London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 29th MARCH 2016 AT 09.30 - 13.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.30	1.	**Welcome and apologies for absence** Apologies received from:			
	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	3.	**Minutes of the public meeting held on 2nd February 2016** To approve the minutes of the meeting held on 2nd February 2016	Approval	RH	TAB
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB
9.40	5.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	FM	TAB
PERFORMANCE AND ASSURANCE					
9.50	6.	**Integrated Board Performance Report – Month 11** 6.1 To receive the integrated board performance report (including Operational Performance) 6.2 Quality report	Information	JP ZP	TAB
10.10	7.	**Quality Improvement Programme** To approve the Quality Improvement Programme	Approval	KB	TAB
10.25	8.	**Quality Governance Committee Assurance Report** 8.1 To receive the Quality Governance Committee Assurance Report - 15th March 2016 8.2 To approve the terms of reference of the Quality Governance Committee	Assurance Approval	BMc	TAB
10.35	9.	**Finance Report – Month 11** 9.1 To receive the finance report for Month 11 **Finance Report** 9.2 To receive the report from Finance and Investment Committee - 24th March 2016	Information Assurance	AG NM	TAB
10.50	10.	**Audit Committee Assurance Report** 10.1 To receive the Audit Committee Assurance Report - 15th February 2016 10.2 To receive a recommendation to establish an Auditor Panel for the appointment of external auditors for 2017/18 and to approve an amendment to the terms of reference of the Audit Committee	Assurance Approval	JJ	TAB
11.00	11.	**Board Assurance Framework and Risk Management** 11.1 To receive the Board Assurance Framework and risk register - March 2016 11.2 To ratify the revised Risk Management Policy	Information	SA	TAB

BREAK 11.15 – 11.25					
GOVERNANCE					
11.25	12.	**Staff Survey 2015** Presentation from Picker Institute	Information	KB	Presentation
11.45	13.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Information	SA	TAB
11.55	14.	**Trust Board Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB
12.00	15.	**Patient Story** To hear a story from a Trust patient	Information	ZP	
12.25	16.	**Questions from members of the public**		RH	
12.30	17.	**2016/17 Business and Financial Planning process** To receive draft Business Plan, draft Financial Plan and draft Key Performance Indicators (KPIs)	Information	AG	TAB
12.50	18.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	
13.00	17.	**Register of Interest** To note the register of interests	Information	SA	TAB
		Any other business		RH	
		Meeting Closed The meeting of the Trust Board in public closes		RH	
		Date of next meeting The date of the next Trust Board meeting in public is on 31st May 2016 at 2:00pm		RH	

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING IN PUBLIC

Minutes of the meeting held on Tuesday 2nd February 2016 at 09:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Chairman
Fionna Moore	Chief Executive
Fergus Cass	Non-Executive Director
Jessica Cecil	Non-Executive Director (joined the meeting at 9:30)
Nick Martin	Non- Executive Director
Andrew Grimshaw	Director of Finance and Performance
Zoe Packman	Director of Nursing and Quality
Paul Woodrow	Acting Director of Operations
Fenella Wrigley	Interim Medical Director

In Attendance:

Sandra Adams	Director of Corporate Affairs/Trust Secretary
Paul Beal	Interim Director of Human Resources
Karen Broughton	Director of Transformation & Strategy
Mercy Kusotera	Committee Secretary (Minutes)
Jill Patterson	Interim Director of Performance
Briony Sloper	Deputy Director of Nursing and Quality
Jane Walters	Governance Consultant

Members of the Public:

Malcolm Alexander	London Ambulance Service Patients' Forum
Jessie Cunnett	Patient Public Involvement (item 3 only)
Darryl Smith	Ferno UK Ltd
Nick White	Grant Thornton
Evening Standard reporter	Member of the public

Members of Staff:

Anna MacArthur	Communications Manager

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01. Welcome and Apologies

01.1 The Chairman welcomed all to the meeting. Apologies were received from Theo de Pencier, John Jones and Bob McFarland.

02. Declarations of Interest

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

03. Patient Story

03.1 Zoe Packman introduced Jessie Cunnett who gave a presentation on feedback and key themes from the Mental Health Focus groups and areas of improving provision to patients with Mental Health needs. Jessie Cunnett outlined feedback from the Mental Health Focus groups which were carried out between March and September 2015. Six Mental Health Focus groups had been held with patients and one had been held with staff. Jessie Cunnett reported that the patients and staff who participated in the exercise had been given a series of questions as detailed below:

Patients views

(i) What does the London Ambulance Service means to patient?
Jessie Cunnett confirmed that many patients responded positively about the LAS; they described it as a life-saving line and as an organisation providing help in

crisis.

(ii) *What's important when I contact the LAS*?
It was noted that some patients expected a calm and reassuring response and they would not want to be treated differently. Some patients saw a direct link between a lack of community based services and their likelihood of having a crisis and needing to call an ambulance. The patients were keen to avoid this situation and they felt that an admission to hospital was not a good outcome.

(iii) How should delays be managed?
Overall, patients felt that continued communication was important. Patients and carers spoke of the need to have clear information and communication about delays; sending texts and email alerts were suggested; honest conversation highlighting what was going on was needed; patients felt that staying on the line and talking things through was very important.

(iv) What would make me say thank you?
It was noted that many patients were positive about the service they receive and the professionalism of the staff. Highlights given included 'treat me like a human being' and 'keep doing what you do.' It was noted that sometimes the patients would not know how to say thank you to staff as they would have no idea how to contact them.

(v) *What advice would I give to the LAS*?
Jessie Cunnett stated that communication came through as a strong theme. The need to be non-judgemental was also emphasised.

Staff views

(i) Why do people ring 999?
Staff felt that patients know if they call 999, they are guaranteed a response. This was due to lack of specialist Mental Health services to get advice from. It was felt that an expansion of a specialist team of call handlers would be a definite benefit.

(ii) What would work for you?
A strong theme was a Pan London approach. This was seen as crucial with clear pathways so that all London Mental Health patients could be supported by the same level of expertise. It was felt that the ambulance services were picking up some issues beyond their reach.

03.2 Jessie Cunnett reported that the evidence gathered from participating patients, carers and staff had been summarised and a number of recommendations had been made. She noted that exploring a number of options in addition to A&E and Mental Health hospitals would be ideal. A further roll out of the existing Street Triage schemes to create a London-wide service was needed.

03.3 The Chairman thanked Jessie Cunnett for sharing her views. He highlighted that Mental Health is an area which the Trust is trying to prioritise. He invited comments from members of the Trust Board.

03.4 Andrew Grimshaw recalled that there were some changes to the NHS Planning system. Working in partnership with Commissioners was one the headlines for 2016/17 NHS Operating Plan. The NHSE, TDA and the Monitor require a five year Sustainability and Transformation Plan (STP). He noted that the shared patient story was a helpful example of working in partnership with Commissioners and was consistent with the emerging STP.

03.5 In discussion the following overarching points were noted:

- Sometimes patients would not want to go to acute hospitals but have nowhere else to go therefore they would call the ambulance services because they are guaranteed a response.
- Alternative care pathway was part of the Mental Health care plan.
- Collaborative work with CCGs and other partners in addressing Mental Health issues was needed.
- There was need to look at the role of the community responder service with a Mental Health specialism.
- To ensure consistency in education and training; it would be helpful for patient facing staff to receive ongoing mental health training.

03.6 It was noted that Fenella Wrigley and Zoe Packman are part of the Healthy London Partnership and they could pick this up and could drive some of the changes needed in supporting Mental Health patients. Zoe Packman reported that the feedback from the Mental Health Focus groups was being used to develop the Mental Health action plan. Regarding training Zoe reported that several sessions had been held, for example joined training on how to manage patients in a crisis. She stated that the Trust was pleased with the progress on recruitment of Registered Mental Health nurses.

03.7 The Board thanked Jessie for the presentation and acknowledged the positive feedback from the Mental Health Focus groups.

04. Minutes of the Board meeting held on 24th November 2015

04.1 The minutes of the meeting held on the 24th November 2015 were approved as a true record of the meeting.

The minutes were duly signed.

05. Matters Arising

05.1 The Trust Board reviewed the action log and noted the following:
119.1 – Karen Broughton reported that she had revisited the original construct of the turnover metrics which had been discussed with the Executive Team as to whether it was deliverable. She stated that there was no science behind the construct and she noted that Jill Patterson would further review that. She highlighted that there was need to review all the indicators on how the targets are set. It was suggested to check with other ambulance Trusts.
Action: Jill Patterson
Date of completion: 29th March 2016

05.2 119.2 and 125.12 – Sandra Adams confirmed that the EOC capacity review would be presented to Executive Team and had been scheduled for discussion on 23rd February 2016 Private Trust Board meeting in the context of 2016/17 business planning.
Action: Paul Woodrow
Date of completion: 23rd February 2016

05.3 Jessica Cecil joined the meeting.

05.4 122.2 – It was noted that Fenella Wrigley would add a deep dive on cardiac care to the next meeting of the Clinical Safety and Standards committee.

05.5 127.3 and 127.5 – procurement of double crewed ambulances: It was noted that the Chairman and Andrew Grimshaw were still working on both items. An update had been provided to the Finance and Investment Committee meeting on 21st January 2016. It

was agreed to carry this item forward.

05.6 132.4 – tackling a bullying and harassment culture: Karen Broughton reported that areas of good practice had been identified and would be synthesised in order to understand how this could be implemented across the organisation.

05.7 The Chairman recommended that for future meetings, the time scheduled for the Chief Executive report should be extended.
Action: Sandra Adams
Date: 29th March 2016

05.8 The Board noted that the layout of Integrated Performance report was being revised to avoid duplication of sections.

06. Report from Chief Executive Officer

06.1 Fionna Moore, Chief Executive provided an update on recent developments, and highlighted the following points:

- The initiative to improve Out Of Hospital Cardiac Arrest survival (OOHCA). Fionna Moore reported that the LAS and the London Fire Brigade would be running a co-responding pilot as part of a national trial. There was a new scheme piloted by the LAS and Metropolitan Police Service; police officers responding to life threatening emergencies. She noted that the Metropolitan Police had been very positive.
- The Public Education team had attended about 600 events, for example Safe Drive Stay Alive aimed at reducing the number of road casualties among young road users.
- The Trust had re-introduced the LAS news - the Service's staff magazine. The last edition was published in October 2014.
- The Quality Summit held in December after the publication of the CQC LAS report was a success.
- Exercise Unified Response (EUR) to be held between 29th February and 3rd March.
- Changes to the NHS Planning systems. Each Local Health and Care System needs to develop a single Sustainability and Transformation Plan in partnership with all relevant organisations including Local Government and NHS Organisations.
- New Year's Eve event – the Trust had received over 500 emergency calls an hour at peak times. However, there were fewer patients treated in the central London event area compared to last year.
- Delegation from the Health ombudsman visited the Trust.

06.2 Paul Woodrow reported that demand levels on New Year's Eve had changed compared to a couple of years ago. Fenella Wrigley stated that a lot of work had been carried out with the media in preparation for New Year's Eve.

06.3 The Trust Board noted the report. On behalf of the Board, the Chair expressed his thanks to all staff who worked so hard during the Christmas period.

07. Performance – Month 9

Integrated Board Performance report

07.1 Jill Patterson presented the Integrated Performance Report outlining key areas across the Service, incorporating Quality, Operations, Workforce, Finance and the Trust Improvement Programme. The report related to performance throughout December

2015. Jill Patterson noted that December was historically challenging due to winter pressures, Christmas and New Year events. December 2015 recorded the highest C incidents since 2014 and was the 2nd busiest month on record for the LAS on Cat A demand.

07.2 It was noted that delivery of care continued to be safe, but quality remained challenged at times. Performance against the 8 minute response target "A8" was 66.07%, higher than the previous months and the new reinstated LAS forecast of 57.3%. Some patients were experiencing longer waiting times due to capacity constraints. Category C incidents saw the highest levels since May 2014.

07.3 The financial position continued to be challenged; a revised target of £8.8 m deficit had been agreed with the TDA. This was related to the receipt of additional specialised services income of £2.0m and a projected increase of £2.5m in Quarter 4. At the time of reporting the level of income was £3.5m adverse for the year. Cash was £8.2m below plan. The Trust was expected to reach its revised target of £8.8m.

07.4 Jill Patterson reported that the Trust turnover had fallen from 13.5% in November to 12.8% in December. The complaints acknowledgment target had been achieved in December with 100% acknowledged within 3 working days. 99% of STEMI patients were conveyed to the correct destination. 4 serious incidents had been declared during December. A paramedic had been seconded to the Clinical and Quality Directorate to support the Medicines Management group.

07.5 The metrics for 'Our people' were moving in the right direction. Frontline and total vacancy rates had continued to improve, with the frontline vacancy rate at 7.66% compared with 10% in October. The trend was expected to continue through to March 2016.

07.6 It was noted that there had been one period at Surge Purple Enhanced lasting 6 hours and the Trust remained at surge Red as agreed for this financial year. Job cycle for the month was considerably lower than expected for December and was expected to peak at 113 minutes in December/January.

07.7 In regards to cardiac care, it was noted that lots of positive messages had been noticed; resuscitation efforts were commenced on 45% of cardiac arrest patients attended by the LAS crews.

07.8 Fergus Cass acknowledged that there was a significant improvement in a number of areas. He asked how the Trust's performance could be compared to other ambulance services. Paul Woodrow noted that the Trust was rated 2nd in terms of performance over Christmas.

07.9 The Chair welcomed the progress outlined in the report and he felt this could be taken as meeting the milestones. He asked for further details on the next step and when we are going to achieve that. Karen Broughton confirmed that this would be discussed further at the next Strategy Review and Planning meeting on 23rd February 2016.

07.10 Jessica Cecil recalled previous discussion regarding careful management of resources and she sought clarification on the clinical implications relating to on scene time and whether there had been any progress in addressing issues relating to BMI representation. Fenella Wrigley commented that this was being progressed via clinical team leaders.

07.11 In response to a question relating to frequent callers, Zoe Packman explained that a critical analysis of the processes to identify and manage frequent callers had been undertaken by the Darzi fellow. She noted that a draft Frequent Caller Strategy had been developed.

07.12 Fionna Moore asked how the Trust would compare to other ambulance services in terms of complaints. Zoe Packman responded that there was a need to improve our trajectory, in particular addressing issues relating to delays in response.

07.13 It was suggested that the Integrated Performance report should include 111 reviews; this is the case in other Trusts.

07.14 In terms of Workforce and turnover Sandra Adams asked whether there were any areas of concern. Karen Broughton reported that more work on retention, in particular Control Services (EOC) was required. She noted that a report on EOC workforce would be presented to the Trust Board in April.
Action: Karen Broughton
Date: 26th April 2016

07.15. The Trust Board noted the report.

08. Resilience

08.1 Paul Woodrow provided an update on progress against the Resilience Action Plan. The following points were noted:

- The Trust had recruited to all of the 84 Hazardous Area Response Team (HART) posts and it was anticipated that 83 of these posts would have completed HART training and be fully operational by March 2016.
- The Major Incident Protocol had been revised.
- HART rosters had been reviewed; new rosters had been designed and implemented to spread skill mix and increase capacity and flexibility.
- A formal agreement had been agreed with South East Coast Ambulance Service to provide additional cover at Heathrow Airport should it be needed.
- At the time of reporting only 4.8% of HART shifts over the next month would not have two full HART teams operating; this was an improved position. It was anticipated that this number would decrease as new recruits complete their training in the coming months.
- The Trust was working on the business case for additional HART operatives (28 HART staff);
- Training records for HART had been reviewed and training gaps were being addressed.
- Notification protocols remain compliant and the Trust had systems in place to notify the London Fire Brigade and the Metropolitan Police Service when two full HART teams are not available.

08.2 Paul Woodrow reported that the Executive team had considered a proposal about HART vehicles and were awaiting the revised national specification for these vehicles before making a final decision.

08.3 The Trust Board noted the update on progress against resilience action plan.

09. Workforce Report

09.1 Karen Broughton presented the workforce report update outlining the progress on the 2015/16 recruitment plan and an overview of the Trust's plans for the Human Resources Function Transformation. She reported that the Trust had a strategic ambition to make the Service a great place to work; a number of objectives had been developed to achieve this.

09.2 It was anticipated that in Quarter 4 2015/16, 282 staff would join the Trust against a plan of 66. Karen Broughton explained that the current variance between actual and planned recruitment plan was due to amendments in graduation dates for the

international paramedics. It was also noted that the Trust was behind its target in Quarter 3.

09.3 Karen reported that since the last update to the Trust Board 26 frontline staff had left the Trust (2 retired, 3 were dismissed and 21 voluntary leavers. Between January and December 2015, 637 new starters had joined the Trust against 290 members of staff who left the Trust.

09.4 It was confirmed that the workforce responsibilities had been transferred from the Director of Transformation and Strategy to the newly appointed interim Director of Human Resources – Paul Beal – who would provide an update on HR at future Trust Board meetings.

09.5 Regarding leavers and starters, Karen Broughton reported that since January 2015 the Trust had an average of 24 leavers per month compared to an average of 53 starters per month.

09.6 The Chair thanked Karen for the work she had done around workforce.

09.7 Fergus Cass asked whether a 5% vacancy rate was still relevant. Andrew Grimshaw explained that there were 2 issues to consider: (i) the proportion of staff required (ii) the level of headroom needed in particular replacing leavers. It was felt that the Trust needed to retain the 5% as this would provide flexibility.

09.8 In response to a question regarding the graduate pipeline, Andrew Grimshaw noted that there were more people in the graduate pipeline. He noted that creating more spaces in universities would require NHS England involvement.

09.10 The Trust Board noted the workforce update and the draft recruitment plan.

10. <u>Quality Report</u>

10.1 Zoe Packman presented the Quality Report which was based on data recorded in December 2015. She outlined the following:

- Core Skills Refresher training CSR 2015.3 commenced in December. The Trust would continue to work on protecting vulnerable people. E-learning tool had been developed.
- In regards to cases relating to 'hoarding', there was collaborative working with the London Fire Brigade.
- NHS CAS Alerts: one patient safety alert relating to manual restraint applied to the Trust. It was confirmed that the Trust's current Service policy had been reviewed and confirmed adherence to this alert.
- Frequent callers – the Darzi fellow appointed last September had made significant progress in addressing issues relating to frequent callers. An enhanced Frequent Caller strategy had been developed and this would support the implementation of 40 care plans. Emerging issues relating to frequent callers were being identified and options to address them were being explored.
- The second Learning from Experience report was presented to the Quality Governance Committee on 12th January 2016.

10.2 In discussion it was noted that survival to discharge data should be reviewed with caution due to incomplete data received from hospital trusts. Fenella Wrigley explained that it could take several months for the hospital outcome data to be received. She reported that the Trust was awaiting missing data from hospitals for 40 cases.

11. Finance Report - Month 9

11.1 Andrew Grimshaw presented the Finance report for month 9. The following key points were noted:

- The Trust was reporting an adverse position of £3.5m from plan, with a revised year-end forecast deficit of £8.8m in the year to date and this is expected to be achieved. Principally the adverse position was driven by a step up in Month 9 in frontline pay related to substantive and overtime hours as well as additional incentive costs; a reduction in income provision of £1.4 million due to the fall in Category C activity.
- The financial position of the Trust was reviewed in detail at the Finance and Investment Committee on 21st January 2016. It was noted that cash remained below target.
- The 12 month rolling cash forecast is being reviewed to include any timing issues with cash and would confirm whether any cash management action was needed, this would be reviewed by the Finance and Investment Committee.

11.2 The Trust Board noted the Finance report.

12. Quality Governance Committee Assurance Report

12.1 In Bob McFarland's absence, Zoe Packman reported on the meeting of the Quality Governance Committee meeting held on 17th November. The Committee had been informed that the EOC staffing report had not been submitted to the Executive Leadership Team as yet and they expressed concern over that delay. This would be followed up as soon as possible.

12.2 Zoe Packman reported that the Committee had discussed the draft Quality Improvement Plan 'Moving Forward Together' prior to submission to the CQC on 15th January.

12.3 The Committee had received a report on the Cost Improvement Programme and related Quality Impact Assessments and had noted that four items had been flagged as having possible consequences to clinical quality. These had all been appropriately considered and no significant negative effect had been identified. The Committee had received a positive report from Improving Patient Experience Committee and had endorsed the End of Life Steering Group.

13. Assurance from Finance and Investment Committee

13.1 Nick Martin provided an update from the meeting of the Finance and Investment Committee (FIC) meeting held on 21st January 2016 with reference to the agenda included in the board papers. He noted that there were no items for the Trust Board approval. Nick Martin reported that cash flow remained challenged.

13.2 The Committee was pleased with the close working relationship between the Finance and Operations teams over Christmas and New Year.

14. Board Assurance Framework (BAF) and Corporate Risk Register

14.1 Sandra Adams presented the current version of the BAF which had already been presented to the Quality Governance Committee. All the risks had been reviewed by the Risk and Audit Manager in conjunction with the risk owners during December 2015 and January 2016 and the risks on the BAF and Trust Risk Register had been updated to reflect changes in controls, mitigating actions and risk rating. Sandra Adams reported that a programme of risk management training had started at the end of November and would run through to the end of March and was being well attended by managers.

14.2 The focus of these training sessions was on the principles of risk management and the application of the process within the LAS. This was aligned to areas of improvement

identified by the CQC, to ensure that the management of risks at local level and the escalation of risks onto the Trust Risk Register is visible to the rest of the organisation. The training would be extended to the Executive Leadership Team and the Trust Board. It was anticipated that all managers would have received risk management training by end of March. Risk Management training dates for the Executive Leadership Team and the Trust Board would be identified.
Action: Sandra Adams
Date: 29th March 2016

14.3 In regards to the risk relating to service performance (BAF 4), the Trust Board was asked to consider accepting the current level of this risk until work had been completed by McKinsey on the restatement of funding and performance. It was noted that a number of actions around the risk were due for completion and there was further work as part of the 2016/17 contracting round with commissioners. Andrew Grimshaw noted that some of the factors around this risk were system issues beyond the scope of the Trust, for example Category A demand was higher than the Trust could deliver, even with current level of full frontline establishment; plus there was national work underway which could inform the risk or controls further. He reported that there were ongoing discussions with Commissioners. The Trust Board acknowledged that the risk continued to exist pending a further review once the McKinsey work had been completed and therefore this risk would be tolerated for the foreseeable period.

14.4 The Trust Board noted the need to clarify how actions for ongoing risks were managed. It was suggested that at the next Strategic Review and Planning meeting on 23rd February, it would be helpful to explore whether the right actions were being taken to address risks on the risk register

14.5 Sandra Adams reported that BAF risk 16 - the risk that patient safety may be compromised for category C call patients due to demand exceeding available resources had been discussed by the Executive Leadership Team. It was noted that consideration needed to be given to the current rating and any assurance provided by the safety review against this risk.

14.6 Andrew Grimshaw reported that the risk relating to delivering a balanced financial plan for 2016/17 (BAF 34) had been discussed by the Finance and Investment Committee and there were actions in place to mitigate the risk.

15. Quality Improvement Programme

15.1 Karen Broughton presented the Quality Improvement Plan which had been developed to address the CQC findings following the inspection of the London Ambulance Service NHS Trust in June 2015. She reported that the LAS had been rated 'inadequate' and the CQC report had been published in November followed by a Quality Summit with key stakeholders in December 2015. It was noted that the LAS had welcomed the CQC report and the findings and would ensure a swift action would be taken to improve service for patients and make LAS a better place to work for staff. A detailed action plan with milestones, key sub-tasks, lead responsibilities and the governance arrangements that should be put in place to manage delivery of the actions identified had been developed.

15.2 Five work streams had been identified in the Quality Improvement Plan, each led by an Executive director:

- Making The London Ambulance Service a great place to work
- Achieving good governance
- Improving the patient experience
- Improving the environment and resources
- Taking pride and responsibility.

15.3 Work had continued since the inspection to address many of the issues and this would continue through the formal programme.

16. Statement of Readiness concerning preparedness for a major incident

16.1 Paul Woodrow reported that following the tragic events in Paris in November 2015 Barbara Hakin, National Director of Commissioning Operations at NHS England, had written a letter to all NHS Trust Chief Executives, NHS Trust Medical Directors and Accountable Emergency Officers in December 2015 about NHS preparedness for a major incident. It was noted that the statement of readiness had been approved by the Trust Executive Leadership Team.

16.2 The Trust Board approved the statement of readiness.

17. Board Declarations – self certification, compliance and board statements

17.1 Sandra Adams presented the Trust Board declarations highlighting areas where there was a risk of or actual compliance.

17.2 The Trust Board acknowledged and noted that there were plans in place to ensure ongoing compliance with Board statements 2, 5 and 10. It was agreed to seek TDA guidance on the Board statement on CQC compliance as the Board was satisfied that plans were in place but it was too early in the programme to see delivery of those plans.
Action: Sandra Adams
Date: 29th March 2016

18. Report from Trust Secretary

18.1 The Trust Board noted the report from the Trust Secretary about the key transactions made in compliance with Standing Orders and Standing Financial Instructions.

19. Report from the Trust Chairman

19.1 The Chairman reported on the following activities he had been involved with since the last Trust Board meeting:

- Christmas and New Year's Eve were handled well. He thanked staff for all the hard work during the Christmas period.
- Attended and gave a speech at the Emergency Medical Services Conference on 21st January 2016.
- Ride outs out with Assistant Directors of Operations and discussing key issues such as rest breaks and shift lengths.

19.2 The Chairman proposed to change the Strategy Review and Planning meetings to Private Board meetings in future in order to facilitate monthly Board discussion on key business items as well as strategy. It was agreed that we would continue to hold some of these meetings off site which would also allow the Board to meet local teams. The Trust Board calendar would be updated.
Action: Sandra Adams
Date: 29th March 2016

20. Trust Board Forward Planner

20.1 The following were proposed:

- To schedule staff survey results for March Trust Board.
- Annual safety review would be presented in March.
- Schedule extraordinary Quality Governance Committee meeting to review the annual report at the end of April or in early May.

20.2 The Trust Board noted the forward planner.

21. Register of Interests

21.1 It was noted that feedback from Paul Beal and Jill Patterson should be sent to Sandra Adams. The Trust Board noted the register.

22. Questions from Members of the Public

22.1 No questions presented.

23. Any Other Business

23.1 There was no other business.

24. Date of next meeting

24.1 The next meeting of the Trust Board would be on Tuesday 29th March 2016 at 09.30am in the Conference Room, Waterloo.

ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
Date of schedule: 2nd February 2016

Meeting Date	Minute No.	Action Details	Responsibility	Progress and outcome
02/02/16	**05.1**	Jill Patterson to review all the indicators on turnover metrics.	**JP**	
02/02/16	**05.2**	Discuss 2016/17 Business Planning	**PW**	
02/02/16	**05.9**	Sandra Adams to extend the Chief Executive report time.	**SA**	
02/02/16	**07.14**	Karen Broughton to present an EOC report to the Trust Board in April 2016.	**KB**	
02/02/16	**14.2**	Sandra to identify dates for ELT and Trust Board risk management training.	**SA**	
02/02/16	**17.2**	Sandra to check with TDA re Board Declarations – self certification, compliance and board statements.	**SA**	
02/02/16	**19.2**	To update Trust Board calendar.	**SA**	
Actions from November 2015				
24/11/15	**132.4**	Karen Broughton to link with the NWAS Chief Executive to explore what learning the Trust could take from the NWAS experience (tackling a bullying and harassment culture over 6 years)	**KB**	
24/11/15	**127.3**	The Chairman to email non-executive directors once he had reviewed the Full Business Case.	**Chairman/AG**	At the time papers are published, work ongoing on both items
24/11/15	**127.5**	The Chairman to authorise inclusion of maintenance following review with Andrew Grimshaw and Nick Martin.	**Chairman/AG**	
24/11/15	**126.1**	Andrew to confirm if any cash management action would be needed.	**AG**	
24/11/15	**125.10**	Paul Woodrow and Karen Broughton to review the operations restructure to ascertain what roles were working well in April.	**PW/KB**	Agenda item in April.
24/11/15	**125.12**	Katy Millard to present a paper outlining EOC costing to EMT and subsequently to Commissioners.	**KB/Katy Millard/PW**	

24/11/15	**122.2**	Fenella Wrigley to add a deep dive on cardiac care to the next meeting of the Clinical safety and Standards committee.	**FW**	
24/11/15	**119.1**	Jill Patterson to review the turnover metric and check with other ambulance Trusts.	**JP**	Merged with 05.1 above.
24/11/15	**119.2**	Sandra Adams to confirm that the EOC capacity review would be presented to EMT and would be scheduled for the next Trust Board meeting.	**SA**	Merged with 125.12 above.
29/09/15	**99.11**	Karen Broughton to revisit the original construct of the turnover metric in order to understand how the target figure had been set.	**KB**	Merged with 119.1 above.
COMPLETED ACTIONS				
24/11/15	**133.1**	Sandra to remove SOC from the planner.	**SA**	Completed
24/11/15	**122.4**	Zoe Packman to provide Malcolm Alexander with a copy of the checks made on PAS clinicians.	**ZP**	Completed

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29 March 2016**
Document Title:	**Chief Executive's report to the Board**
Report Author(s):	**Fionna Moore**
Presented by:	**Fionna Moore**
Contact Details:	**fionna.moore@lond-amb.nhs.uk**
History:	**n/a**
Status:	**For information**

Background/Purpose

This Chief Executive's report gives an overview of what has been happening in the Service since the Board meeting in February. The report is in four sections, based on areas of primary areas of interest, and the role of the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement

Action required

For Board members to receive the report and have an overview of recent developments in the Service in a strategic context.

