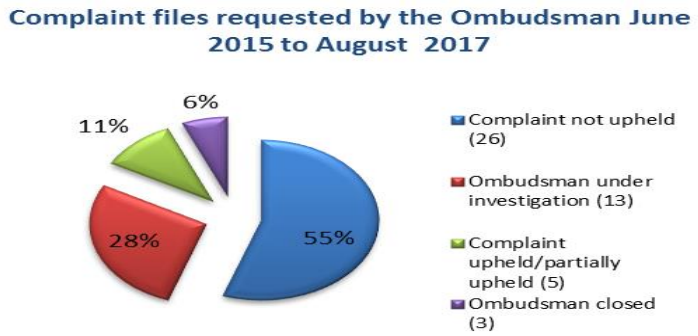
Learning examples from July/August 2017:

Example 1: Interface with NHS111

The Adastra database is an electronic clinical patient management system specifically designed to be used by out-of hours primary care – such as GP's and ambulance services across the UK.

On this occasion the patient was concerned at the content of questions asked by the attending ambulance crew who had been sent a number of possible diagnoses of the patient via the Adastra system (including carpel tunnel syndrome and depression). We have asked the complainant to contact their GOP practice to discuss the electronic record and the information it contains.

Overview of Ombudsman cases 2015-2017



Assurance and learning

Example 2: Non attendance

The patient complained that despite his symptoms, he was declined an ambulance and requested an explanation of that.

The Quality Assurance evaluation identified that the call handler made a technical error when applying the triage protocol which would have otherwise achieved a C1 priority from the outset. Although this priority would have been given to patients determined at a higher categorisation, feedback will be given to the call handler concerned.

Quality Account 2017-18 CQUINs

Exec Lead: Dr. Trisha Bain

National CQUIN	CQUIN Indicator descriptor UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status				Risk / Issue / Notes
					Qtr 1	Qtr 2	Qtr 3	Qtr 4	
N1a	Improvement of health and wellbeing of NHS Staff	£263,701	Final Period – Q4 17-18	0.08%	n/a				Q1 – update report submitted to commissioners for information on 24th July 2017.
N1b	Healthy food for NHS staff, visitors and patients	£260,562	Final Period – Q4 17-18	0.08%	n/a				Q1 – update report submitted to commissioners for information on 24th July 2017.
N1c	Improving the uptake of flu vaccinations for frontline staff within providers	£260,562	Final Period – Q4 17-18	0.08%	n/a				Q1 – update report submitted to commissioners for information on 24th July 2017.
12	Improving Ambulance Conveyance	£784,825	Final Period – Q4 17-18	0.25%	n/a				Q1 – Submitted proposal. Number of items to be locally agreed with commissioners. Current weighting based on national indicator outline
STP 1	Supporting local areas - STP engagement	£1,569,650	Final Period – Q4 17-18	0.50%	n/a				Q1 – update report submitted to commissioners for information on 24th July 2017.
STP 2	National CQUIN: STF Delivery (Control Total)	£1,569,650	Final Period – Q4 17-18	0.50%	Q1 = 100% £1,569,650				Achieved, based on 16/17 control total. Commissioners currently withholding release based upon NHSE instructions.

Local CQUIN	CQUIN Indicator descriptor UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status				Risk / Issue / Notes
					Qtr 1	Qtr 2	Qtr 3	Qtr 4	
SDIP	Service Development Improvement Plan	£3,139,299	Final Period – Q4 17-18	1.00%	n/a				*Note that SDIP is yet to be confirmed as a CQUIN. Requires sign off at CQRG in September.