Assurance

Detailed assurance for Board members will be received in the main body of the Board papers and formal reports.

Key implications and risks arising from this paper	
Clinical and Quality	As described in the sections on quality and delivery.
Performance	As described in the sections on quality and delivery.
Financial	As described in the sections on quality and delivery.
Governance and Legal	**As described in the sections on strategy and quality.**
Equality and Diversity	
Reputation	**As described in the sections on strategy and culture and engagement.**
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**Yes**
To make LAS a great place to work	**Yes**
To improve the organisation and infrastructure	**Yes**
To develop leadership and management capabilities	**Yes**

CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING TO BE HELD ON 29th MARCH 2016

This Chief Executive's report gives an overview of what has been happening in the Service since the Board meeting in February. I have divided the report into four sections, based on areas of primary areas of interest, and the role of the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement.

Strategy

Blue Light Collaboration
As I have previously briefed the Board, we are working jointly with the Metropolitan Police Service and the London Fire Brigade to make London the safest global city. We are aiming for the highest cardiac arrest survival rates in the world, the lowest levels of crime and disorder, and the lowest incidences of fires in dwellings, fire injuries and fire deaths. We want to ensure that collaboration and prevention are at the heart of everything we do. One of the many collaborative projects we are part of includes the recent launch of an initiative where fire-fighters from London's Fire Brigade now co-respond to around 28 life threatening emergencies a week, alongside our staff in the boroughs of Merton, Newham, Wandsworth and Lambeth. Another is the Metropolitan Police Service initiative to carry defibrillators on response cars in three Boroughs. This pilot has seen police officers respond to cardiac arrests alongside our crews. Both these initiatives are being evaluated, but anecdotally have led to much improved understanding between the three Services.

I also spoke, with my blue light colleagues, at the London Assembly Budget and Performance Committee on 8th March about closer working between emergency services. The Committee were exploring the government's announcement that they will legislate for a high level duty to collaborate. The committee asked a number of questions regarding existing collaboration and the potential for collaboration in the future. The speakers all provided examples of ways we work together and were positive about the potential for expanding existing collaboration and other collaboration opportunities in the future.

Chairman Richard Hunt to leave the Service at the end of the financial year
As colleagues will know, Chairman Richard Hunt announced earlier in this year that he would be leaving the Service at the end of the financial year on 31 March 2016, after seven years in the role. Richard has made an exceptional contribution to the Service and has been incredibly supportive towards everyone who works here, and especially to me, when I was a new Chief Executive. He will be greatly missed.

Heather Lawrence has been appointed by the NHS Trust Development Authority to take up the post from the beginning of April. We look forward to welcoming Heather, and her knowledge and experience will be invaluable as we focus on improving our Service to patients.

Quality

Making lasting improvements since the CQC visit
The Board has been briefed on the five work streams identified to deliver our Quality Improvement Plan following the CQC inspection report at the end of last year. These are: making the London Ambulance Service a great place to work, achieving good governance, improving the patient experience, improving environment and resources, and taking pride and responsibility. We are working hard and have delivered on detailed action plans in each area for January and February; the progress report is on our website and has been shared internally. Highlights include:

- 263 of our managers have undertaken training in risk management.

- We have been working closely with NHS England (London) and the hospitals that have the greatest challenges with delayed patient handovers. A workshop was hosted by the TDA and NHS England (London), with senior representation from the hospitals and our Service. The impact for organisations and patients of the delays to handover were shared, and joint action plans are now being developed. The Service gave a commitment to working closely with the hospitals and ensuring that the trolley-clear-to-green time (for which we are responsible) is closely monitored.
- We have fully recruited paramedics to the Hazardous Area Response Team (HART) to meet the requirements under the National Ambulance Resilience (NARU) specification.
- Significant work continues on the management of medicines, and progress is assessed through audits.

We have also engaged our local management teams across the Service in designing their own local actions plans. Over 350 managers attended working group sessions in February to talk in detail about actions in their area and how they would deliver these.

Recent external review

As these papers went to print we had just received the feedback from a review of as a result of a team of 20 people from the TDA, CCGs, NHS England (London), the Patients Forum and Health Watch inspecting a random selection of our stations and sites, following the CQC report we had last year. The reviewers came to look at frontline staffing, resilience, medicines management, and governance, risk and the culture within the Service. The feedback was that though we still have some way to go, we have made some great progress since the CQC inspection and report.

The review team said resilience had hugely improved in terms of staffing numbers, and training plans and records being comprehensive and complete. They also reported medicines cabinets were locked, and controlled drugs were well managed, but that we needed to do more to make the medicines management process easier for people, and the traceability of drugs from pharmacy to patient more streamlined; we are looking at how we do that.

I have made a short video to thank the staff who they spoke to for being open about their view on how we have improved and what more we need to do, and to emphasise the continued focus we need on medicines management. I am really proud of what we have achieved so far and I am confident we will all keep up the good work.

Clinical Quality and Patient Experience

- The monthly quality report has been shared and highlights on-going focus on maintaining safety and improving the patient experience.
- The unprecedented demand experienced within Urgent and Emergency Care since January has continued and has made it necessary for us to use a higher surge level on occasion to maintain our response to the sickest and most seriously injured patients. This undoubtedly impacts on the quality and timeliness of care we provide to patients, and has been reflected in an increase in the number of complaints.
- There is a welcome increase in the reporting of clinical concerns and incidents of note; the Serious Incident group reviews on average about 10 cases per week. It is encouraging to see incidents being reported and the introduction of the new DatixWeb system in 2016/17 will further support staff to do this.
- Compliance on delivery of the complete pain-care bundle for STEMI patients has increased by 4% in January 2016 compared to December's data, however on-scene times remain high. This is an area that is being discussed one–to-one in the new Clinical Team Leader CISO feedback with frontline staff.

Medical Director Appointment

I am delighted to announce that Dr Fenella Wrigley has been appointed Medical Director following a national recruitment process. Fenella has been undertaking the role on an interim basis since January 2015. Prior to that Fenella was Deputy Medical Director, having joined the Service in 2008 as Assistant Medical Director for Control Services. Fenella brings a wealth of clinical experience from both the pre hospital setting and as an A&E consultant. She is committed and passionate about providing the best possible patient outcomes for Londoners. We are delighted Fenella has accepted this role on a permanent

basis. Fenella will continue to work clinically one day a week as a consultant in emergency medicine for Barts Health NHS Trust.

Delivery – performance, money and workforce

The Board papers in this pack explain in detail our operational and financial performance and the workforce position. Performance is not where we would want it to be, and the quality of the service we provide to our patients remains challenged at particularly busy times. It is also worthy of note, that demand has risen and remains higher than either we, or the NHS as a whole, expected. Category A demand for February 2016 was the fourth busiest month on record for the Service, and Category C demand continues to grow. Our capacity, or the hours of frontline operational staff we are putting out each day, is also below where we would want it to be. We are keeping the focus on recruitment, and working with staff to encourage the uptake of over-time and increase bank staff capacity. We have been working hard on Easter resilience planning, and I am pleased to report we have seen some improved capacity in March and into April.

Our financial position is expected to deliver in-line with the forecast for year end. We are currently working hard with commissioners around the planning and contracting for next year, building in service quality improvement for patients, operational and performance requirements, and the work we need to deliver as a result of the CQC report.

Our vacancy rate for substantive staff has improved slightly and is now 7% and our paramedic vacancy rate has also improved, and reduced by 3%. We are keeping up the pressure up on our recruitment and will be attending graduate fairs and continuing our overseas recruitment programme over the next few weeks.

Improving our Fleet – "Make Ready" pilot

The CQC report highlighted that we needed to improve in the preparation of vehicles pre-shift and the availability of replacement equipment during the course of the working day. We have invested more resource and better specification into a 3 month pilot in the North East sector, which began on 29th February. The pilot includes the creation of a daytime "Quarter Master" role, a dedicated deep clean team and the testing of an electronic asset tracking device.

The London Ambulance Service Academy

The new London Ambulance Service Academy launched in January and is providing an opportunity for 36 people to train to become paramedics. The education academy has been designed after feedback from staff on the need for further education and development and has been delivered as the first part of our CQC improvement plan.

The places are currently being offered to existing emergency ambulance crew and medical technicians and gives staff the opportunity to become a registered paramedic improving retention and in addition to our current recruitment campaign. Once qualified, trainees will also have the option to further their career development by going on to train as a senior paramedic, advanced paramedic practitioner or a consultant paramedic.

Major incident training

As I referenced at the last Board meeting, the London Ambulance Service took part in Europe's largest disaster training exercise in February to increase preparedness for a major incident in London. Exercise Unified Response saw ambulance crews responding to a simulated building collapse onto a tube train. Over the four days our staff treated over 1000 "casualties", treating hundreds of "injuries" that would be typical during an incident like this. In addition to ambulance crews and specialist staff from the Hazardous Area Response Team, control room colleagues were also involved testing that we dispatch the right type of resource and coordinating which hospitals we took the "patients" to. As well as improving resilience and preparedness, it was a great opportunity to test how we work with emergency services and other partners, including our major trauma centres, across London.

Culture and Engagement

Bullying and Harassment
We have held 15 workshops and 12 briefing sessions to raise awareness about bullying and harassment across the Service. Forums have been created to raise awareness of the issue and to also hear from a cross-section of staff about possible solutions.

Staff Welfare
To mark Time To Talk Day (4 February) the Service has signed the Blue Light Time to Change pledge, offering dedicated wellbeing support to our staff as they work round the clock to keep Londoners' safe. The initiative marks the latest in a number of steps taken by the Service to support people with mental health issues both within the Service and for Londoners more widely.

GP Engagement
We have commissioned Ipsos Mori to survey GPs to find out their perceptions of the Service. The survey includes questions about awareness of the services we offer, how we respond to their needs and their patients, as well as their views on value for money and how we communicate with them as a Service. 160 GPs and CCG board members have been surveyed and 18 in depth interviews are now taking place. We expect the results in April.

VIP Awards – staff recognition
I was immensely proud to present certificates to the latest area winners of our VIP Awards on Friday 11 March. The VIP Awards are a fantastic way to recognise colleagues in their different roles across the Service and it was inspiring to see the range of reasons for which people received their nominations.

The second round winners were:

- Emergency Medical Technician Brian Beard
- Emergency Medical Dispatcher Samad Billoo
- Team Leader NHS 111 Penny Francis-Dyer
- Senior Management Information Analyst Ben Hodgkinson
- Paramedic Susan Hunter
- Team Leader Karen MacDonald
- Administrator for NETS/PTS Kay Robson
- HART Supervisor Shaun Rock
- Station Administrator June Singh
- West Sector Delivery Manager Paul Smith
- Deputy Medical Director Neil Thomson
- Paramedic Hollie Thomson-Young
- Senior Paramedic Scott Windley

The VIP Awards annual event is on 28th April. All the nominators and the nominees have been invited, with 13 of the winners going forward to an all-staff vote to be chosen as the Employee of the Year. This process will be run on our intranet site – everyone will be able to watch a short video about each nominee and then cast their vote for who they would like to win.

Leadership Visibility
The CQC told us that our senior leadership team was not well-known enough across the organisation. To improve this, each Director has adopted a sector or departmental areas, to get to know the people, the issues and challenges they face in more depth. The areas are as follows:

Sandra Adams, Director of Corporate Affairs – South West sector
Andrew Grimshaw, Director of Finance – North Central sector
Jill Patterson, Director of performance - Waterloo corporate departments, NHS 111, EOC
Karen Broughton, Director of Strategy and Transformation - South West sector
Zoe Packman, Director of Quality – East Central sector, including Cody Road and Bow

Fionna Moore, Chief Executive – West sector
Fenella Wrigley, Medical Director- South East sector
Paul Woodrow, Director of Operations - South East sector
Charlotte Gawne, Director of Communications – North West Sector

I also worked on the following clinical shifts:

- 29th January 2016 – Incident Response Officer
- 4th February 2016- Fast Response Unit
- 12th February 2016 -Medic 3 Physician Response Unit
- 29th February & 1st March- Exercise Unified Response (Doctor)
- 10th March – LAA Physician Response Unit
- 17th March – Advanced Paramedic Practitioner (AP62)

Local stakeholder engagement
As the Chief Executive, with my Directors, we mainly engage with pan-London stakeholders like the GLA, the Mayor, Blue Light colleagues, and London and national NHS colleagues. Our Assistant Directors of Operations and Assistant Medical Directors are focused on local engagement in the boroughs. We have regular feedback about how stakeholders view the Service and their perception on how we are progressing with our improvement plan. So far London stakeholders both regionally and locally have received our Quality Improvement Plan positively and are broadly supportive of our progress, approach and delivery to date.
We held a pilot MP surgery session for SE London MPs, including Heidi Alexander (shadow Secretary of State for Health) - to update them on progress since our CQC report. These sessions were received positively and will now be rolled out across each sector.

BBC documentary

We have agreed to take part in a documentary series about the London Ambulance Service. The BBC have commissioned the Dragonfly production company to follow ambulance crews and control room staff as they respond to incidents in the capital for three one-hour episodes. This will be broadcast on BBC 1 in the autumn. They are interested in how London's health needs have changed as well as how many incidents we respond to, and the nature of illnesses and injuries in the Capital.

I believe this documentary will show the huge efforts we make to provide the best service we can for Londoners. It will recognise our caring and compassionate staff in control and on the road. I hope it will demonstrate the great contribution our people make to the Capital city, and perhaps help Londoners use our Service more wisely. Patient confidentiality is of course paramount and comprehensive preparations and controls have been set in place.

Staff voted to select the new Chief Executive's charity
The Charlie Chaplin Adventure Playground is the new Chief Executive's charity for the next two years. The charities put forward to the staff vote were all shortlisted because they are London-focused, small and less well known, they address issues that affect our patients, and are different to any previously supported charities. The Charlie Chaplin Adventure Playground (CCAP) provides high quality play for disabled children, their brothers and sisters and children from the local community.

Dr Fionna Moore
Chief Executive

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Integrated Performance Report – Trust Board Executive Summary.**
Report Author(s):	**Jill Patterson**
Presented by:	**Andrew Grimshaw**
Contact Details:	**0207 783 2037 / 07825733445**
History:	**Executive Leadership Team – 16/03/2016**
Status:	**Information Assurance and Discussion.**

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.

It brings together the areas of Quality, Operations, Workforce, Finance and the Trust Service Improvement Programme. Key messages from all areas are escalated on the front summary page.

This Integrated Report benchmarks Trust-wide performance against Key National, Local and Contractual Indicators.

This Executive Summary is designed to inform the business decisions of the Trust.

Action required

For Trust Board to note the Integrated Performance Report and receive it for information, assurance and discussion.

Assurance

- To assure the provision of high quality data and intelligence to support the Trust's decision making processes.
- To provide an integrated and comprehensive picture of the Trust's overall performance.
- To ensure that the Trust Board receives early oversight of trends and issues.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Governance and Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**YES**
To make LAS a great place to work	**YES**
To improve the organisation and infrastructure	**YES**
To develop leadership and management capabilities	**YES**

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

MARCH 2016

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

* Please note that this report relates to performance throughout February 2016 unless otherwise stated.

Delivery of care continues to be safe, but quality remains challenged at times. Some patients experience longer waits due to capacity constraints
The financial position continues to be challenging with pressure on the forecast outturn. A revised Target of £4.4m deficit is now expected
A8 performance ended at 56.49%. This is lower than the newly reinstated LAS forecast of 68.4%
Front line vacancy rate is now at 6.6% down from 8.5% in January

OUR PATIENTS

↑ STEMI performance has increased in January by 4% from December's data for delivery of complete care bundle (i.e. analgesia) to this group of patients

↓ The overall on scene time for STEMI patients has increased by 2 minutes to 45 minutes in January 2016

↔ There have been 5 serious incidents declared out of 42 incidents reviewed during February

↓ Surge Purple enhanced was invoked for 13 periods during February, mainly due to unprecedented spike in incoming calls. This was to maintain clinical safety of patients

OUR PERFORMANCE

↓ A8 Performance was 56.49% for February 2016. This is lower than the previous month's figure of 61.1% and below the trajectory of 68.4%

↓ Cat A demand for February 2016 was the 4th busiest month on record for the LAS

↓ Category C demand continues to increase

↓ Job cycle time rose to 114 minutes for the month. This is now 4 minutes above the trajectory of 110 minutes

↓ Capacity fell again in the month, mainly due to a combination of reduced overtime and substantive hours

OUR MONEY

↔ Plan / Target – The Trust has a revised Deficit target of £4.4.m. This is related to the receipt of additional specialised services income £2.0m and a projected increase of £4.5m in Quarter 4 from a Capital to Revenue Transfer and a further £2.4m for system resilience income

↔ Year To Date - The trust reports £1.7m favourable variance from plan. The Trust is expected to reach its revised target of £4.4m

↔ Cost Improvement - CIP remains adverse to plan due to unidentified savings programmes required due to the reduction in specialised services funding but the full target of £8.9m is expected to be delivered by Month 12

↑ Cash is £17.6 m, £0.6m above plan. The Trust has now received payment for the majority of its overdue transformation and Contract income

OUR PEOPLE

↑ Vacancies - the vacancy rate for front line staff has reduced by a further 2% to 6.56% (against a 5% target). By the end of March we expect to have exceeded our planned recruitment levels

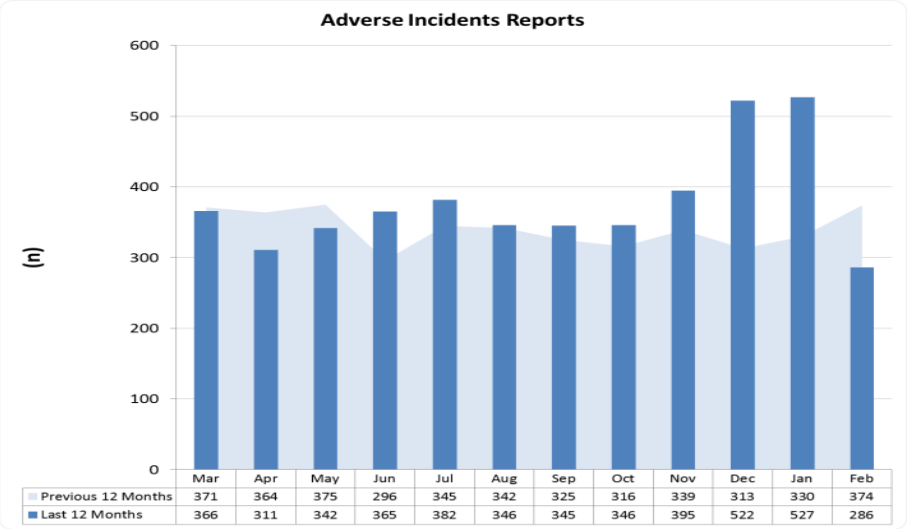
↔ Turnover has improved from 12.4% in January to 12.2% in February

↔ Sickness levels have improved from 5.3% to 5.2%

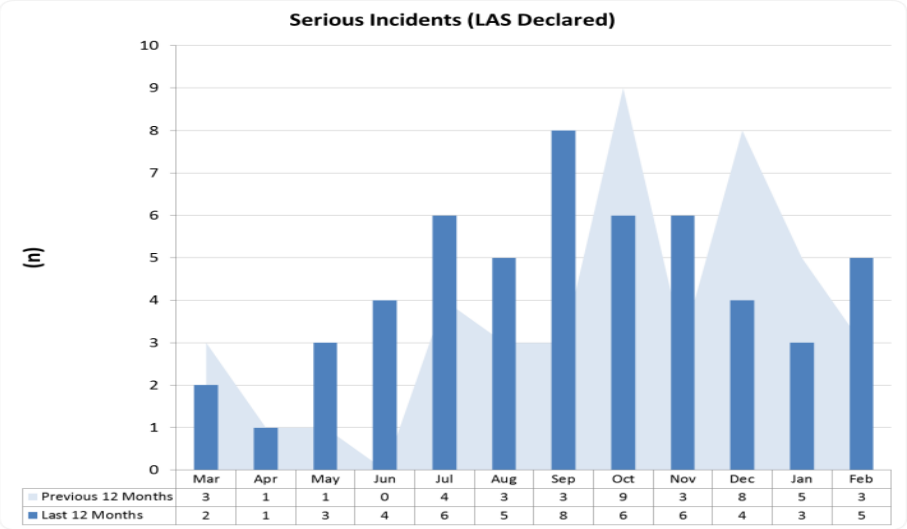
Our Patients

Section	Key Headlines From Each Sub-Section.	Feb	Jan	
SAFETY	• A reduction in overall staff related adverse incidents • CSR 2015.3 attendance is at 47%, a reduction on expected numbers. This is due to non attendance of staff (i.e. double booked on courses, unwilling to travel to other training facilities) and cancelled courses due to insufficient attendance numbers • Adrenaline 1:1000 samples labels procured for evaluation to reduce medication administration errors • One Preventing Future Death report received by the LAS for response			
EFFECTIVE	• Compliance on delivery of complete pain care bundle for STEMI patients has increased by 4% in January 2016 compared to December's data			
CARING	• CPI completion rates is at 88%, the highest amount recorded in the last two years • Hillingdon have had the highest CPI feedback and completion rates for the last two and six months consecutively			
RESPONSIVE	• There were 13 periods of Surge Purple Enhanced during February, due to unexpected spikes in incoming call demand			
WELL LED	• Work continues to progress on the QIP to address the CQC recommendations • 6 Executive visits to their individual sectors have taken place Feb-March 2016	**N / A**	**N / A**	

Serious & Adverse Incidents (SI)



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	371	364	375	296	345	342	325	316	339	313	330	374
Last 12 Months	366	311	342	365	382	346	345	346	395	522	527	286



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	3	1	1	0	4	3	3	9	3	8	5	3
Last 12 Months	2	1	3	4	6	5	8	6	6	4	3	5

We estimate that 60.7% of incidents that took place in February 2016 have been received and entered onto the database, so data below is a forecast based on this estimate.

Staff Incidents: 238 (previous: 287, ↓ -17.1%)

- Manual Handling incidents: 38 (previous: 61, ↓ -37.7%)
- Assault and Abuse: 53 (previous: 87, ↓ -39.1%)
- Sharp Object (incl. needle sticks): 21 (previous: 14, ↑ +50%)

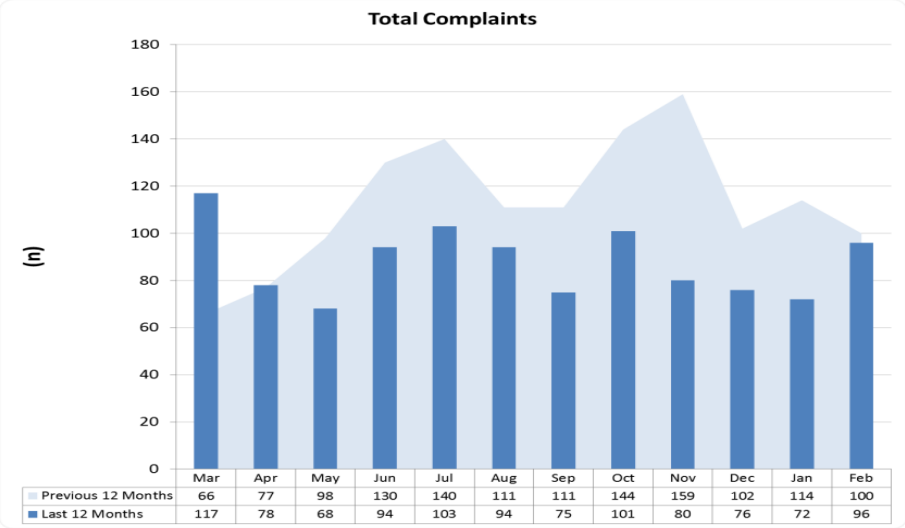
Patient Incidents: 267 (previous: 256, ↑ +4.3%)

- Failure of equipment: 67 (previous: 58, ↑ +15.5%)
- Missing Equipment: 31 (previous: 41, ↓ -22.5%)
- Issues with resource dispatch: 23 (previous: 36, ↓ -36.1%)

Serious Incidents – February 2016 data

- 5 SIs declared having reviewed 43 incidents
- As at the end of January, 24 SI's remain open , an increase of 5 on the previous month
- 10 are overdue, with 14 within timescale. All overdue SI's have been escalated internally to Executive Leads to ensure progression towards completion. Some incidents are awaiting further information from external agencies due to complexity of the investigations
- 2 SI's have been closed , down from 9 in January
- 4 completed SI reports are awaiting final sign off

Complaints – Volume & Response time



96 complaints were received in February which is an increase over the previous three months - 72 complaints in January, 76 in December and 80 in November.

The increase in complaints for February is unusual compared to historical data. The themes relate to delays and non-conveyance and may reflect the unprecedented demand seen from January 2016. This trend is being closely monitored.

It has been acknowledged regarding the increasing numbers and will be reviewed over the next couple of months.

2015/16	Total complaints	Number of closed complaints by month	Totals closed within 35 working days
July	104	122	51
August	94	130	37
September	75	118	35
October	101	114	36
November	80	80	31
December	76	93	34
January	72	78	25
February	96	74	14
Totals:	**698**	**809**	**263**

Month	Complaint numbers	Acknowledged in 3 working days
Apr-15	78	73 (94%)
May-15	68	68 (100%)
Jun-15	94	93 (99%)
Jul-15	104	102 (99%)
Aug-15	94	93 (99%)
Sep-15	75	74 (99%)
Oct-15	101	101 (100%)
Nov-15	80	78 (98%)
Dec-15	76	76 (100%)
Jan-16	72	72 (100%)
Feb-16	96	96 (100%)
Totals	**938**	**926**

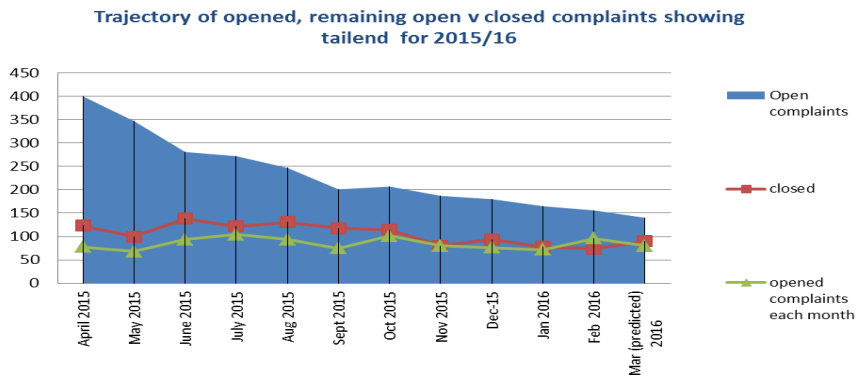
Complaints – Volume & Response time

Comparison of complaints received against calls attended by month

February 2015 to February 2016

Month	Calls attended	Complaints received
Feb-15	76560	100
Mar-15	85203	117
Apr-15	81523	78
May-15	84230	68
Jun-15	82847	94
Jul-15	86074	103
Aug-15	84876	94
Sep-15	82964	75
Oct-15	88283	101
Nov-15	88106	80
Dec-15	92248	76
Jan-16	91193	72
Feb-16	85605	96

The following graph shows 'open' complaints , versus 'closed' cases 2015/16 showing tail end detail



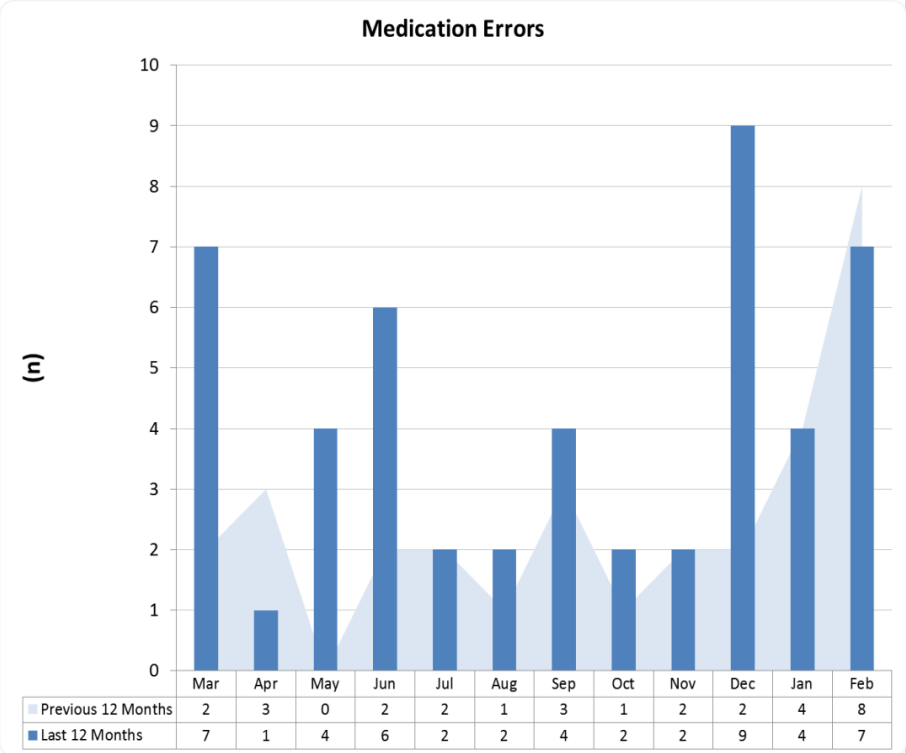
Based on current complaint numbers, performance and closure rates by the end of August 2016, all complaints will be managed within the 35 day target. The current shortage of staff has been taken into account provided complaint numbers do not increase exponentially, then we should maintain this target.