Quality Risk Register

All Quality/Clinical Risks by Sector/Department	Serious Risk						
	10	12	15	16	20	25	Total
Emergency Operations Centre	2	2		1			5
Fleet and Logistics		4					4
Information Management & Technology (IM&T)		2	1				3
Medical Directorate		2	2				4
Operations				1			1
Quality		3					3
Safeguarding		3					3
Communications		1					1
Health Safety and Security		1					1
Total	**2**	**18**	**3**	**2**	**0**	**0**	**25**

Actions

- Risk discussions are taking place by Directorate within performance management meetings with the Chief Executive, with a focus on identifying strategic risks and their articulation in the Board Assurance Framework (BAF).
- The Interim Director of Corporate Affairs and the Risk and Audit Manager are working with members of the Executive Leadership Team to ensure their top risks have been appropriately articulated within the BAF. A reformatted BAF was presented to the Audit Committee in September with a view to a revised document being available for the Trust Board in October 2017.
- A paper was presented to the Trust Board in July 2017, setting out the level of 'risk conversations' which are expected to take place from local to Trust Board level to enable the appropriate escalation of strategic risks,.
- Further feedback has been provided to all Sectors and Departments following a quarterly risk management audit in areas which required improvement.

Assurance / Progress

- There are currently four risks on the Trust Risk Register that are included on the Board Assurance Framework (BAF) which have a clinical and quality impact. The Executive Leadership Team have recently discussed what they consider to be the Trust's top risks and these are being looked at specifically in how they link to the Trusts goals and objectives to ensure they are reflected in the BAF.
- A quarterly Risk Register Audit was carried out in July 2017 on compliance with the risk management process which indicated a significant improvement in the review of risks across Sectors and Departments.
- Emerging risks scored at 10 and above are being flagged to RCAG monthly with strict timelines for submission stated.
- Quality Assurance Committee has oversight of all quality risks rated greater than 10

There will be a review of the Quality Risk Register on the 26th September 2017

NHS
London Ambulance Service
NHS Trust

Well Led CQC Key Lines of Enquiry (KLOE) Analysis Getting the LAS to Good…

Tuesday 3rd October 2017

Dr. Trisha Bain, Chief Quality Officer

W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Good

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.

The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them

Requires Improvement

Not all leaders have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff do not consistently know who their leaders are or how to gain access to them.

The need to develop leaders is not always identified or action is not always taken. Leaders are not always aware of the risks, issues and challenges in the service.

Leaders are not always clear about their roles and their accountability for quality.

Outstanding

There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce.

Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.

Inadequate

Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There is no stable leadership team, with high unplanned turnover and/or vacancies. Leaders are out of touch with what is happening on the front line, and they cannot identify or do not understand the risks & issues described by the staff.

There is little or no attention to succession planning and development of leaders. Staff do not know who their leaders are or what they do, or are unable to access them. There are few examples of leaders making a demonstrable impact on the quality or sustainability of services.

	Sub domain	
W1.1	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?	
W1.2	Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?	
W1.3	Are leaders visible and approachable?	
W1.4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	

Good

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.

The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them

	Key Requirements
W1.1	Complete recruitment of the Executive team Implement Board and Executive Development programmes Deliver Leadership development pathway, implementing Leaders of Tomorrow programme
W1.2	Develop clear narrative to identify actions relating to Quality & Sustainability
W1.3	Ensure the Trust has a clear Communications Strategy and an on-going programme of Executive and Non Executive visits
W1.4	Finalise and approve the People & OD Strategy with a clear implementation programme and time table

W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?

Good

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well- defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this.

Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Requires Improvement

The strategy and plans have some significant gaps or weaknesses that undermine their credibility, and do not fully reflect the health economy in which the service works. They may not have been recently created or reviewed. Staff do not always understand how their role contributes to achieving the strategy. The statement of vision and guiding values is incomplete, out of date, or not fully credible. Results of stakeholder consultation are not always taken into account in strategies or plans. Staff are not always aware of, support, or do not understand the vision and values, or have not been fully involved in developing them. Progress against delivery of the strategy and plans is not consistently or effectively monitored or reviewed and there is no evidence of progress.

Leaders at all levels are not always held to account for the delivery of the strategy.