There is a risk that the implementation of the recommendations within the Quality Improvement Plan (QIP) to improve accessibility to our stakeholders, in relation to making a complaint, could increase complaint numbers. This could impact on our trajectories but will be under close review.

Awaiting QA reports continues to remain the predominant cause of delays in performance throughput (currently 41/179 = 23% awaiting QA analysis). The team dynamically assess individual complaints to deem whether a QA report is essential. The backlog of QA's has reduced significantly in recent months.

Complaints about delay have remained steady although complaints across all subject areas are lower than 2015/16 but have risen slightly during this month. The Resource Escalatory Action Plan (REAP) 4 has been in place for the whole of 2015/16 with Surge levels mainly at red or purple.

Medicines Management



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	2	3	0	2	2	1	3	1	2	2	4	8
Last 12 Months	7	1	4	6	2	2	4	2	2	9	4	7

It has been reported that the logistics department currently re-seal plastic drug containers where the manufacturers seal is broken. The chair of the medicines management group has contacted the logistics management team to advise that this practice must cease with immediate effect and that any affected drugs (currently amiodarone and glucagon) must be removed from circulation and disposed of in the event that a defective seal is identified.

Sample warning labels have been procured for adrenaline 1:1000 ampules. This label will have 'IM use only' printed on it and will be secured to the ampoule to reduce risk of incorrect route administration.

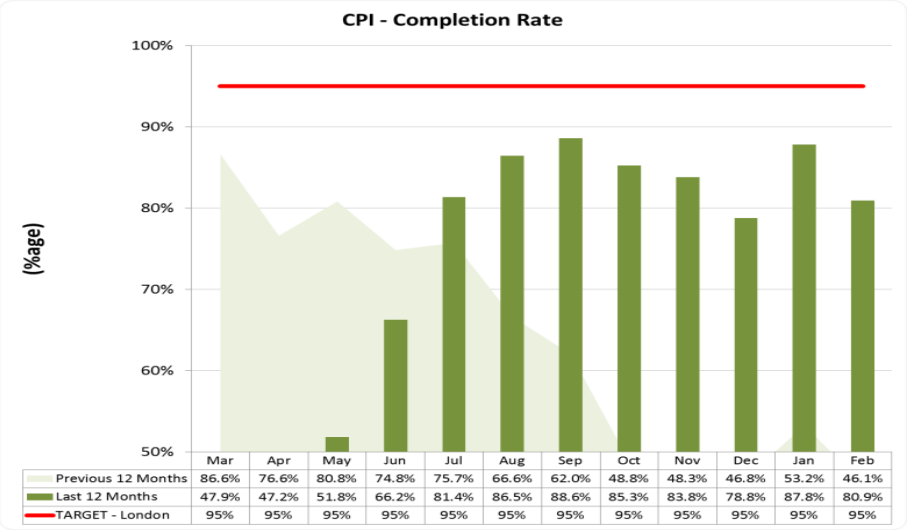
The Metropolitan Police Service (MPS) Controlled Drugs Liaison team undertook an 'out of area' inspection of the provisions for the storage and management of controlled drugs for the duration of exercise unified response. The MPS team identified that great care had been taken to ensure compliance with the CD legislation for the duration of the exercise and commended the responsible manager for his efforts.

A recent audit conducted between 15/2/16 and 22/2/16 at LAS logistics identified that a mean of 42% of LAS drug usage forms (LA290) contained within sealed drugs packs were fully completed to indicate the drugs used. In order to address this an email has been sent to Trust CTLs, QGAMs and GSMs providing further promotional materials and requesting that staff are reminded of the need to complete these forms on every occasion that drugs are administered from a sealed pack.

A new Medicines Safety Officer Ambulance group is to be established which will be attended by the Trust Medicines Safety Officer (David Whitmore).

An application has been submitted for a Darzi Fellow Pharmacist to specifically develop the LAS medicines management strategy.

CPI Completion, Feedback Sessions and Compliance (January 2016 data)



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	86.6%	76.6%	80.8%	74.8%	75.7%	66.6%	62.0%	48.8%	48.3%	46.8%	53.2%	46.1%
Last 12 Months	47.9%	47.2%	51.8%	66.2%	81.4%	86.5%	88.6%	85.3%	83.8%	78.8%	87.8%	80.9%
TARGET - London	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

CPI Completion

- January 2016 had one of the highest completion rates of CPIs in the last two years at 88%. In addition, all Group Stations completed over 25% of CPI audits available for the first time in six months.

  A number of Group Stations achieved 100% completion which should be commended. In particular, Deptford, Edmonton, Friern Barnet, HART and Hillingdon should be congratulated for achieving 100% completion for the sixth month in a row. Similarly, Central Operations, Greenwich and Romford audited all available PRFs for the fourth month in a row.

  Bromley, Westminster, Brent and Homerton Group Stations require improvement and it is suggested that assistance is sought from Group Stations that are continually performing well.

CPI Compliance

- The LAS provided a high standard of care to ACS (96%), Non Conveyance (97%), Cardiac Arrest (98%), Glycaemic Emergencies (97%) and Stroke (97%).
- Documentation of care provided by the LAS to patients with a diagnosed psychiatric problem still requires improvement. The roll out of the Mental Health Awareness Tool should assist with this CPI compliance. Areas for focus include safeguarding considerations for patients and children, and assessment of patients thoughts, appearance and communication.
- Greenwich was the only Group Station to achieve above 95% completion for the Mental Health CPI and the only Group Station to achieve above 95% across all the CPIs.

CPI Feedback

- For the second month in a row, **Hillingdon** continue to deliver a high proportion of face to face sessions and has exceeded the 100% target. Whilst Edmonton and Fulham have not delivered the expected number of face-to-face feedback sessions, they are undertaking more feedback than other Group Stations across the Service and, resources allowing, they may reach the 100% feedback target for 2015/16.
- Notably, the proportion of staff who have received two or more face-to face feedback sessions still remains below a third of what is expected at this point at Brent, Camden, CRU, New Malden, St Helier and Volunteer Responders.
- All Group Station Management teams are informed of their CPI compliance data, which is should be used for discussion at local and area meetings to assist with improvement.

CARU Reports (Cardiac and Stroke) - January 2016

CARDIAC ARREST

- Resuscitation efforts were commenced on **41%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **9 minutes**, thus exceeding the target by 1 minute. 6 Station Groups had an average 999 call to arrival on scene time of 7 minutes or less – St. Helier and Westminster at 6 minutes response.
- An advanced airway management device was placed successfully in **90%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **Four** patients had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout. Details of the cases requiring feedback have been shared with the management teams. Unsuccessful advanced airway placements have been recorded as soiled airways or unable to get an ETCO2 reading when placed.
- Approximately **5%** of cases had defibrillator downloads submitted.

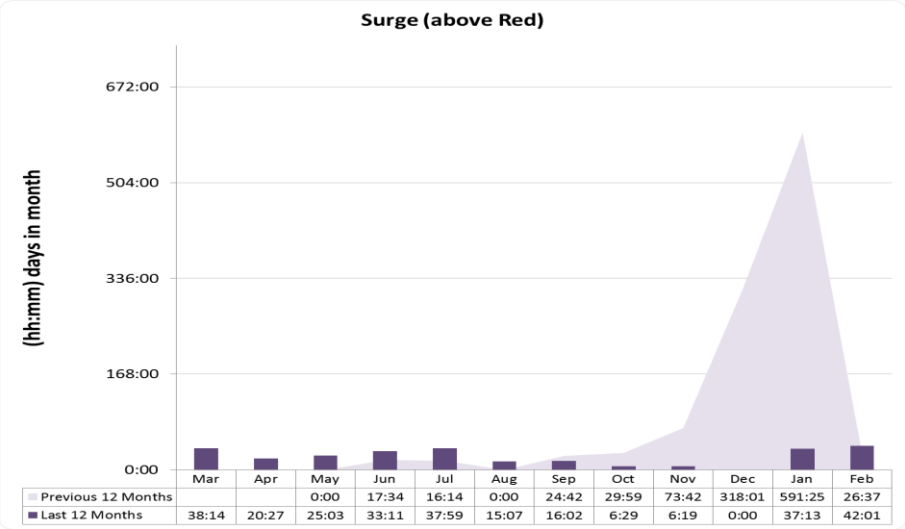
STROKE

- **98%** FAST positive patients had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- **99%** FAST positive patients were conveyed to the most appropriate destination for their condition. 5 patients were taken to an ED inappropriately instead of a HASU; details of these incidents have been shared with the management teams to enable feedback to the staff involved.
- The average response time for 999 call to arrive on scene is **15** minutes. This is a **3** minute increase from December.
- 98% of patients arrived at a HASU within 30 minutes of leaving scene which is the timeframe set by the London Stroke Network.
- The average time on scene is **36** minutes, which remains longer than the recommended 30 minutes.

STEMI

- 99% of patients were conveyed to an appropriate destination.
- 1 patient was taken to an ED inappropriately instead of a HAC; details of this case have been sent to the local management team to enable feedback to the staff involved.
- The average time from the 999 call to arrival on scene decreased by **1** minute to **12** minutes in January for all call categories.
- Average overall on scene time has increased by **2** minutes to **45** minutes, while call to hospital times have decreased by **3** minutes to **74** minutes. These continue to require monitoring.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessment scores and analgesia has increased by **6%** to **74%** in January 2016. 81% of patients received analgesia during January, however 19% of patients did not receive at least one form of analgesia. This has been fed back to Group Stations and they should examine why this has occurred.

EOC Surge Status



- There were 13 periods at Surge Purple Enhanced during February 2016. The periods of Surge Purple Enhanced can be attributed to unprecedented increases in incoming call demand
- The maximum time at Surge Purple Enhanced was 8 hours whilst the minimum time was 36 minutes
- We remain at surge RED as agreed for this financial year and a review of the criteria to continue at this level confirms we are still operating under significant operational pressure

Ambulances Saved YTD	
Date	Surge Saves
April	7312
May	7421
June	7552
July	7587
August	6933
September	7016
October	7124
November	7058
December	7189
January	7166
February	6890
March	

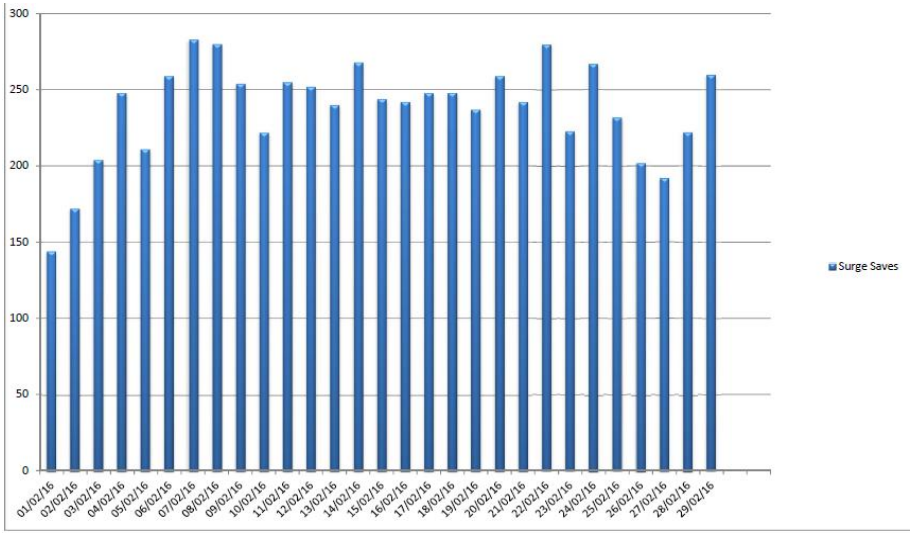
Total Surge Green Saves	Total Surge Pre Amber Saves	Total Surge Amber Saves	Total Surge Red Saves	Total Surge Purple/Purple Enhanced Saves	Total Surge Blue Saves	Total Surge Black Saves
			6652	660		
			7094	327		
			7448	104		
			6936	460	191	
			6676	257		
			6467	549		
			7113	11		
			6936	122		
			7013	176		
			6735	431		
			5882	1008		

Total Saves	
Total Green Saves	0
Total Pre-Amber Saves	0
Total Amber Saves	0
Total Red Saves	74952
Total Purple Saves	4105
Total Blue Saves	191
Total Black Saves	0

TOTAL SAVES	79248

Total Saves	79248

0	0	0	74952	4105	191	0



Our Performance

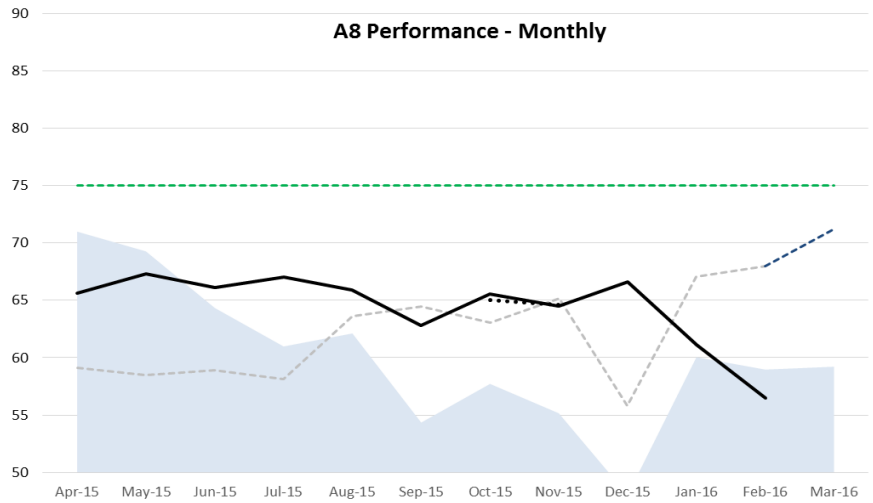
Sub-Section	Comment	Current **Feb**	**Jan**	**Dec**	**Nov**
A8 Performance	A8 Performance was 56.49% for the month of February. This is lower than the trajectory figure of 68.4% agreed at the end of September.				
Other Performance	Performance across all categories of incident from category A to category C has fallen this month.				
Demand	It was 4th busiest month ever for category A incidents, at 43,475. Category C demand is on the rise (specifically C3), in part due to reduced H&T/Surge numbers.				
Capacity	The patient facing vehicle hours (PFVH) deployed during February were lower than the previous month, on average 248 PFVH per day. This was mainly due to substantive hours and reduced overtime.				
Efficiency	JCT has risen slightly to 88.4 minutes [114 Full JCT]. Which is now 4 minutes above the expected trajectory of 110 minutes. JCT forecasts for year end have been revised to 107, peaking at 113 for Dec/Jan.				
Forecasting	The forecasting model is still tracking below performance by 3.6%.				

Ambulance Quality Indicators (AQI) Update – January 2016

The AQIs for January 2016 were published on 10th March 2016. The AQI comprise of 2 parts. The Ambulance Systems Indicators (AmbSYS) and the Clinical Outcomes (AmbCO). These indicators enable comparison between the 11 Ambulance Trusts across England.
The table below details 7 of the AmbSYS indicators. It shows the indicator description, the LAS performance and it's position in relation to the other 11 ambulance trusts.

Source: NHS ENGLAND			**Last 3 months**			**Ranking Position**		
AQI Description	**Unit**	**Target**	Jan	Dec	Nov	Jan	Dec	Nov
The time taken to answer 95% of 999 calls in the emergency control room	secs	5 secs	2	2	2	2	2	2
The percentage of callers who have hung up before their call was answered in the emergency control room	%		0.1%	0.1%	0.1%	1	1	1
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	67.4%	72.8%	69.0%	8	6	9
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	60.9%	65.9%	64.4%	8	7	9
The time taken to reach 95% of Category A (Red 1) calls	mm:ss		13.7	13.8	14.3	3	4	6
The percentage of Category A calls reached within 19 minutes	%	95%	92.2%	93.4%	93.4%	6	6	6
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	mm:ss		20.2	19	18.9	5	6	5

A8 Performance

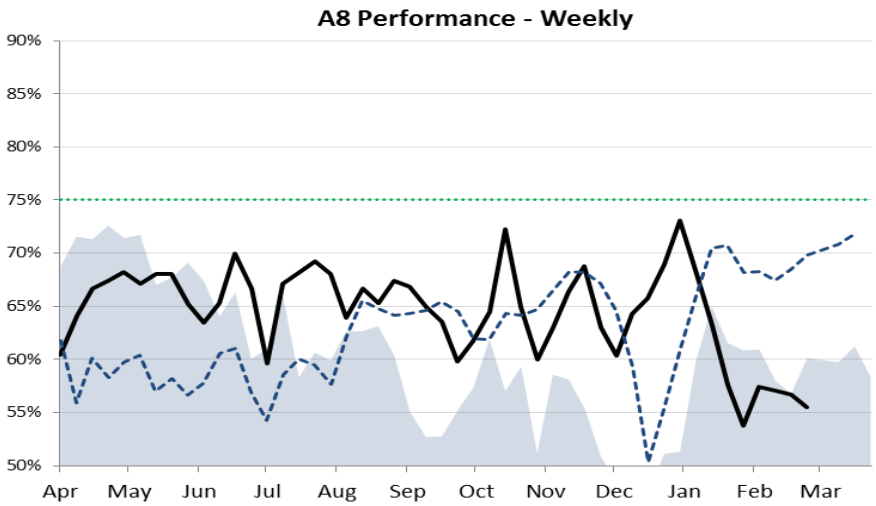


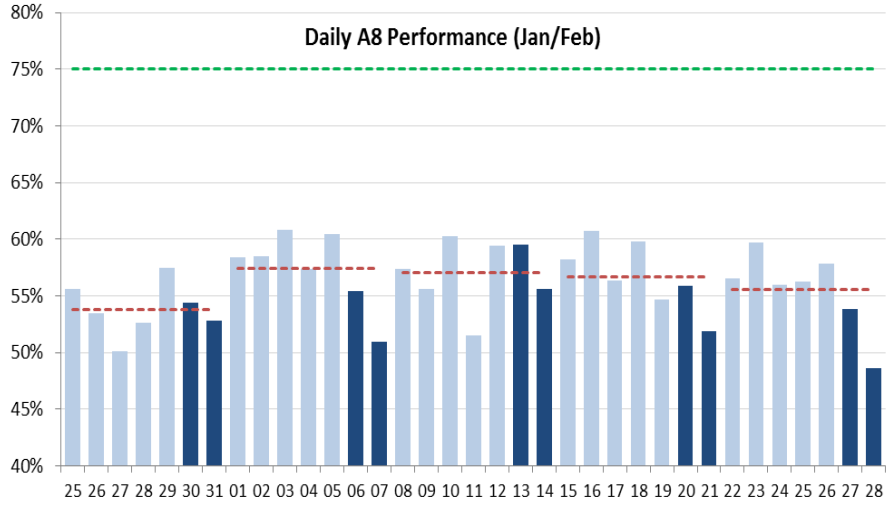
A8 Performance for February 2016 was 56.49%. This was lower than the contract trajectory of 80.5% and lower than the newly restated LAS forecast of 68.4%, for additional context, February 2015's figure was 58.97%.

The following factors may have contributed significantly to February's Cat A performance:

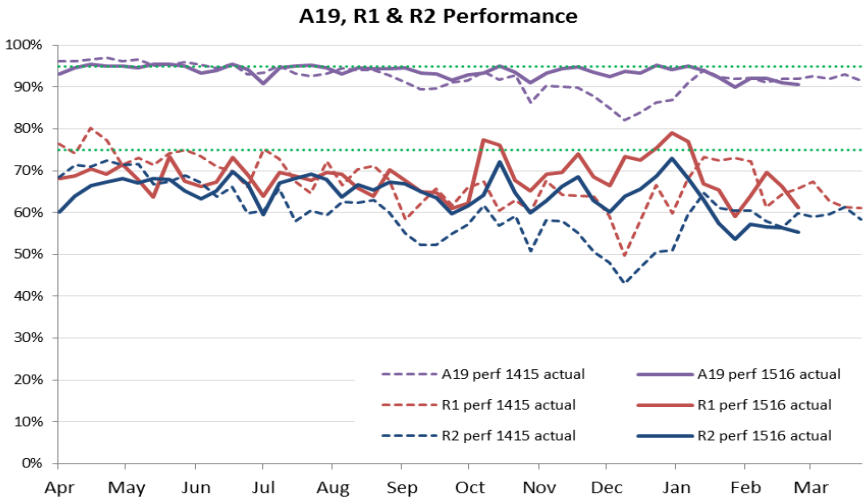
- Demand – All incidents were 7% above plan. Cat A was slightly above plan at 0.2%, however Cat C was 15% above plan.
- Capacity - Patient Facing hours were 10% below plan with overtime hours 47% below the plan for February.
- Efficiency - JCT was just over 3 minutes above the plan, but MAR was below (1.28 against 1.32).

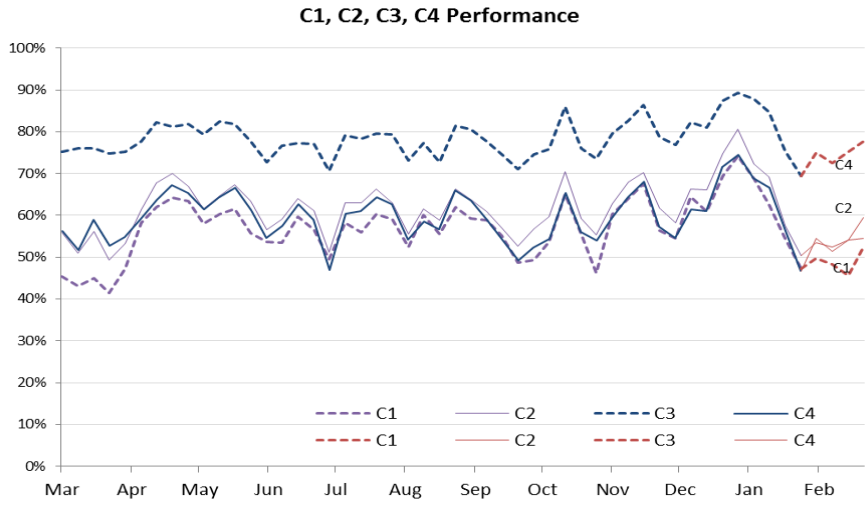
14/15 actual data
15/16 actual data
Revised trajectory (Oct 15)
National target





Other Performance





Performance in February 2016 was lower compared to January across all categories, with the biggest falls seen for C1s and C2s (10%). However C1, C3 and C4 did see a performance uplift in the last week of the month.

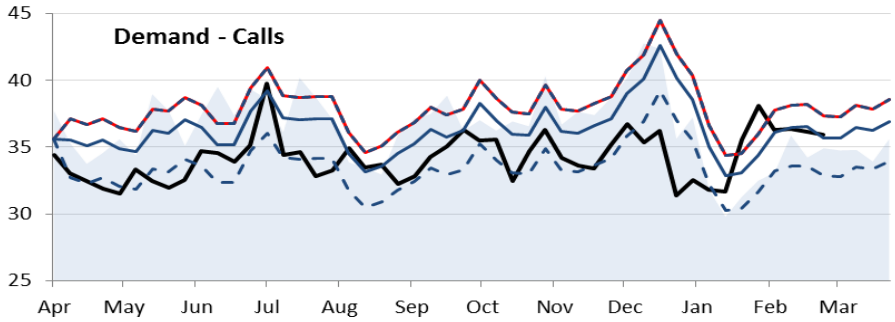
As previously outlined, Cat C demand is 15% above the plan for February, as well as being 9% above the demand we saw in February last year.

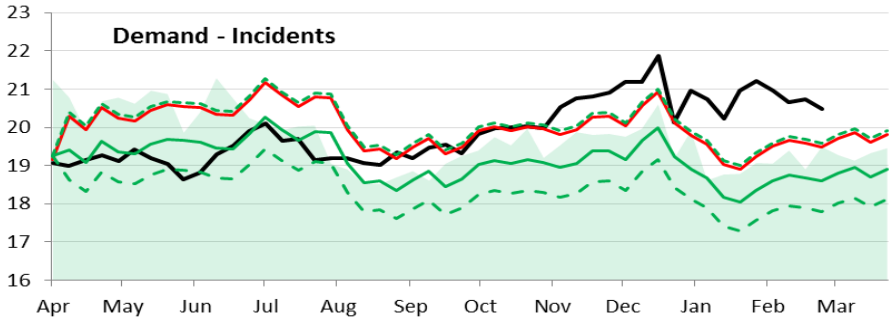
In terms of Cat C demand management, Taxi activity volumes have consistently been above their plan since January and there is an updated NETS plan that is being reviewed with the intention to try and increase their volumes.

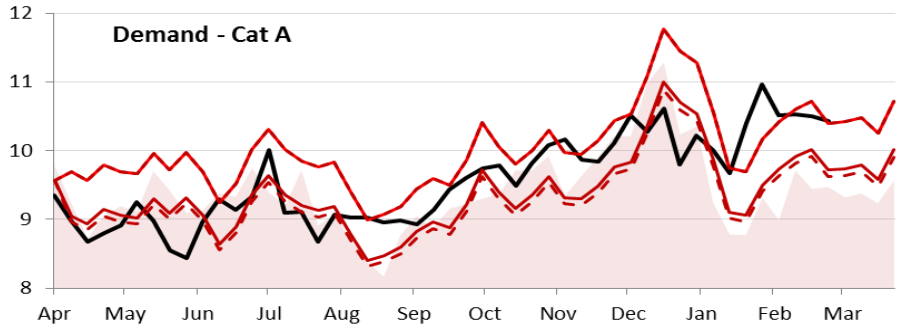
Analysis of Cat C demand has been undertaken and is being reviewed Demand and performance have also been forecasted for each day of the forthcoming Easter period.

wk ending	A8	A19	R1	R2	C1	C2	C3	C4
31-Jan	54	90	59	54	47	50	69	47
07-Feb	57	92	64	57	50	54	75	54
14-Feb	57	92	70	57	48	52	73	51
21-Feb	57	91	66	56	46	54	75	54
28-Feb	56	91	61	55	53	54	78	60
Dec-15	67	94	74	66	65	69	84	65
Jan-16	61	93	67	61	59	63	80	60
Feb-16	56	91	65	56	49	53	75	55

Demand





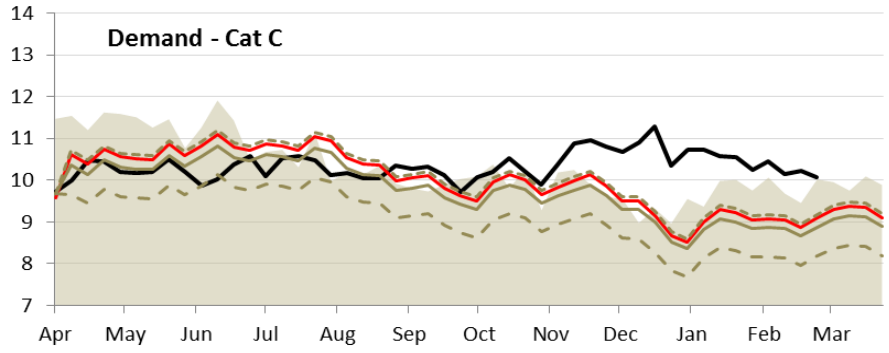


Cat A demand in February 2016 was the fourth busiest month on record for the LAS.

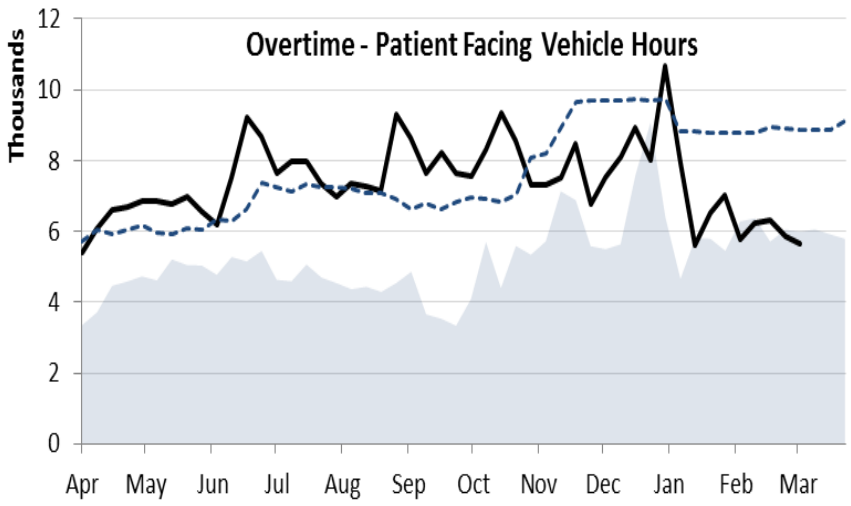
Category C incidents remains above contracted levels and continues to grow.

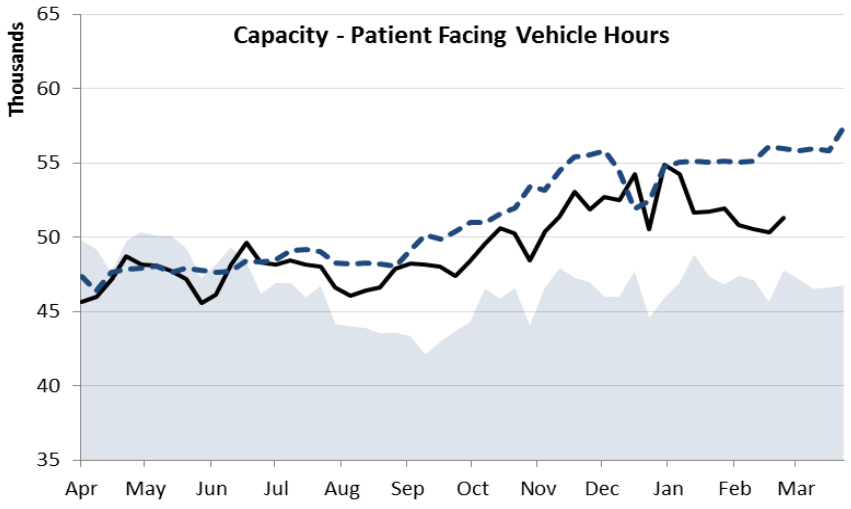
Call volumes continue to be above contracted levels.

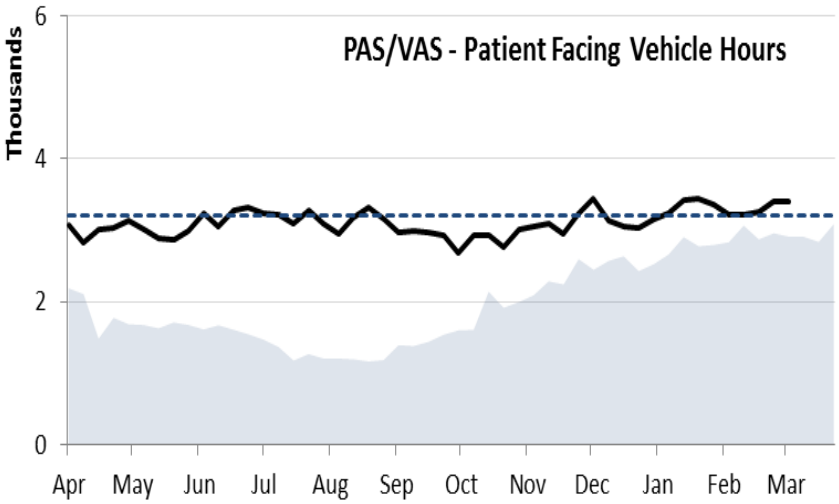
	Key	Calls	Inc.	Cat A	Basis
High	Short Dash	4.6%	5%	7%	contract
Medium	Solid Line	0%	0%	0%	14/15 actual
Low	Long Dash	- 8%	-4%	-1%	Q1 actual



Capacity







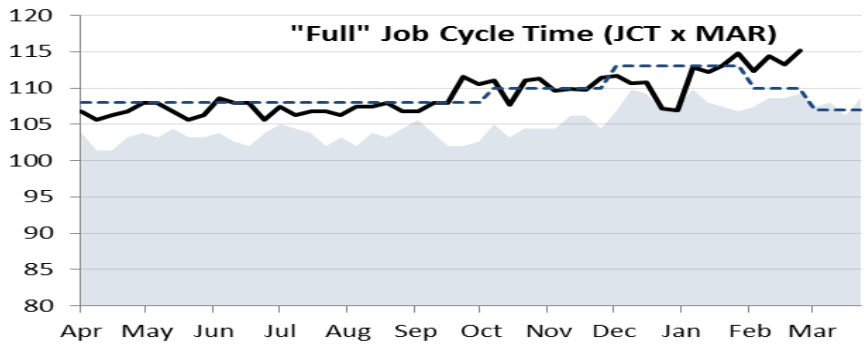
14/15 actual data
15/16 actual data
Revised trajectory (Oct 15)

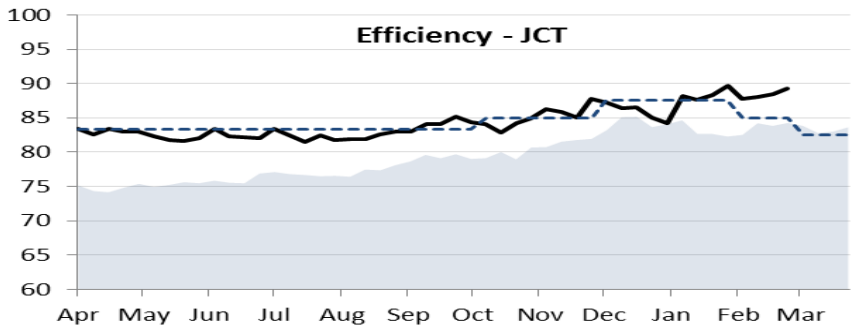
Capacity had dropped slightly in February 2016 from January. This was lower on average by 248hrs per day.

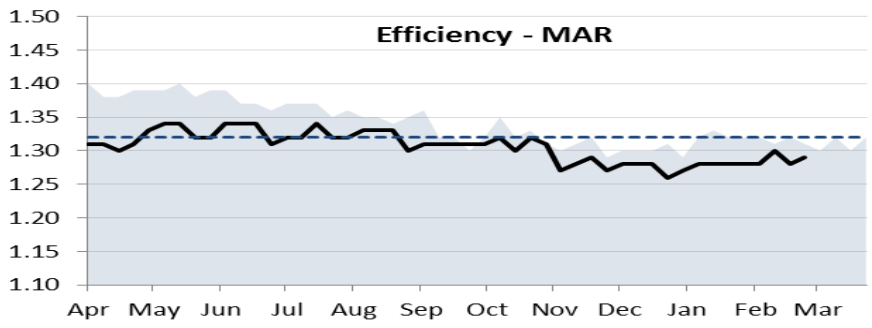
Overtime hours continued to fall in the month of February, but we have already started to see a rise during the early part of March.

PAS/VAS hours remain above the revised forecasted level.

Efficiency







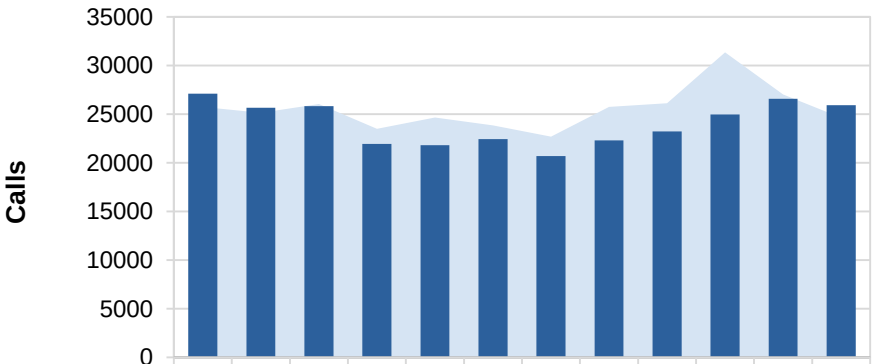
Job Cycle Time has risen slightly to 88.4 minutes (114 minutes for Full Job Cycle Time). This is now 4 minutes above the expected trajectory for February (110 minutes), (graph opposite shows highest weekly position).

The re-forecast JCT trajectory peaks at 113 minutes in Dec/Jan returning to 107 minutes by March.

14/15 actual data
15/16 actual data
Revised trajectory (Oct 15)

LAS 111 (South East London) - Demand and Capacity

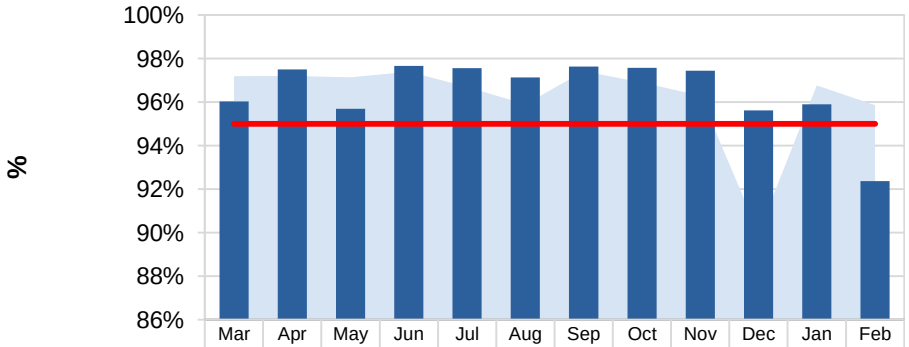
QR02: Total calls answered



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	25734	25137	26036	23492	24654	23842	22685	25743	26118	31346	27019	24631
Current year	27091	25648	25812	21939	21794	22442	20697	22305	23219	24963	26573	25935

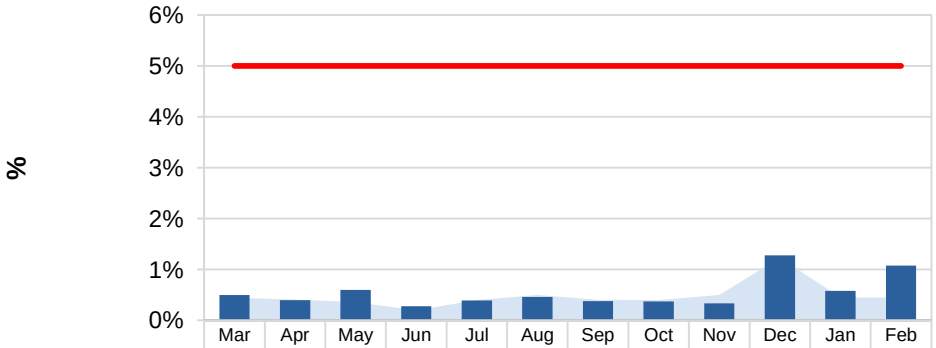
- **Demand**: Call volumes have been higher than for February 2015 and for predicted demand in 2016. There have been increases of up to 15% above prediction on weekdays.
- **Capacity**: There are 7.9 WTE Call Handler and 15.5 WTE Clinical Advisor vacancies. The next induction is in May and a combination of overtime and agency is in place to backfill roster gaps.
- **Efficiency**: Calls answered in 60 seconds fell below 95% for the first time since December 2014. The operational focus has been on balancing access to the service and minimising time to clinical call back.
- **Service Projects**: The service will relocate to Croydon in late spring/ early summer. A phased change of telephony is being implemented. Three pilots are currently in set up phase, following Commissioner request to allow direct bookings into one OOH and two GP hubs (Lambeth and Bromley), thereby improving the patient experience and minimising steps in the patient journey.

QR05: Calls answered within 60s



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	97.2%	97.2%	97.1%	97.4%	96.7%	95.9%	97.4%	96.9%	96.3%	90.0%	96.8%	95.9%
Current year	96.0%	97.5%	95.7%	97.7%	97.6%	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%
QR Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

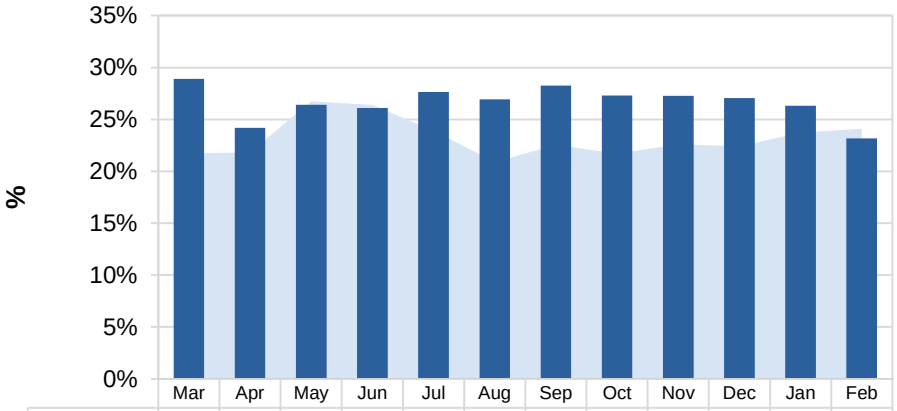
QR04: Calls abandoned after 30s



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	0.4%	0.4%	0.4%	0.2%	0.4%	0.5%	0.4%	0.4%	0.5%	1.2%	0.5%	0.5%
Current year	0.5%	0.4%	0.6%	0.3%	0.4%	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%
QR Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

LAS 111 (South East London): Call Destinations

QR12a: % of calls referred to a clinical advisor



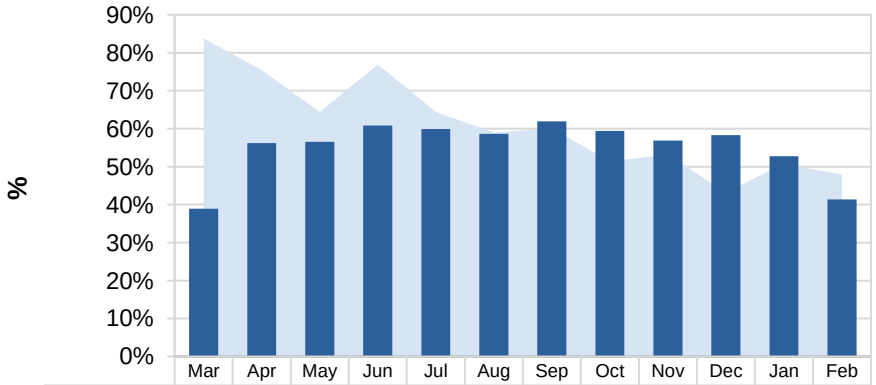
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	21.7%	21.8%	26.7%	26.4%	23.9%	20.9%	22.5%	21.7%	22.6%	22.4%	23.7%	24.1%
Current year	28.9%	24.2%	26.4%	26.1%	27.7%	26.9%	28.3%	27.3%	27.3%	27.1%	26.3%	23.2%

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 61 Incidents reported in Datix by the LAS 111 Team. Of these, 34% related to calls referred to an incorrect OOH Provider, 30% to demographic errors, 18% breaches of procedure and the remaining 18% to other issues. Incidents are under investigation and feedback given to staff where appropriate.

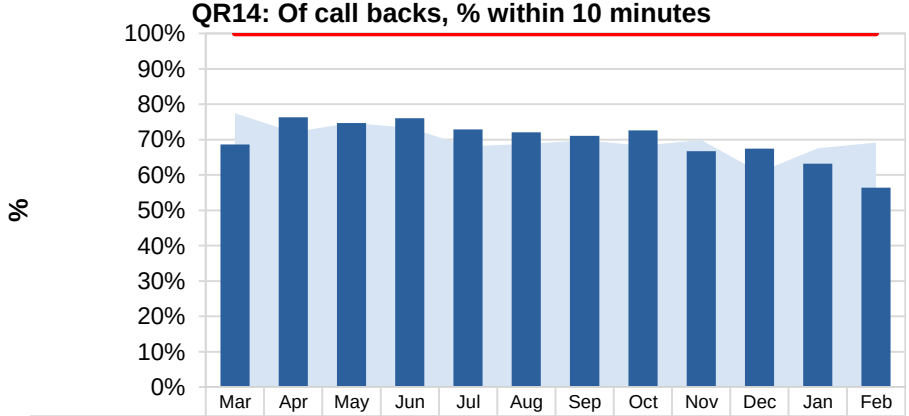
No Serious Incidents (SIs) were identified and the service received three complaints, one HCP feedback and two compliments. No SIs are under investigation.

QR12: Of calls transferred, % transferred warm



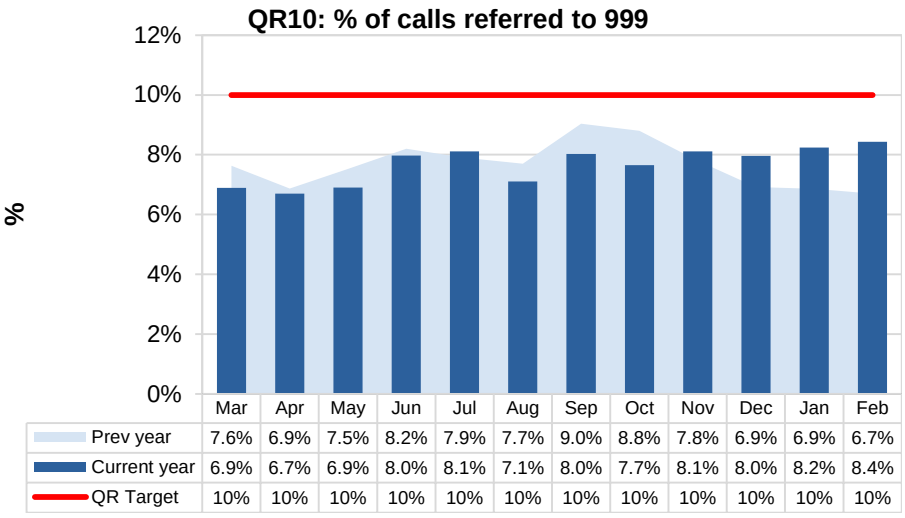
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	83.7%	75.4%	64.4%	76.9%	64.4%	59.0%	60.0%	51.4%	53.2%	43.2%	50.8%	47.9%
Current year	38.9%	56.2%	56.5%	60.8%	59.9%	58.7%	61.9%	59.4%	56.9%	58.3%	52.7%	41.4%

QR14: Of call backs, % within 10 minutes

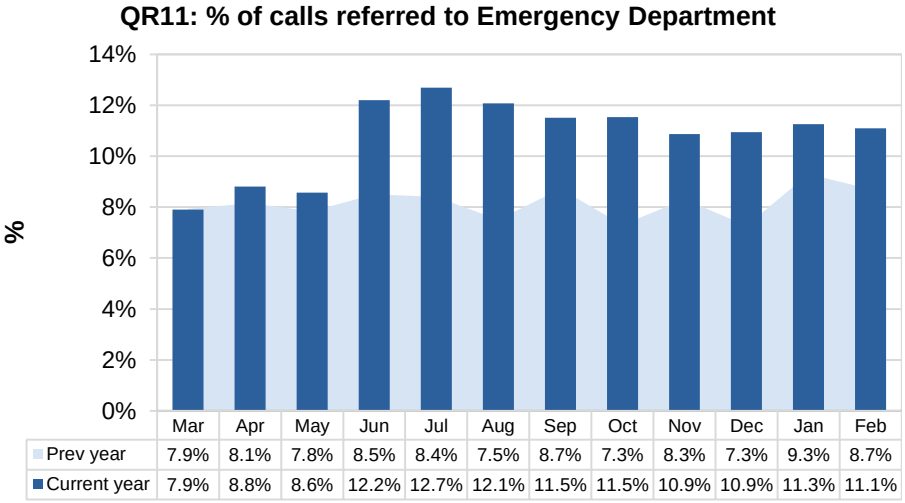


	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	77.4%	72.1%	74.8%	73.3%	68.1%	68.8%	69.8%	68.3%	69.9%	60.8%	67.6%	69.2%
Current year	68.6%	76.3%	74.7%	76.0%	72.9%	72.1%	71.1%	72.6%	66.7%	67.5%	63.2%	56.4%
QR Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

LAS 111 (South East London): Triage Destinations



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	7.6%	6.9%	7.5%	8.2%	7.9%	7.7%	9.0%	8.8%	7.8%	6.9%	6.9%	6.7%
Current year	6.9%	6.7%	6.9%	8.0%	8.1%	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%
QR Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Prev year	7.9%	8.1%	7.8%	8.5%	8.4%	7.5%	8.7%	7.3%	8.3%	7.3%	9.3%	8.7%
Current year	7.9%	8.8%	8.6%	12.2%	12.7%	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%

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.

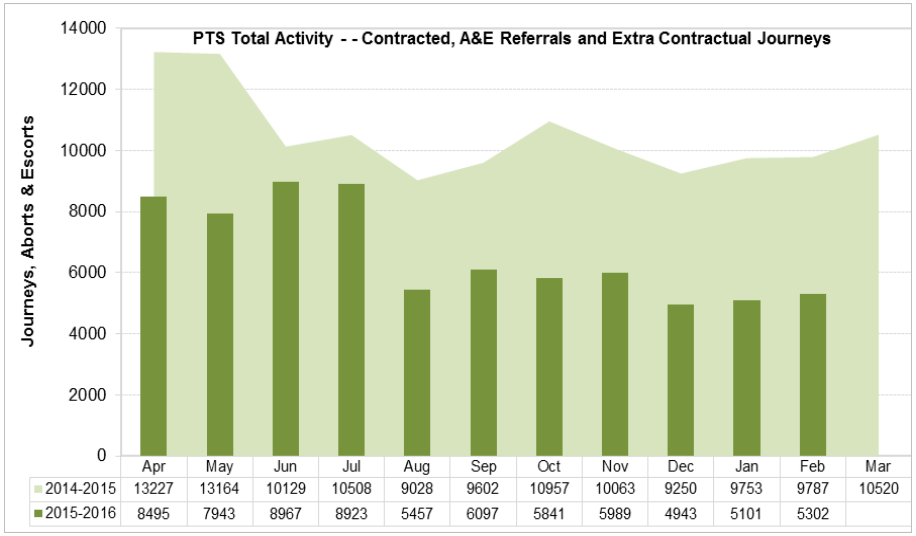
When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 is on a par with other London Providers.

We are undertaking a project to review referrals to ED.

LAS 111 (South East London): Glossary

QR	Measure	Target	Description
	Total calls answered	N/A	Number of calls made to 111 and answered by an LAS call handler.
05	Calls answered within 60 seconds	95%	Of the total answered calls, how many were answered within 60 seconds of being queued for an advisor?
04	Calls abandoned after 30 seconds	1%	Of the total calls offered and reaching 30 seconds following being queued for an advisor, how many did the caller hang up before they were answered?
	Calls referred to a clinical advisor	N/A	Of the total answered calls, what percentage were directly triaged by a clinician during their 111 episode?
	Of calls transferred, percentage transferred warm	N/A	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	N/A	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?

Patient Transport Service – Activity and Profitability Update

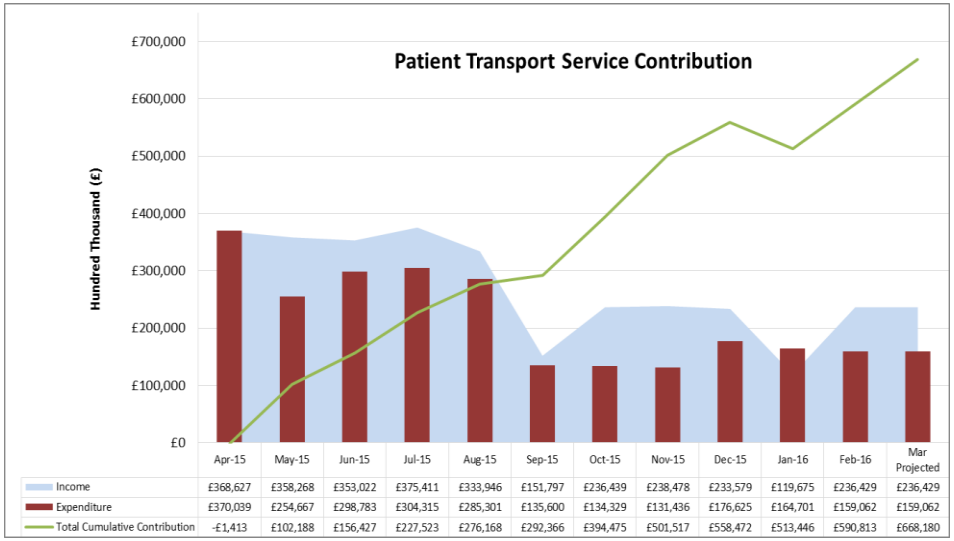


5,302 journeys were completed in February 2016, an increase from the previous month's total of 5101 journeys.

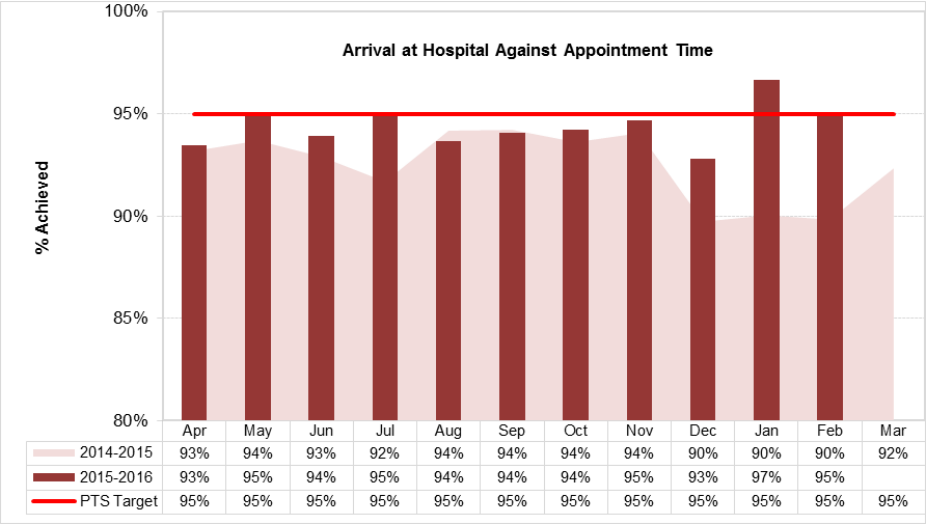
Income for the month has been supported by additional numbers of Extra Contractual Journeys completed in the month.

PTS is currently £454,820 ahead of budget as at month 11. The following graph shows income and expenditure for each moth with a total cumulative contribution back to the LAS. This is a projected figure for the 2015/16 financial year.