Outstanding

The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership.

There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

Plans are consistently implemented, and have a positive impact on quality and sustainability of services.

Inadequate

There is no current strategy, or the strategy is not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery, and it does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy.

There is no credible statement of vision and guiding values. Key stakeholders have not been engaged in the creation of the strategy. Staff are not aware of or supportive of, or do not understand, the vision and values, or they were developed without staff and wider engagement. There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy has not been translated into meaningful and measurable plans at all levels of the service.

	Sub domain	
W2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	
W2.2	Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?	
W2.3	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?	
W2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?	
W2.5	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?	
W2.6	Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?	

Good

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well- defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this.

Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

	Key Requirements
W2.1	Complete the definition of the Trust supporting strategies, and implement the Quality Plan
W2.2	Finalise & approve core strategies, ensuring that there is overall alignment to business plan goals & objectives
W2.3	Evidence that there has been a structured planning process with staff involvement at all levels
W2.4	Goals & objectives must be communicated to all staff, with engagement from Senior Managers, ensuring overall alignment
W2.5	Engage partners and commissioners to ensure the Reference Case (Joint Strategic Needs Assessment) links into the STP plans
W2.6	Set a clear timetable to review progress against delivery of the strategy

W3: Is there a culture of high-quality, sustainable care?

Good

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Behaviour and performance inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. Equality and diversity areactively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Requires Improvement

Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively. Staff do not always raise concerns or they are not always taken seriously, appropriately supported, or treated with respect when they do.

People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again.

Staff development is not always given sufficient priority. Appraisals take place inconsistently or are not of high quality. Equality and diversity are not consistently promoted and the causes of workforce inequality are not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, do not always feel they are treated equitably.

Outstanding

Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce.

Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.

There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

Inadequate

There is no understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload

.

Staff do not feel respected, valued, supported or appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict. The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour.

When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate.
There are high levels of bullying, harassment, discrimination or violence, and the organisation is not taking adequate action to reduce this. When staff raise concerns they are not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. The culture is defensive. There is little attention to staff development and there are low appraisal rates.

	Sub domain	
W3.1	Do the staff feel supported, respected and valued?	
W3.2	Is the culture centred on the needs and experience of people who use services?	
W3.3	Do staff feel positive and proud to work in the organisation?	
W3.4	Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?	
W3.5	Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	
W3.6	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?	
W3.7	Is there a strong emphasis on safety and well-being of staff?	
W3.8	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	
W3.9	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	

Good

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Behaviour and performance inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

	Key Requirements
W3.1	Implement Staff Survey Action Plan and Engagement Strategy
W3.2	Ensure key focus of the Culture Change under Programme 2 of the Transformation Programme
W3.3	Implement Engagement Strategy and Evidence that staff have been involved in 'Shaping our Culture'.
W3.4	Continue to tackle bullying within the organisation Deliver the WRES Action Plan Improve staff appraisal rates and quality Promote & engage all staff in Behaviours framework
W3.5	Increase incidence of whistle blowing and improve Freedom to Speak Out Safely Implement Culture changes (under Transformation programme 2) Promotion of Duty of Candour Improve learning from incidents
W3.6	Improve appraisal rates Improve MAST Improve CPD training Implement the Learning Framework
W3.7	Evidence work associated with addressing rosters, rest breaks, sickness & absence Implement Health & Wellbeing programme Implement recommendations from Health & Safety review
W3.8	Deliver the WRES Action Plan Deliver Staff Survey Action Plan Deliver People & OD Strategy
W3.9	Ensure key focus of the Culture Change under Programme 2 of the Transformation Programme

W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Good

The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

Staff are clear about their roles and accountabilities.

Requires Improvement

The arrangements for governance and performance management are not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans.

Staff are not always clear about their roles, what they are accountable for, and to whom.

Outstanding

Governance arrangements are proactively reviewed and reflect best practice.