Month	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Apr	13062	13533	15044	13227	8495
May	14090	16100	15987	13164	7943
Jun	15123	13459	14852	10129	8967
Jul	14350	17879	16481	10508	8923
Aug	16070	18494	14401	9028	5457
Sep	15859	14742	15002	9602	6097
Oct	15369	15406	16739	10957	5841
Nov	15790	14898	15981	10063	5989
Dec	13395	11398	13986	9250	4943
Jan	15497	14495	16409	9753	5101
Feb	15513	13531	15232	9787	5302
Mar	15886	13444	13978	10520	0
Total	**180004**	**177379**	**184092**	**125988**	**73058**



Patient Transport Service – KPI Update

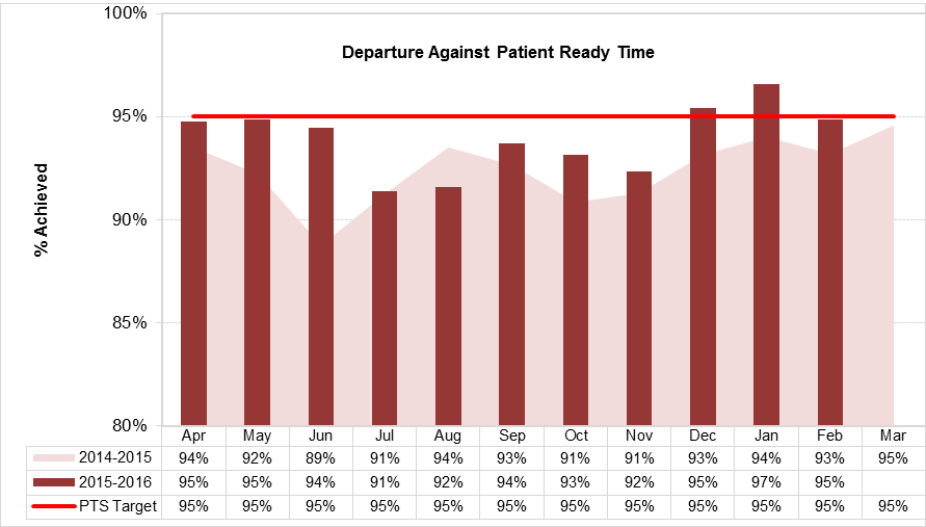


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	93%	94%	93%	92%	94%	94%	94%	94%	90%	90%	90%	92%
2015-2016	93%	95%	94%	95%	94%	94%	94%	95%	93%	97%	95%	
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

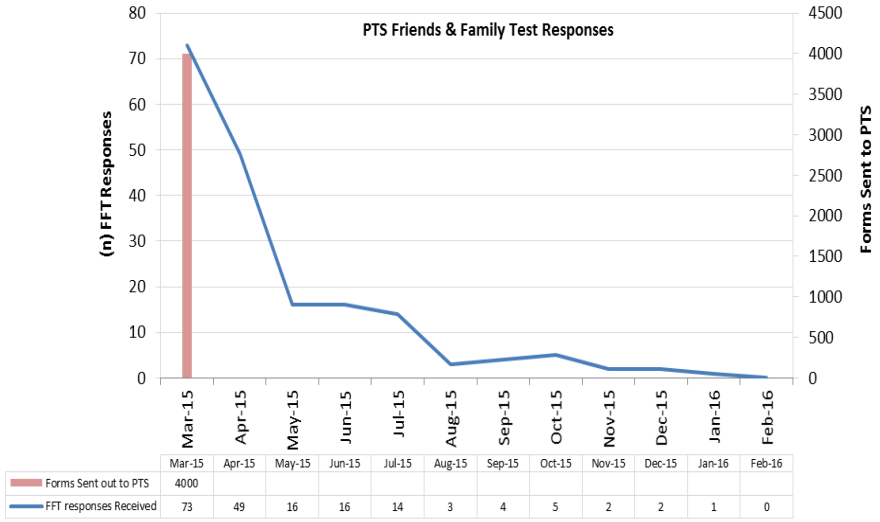
Performance against KPI's for the month are shown in graphs attached. February saw a slight decrease in both arrival & departure time with both at 95%. This has continued to meet the LAS target.

The plans to address departure times as part of the QIP are well under way with meetings now taking place with individual contract authorised officers.

The FFT responses have significantly reduced. This is linked to the smaller number of patients conveyed and the number of regular patients who comment that they have already completed a return. Road staff are being encouraged to complete a form with patients for every journey taken with us.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	94%	92%	89%	91%	94%	93%	91%	91%	93%	94%	93%	95%
2015-2016	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

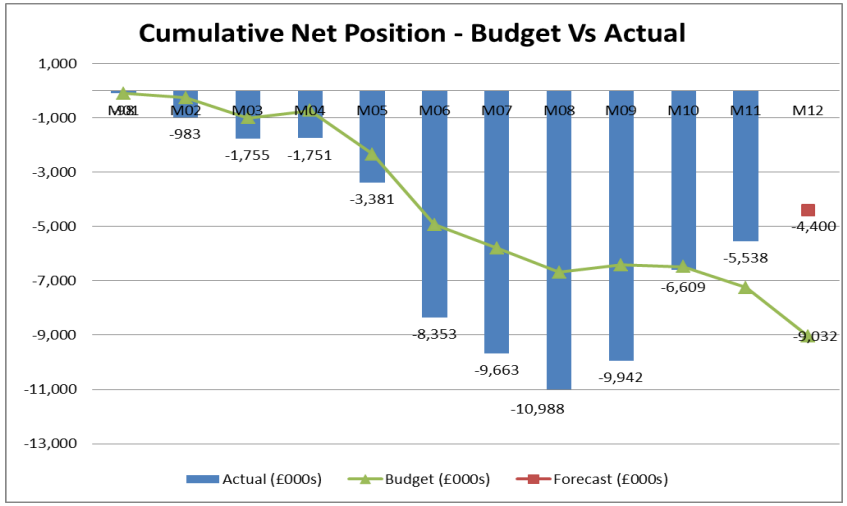


	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Forms Sent out to PTS	4000											
FFT responses Received	73	49	16	16	14	3	4	5	2	2	1	0

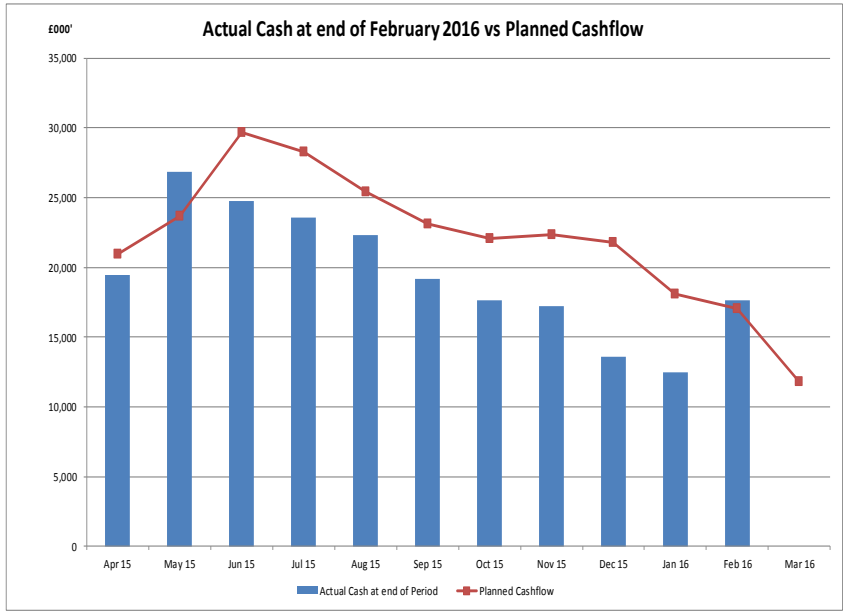
Our Money

Financial Indicator	Finance Summary: M10 – February (2016/17)	Feb	Jan
Surplus	In month the position is £1.8m favourable to plan, with the year to date reporting £1.7m favourable to plan. The Trust is reporting a £5.5m deficit YTD. The year end forecast is now £4.4m deficit due to the expected receipt of system resilience funding of £2.4m. The favourable position in month is driven by: • £4.5m has been transferred from Capital to revenue as agreed with the TDA, £4.1m reported YTD. • Income provision of £1.5m related to a >2% reduction in Cat C has been released following return to plan of CAT C activity across Q3 and 4 and agreement with CCGs. • The Trust has now agreed a revised level of specialised services income of £2.0m. This will, however, represent a £2.3m shortfall against the original £4.3m plan. • It should be noted that the Trust's underlying position once the non-recurrent Capital to Revenue adjustment and system resilience funding is excluded is £11.3m deficit (£4.4m plus £4.5m plus £2.4m) which would be a shortfall against the planned £9.0m deficit of £2.3m.		
Income	Income is £3.3m favourable in Month and £2.3m favourable year to date. The key drivers for this position are: • Income provision of £1.5m related to a >2% reduction in Cat C has been released following recovery of CAT C activity across Q3 and 4 and agreement with CCGs. • The Trust agreed a revised level of specialised services income of £2.0m in Month 9. £1.8m of this has been recognised YTD. • £4.5m has been transferred from Capital to revenue, £4.1m reported YTD. Securing all the additional transformation funds is now expected and being finalised with Commissioners.		
Expenditure (incl. Financial Charges)	In month expenditure is £1.5m adverse to plan, and year to date £0.6m adverse. The key drivers for this position are: • Frontline capacity support is reducing in line with plans across Quarter 4. Overtime rates, hours and incentives are reducing as fully operational recruits become available. However, resource remains available to support increased activity and is being targeted at FRU and week-end cover. • Partially offset by £3.9m of planned reserves released to support the position. The Trust's main cost pressures arise from additional frontline resourcing costs. There are 3 key drivers for the additional expenditure: • In Month Substantive Frontline WTEs increased due to ongoing recruitment. • Overtime spend remain high but have significantly reduced due to Increasing levels of new recruits becoming operational, reduced appetite to work overtime after busy Christmas period, rates reduced from double time to time and a half in line with plan. • Incentives remain in place for disruption and have been focused on FRU and weekend cover.		
CIPs	Year to date CIPs are £0.3m adverse to plan. The full year plan of £8.9m is still expected to be largely achieved as benefits expected in Month 12 are realised		
Balance Sheet	Capital expenditure totals £6.4m to the end of M11, with spend of £3.8m expected before the end of the year. The Trust CRL was amended to reflect the recent capital to revenue transfer of £4.5m. The revised CRL is now £10.2m.		
Cashflow	Cash is £17.6m this is £0.6m above plan. The Trust has received payment for some of the overdue transformation and other contract income. The year-end forecast is £18.6m which is £6.8m above plan this assumes that the CCGs pay all of the outstanding overdue debts for the SLAs and Transformation Income for periods Q1 to Q3 in March. The reason for the favourable variance is the unplanned £4.5m capital to revenue transfer and £2.4m system resilience funding.		

Executive Summary - Key Financial Metrics



	2015/16 - Month 11			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(776)	1,071	1,847	(7,260)	(5,533)	1,727	(9,025)
EFL				3,675	(5,424)	9,099	8,648
CRL				17,278	6,378	10,900	20,664
Suppliers paid within 30 days - NHS	95%	48%	(47.0%)	95%	70%	(25.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	78%	(17.0%)	95%	86%	(9.0%)	95%
Monitor							
EBITDA %	2.9%	8.8%	5.9%	3.1%	3.4%	0.3%	6.3%
EBITDA on plan	741	2,526	1,785	9,008	9,833	824	8,756
Net Surplus	(776)	1,071	1,847	(7,260)	(5,533)	1,727	(9,025)
NRAF (net return after financing)				(5.5%)	(4.1%)	1.4%	-6.90%
Liquidity Days				(2.11)	1.58	3.7	(10.86)
FSRR (Financial Sustainability Risk Rating)				2.0	2.0	0.0	2.0



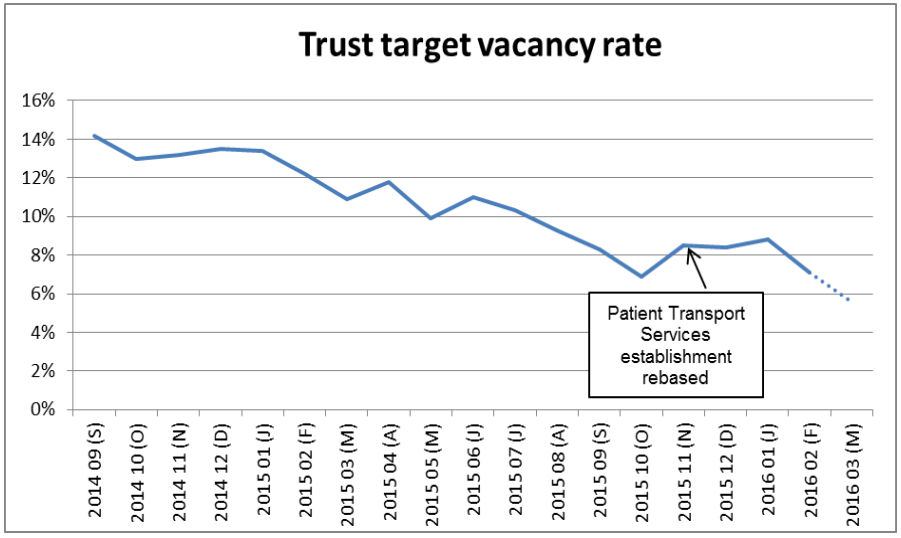
- In Month the position is £1.8m favourable to plan while year to date the Trust is reporting a £1.7m favourable variance from plan.
- On-going pressures are:
  - Additional spend in support of performance.
  - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
  - Identification and delivery of CIPs.
  - specialised services Income £4.3m will not be received in full. The Trust will now receive £2.0m
- Cash is £17.6m, £0.6m above plan. The Trust has received payment for some of the overdue transformation and other contract income.
- The EFL variance is due to higher than planned cash balances £0.6m, planned loan of £6.0m not being drawn down and capital to revenue transfer of £2.5m.
- Monitor has replaced the existing Continuity of Service Risk Rating (CSRR) with the Financial Sustainability Risk Rating (FSRR). FSRR includes two new measures I&E Margin and I&E Margin variance from plan. The Trust would expect to score a FSRR of 2 for the YTD results based on the current Monitor metrics (maximum rating).
- CRL position – The capital plan is £10.9m behind target, of which £4.4m is due to slippage, £2.5m is due to the capital to revenue transfer and £4.0m has been deferred due to the Trust not going ahead with the £6.0m capital investment loan this year. The TDA have approved an additional capital to revenue transfer of £2.0m in month 10. The TDA has amended the Trust's CRL to £10.2m.
- The Trust has revised its plan in line with NTDA guidance and committed to additional savings of £0.5m.

Our People

Section	Key Headlines From Each Section.	Feb	Jan	Dec
Vacancy	• Vacancy rate for the Trust as a whole is 7% for substantive staff • Vacancy Rate for front line now stands at 6.56% • We are confident, based on recruitment estimates and current turnover, that vacancy rates will continue to fall through March 2016			
Turnover	• Trust turnover has fallen from 12.4% to 12.2% this month (12 m rolling figure) • Trust turnover has fallen month on month for the past five months • The turnover figure for frontline paramedic staff continues to improve, down from 12.3% to 12.2%. This has been falling since June 2015			
Recruitment	• 267 new staff are planned to join our payroll during Q4 • 2,932 operational staff are working on the front line (93% of planned recruitment target) and 283 staff are in supervision and training • By the end of March we expect to have exceeded our planned recruitment levels			
Sickness	• Sickness levels have continued to reduce. The total trust sickness level is 5.2% having peaked at 6.6% in March 2015 • Annual sickness levels for operational sectors stand at 8.5% for North East and 5.0% for North West over the past 12 months, both down on last month			

Vacancy – Trust wide

	Target Inpost	Inpost	Target Vacancy	Vacancy %
1. Paramedic	1860.6	1650.81	209.79	11.28%
2. Apprentice Paramedics	86.32	126	-39.68	-45.97%
3. Frontline EAC / TEAC	772.79	746.25	26.54	3.43%
4. Frontline EMT & Support Tech	445.97	435.03	10.94	2.45%
Subtotal	**3165.68**	**2958.1**	**207.59**	**6.56%**
5. Non frontline Paramedics	281.02	237.69	43.33	15.42%
6. EOC staff on watches	371	386.19	-15.19	-4.09%
7. All other staff	1257.01	1134.58	122.43	9.74%
Total	**5074.71**	**4716.6**	**358.16**	**7.06%**
Total Paramedic	2141.62	1888.5	253.12	11.82%
Total Non FL Staff	1909.03	1758.46	150.57	7.89%



- The total vacancy rate has improved from 8.8% to 7%
- The vacancy rate for Paramedics has reduced from 14.36% to 11.28%
- The total number of paramedics in post has improved from 1,594 WTE to 1,650 WTE
- The February 'Super Saturday' recruitment events were a success with 48 conditional offers being made

**WTE - whole time equivalent

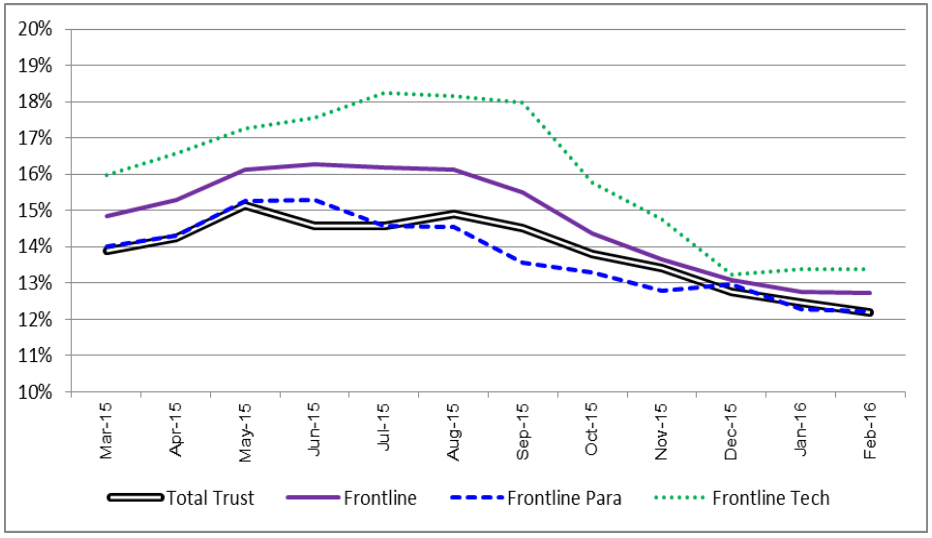
- The Patient Transport Services (PTS) establishment has been rebased in the General Ledger. 108 WTE of posts relating to PTS were added to the establishment in November and 32 more in January
- Staff in Post numbers will rise in February and March due to international recruitment for front line staff

**WTE - whole time equivalent

Turnover – Trust wide

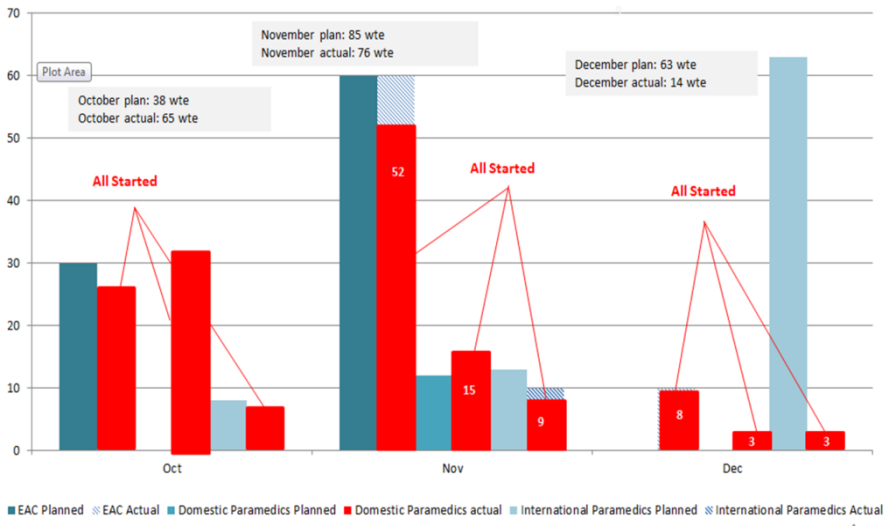
12 Month Rolling Turnover	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Frontline Paramedics	14.6%	14.5%	13.5%	13.3%	12.8%	13.0%	12.3%	**12.2%**
Apprentice Paramedics	11.4%	10.8%	10.2%	7.3%	8.1%	6.2%	5.4%	**3.1%**
Frontline Technicians	18.2%	18.1%	18.0%	15.8%	14.8%	13.2%	13.4%	**13.4%**
Non-Frontline Paramedics	4.8%	5.1%	5.0%	5.3%	5.0%	4.8%	5.3%	**4.9%**
PTS & Ambulance Persons	13.5%	21.2%	21.4%	21.3%	21.2%	19.0%	19.0%	**19.5%**
EOC Staff on Watches	19.7%	20.8%	21.3%	21.4%	22.2%	21.1%	20.0%	**17.3%**
All Other Staff	11.4%	11.8%	11.7%	11.6%	11.4%	10.9%	10.7%	**11.1%**
Trust Total	**14.6%**	**14.9%**	**14.5%**	**13.8%**	**13.4%**	**12.7%**	**12.4%**	**12.2%**
(All Frontline Staff)	16.2%	16.1%	15.5%	14.4%	13.7%	13.1%	12.8%	**12.7%**

- The turnover figure for frontline paramedics is 12.2%, down from 12.3% last month
- Trust total turnover fell this month from 12.4% to 12.2% (12 month rolling figure)
- Trust turnover has fallen month on month for the past five months
- As part of the QIP Programme we are refreshing the retention strategy

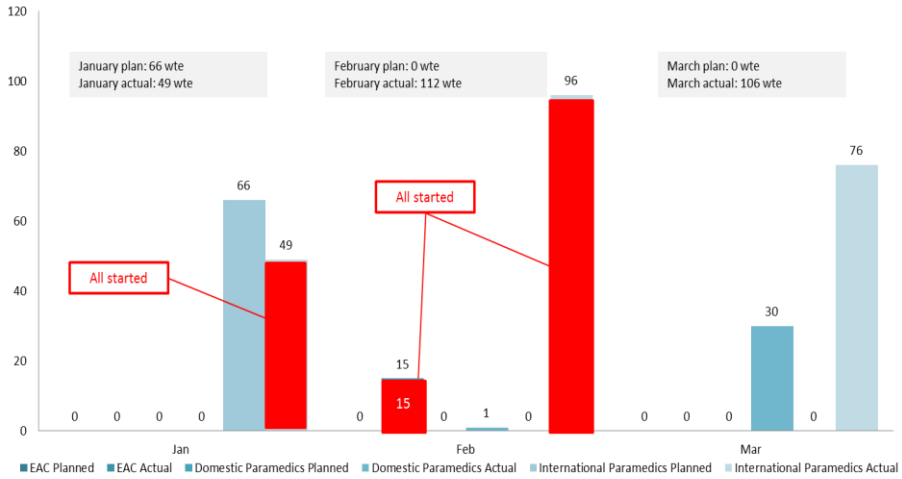


- The graph at left shows the 12 month rolling turnover since March 2015
- Frontline paramedic turnover has been falling since June 2015
- Total Trust turnover has been falling since August 2015

Recruitment

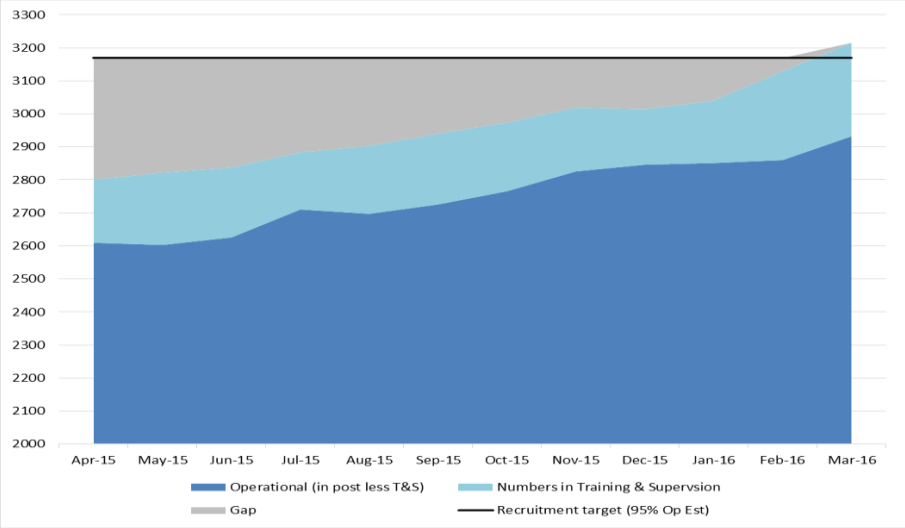


- The graph on the left shows the frontline recruitment plan from October to December. Figures are new staff starting at LAS in each month
- We had 155 starters against a plan of 186 for the quarter. This change is due to the difference between the original analysis of international paramedics and their actual start dates



- The graph on the left shows planned numbers of frontline staff joining London Ambulance Service during quarter 4
- 267 new staff are planned to join our payroll in Q4. The variance between actual and planned numbers is due to amendments in graduation dates for the international
- These cohorts of staff will undergo a period of training and supervision prior to becoming fully operational on the frontline
- There will be a fourth recruitment trip to Australia in April ’16
- A programme is in place to build partnerships with Universities to attract UK graduates into LAS roles

Operational In post - Trajectory

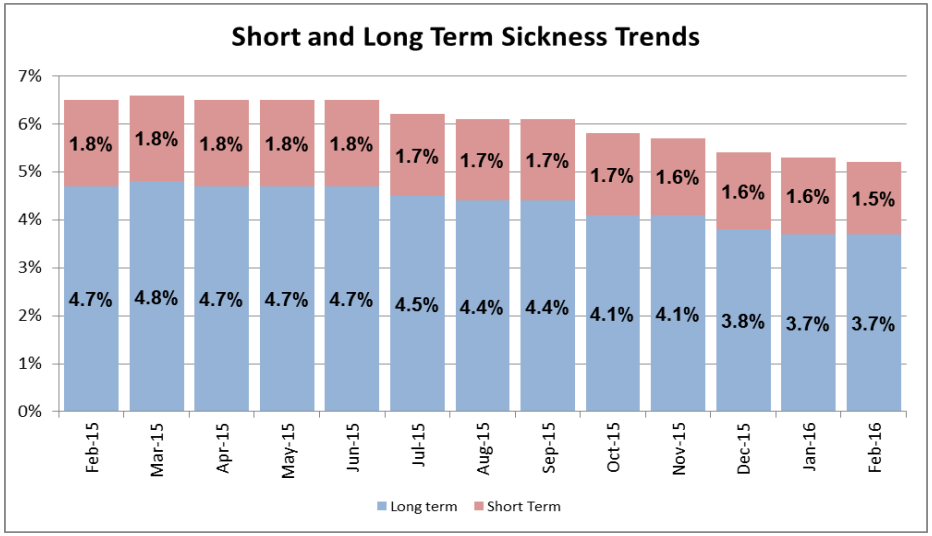


- This graph shows our operational staff in post position by month, including those in training and supervision

By the end of March we will have:

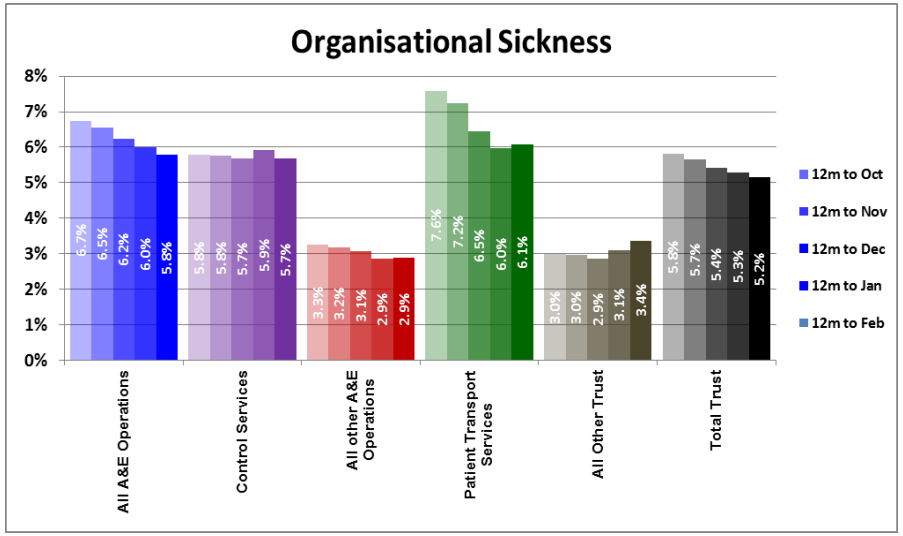
- 2,932 operational staff working on the front line (93% of planned recruitment target) and 283 staff in supervision and training
- By the end of March we expect to have exceeded our planned recruitment levels

Short and Long Term Sickness

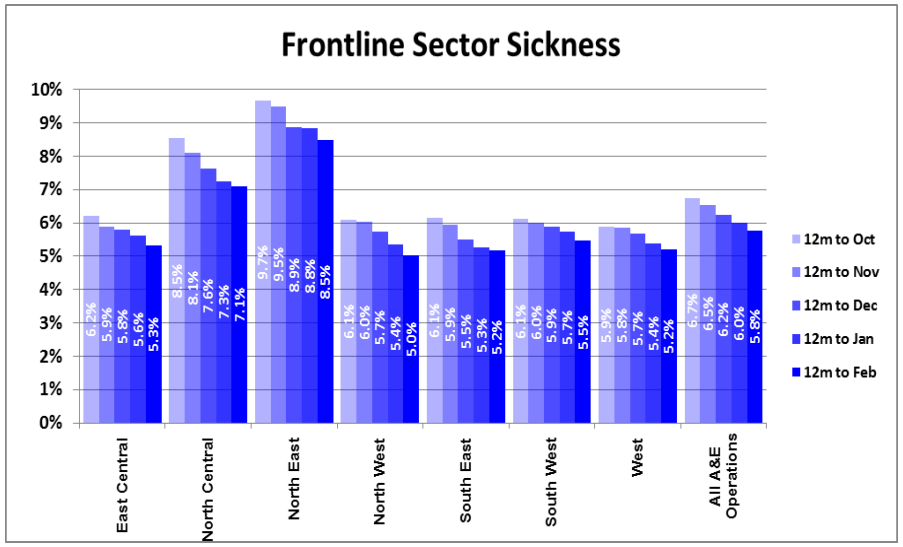


- The current trust 12 month sickness level is 5.2%, down from 5.3% last month (source: ESR)
- The Trust 12 month sickness level has reduced by 1.4% since its peak of 6.6% in March and the monthly trend has continued to reduce month on month
- Long term sickness shows a greater decline than short term
- The 'Supporting Your Health and Well-Being' objective under the Trust's retention strategy is under review as part of Theme 1: Making the London Ambulance Service (LAS) a great place to work

Operational and Business Area Sickness



- 12 month sickness figures for major business areas vary between 6.0% for Patient Transport Service (down from 8.2% in August) to 2.9% for A&E areas outside sectors and control
- Both Control Services and Corporate had small rises in the 12-month rolling sickness this month
- The Trust total sickness level fell from 5.3% to 5.2% (12 m rolling figure, source ESR)



- 12 month sickness for individual sectors varies between 8.5% for North East to 5.0% for North West
- The biggest fall in 12 month sickness rates was in North East Sector (with 0.4%)
- No operational sector has shown a rise in 12 months sickness rates at any time since September

Update: CQC Action Plans and Bullying & Harassment Workshops

Local managers meet to map out CQC action plans

Managers and team leaders from across the Service attended a series of briefings in February to help develop the response to last year's CQC inspection and report.