A systematic approach is taken to working with other organisations to improve care outcomes.

Inadequate

The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individuals are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework.

Staff and their managers are 10not clear on their roles or accountabilities. There is a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions.

	Sub domain	
W4.1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	
W4.2	Do all levels of governance and management function effectively and interact with each other appropriately?	
W4.3	Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?	
W4.4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person- centred care?	

Good

The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

Staff are clear about their roles and accountabilities.

	Key Requirements
W4.1	Implement Quality Plan and Maintain Deep Dive programme
W4.2	Good governance reviews undertaken regularly Annual assessments of Board and its sub-committees
W4.3	Ensure revised structures are clear, job descriptions and roles are aligned and objectives are aligned to the Trust Goals.
W4.4	Ensure that are individuals who have management responsibility to develop operational relationship with partners and 3rd Party Partners to improve patient care.

W5: Are there clear and effective processes for managing risks, issues and performance?

Good

The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood

Requires Improvement

Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes.

The approach to service delivery and improvement is reactive and focused on short-term issues. Clinical and internal audit processes are inconsistent in their implementation and impact.

The sustainable delivery of quality care is put at risk by the financial challenge.

Outstanding

Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes.

The approach to service delivery and improvement is reactive and focused on short-term issues. Clinical and internal audit processes are inconsistent in their implementation and impact.

The sustainable delivery of quality care is put at risk by the financial challenge.

Inadequate

There is little understanding or management of risks and issues, and there are significant failures in performance management and audit systems and processes.

Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated.

Meeting financial targets is seen as a priority at the expense of quality.

	Sub domain	
W5.1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?	
W5.2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	
W5.3	Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?	
W5.4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is on their 'worry list'?	
W5.5	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?	
W5.6	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?	

Good

The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care.

Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood

	Key Requirements
W5.1	Roll out updated risk management training. Undertake regular monitoring/audit of risk registers and the Datix system
W5.2	Raise awareness of incident reporting Develop Datix system to improve shared learning Review use of bank workers Monitor effectiveness of Performance Reporting to ensure tracking of low and no harm incidents Ensure Board and sub-committee effectiveness
W5.3	Complete restructure of Quality Assurance directorate Review Quality Processes to ensure effectiveness Deep dive into risk management processes and systems
W5.4	Complete review of local risk registers Carry out internal and external assessments of governance and risk framework. Review risk management policy, risk appetite and BAF Review performance of the Audit Committee to ensure a balance between quality and finance Review effectiveness of Internal Audit in identifying or corroborating risks Finalise and deliver Data Quality Strategy Ensure Operational Restructure is shared
W5.5	Ensure Business Continuity Programme is shared
W5.6	Ensure QIA process can be evidenced including where changes have been rejected Review processes around CIP programmes Review quality of data submissions to STEIS and NRLS

W6: Is appropriate and accurate information being effectively processed, challenged and acted on?

Good

Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems are used effectively to monitor and improve the quality of care.

Requires Improvement

The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance.

Information is used mainly for assurance and rarely for improvement.

Required data or notifications are inconsistently submitted to external organisations. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems are not always robust

Outstanding

The service invests in innovative and best practice information systems and processes.

The information used in reporting, performance management and delivering quality care is consistently found to be accurate, valid, reliable, timely and relevant.

There is a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.

Inadequate

The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making.

There is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for the management or sharing of data.

	Sub domain	
W6.1	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?	
W6.2	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?	
W6.3	Are there clear and robust service performance measures, which are reported and monitored?	
W6.4	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	
W6.5	Are information technology systems used effectively to monitor and improve the quality of care?	
W6.6	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?	
W6.7	Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	

Good

Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information.

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
Information technology systems are used effectively to monitor and improve the quality of care.