A full quality improvement plan was submitted and published in January 2016- with a key part of its delivery ensuring its relevance to and engagement of all staff groups.

Around 100 people from corporate and support departments attended the first events, followed by South East sector managers in the afternoon.

Further sessions for EOC and other operational areas were held to give groups the chance to start developing their own action plans to take back to their local teams.

Bullying and Harassment awareness workshops reach 180 staff

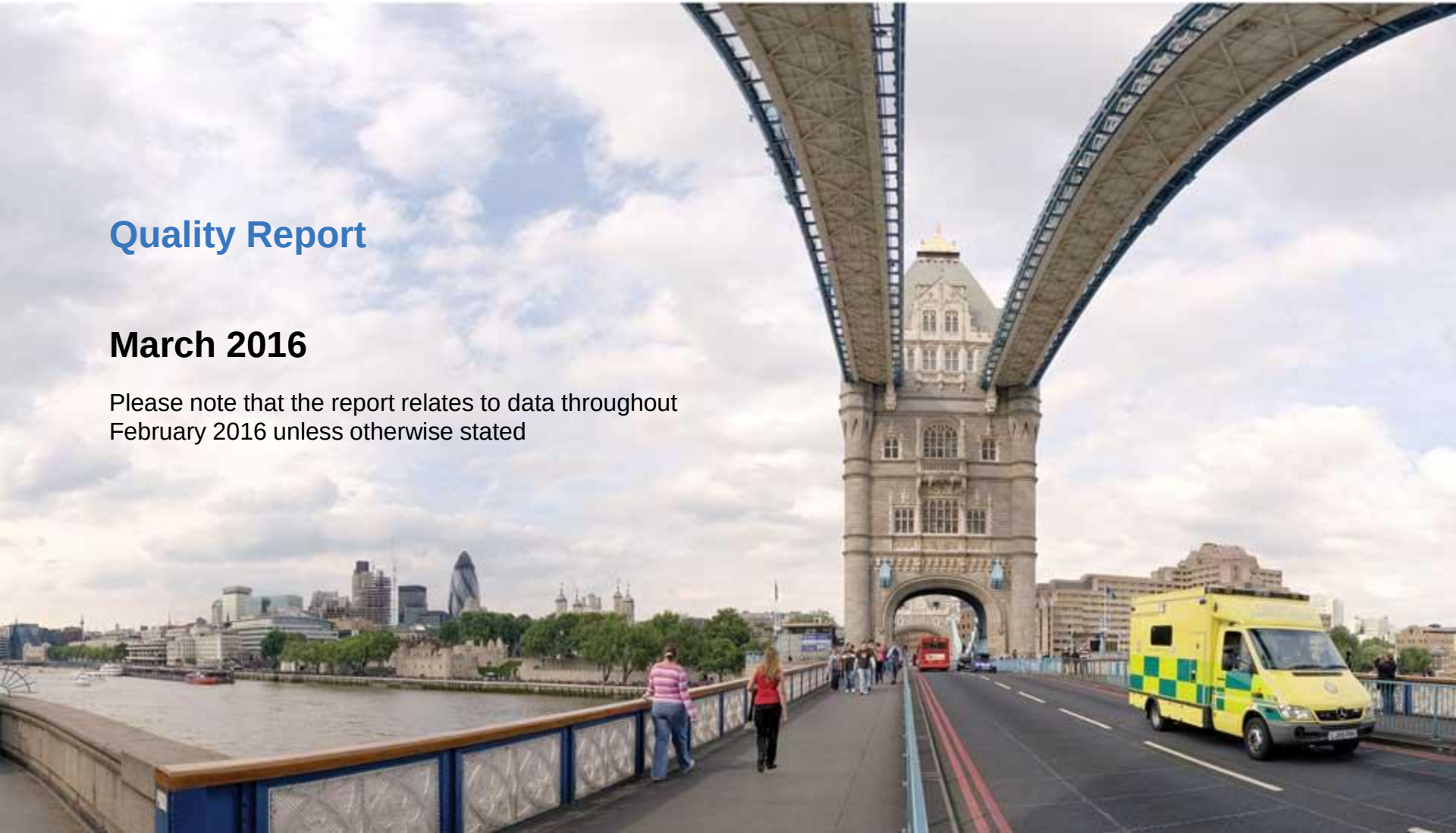
Since December 2015, bullying and harassment awareness workshops have been rolled out across the organisation, to discuss the CQC's findings concerning the "bullying culture" and to hear staff views about what the solutions are to make the Service a great place to work, as well as sharing the on-going work being undertaken to reduce bullying incidents.

London Ambulance Service
NHS Trust

Quality Report

March 2016

Please note that the report relates to data throughout February 2016 unless otherwise stated



Our Patients

Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	RAG
SAFETY	• A reduction in overall staff related adverse incidents. • CSR 2015.3 attendance is at 47%, a reduction on expected numbers. This is due to non attendance of staff (i.e. double booked on courses, unwilling to travel to other training facilities) and cancelled courses due to insufficient attendance numbers. • Adrenaline 1:1000 samples labels procured for evaluation to reduce medication administration errors. • One Preventing Future Death report received by the LAS for response			
EFFECTIVE	• Compliance on delivery of complete pain care bundle for STEMI patients has increased by 4% in January 2016 compared to December's data.			
CARING	• CPI completion rates is at 88%, the highest amount recorded in the last two years. • Hillingdon have had the highest CPI feedback and completion rates for the last two and six months consecutively.			
RESPONSIVE	• There were 13 periods of Surge Purple Enhanced during February, due to unexpected spikes in incoming call demand.			
WELL LED	• Work continues to progress on the QIP to address the CQC recommendations. • 6 Executive visits to their individual sectors have taken place Feb-March 2016	**N / A**	**N / A**	

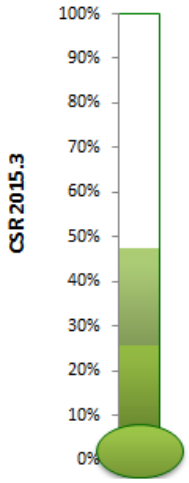
SAFETY

Sub-Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	RAG
Training & CSR	• CSR 2015.3 had 47% attendance as of the end of February. This can be attributed to:- • Students double booking onto courses via the ebooking system • Students on long term sick and courses not cancelled • Courses were cancelled across all centres due to low booking numbers (minimum 6 per course) • Students not willing to travel to other training centres further afield.			
Adverse Incidents	• A reduction in reported staff incidents from last month, however an increase of 4% of patient related incidents recorded mainly due to equipment failures			
Medicines Management	• Sample warning labels for Adrenaline 1:1000 received for trial to minimise medication errors • Audit of drug usage forms completed in February and some compliance issues identified . This has been escalated to QGAM's and GSM's to manage locally to ensure compliance, along with promotional materials to explain procedure.			
Safeguarding	• Safeguarding training completion is at 93% which is over the agreed target of 90% and exceeded the national target of 85%. • Bank staff training has been escalated to ELT as a concern			

SAFETY

Sub-Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	RAG
Serious Incidents	• 5 SI's declared out of 42 incidents reviewed. • 24 SI's remain open, an increase of 5 on the previous month. • 10 are overdue which is an increase of 4 on the previous month. All overdue SI's have been escalated to ELT for progression, with some waiting for additional information being provided by external agencies due to the complexity of the cases. • 2 SI's have been closed, down from 9 closed in January.			
Total Complaints	• 96 complaints received in February, an increase on the previous three months. Causes are predominately relating to delay and non conveyance. • Awaiting QA reports is a key issue in the delay in performance throughput of complaints. The complaints team are working with the QA team to prioritise this workload.			
NHS CAS Alerts	• 2 Estates Field alerts and 2 medical device alerts were received with no action required by the LAS. • 1 general notice received relating to Estates and Facilities which has been passed to the Estates Department to action.			
Prevention of Future Deaths and Legal Claims	• The LAS received one Regulation 28 Prevention for Future Deaths Report following an inquest. • A response is due by 18th April 2016			

Training and CSRs



Core Skill Refresher (CSR)

CSR 2015.3 is in its third month of delivery, with **1751 (47%)** students having completed as of 29th February 2016. All clinical staff are required to attend this training, therefore this figure is based on 100% attendance by all staff by the end of the CSR 2015.3 programme.

This is well under the expected rate of completion for this CSR, and a concerning trend. The main reasons for this are:-

- Reduction in courses delivered during December to support operational cover
- High levels of non-attendance (32 Staff in February) at courses due to some locations over subscribed and other under subscribed with bookings. This is challenging as some students are reluctant to travel to training centres further afield.
- Double bookings on multiple course dates via ebooking system leading to spaces being unavailable by other students
- Cancelled courses due to insufficient booking numbers (requirement of at least 6 students per course) – 8 courses cancelled in February, as opposed to 1 course in January.

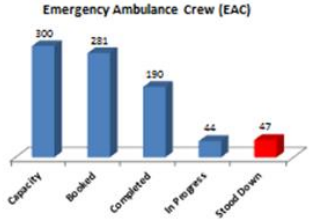
It may be difficult to offer the amount of catch-up sessions required as the training calendar and resource allocation for next year is near full with recruitment, EAC Conversion and CSR 2016.

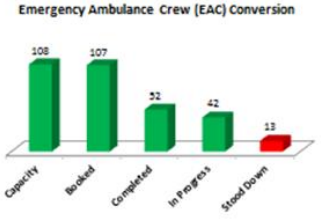
All staff who do not attend are reported to Resource Centres for follow up with Group Station Management.

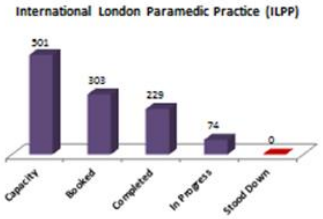
New Entrant Course Numbers

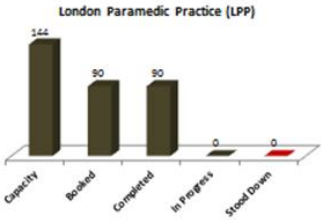
Year to date for New Entrant Courses (February 2016) show large numbers of students across all courses. The clinical bridging programmes for International Paramedics and London Paramedics have resulted in high levels of success with 319 students successfully completed and 74 in progress. A large number of those have only commenced in Q4.

The EAC course and EAC Conversion courses are well subscribed, but present some challenges with some staff failing to progress / failed the course (identified as “Stood down” on the graph). In most cases this is due to failure to meet assessment criteria and work is being done to review the entry standards.

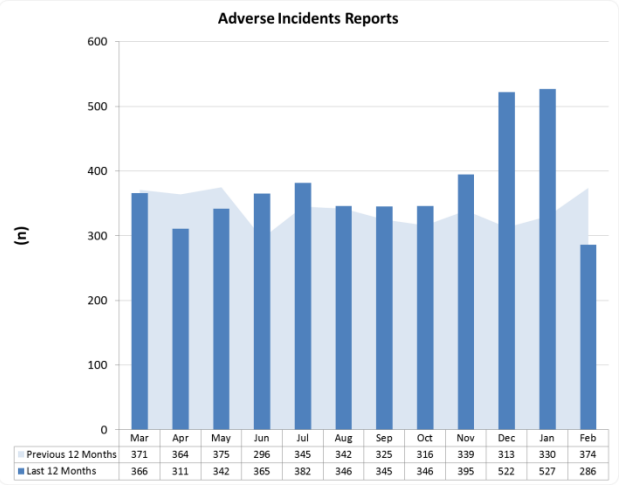




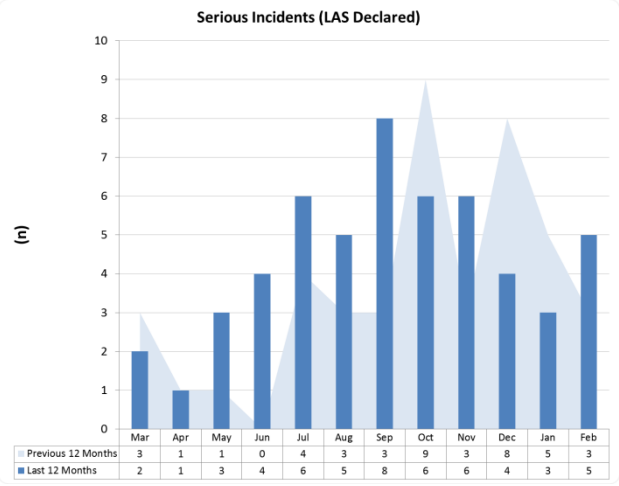




Serious & Adverse Incidents (SI)



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	371	364	375	296	345	342	325	316	339	313	330	374
Last 12 Months	366	311	342	365	382	346	345	346	395	522	527	286



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	3	1	1	0	4	3	3	9	3	8	5	3
Last 12 Months	2	1	3	4	6	5	8	6	6	4	3	5

We estimate that 60.7% of incidents that took place in February 2016 have been received and entered onto the database, so data below is a forecast based on this estimate.

Staff Incidents: 238 (previous: 287, ↓ -17.1%)

- Manual Handling incidents: 38 (previous: 861, ↓ -37.7%)
- Assault and Abuse: 53 (previous: 87, ↓ -39.1%)
- Sharp Object (incl. needlesticks): 21 (previous: 14, ↑ +50%)

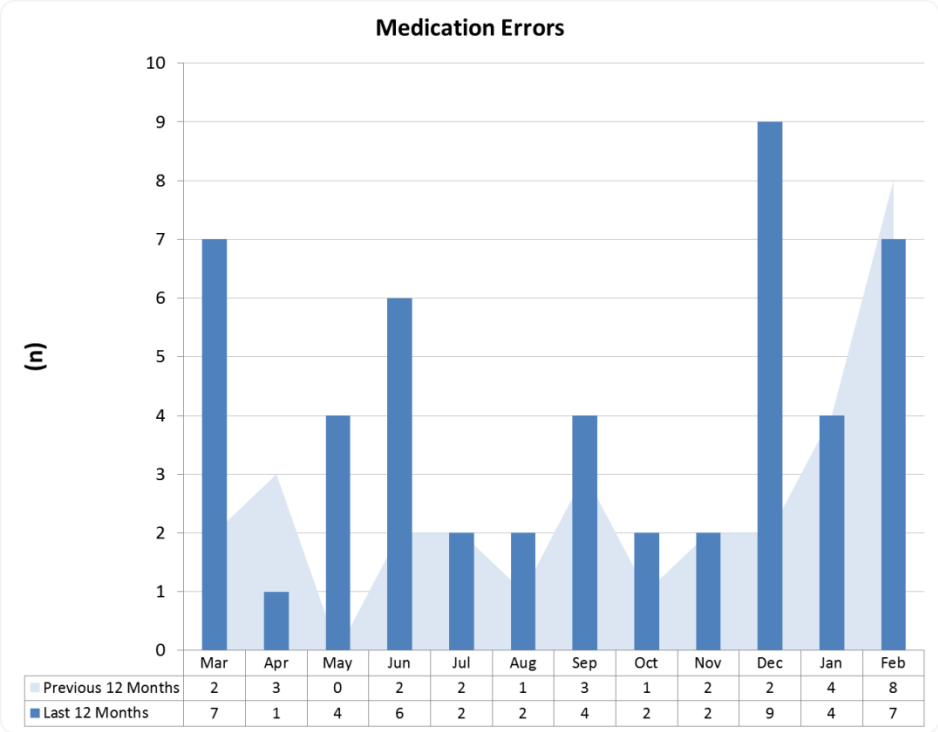
Patient Incidents: 267 (previous: 256, ↑ +4.3%)

- Failure of equipment: 67 (previous: 58, ↑ +15.5%)
- Missing Equipment: 31 (previous: 41, ↓ -22.5%)
- Issues with resource dispatch: 23 (previous: 36, ↓ -36.1%)

Serious Incidents – February 2016 data

- 5 SIs declared having reviewed 43 incidents.
- As at the end of January, 24 SI's remain open , an increase of 5 on the previous month.
- 10 are overdue, with 14 within timescale. All overdue SI's have been escalated internally to Executive Leads to ensure progression towards completion. Some incidents are awaiting further information from external agencies due to complexity of the investigations.
- 2 SI's have been closed , down from 9 in January.
- 4 completed SI reports are awaiting final sign off.

Medicines Management



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	2	3	0	2	2	1	3	1	2	2	4	8
Last 12 Months	7	1	4	6	2	2	4	2	2	9	4	7

It has been reported that the logistics department currently re-seal plastic drug containers where the manufacturers seal is broken. The chair of the medicines management group has contacted the logistics management team to advise that this practice must cease with immediate effect and that any affected drugs (currently amiodarone and glucagon) must be removed from circulation and disposed of in the event that a defective seal is identified.

Sample warning labels have been procured for adrenaline 1:1000 ampules. This label will have 'IM use only' printed on it and will be secured to the ampoule to reduce risk of incorrect route administration.

The Metropolitan Police Service (MPS) Controlled Drugs Liaison team undertook an 'out of area' inspection of the provisions for the storage and management of controlled drugs for the duration of exercise unified response. The MPS team identified that great care had been taken to ensure compliance with the CD legislation for the duration of the exercise and commended the responsible manager for his efforts.

A recent audit conducted between 15/2/16 and 22/2/16 at LAS logistics identified that a mean of 42% of LAS drug usage forms (LA290) contained within sealed drugs packs were fully completed to indicate the drugs used. In order to address this an email has been sent to Trust CTLs, QGAMs and GSMs providing further promotional materials and requesting that staff are reminded of the need to complete these forms on every occasion that drugs are administered from a sealed pack.

A new Medicines Safety Officer Ambulance group is to be established which will be attended by the Trust Medicines Safety Officer (David Whitmore).

An application has been submitted for a Darzi Fellow Pharmacist to specifically develop the LAS medicines management strategy.

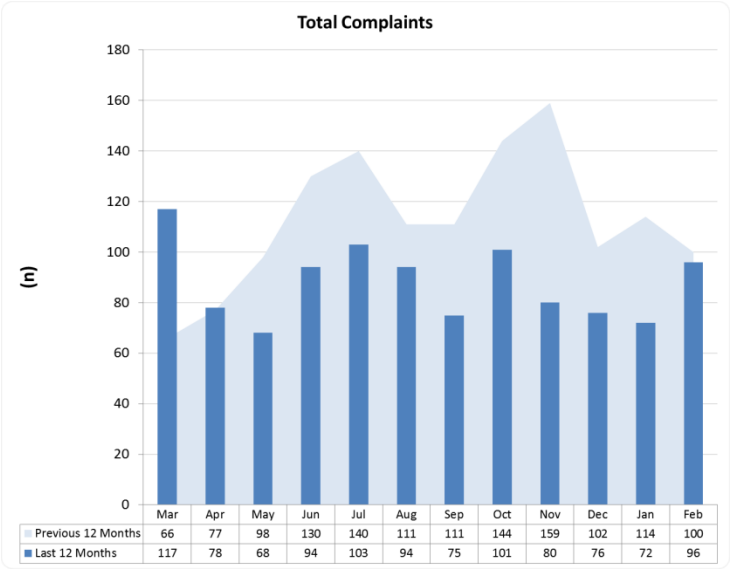
Safeguarding

Safeguarding Training figures

Training required	owner reporting	Total Staff	Frequency of training	2014	Target to be trained 2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total trained 2015/16	% of target 2015/16	3 year cummulative -% of total staff trained
Level One																				
Induction	HR-	various	on joining		various	28	10	14	9	0	14	19	19	17	53			183		
E Learning	Raja Habib	1389	3 yearly	672	356	69	220	67	35	18	40	60	34	22	32			597	168%	91%
Level Two																				
New Recruits	Ed Dev	Various	on joining		various	Nil	53	88	31	39	124	13	16	47	27			438		
Core Skills Refresher	Ed Dev	3019	annually		3019	N/A	N/A	N/A	N/A	310	596	785	936	N/A	178	N/A	N/A	2805	93%	
EOC Core Skills Refresher	Jules Lockett	443	annually		443	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0%	
EOC new staff	Jules Lockett	Various	on joining		various	34	10	9	27	4	12	17	0	14	7			134		
PTS/NET	Jason Challen	114	annually		114	Nil	N/A	20	N/A	25	29	0	0	0	0			74	65%	
Bank staff	Gareth Hughes	390	annually	58	390		N/A	N/A	N/A	6	8	43	66	0				123	32%	46%
111	Jane Burke	152	annually	101	51	9	15	3	0	1	2	16	9	5				60	118%	106%
Community first Responders (St John)	Chris Hartley-Sharp	140	3 yearly	135	50	Nil	12	13	10	13	12	12	14	15	N/A			101	202%	169%
Emergency responders	Chris Hartley-Sharp	150	3 yearly		100	Nil	Nil	Nil	Nil	Nil	29	11	Nil	69				109	109%	
Level Three																				
EBS	Alan Hay	30	3 yearly		25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13	14	N/A	27	108%	
111	jane Burke	11	3 yearly	11	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0		100%
Local leads	Alan Taylor	various	3 yearly		various	6	5	N/A	N/A	N/A	7	N/A	12	0				30		
Specific training																				
Prevent- clinical staff	Ed Dev	3019	one off		3019	N/A	N/A	N/A	N/A	310	596	785	936	0	178			2805	93%	
Prevent- Non clinical	Alan Palmer	1389	one off		0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			0	0%	
Trust Board	Alan Taylor	17	3 yearly		17	N/A	N/A	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A			12	71%	
HR/ Ops managers	Alan Taylor	Various			various	29	N/A	N/A	N/A	N/A	7	N/A	N/A	N/A	N/A			36		
Private providers	Jon Goldie	450	3 yearly	226	112	23	13	6	11	3	13	7	7	0	9			92	82%	71%
Other safeguarding	Various	various	as required			104	N/A	N/A	N/A	N/A	N/A	N/A	12	0				116		
Nil = no figures provided N/A= no course planned this month																		7742	total	

- Safeguarding training for clinical staff is 93% which is above national target of 85% and contracted target of 90%.
- EOC staff training refreshers planned for May-Nov 16.
- PTS training planned for completion by end of Q1 2016.
- Developing Prevent e-learning for non-clinical staff to be introduced in 2016
- Trust board training being arranged for Q1 2016.
- Issues with bank staff compliance currently being addressed via ELT.

Complaints – Volume & Response time



96 complaints were received in February which is an increase over the previous three months - 72 complaints in January, 76 in December and 80 in November.

The increase in complaints for February is unusual compared to historical data. The themes relate to delays and non-conveyance and may reflect the unprecedented demand seen from January 2016. This trend is being closely monitored.

It has been acknowledged regarding the increasing numbers and will reviewed over the next couple of months.

2015/16	Total complaints	Number of closed complaints by month	Totals closed within 35 working days	Percentage of complaints closed within 35 working days
July	104	122	51	50%
August	94	130	37	39%
September	75	118	35	47%
October	101	114	36	36%
November	80	80	31	40%
December	76	93	34	45%
January	72	78	25	35%
February	96	74	14	40%**
Totals:	**698**	**809**	**263**	**292%**
35 day response **				**37%**

** A true reflection of the 35 day response target will not be met until 26 March 2016 and have thus used a predicted figure of 40% based on current staff numbers and demand

Month	Complaint numbers	Acknowledged in 3 working days	Outside target
Apr-15	78	73 (94%)	5 (6%)
May-15	68	68 (100%)	0%
Jun-15	94	93 (99%)	1 (1%)
Jul-15	104	102 (99%)	1 (1%)
Aug-15	94	93 (99%)	1 (1%)
Sep-15	75	74 (99%)	1 (1%)
Oct-15	101	101 (100%)	0%
Nov-15	80	78 (98%)	2 (1%)
Dec-15	76	76 (100%)	0%
Jan-16	72	72 (100%)	0%
Feb-16	96	96 (100%)	0%
Totals	**938**	**926**	**99%**

Complaints – Volume & Response time

Comparison of complaints received against calls attended by month

February 2015 to February 2016

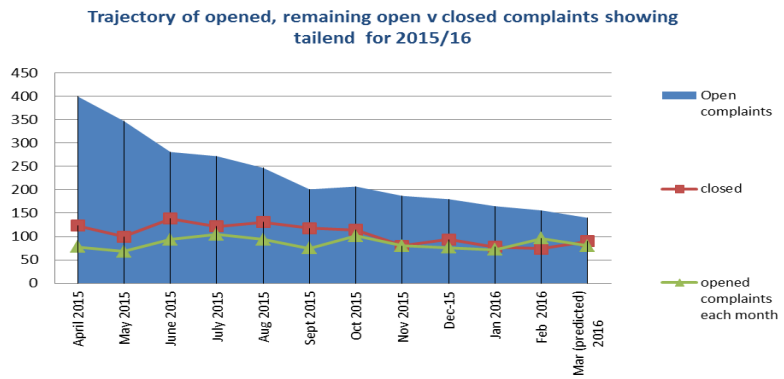
Month	Calls attended	Complaints received	Percentage of complaints against calls attended (rounded)
Feb-15	76560	100	0.13
Mar-15	85203	117	0.13
Apr-15	81523	78	0.10
May-15	84230	68	0.08
Jun-15	82847	94	0.11
Jul-15	86074	103	0.12
Aug-15	84876	94	0.11
Sep-15	82964	75	0.09
Oct-15	88283	101	0.11
Nov-15	88106	80	0.09
Dec-15	92248	76	0.08
Jan-16	91193	72	0.08
Feb-16	85605	96	0.11
Totals	**1109712**	**1154**	**134.00%**
		Average	0.11%

Based on current complaint numbers, performance and closure rates by the end of August 2016, all complaints will be managed within the 35 day target. The current shortage of staff has been taken into account provided complaint numbers do not increase exponentially, then we should maintain this target.

There is a risk that the implementation of the recommendations within the Quality Improvement Plan (QIP) to improve accessibility to our stakeholders in relation to making a complaint that complaint numbers could increase. This could impact on our trajectories but will be under close review.

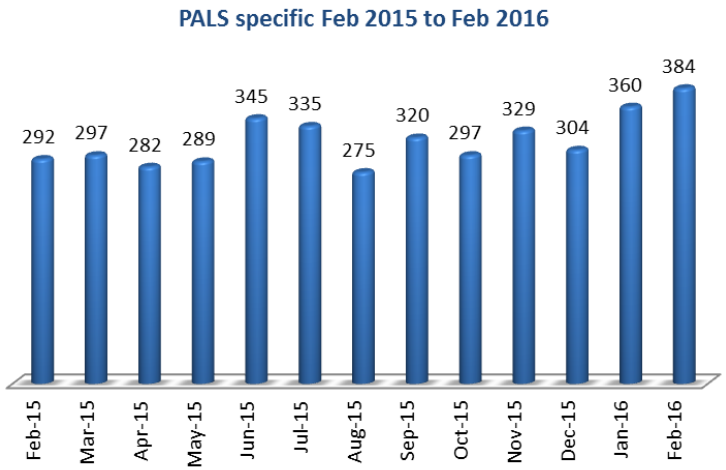
Awaiting QA reports continues to remain the predominant cause of delays in performance throughput (currently 41/179 = 23% awaiting QA analysis). The team dynamically assess individual complaints to deem whether a QA report is essential and the backlog of QA's has reduced significantly in recent months.

The following graph shows 'open' complaints , versus 'closed' cases 2015/16 showing tail end detail



Complaints about delay have remained steady although complaints across all subject areas are lower than 2015/16 but have risen slightly during this month. REAP 4 has been in place for the whole of 2015/16 with Surge levels mainly at red or purple.

PALS



Subject – February 2016	Number of enquiries
Information/Enquiries	242
Lost Property	62
Other	46
Medical Records (patient request)	23
Appreciation	11
Totals:	**384**

PALS specific enquiries February 2016 = **384**

- Average monthly PALS for 2013/14 = 287.
- Average monthly for 2014/15 = 298.
- Current average for 2015/16 = 320

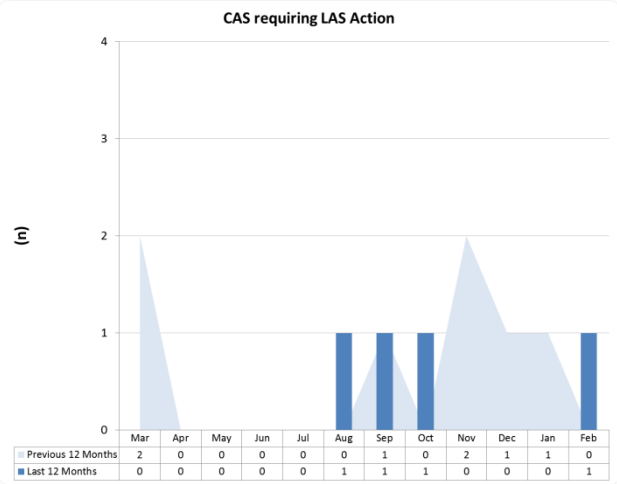
At the time of writing there are 80 x PALS cases remaining open; this includes 18 requests for medical records awaiting consent from the patient, 52 cases awaiting QA reports/further supporting information and 10 cases under liaison with the Consultant Midwife.

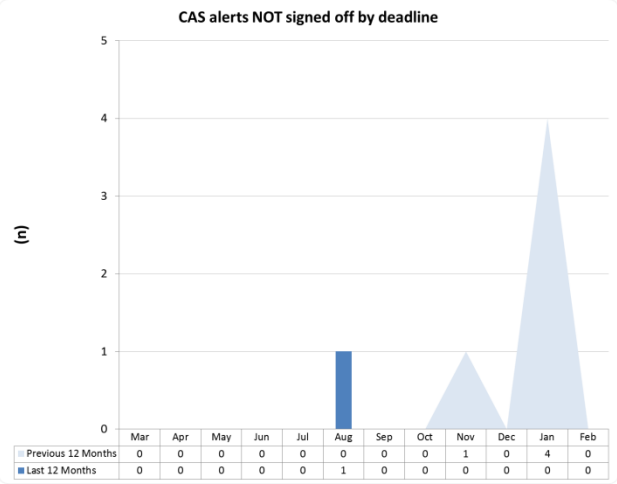
Consistent themes remain;

- patient destination,
- signposting to other departments,
- policy and procedure requests
- families seeking clarification of events.

A number of PALS enquiries have a higher level of complexity, for example 18 cases in February 2016 required a written organisational response or written local resolution.

NHS CAS Alerts & Preventing Future Death (PFD) Notifications





During February 2016:

2 estates fields notices were received for high voltage hazard alerts for electrical incidents. None were relevant

2 alerts were received relating to devices not used by the Trust. One general notice was received regarding reporting Estates and Facilities issues. This was passed to the Estates Department.

All notifications were acknowledged and no action was required to be taken by the Trust.

The Safety and Risk department continues to respond appropriately on behalf of the Service for modifiable alerts within the notification window.

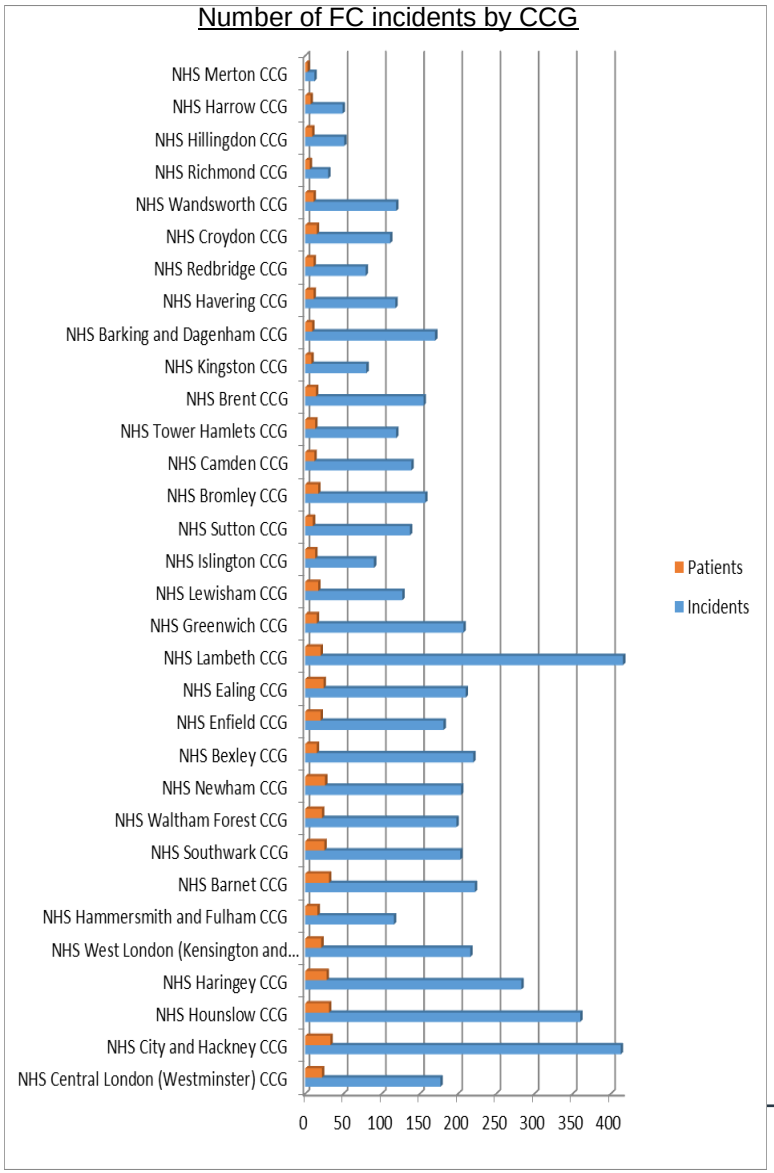
Preventing Future Deaths Reports:

- The LAS received one Regulation 28 Prevention for Future Deaths Report following an inquest.
- The statuatory timscale of 56 days to reply expires on 18th April 2016 which the LAS will share with the Medical Director of 111, Association of Ambulance Chief Executives (AACE) and the National Ambulance Service Medical Directors Group (NASMed).

EFFECTIVENESS

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
Frequent Callers	The enhanced FC reporting tool is live and is being distributed internally to support local management of these cases. This allows Frequent Caller cases by individual CCG.			
STEMI Performance	STEMI complete pain care bundle administration to patients has increase by 4% to 72% in January 2016.	N/A	N/A	
ROSC at Hospital	LAS Cardiac Arrest report shows 29% patients had sustained ROSC to hospital in January 2016, an increase of 1% on last month (December 2015).	N/A	N/A	
Survival to Discharge	Currently the national database contains incomplete survival to discharge data.	N/A	N/A	
CARU Reports	Cardiac Care and Stroke Care packs published since last months report			
Other				

Frequent Callers

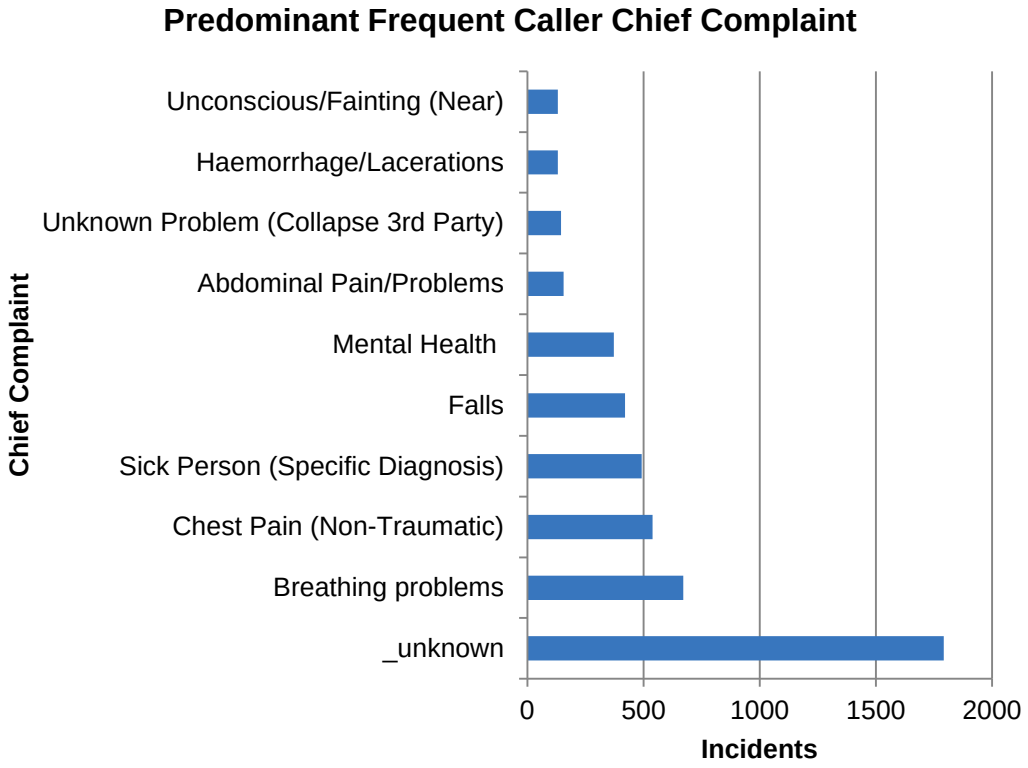


The number of frequent caller incidents continue to increase, however the number of identified frequent caller cases has declined.

- No cases were closed in February due to the absence of the PCAT Frequent Caller lead through prolonged illness.
- 10 care plans were submitted to the frequent caller database by the Darzi Fellow who has increased Frequent Caller management activity.
- The enhanced FC reporting tool is live and is being distributed for local usage.
- The graph demonstrates the number of patients per CCG in orange and the number of incidents they generated in blue. CCG's are ranked by calculating the number of frequent callers relative to their population i.e. NHS Merton is the best performing.
- CQUIN Q4 report containing recommendations has been drafted and is awaiting review.

		10 or more calls	15%	FC plans	MH issues	Open/actual cases	Closed during month	**5 or more calls**	15%	**12 or more calls over 3 months**
2015	Jul	192	29	60	30	86	3	1217	183	756
2015	Aug	194	29	71	29	92	25	1150	172	806
2015	Sep	191	29	65	27	77	19	1251	188	841
2015	Oct	194	29	43	15	66	3	1164	175	796
2015	Nov	159	24	34	13	60	36	1009	151	740
2015	Dec	184	28	39	13	72	22	1071	160	742
2016	Jan	196	29	60	33	86	6	1133	170	751
2016	Feb	176	26	52	26	90	0	1074	161	797

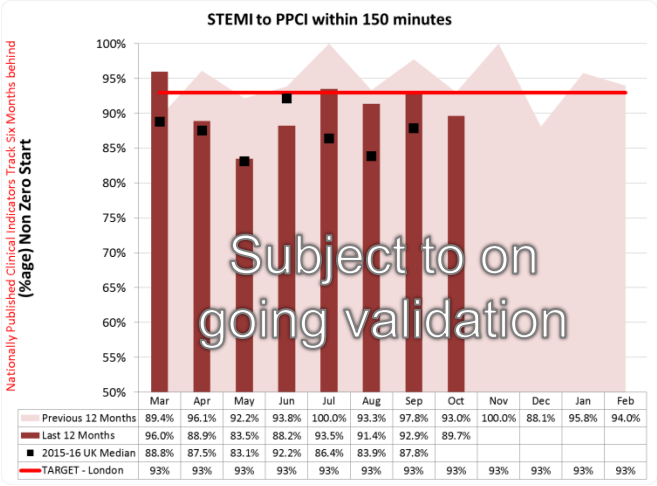
Frequent Callers



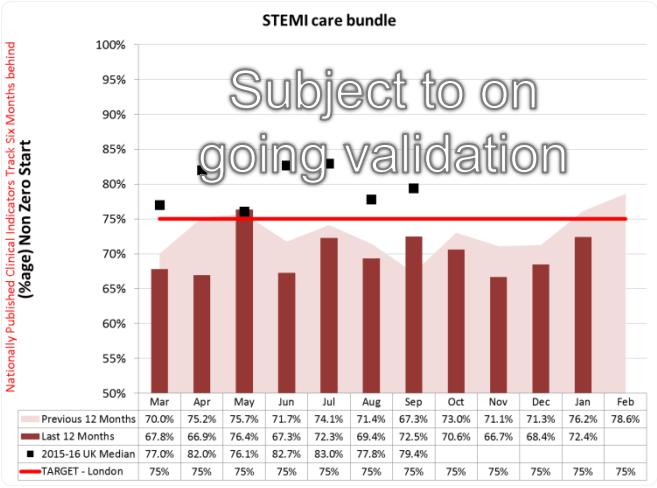
Row Labels	HRGcost	Cumulative Resource time (mins)
NHS City and Hackney CCG	£32,115.42	18127
NHS Hounslow CCG	£26,604.92	13440
NHS Greenwich CCG	£25,382.52	14374
NHS Haringey CCG	£21,419.70	10628
NHS Lambeth CCG	£21,388.02	9340
NHS Bexley CCG	£19,713.34	10881
NHS Barking and Dagenham CCG	£19,620.84	8472
NHS Barnet CCG	£19,501.66	11090
NHS Southwark CCG	£18,238.44	9068
NHS Newham CCG	£17,824.60	8909
NHS Waltham Forest CCG	£17,514.72	9108
NHS Bromley CCG	£16,936.72	10110
NHS Sutton CCG	£15,733.54	7947
NHS Central London (Westminster) CCG	£15,672.80	8148
NHS Ealing CCG	£15,518.82	8590
NHS Hammersmith and Fulham CCG	£15,393.26	7117
NHS West London CCG	£13,804.32	6955
NHS Havering CCG	£13,412.34	6865
NHS Croydon CCG	£11,802.14	5507
NHS Brent CCG	£11,439.42	5460
NHS Enfield CCG	£11,219.48	6019
NHS Lewisham CCG	£9,107.24	4309
NHS Camden CCG	£8,431.50	4456
NHS Wandsworth CCG	£7,969.86	3674
NHS Islington CCG	£7,605.06	3280
NHS Kingston CCG	£7,343.02	3446
NHS Redbridge CCG	£7,308.94	4246
NHS Tower Hamlets CCG	£7,143.34	2990
NHS Hillingdon CCG	£6,715.86	3794
NHS Harrow CCG	£6,314.68	2694
NHS Richmond CCG	£4,002.78	1966
NHS Merton CCG	£1,389.14	568
Grand Total	**£453,588.44**	**231578**

- The table to the right indicates cumulative HRG cost and resource time for frequent user activity throughout February.
- The table above demonstrates the top ten chief complaints presented by the frequent caller cohort. A total of 30 chief complaints were used throughout February.

STEMI



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	89.4%	96.1%	92.2%	93.8%	100.0%	93.3%	97.8%	93.0%	100.0%	88.1%	95.8%	94.0%
Last 12 Months	96.0%	88.9%	83.5%	88.2%	93.5%	91.4%	92.9%	89.7%				
2015-16 UK Median	88.8%	87.5%	83.1%	92.2%	86.4%	83.9%	87.8%					
TARGET - London	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	70.0%	75.2%	75.7%	71.7%	74.1%	71.4%	67.3%	73.0%	71.1%	71.3%	76.2%	78.6%
Last 12 Months	67.8%	66.9%	76.4%	67.3%	72.3%	69.4%	72.5%	70.6%	66.7%	68.4%	72.4%	
2015-16 UK Median	77.0%	82.0%	76.1%	82.7%	83.0%	77.8%	79.4%					
TARGET - London	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

STEMI to PPCI within 150 minutes (data from AQI's):

Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

October 's data (the most recent national data available) shows a decrease in performance to the STEMI to PPCI within 150 minutes AQI, from 93% in September to 90%. Please note that the data for this indicator is dependent on the reliability of the data entered by the Heart Attack Centres into a national registry and the LAS cannot amend this data directly. Currently one out of the eight hospitals does not provide data to the national registry that the LAS can view and this will affect the accuracy of the data. The y.t.d performance of 89% is lower than previous years and this may be a result of the absence of data from this hospital. CARU continue to liaise with the hospitals to ensure data is supplied to the national registry accurately.

The data reported is valid on the day the AQI is submitted but may change as additional data is added from hospitals and resubmissions are made to NHS England.

STEMI Care bundle (provisional data from LAS STEMI registry):

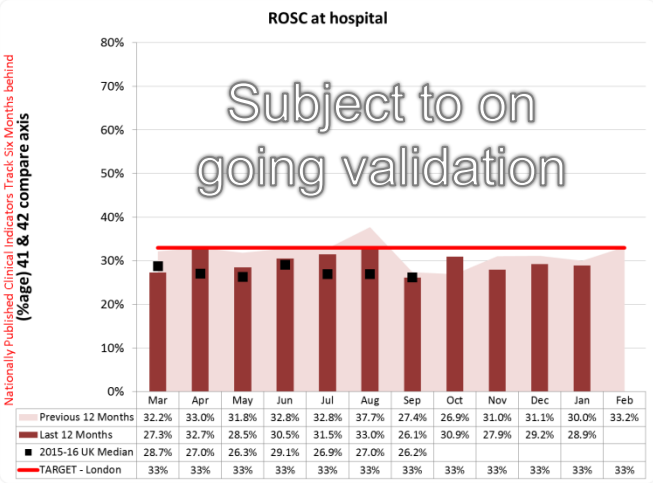
Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) has increased by 4% to 72% from December 2015 to January 2016. Greenwich was the only station group to supply a full care bundle (or documented exceptions) to all patients attended.

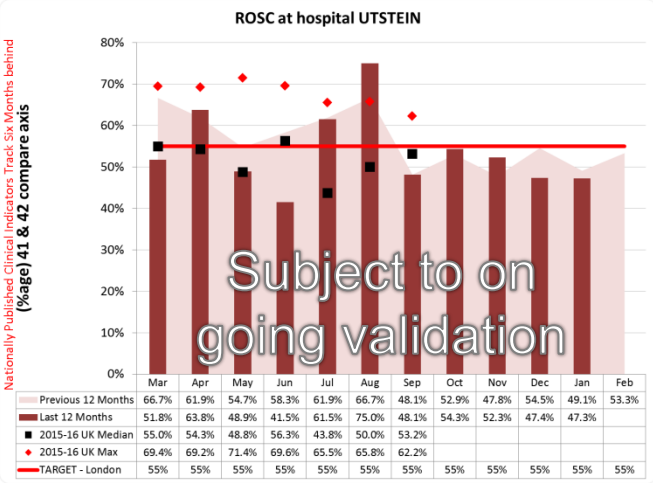
The y.t.d performance is 70% is lower than the previous year and reflects a downward trend over the last two years. Analgesia delivery remains the element of the care bundle that continually performs the lowest.

Monthly data should be viewed with caution as there will be variation due to the small numbers of cases involved.

ROSC



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	32.2%	33.0%	31.8%	32.8%	32.8%	37.7%	27.4%	26.9%	31.0%	31.1%	30.0%	33.2%
Last 12 Months	27.3%	32.7%	28.5%	30.5%	31.5%	33.0%	26.1%	30.9%	27.9%	29.2%	28.9%	
2015-16 UK Median	28.7%	27.0%	26.3%	29.1%	26.9%	27.0%	26.2%					
TARGET - London	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	66.7%	61.9%	54.7%	58.3%	61.9%	66.7%	48.1%	52.9%	47.8%	54.5%	49.1%	53.3%
Last 12 Months	51.8%	63.8%	48.9%	41.5%	61.5%	75.0%	48.1%	54.3%	52.3%	47.4%	47.3%	
2015-16 UK Median	55.0%	54.3%	48.8%	56.3%	43.8%	50.0%	53.2%					
2015-16 UK Max	69.4%	69.2%	71.4%	69.6%	65.5%	65.8%	62.2%					
TARGET - London	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%

ROSC at hospital (provisional data from LAS Cardiac Arrest registry):

Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

- **The percentage of patients who achieved ROSC sustained to hospital remained stable at 29% in January 2016.**
- The y.t.d figure of 30% is slightly lower than the previous year by 1%.

Monthly data should be viewed with caution as there will be variation due to the small numbers of cases involved.

ROSC at hospital for Utstein sub-group (provisional data from LAS Cardiac Arrest registry):

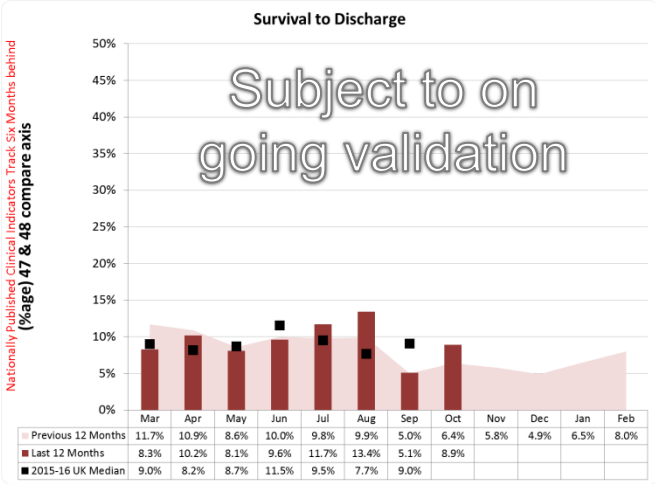
Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

- **The percentage of patients who achieved ROSC sustained to hospital remained stable at 47% in January 2016.**
- The y.t.d figure of 54% is slightly lower than the previous year by 1%.

Monthly data should be viewed with caution as there will be large variation due to the extremely small numbers of cases that meet the Utstein criteria (bystander witnessed, VF arrest of cardiac cause).

NB: These figures are from incomplete data sets – complete data will be available in August 2016.

Survival to Discharge



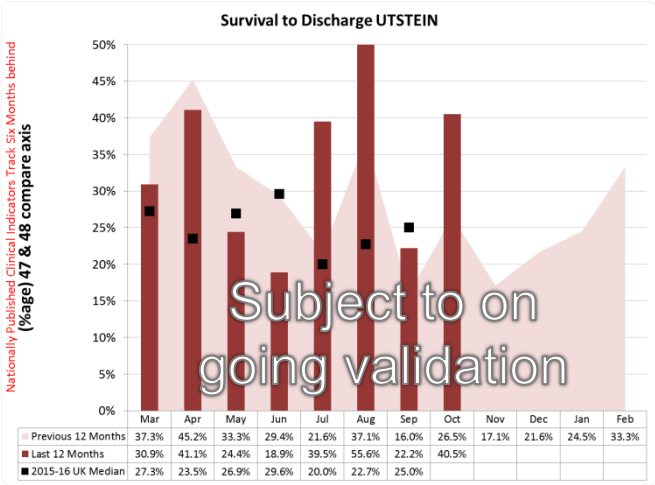
Survival to discharge from hospital (data from AQI's):

Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

Survival to discharge figures should be viewed with caution as outcomes may not be known at the time of the AQI submission (e.g. patient is still in hospital) or if data is not received from hospital trusts. Therefore, the data may change as additional data is added from hospitals and resubmissions are made to NHS England (in February and August).

October's data (the most recent national data available) shows an increase from last month to 9%. Following a resubmission of data to NHS England in February, y.t.d overall survival figure is 10% based on April to October data. This is an improvement on last years average of 9%.

Monthly data should be viewed with caution as there will be variation due to the small numbers of cases involved.



Survival to discharge from hospital for Utstein sub-group (data from AQI's):

Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources).

Survival to discharge figures should be viewed with caution as outcomes may not be known at the time of the AQI submission (e.g. patient is still in hospital) or if data is not received from hospital trusts. Therefore, the data may change as additional data is added from hospitals and resubmissions are made to NHS England (in February and August).

October's data (the most recent national data available) shows an increase from last month to 41% . Following a resubmission of data to NHS England in February, y.t.d Utstein survival figure is 34% based on April to October data. This is an improvement on last years average of 31%.

Monthly survival data is expected to fluctuate and should be viewed with caution as there will be large variation due to the extremely small numbers of cases that meet the Utstein criteria.

CARU Reports (Cardiac and Stroke)

CARDIAC ARREST (January 2016)

- Resuscitation efforts were commenced on **41%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **9 minutes**, thus exceeding the target by 1 minute. 6 Station Groups had an average 999 call to arrival on scene time of 7 minutes or less – St. Helier and Westminster at 6 minutes response.
- An advanced airway management device was placed successfully in **90%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **Four** patients had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout. Details of the cases requiring feedback have been shared with the management teams. Unsuccessful advanced airway placements have been recorded as soiled airways or unable to get an ETCO2 reading when placed.
- Approximately **5%** of cases had defibrillator downloads submitted.

STROKE (January 2016)

- **98%** FAST positive patients had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- **99%** FAST positive patients were conveyed to the most appropriate destination for their condition. 5 patients were taken to an ED inappropriately instead of a HASU; details of these incidents have been shared with the management teams to enable feedback to the staff involved.
- The average response time for 999 call to arrive on scene is **15** minutes. This is a **3** minute increase from December.
- 98% of patients arrived at a HASU within 30 minutes of leaving scene which is the timeframe set by the London Stroke Network.
- The average time on scene is **36** minutes, which remains longer than the recommended 30 minutes.