	Key Requirements
W6.1	Review Board and sub-committee performance to ensure balanced focus on quality, operational and financial matters. Finalise and deliver Data Quality Strategy
W6.2	Finalise and deliver Data Quality Strategy
W6.3	Review Quality Indicators for patient care and engagement Monitor effectiveness of Performance Reporting Design and implement an IM&T assurance framework Review supply chain and distribution processes
W6.4	Finalise and deliver Data Quality Strategy Establish robust audit process for equipment Improve Emergency Control Room and Dispatch processes
W6.5	Develop and implement an IT strategy that will support the Trust in its quality of care and ongoing improvements
W6.6	Implement Quality Plan Review quality of data submissions to STEIS and NRLS
W6.7	Finalise and deliver Data Quality Strategy

W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Good

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

Requires Improvement

There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders, or insufficient attention to appropriately engaging those with particular protected equality characteristics.

Feedback is not always reported or acted on in a timely way.

Outstanding

There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account.
Services are developed with the full participation of those who use them, staff and external partners as equal partners.

Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback.

The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.

Inadequate

There is minimal engagement with people who use services, staff, the public or external partners. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment.

Staff or patient feedback is inappropriately filtered or sanitised before being passed on

	Sub domain	
W7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?	
W7.2	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?	
W7.3	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?	
W7.4	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	
W7.5	Is there transparency and openness with all stakeholders about performance?	

Good

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

	Key Requirements
W7.1	Implement Patient Engagement Plan Implement Staff Engagement Plan and Communications Strategy Deliver the WRES Action Plan
W7.2	Implement Patient Engagement Plan Develop a Community Engagement Strategy
W7.3	Implement Staff Engagement Plan and Communications Strategy Deliver the WRES Action Plan
W7.4	Work with partners to define collaboration and procurement opportunities Maximise value for money through back office collaboration with partners Review control room usage and future opportunities with Blue Light partners Pan London EOLC pathway 111/999 Improve referrals Healthcare partners improve referrals Reduce time lost through handover delays Monthly analysis of health data shared with STP partners to improve London's health system Expand the co-responding pilot Work with partners to improve services to frequent callers Improve support to Care Homes Maintain up to date organisation structures and ensure operational management structures are restructured to align to the five STPs.
W7.5	Implement Patient Engagement Plan Develop a Community Engagement Strategy Improve engagement with Patient and Partner stakeholder forums

W8: Are there robust systems and processes for learning, continuous improvement and innovation?

Good

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Requires Improvement

There is weak or inconsistent investment in improvement skills and systems among staff and leaders. Improvements are not always identified or action is not always taken.

The organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed.

Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or is not monitored

Outstanding

There is a fully embedded and systematic approach to improvement, which makes consistent use of a recognised improvement methodology.

Improvement is seen as the way to deal with performance and for the organisation to learn.

Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change.

Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.

Inadequate

There is little innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement is not a priority among staff and leaders.

There is minimal evidence of learning and reflective practice.

The impact of service changes on the quality and sustainability of care is not understood.

	Sub domain	
W8.1	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	
W8.2	Are there standardised improvement tools and methods, and do staff have the skills to use them?	
W8.3	How effective is participation in, and learning from, internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?	
W8.4	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?	
W8.5	Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	

Good

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

	Key Requirements
W8.1	Implement annual plan of clinical education updates for all clinical supervisors Learning from feedback will be routinely incorporated into all education programmes Develop a reporting and learning framework that includes events Clarify the mechanism for recording and sharing local engagement activity led by SEM' and CEO's
W8.2	Develop the Learning Framework to involve patients in gaining feedback and service development
W8.3	Produce 'step back' analysis to ensure each local Business Plan/Transformation project has a project plan to ensure all necessary steps have been thought about in advance Implement Staff Engagement Plan and Communications Strategy
W8.4	Define and embed a Trust wide Improvement Methodology which enables all staff to become involved
W8.5	Maintain Deep Dives Launch Quality Assurance Visit process Reinforce Executive/Non Executive visits