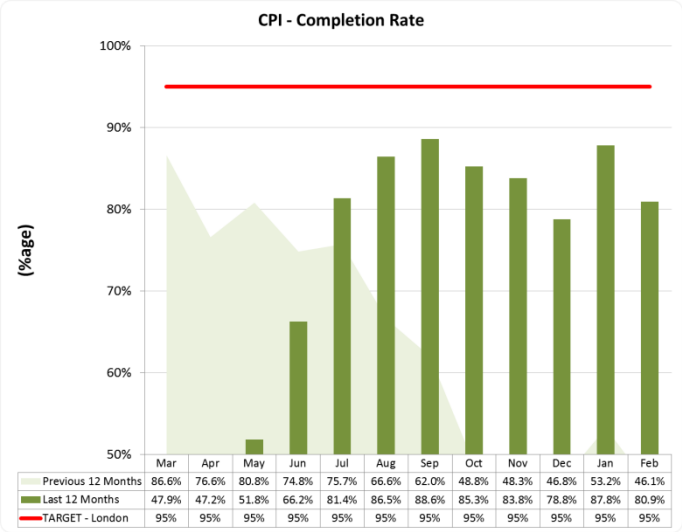
STEMI (January 2016)

- 99% of patients were conveyed to an appropriate destination.
- 1 patient was taken to an ED inappropriately instead of a HAC; details of this case have been sent to the local management team to enable feedback to the staff involved.
- The average time from the 999 call to arrival on scene decreased by **1** minute to **12** minutes in January for all call categories.
- Average overall on scene time has increased by **2** minutes to **45** minutes, while call to hospital times have decreased by **3** minutes to **74** minutes. These continue to require monitoring.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessment scores and analgesia has increased by **6%** to **74%** in January 2016. 81% of patients received analgesia during January, however 19% of patients did not receive at least one form of analgesia. This has been fed back to Group Stations and they should examine why this has occurred.

CARING

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
CPI Compliance	There was good overall compliance of care delivered for ACS (96%), Non Conveyance (97%), Cardiac Arrest (98%), Glycaemic Emergencies (97%) and Stroke (97%). Greenwich Group Station achieved over 95% compliance for the Mental Health CPI.			
CPI completion	January had the highest completion rates of CPI's in last two months at 88%. Hillingdon have achieved 100% completion rate for sixth month in a row.			
CPI Feedback	The top Group Station for Feedback is Hillingdon for the second month in a row. Half of the expected number of frontline staff have received two or more face to face feedback sessions which is an area requiring improvement.			
Friends & Family Test	Total number of FFT responses received = 2. To increase response, results are posted on the Pulse. Promotional posters sent to stations to promote FFT and what it is, in order to increase responses.			
Patient & Public Education	The Patient and Public Involvement Team attended 44 events during December 2015 out of 62 entered onto the database. 16 were BLS sessions delivered.			

CPI Completion, Feedback Sessions and Compliance (January 2016 data)



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Previous 12 Months	86.6%	76.6%	80.8%	74.8%	75.7%	66.6%	62.0%	48.8%	48.3%	46.8%	53.2%	46.1%
Last 12 Months	47.9%	47.2%	51.8%	66.2%	81.4%	86.5%	88.6%	85.3%	83.8%	78.8%	87.8%	80.9%
TARGET - London	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

CPI Completion

- January 2016 had one of the highest completion rates of CPIs in the last two years at 88%. In addition, all Group Stations completed over 25% of CPI audits available for the first time in six months.

  A number of Group Stations achieved 100% completion which should be commended. In particular, Deptford, Edmonton, Friern Barnet, HART and Hillingdon should be congratulated for achieving 100% completion for the sixth month in a row. Similarly, Central Operations, Greenwich and Romford audited all available PRFs for the fourth month in a row.

  Bromley, Westminster, Brent and Homerton Group Stations require improvement and it is suggested that assistance is sought from Group Stations that are continually performing well.

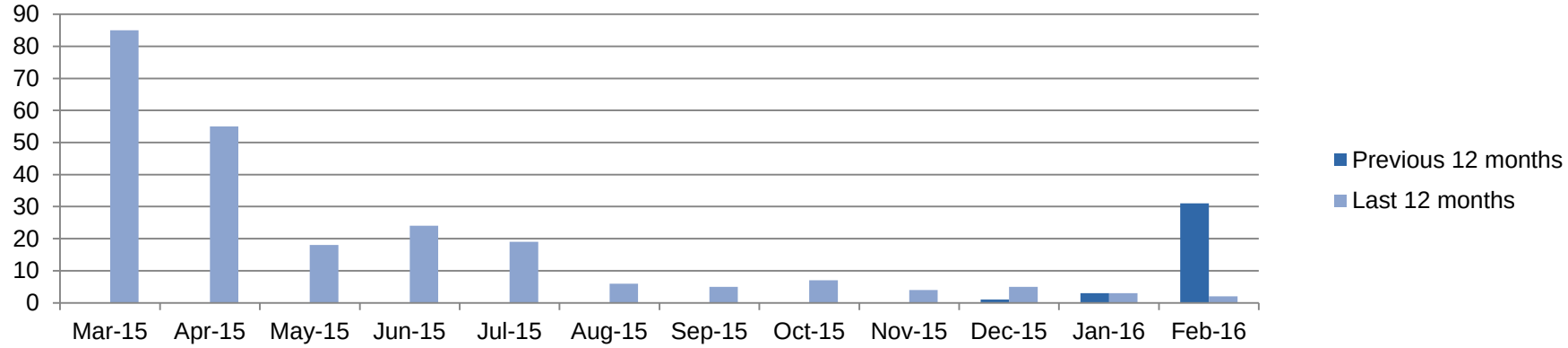
CPI Compliance

- The LAS provided a high standard of care to ACS (96%), Non Conveyance (97%), Cardiac Arrest (98%), Glycaemic Emergencies (97%) and Stroke (97%).
- Documentation of care provided by the LAS to patients with a diagnosed psychiatric problem still requires improvement. The roll out of the Mental Health Awareness Tool should assist with this CPI compliance. Areas for focus include safeguarding considerations for patients and children, and assessment of patients thoughts, appearance and communication.
- Greenwich was the only Group Station to achieve above 95% completion for the Mental Health CPI and the only Group Station to achieve above 95% across all the CPIs.

CPI Feedback

- For the second month in a row, **Hillingdon** continue to deliver a high proportion of face to face sessions and has exceeded the 100% target. Whilst Edmonton and Fulham have not delivered the expected number of face-to-face feedback sessions, they are undertaking more feedback than other Group Stations across the Service and, resources allowing, they may reach the 100% feedback target for 2015/16.
- Notably, the proportion of staff who have received two or more face-to face feedback sessions still remains below a third of what is expected at this point at Brent, Camden, CRU, New Malden, St Helier and Volunteer Responders.
- All Group Station Management teams are informed of their CPI compliance data, which is should be used for discussion at local and area meetings to assist with improvement.

Friends and Family



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Previous 12 months		0	0	0	0	0	0	0	0	1	3	31
Last 12 months	85	55	18	24	19	6	5	7	4	5	3	2

Friends and Family Test figures for February 2016

- Total number of FFT responses received = 2
  - Extremely likely = 2
  - Likely = 0
  - Unlikely = 0
- PTS responses = 0
- Number of PTS journeys = 4,005
- See & treat responses = 2
- Number of see & treat patients = 23,423

We now publish the Friends and Family monthly results on our "Other Public Engagement Projects" page on The Pulse giving all staff the opportunity to access them.

We sent a FFT poster out to all station groups, explaining FFT and also included some positive quotes received so far on the topic. We regularly contact the station groups with updates.

Although our responses are very low, NHS England are very pleased with the efforts we are making to promote FFT. The Trust are meeting with the TDA and Commissioners to see what other methods of patient feedback is suitable.

Patient & Public Engagement

February 2016

Events on database = 62

Events attended = 44

- 16 BLS session
- 6 Careers events
- 7 People who help us (4-5yr olds)
- 1 Junior Citizen Scheme
- 1 Road safety
- 13 Other

Primary School visit – 29th January – EMT4 & TEAC
What a fantastic visit from two very enthusiastic and entertaining people. Both children and staff loved learning all about the paramedics and what they do to help other people. The children/adults were given opportunity to try on clothes, hats and have a go at using the equipment! EMT4 / TEAC explained all about the paramedics amazingly well in a child friendly way and were extremely patient with our very very young listeners! Thank you

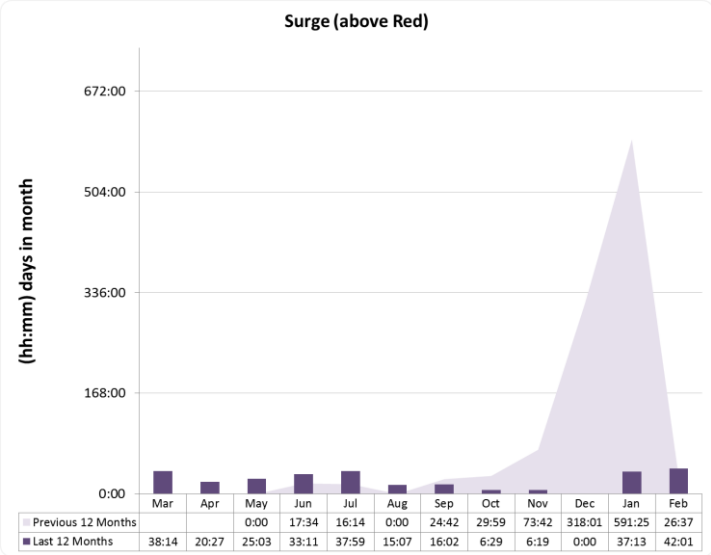
School – 4th February –Clinical Team Leader (CTL)
CTL was brilliant. Very knowledgeable and a great sense of humour. Thank you.

School visit – 11th February 2016 – Clinical Team Leader and Paramedic,
Thank you very much for participating, I have had great feedback from our students and parents.

RESPONSIVENESS

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
EOC Surge Plans	• The Trust has remained at Surge Red as agreed for this financial year and a review of the criteria to continue at this level confirms we are still operating under significant operational pressure. • There were 13 periods of Surge Purple Enhanced during February, due to unexpected spikes in incoming call demand.			

EOC Surge Status



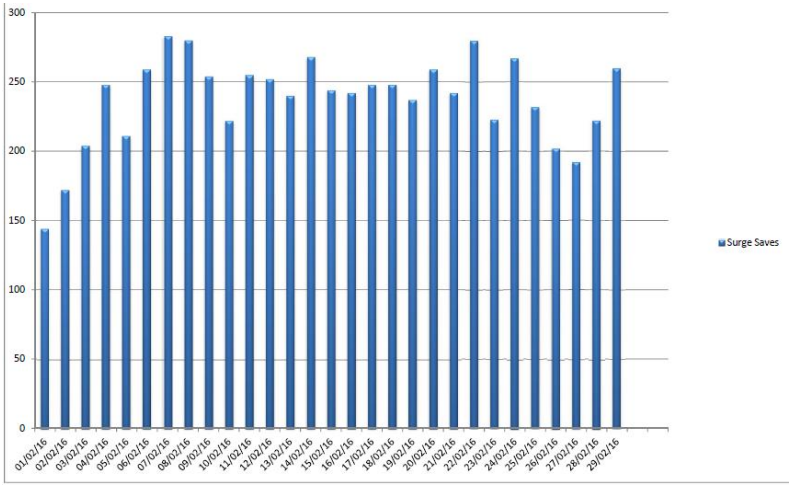
- There were 13 periods at Surge Purple Enhanced during February 2016. The periods of Surge Purple Enhanced can be attributed to unprecedented increases in incoming call demand.
- We remain at surge RED as agreed for this financial year and a review of the criteria to continue at this level confirms we are still operating under significant operational pressure.

Ambulances Saved YTD	
Date	Surge Saves
April	7312
May	7421
June	7552
July	7587
August	6933
September	7016
October	7124
November	7058
December	7189
January	7166
February	6890
March	
Total Saves	79248

Total Surge Green Saves	Total Surge Pre Amber Saves	Total Surge Amber Saves	Total Surge Red Saves	Total Surge Purple/Purple Enhanced Saves	Total Surge Blue Saves	Total Surge Black Saves
			6652	660		
			7094	327		
			7448	104		
			6936	460	191	
			6676	257		
			6467	549		
			7113	11		
			6936	122		
			7013	176		
			6735	431		
			5882	1008		
0	0	0	74952	4105	191	0

Total Saves	
Total Green Saves	0
Total Pre-Amber Saves	0
Total Amber Saves	0
Total Red Saves	74952
Total Purple Saves	4105
Total Blue Saves	191
Total Black Saves	0

TOTAL SAVES	79248



WELL LED

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
Quality Improvement Plan / CQC	➢ CQC workshops for Band 6 Managers and above held to update staff on the Quality Improvement Plan. ➢ Quality Improvement Plan key workstreams for February including;- completion of audit reports for medicines management; preparation of Aide Memoire on the Mental Capacity act; Review of guidelines for managing patients with mental health issues following discussion and agreement with Metropolitan Police colleagues.	N / A		
Executive visibility	6 visits have taken place between February and early March by members of the Executive to their allocated sectors.	N/A		

QUALITY IMPROVEMENT PLAN – FEBRUARY UPDATE

Taking Pride and Responsibility

HIGHLIGHTS THIS MONTH

- **Mental Capacity Act:** An Aide Memoire on the mental capacity act has been prepared and published on the LAS App to assist staff. In addition, training materials have been completed for use by the Clinical Education Department and tutor development materials have been completed. The Medical Directorate will be providing train the trainer sessions for core skill refresher modules for Quarter 1 2016/17.
- **Clinical supervision:** Clinical Team Leaders have been trained as mentors in order for them to undertake the clinical supervision, and a review of the delivery against the abstraction plans has started.
- **Medicines Management:** The medicine management and audit report for the all station audit has been prepared, and an audit of the paperwork in the drug pack completed. An audit of security codes, sealed drug packs, station based drugs and medical gases (cabinets) has been implemented and a process set up to check that medicines removed from the packs have been administered to patients. The combined policy is being drafted and unannounced spot checks by Incident Review Officers (IROs) are due to start.
- **Safeguarding:** A standard paragraph for job descriptions has been developed (only due in March) and will be embedded in all new role profiles

Improving Patient Experience

HIGHLIGHTS THIS MONTH

- The guidelines for managing patients with mental health issues have been reviewed and updated. These have been discussed with and agreed with Metropolitan Police (MPS) colleagues.
- This guidance has also been included in the standard operating procedure for the dedicated MPS telephone line in the EOC, and we are also working towards inclusion of these guidelines into a memorandum of understanding for the MPS/LAS which is due to be published in early March.
- The HAS- Pin (hospital notification system) review has been completed with a table top review taking place in February as well as site visits for user input. Recommendations are being developed following this review.
- In an effort to support NHS England (London) plan to reduce handover times at the eight worst performing emergency departments across London the LAS Senior Team attended the pan-London handover workshop held on 26/02/16.
- A review of current waiting times for PTS patients against contractual KPIs took place on the 17th and 23rd of February, and areas for improvement have been identified. An action plan has been developed and implementation of these have commenced

Executive Visibility

The introduction of structured executive walk-rounds in February 2016 supports the aims and objectives of the Sign up to Safety campaign, promotes an open, responsive and supportive safety culture, ensuring visibility of the Executive Leadership Team (ELT) and engagement from staff across all areas of the organisation.

Each member of the ELT has an allocated sector and are committed to spending time each month either on a ride out or a locality visit such as a training centre, annexes or stations. A structured programme of feedback and learning has been instigated which will feed into the monthly quality report and be discussed at ELT, inform strategic and operational planning with appropriate actions identified as required.

Between Mid February and Mid March a total of 6 visits have been completed which include ride outs, visits to various stations, our 111 centre and the Emergency Operations Centre in Bow. Key themes from these include:

- Challenging physical environment (111)
- The importance of branding to staff – being seen as part of LAS whether uniformed or non-uniformed
- Positive attitudes among new starters
- Individual bullying claim highlighted and escalated
- Pressurised environment for staff with escalating workload (EOC)
- Lack of awareness of the LAS core values – the 3 Cs, but good understanding and engagement with the Quality Improvement Plan
- Lack of clarity for staff on how information/communication is cascaded relating to key strategic issues
- The importance and impact of having locally initiated and owned improvements

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Quality Improvement Programme Board – Terms of Reference**
Report Author(s):	**Donna Fong** **PMO Manager, Quality Improvement Programme**
Presented by:	**Richard Hunt** **Chair, Quality Improvement Programme Board**
Contact Details:	
History:	**Presented to the Quality Improvement Programme Board on 10/02/2016**
Status:	**For approval**

Background/Purpose

The Quality Improvement Programme (QIP) launched in January 2016 sets out the immediate priorities to be addressed by the Trust following the CQC review.

The role of the QIP Board is to provide assurance to the Trust Board of delivery against the QIP plan, and these functions are described in the terms of reference.

At the Quality Improvement Programme Board meeting on 15/03/2016 the terms of reference for the Quality Improvement Group (QIG) were approved. The QIG includes all members of the Executive Leadership Team and is led by the Chief Executive as the Senior Responsible Officer. The role and responsibility of the QIG is to deliver the activities as detailed in the Quality Improvement Plan.

Action required

The Trust Board are asked to:

- review and approve the draft terms of reference for the Quality Improvement Programme Board (Appendix A)
- note the approved terms of reference for the Quality Improvement Group (Appendix B)

Assurance
Internal assurance for delivery of the QIP will be provided through the QIP Board and Trust Board. External scrutiny and assurance measures include the appointment of the TDA Improvement Director, and regular reporting to NHSE, TDA, and Commissioners through the Regional Oversight Group.

Key implications and risks arising from this paper	
Clinical and Quality	The QIP details activities to mitigate against clinical risks including deliverables relating to medicines management, improving patient outcomes for bariatric and mental health patient groups, and how the organisation learns from reportable incidents, risks and complaints. Additionally, the development of a Trust Quality and Clinical strategy will set the direction and organisational approach to managing clinical and quality risks.
Performance	There may be risk to Trust performance if activities within the QIP are not delivered to time, or they do not have the anticipated impact on operational functions to improve performance. This needs to be continually reviewed and understood.
Financial	Delivery of the QIP will require dedicated funding. These requirements will be included in the 2016/17 contract negotiations with Commissioners.
Governance and Legal	The QIP Board is a sub committee of the Trust Board which meets monthly. It will provide a monthly report to the Trust Board on progress
Equality and Diversity	There are no specific equality and diversity risks identified in this paper.
Reputation	There may be a reputational risk if the Trust does not deliver against the QIP in making effective changes that result in meeting the standards required by the CQC and other stakeholders.
Other	

This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Activities within the QIP will lead in due course to achievement of this objective.
To make LAS a great place to work	Activities within the QIP will lead in due course to achievement of this objective.
To improve the organisation and infrastructure	Activities within the QIP will lead in due course to achievement of this objective.
To develop leadership and management capabilities	Activities within the QIP will support achievement of this objective, over time.

Appendix A

Quality Improvement Programme Board

Terms of Reference

1. Authority

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

1.2 The Quality Improvement Programme Board 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 Quality Improvement Programme Board is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of external representatives with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The primary focus of the Quality Improvement Programme Board will be to update and assure the Board on delivery against the Quality Improvement Plan.

2.2 The Quality Improvement Programme Board shall:

- Provide direction to the programme to ensure it achieves the desired outcomes and benefits;
- To receive highlight reports on the progress and outcomes of the five work stream that support the Quality Improvement Plan;
- Scrutinise, if required, any areas that are off-plan to ensure that appropriate and timely actions are in place to recover any slippage from plan;
- Monitor the status and progress of project delivery and agree significant variations to the programme plan;
- Review key performance indicators of the plan to assure the Trust Board that the right progress is being made and that any associated risks are being monitored and managed;
- Scrutinise mitigation plans for escalated risks and issues, and ensure that mitigating actions have been carried out in a timely manner;
- Consider the findings from internal quality inspection team audits to provide assurance that, actions taken through the Quality Improvement Plan, are making a difference to the day to day running of the Service and improving the experience of staff working within it.

- To oversee the communications and engagement plan, and agree key messages for circulation internally and externally at each meeting, to ensure that staff and stakeholders are engaged in delivery of the quality improvement plan;
- Provide assurance to the Trust Board on the progress towards the plan;
- Approve the completion of projects.

3. Membership

3.1 The Committee shall be appointed by the Board and shall comprise the following:

Core members

- Chairman (Chair)
- Chair of the Quality Committee (Non-Executive)
- Chair of the Workforce Committee (Non-Executive)
- Chief Executive Officer
- Director of Transformation and Strategy (Programme Director/Senior Responsible Officer)
- Director of Strategic Communications
- Staff Side Representative

Core members will nominate a deputy to represent the project if they are not able to attend a meeting.

In regular attendance

- Trust Development Agency (TDA) Improvement Director
- Programme Management Office (PMO) Lead

By invitation

- Director of Corporate Affairs [Executive Sponsor]
- Director of Finance and Performance [Executive Sponsor]
- Director of Human Resources [Executive Sponsor]
- Director of Nursing and Quality [Executive Sponsor]
- Medical Director [Executive Sponsor]
- Business Owners or Delivery Team members
- Internal Quality Inspection Team Audit Leads

4. Monitoring and Reporting

4.1 To monitor monthly delivery against the 2016/17 Quality Improvement Plan.

4.2 To receive regular assurance reports from the Quality Improvement Group on work stream progress and outcomes.

4.3 To receive key performance indicator reports in relation to the Quality Improvement Plan.

4.4 To receive reports on internal quality improvement audits.

5. Accountability

5.1 The Quality Improvement Programme Board shall be accountable to the Trust Board.

6. Responsibility

6.1 The Quality Improvement Programme Board is time limited (12 months) formal sub-committee of the Board of Directors and has no executive powers other than those specifically delegated in these Terms of Reference.

7. Reporting

7.1 The minutes of the Quality Improvement Programme Board meetings shall be formally recorded by the Programme Management Office.

7.2 An assurance report will be provided to the next meeting of the Trust Board. The emphasis of the report will be to highlight the progress, and strategic and corporate risks associated with items considered by the Quality Improvement Programme Board and provide assurance to the Trust Board of the mitigation. This report will be given to the Trust Board at each meeting.

7.3 The Chair of the Quality Improvement Programme Board shall draw the attention of the Board to any issues that require disclosure to the full Board or that require executive action.

7.4 Responsibility for monitoring action to be taken rests with the Director of Transformation and Strategy and Executive Sponsors of each Work Stream.

8. Administration

8.1 Secretarial support will be provided by the Programme Management Office and will include the agreement of the agenda with the Chair of the Quality Improvement Programme Board and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues

carried forward.

8.2 Agenda items shall be forwarded to the Programme Management Office one week before the date of the committee meeting.

8.3 The draft minutes and action points will be available to Quality Improvement Programme Board members within four weeks of the meeting.

8.4 Papers will be tabled at the discretion of the Chair of the Quality Improvement Programme Board.

9. Quorum

9.1 The quorum shall be two non-executive director members and one executive director member.

10. Frequency

10.1 Meetings shall be held monthly.

10.2 Any formal member of the committee may request a meeting if they consider that one is necessary.

10.3 Committee members are required to attend at least 50% of the committee's meetings per financial year. Committee members' attendance will be recorded in the minutes of each meeting and reviewed at the end of each year to ensure that this requirement is met.

11. Review of Terms of Reference

11.1 The Quality Improvement Programme Board will review as required, but no later than February 2017 if it is agreed there is a requirement for the programme Board to continue into 2017/18.

11.2 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.

Appendix B

Quality Improvement Group

Terms of Reference

1. Authority

1.1 The Committee is to be known as the Quality Improvement Group and its constitution and terms of reference are set out below and subject to amendment when directed and agreed by the Quality Improvement Programme Board (QIPB).

1.2 The Group is authorised by the QIPB 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 QIPB.

1.3 The Group is authorised by the QIPB 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 committee's prime purpose is to review progress against the quality improvement plan and each of the five work steams individually, assessing risks and directing interventions to ensure deadline delivery.

2.2 The Quality Improvement Group is responsible for:

- Scrutinising the 5 work streams of the quality improvement plan to ensure they achieve the desired outcomes and benefits;
- Scrutinising areas that are off-plan to ensure that appropriate and timely actions are in plan to recover any slippage from plan;
- Monitoring the status and progress of project delivery and agree significant variations to the programme plan;
- Proactively managing programme risks and issues, and for gaining assurance of mitigation plans
- Reviewing key performance indicators of the plan to ensure the right progress is being made;
- Providing assurance to the Quality Improvement Programme Board on the progress towards the plan;
- Reviewing any emerging financial issues in relation to the quality improvement plan;
- Managing identified interdependencies between projects, and clearing any blockages or issues that may arise;
- Reviewing support to Executive Sponsors to ensure delivery of their work stream
- Reviewing 30, 60 and 90 day deliverables to identify any issues that may prevent successful delivery

3. Membership

3.1 The Quality Improvement Group shall comprise:

- Chief Executive (Chair)
- Director of Transformation and Strategy (Deputy Chair)
- Director of Corporate Affairs [Executive Sponsor]
- Director of Finance and Performance [Executive Sponsor]
- Director of Operations
- Director of Human Resources [Executive Sponsor]
- Director of Nursing and Quality [Executive Sponsor]
- Director of Performance
- Medical Director [Executive Sponsor]
- Director of Strategic Communications

3.2 In regular attendance

- Trust Development Agency (TDA) Improvement Director
- Programme Management Office (PMO) Lead
- Programme Administrator

The following members may be required to attend for specific agenda items:

- Project Leads or Task Owners
- Quality Improvement Audit Leads

4. Accountability

4.1 The Quality Improvement Group shall be accountable to the QIPB.

5. Reporting

5.1 The minutes of the Quality Improvement Group meetings shall be formally recorded by the Programme Management Office.

5.3 The Chair of the Quality Improvement Group shall draw the attention of the QIPB to any issues that require disclosure to the full Trust Board.

5.4 The Quality Improvement Group shall receive regular reports from:

- Executive Sponsors of each of the five Work Streams
- Quality Improvement Audit Team – following presentation at the Quality Improvement Programme Board
- Director of Performance on key performance indicators

5.5 Responsibility for monitoring action to be taken rests with the Programme Management Office, reporting through to the Director of Transformation and Strategy.

5.6 The Group shall provide an annual assurance report to the Quality Improvement Programme Board on work stream delivery and key performance indicators.

5.7 The Group will review its effectiveness against these terms of reference and the work programme annually and provide a report to the Quality Improvement Programme Board for onward assurance to the Trust Board.

6. Administration

6.1 Secretarial support shall be provided by Programme Management Office and shall include the agreement of the agenda with the Chair of the Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

6.2 The Director of Transformation and Strategy will maintain the annual work programme for the Group.

6.3 Agenda items shall be forwarded to the Programme Management Office six days before the date of the meeting.

6.4 The action points shall be available to members within one week of the meeting.

6.5 The draft minutes shall be available to the Director of Transformation and Strategy and the Chair of the Group one week after the meeting.

6.6 Papers shall be tabled at the discretion of the Chair of the Group.

7. Quorum

7.1 The quorum for this group shall be (Chief Executive or Director of Transformation and Strategy, and two Executive Sponsors). Members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

8. Frequency

8.1 The Quality Improvement Group shall meet monthly.

8.2 The Chief Executive or the Director of Transformation and Strategy may request a meeting if they consider that one is necessary.

9. Review of Terms of Reference

9.1 The Quality Improvement Group shall review these as required but no less than in February 2017 if it is agreed there is a requirement for the programme Board to continue into 2017/18.

9.2 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

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Quality Improvement Programme - March Progress Report**
Report Author(s):	**Donna Fong** **PMO Manager, Quality Improvement Programme**
Presented by:	**Richard Hunt** **Chair, Quality Improvement Programme Board**
Contact Details:	
History:	**Update follows the Quality Improvement Programme Board meeting held on 15/03/2016**
Status:	**For assurance and information**

Background/Purpose

The purpose of this paper is to provide the Trust Board a status report on the delivery of the Quality Improvement Programme during February, and to provide an update on the Trust Development Authority (TDA) audit of the Care Quality Commission (CQC) Warning Notice conducted on 16 March 2016.

Action required

The Trust Board are asked to note:

- the QIP Board report for March
- the QIP progress report on February deliverables
- the outcome of the TDA audit of the CQC Warning Notice conducted on 16 March 2016

Assurance

The Quality Improvement Programme Board have reviewed activities delivered for February, and no significant concern has been raised on programme delivery in relation to the milestones and actions that required completion

Key implications and risks arising from this paper	
Clinical and Quality	The QIP details activities to mitigate against clinical risks including deliverables relating to medicines management, improving patient outcomes for bariatric and mental health patient groups, and how the organisation learns from reportable incidents, risks and complaints. Additionally, the development of a Trust Quality and Clinical strategy will set the direction and organisational approach to managing clinical and quality risks.
Performance	There may be risk to Trust performance if activities within the QIP are not delivered to time, or they do not have the anticipated impact on operational functions to improve performance. This needs to be continually reviewed and understood.
Financial	Delivery of the QIP will require dedicated funding. These requirements will be included in the 2016/17 contract negotiations with Commissioners.
Governance and Legal	The QIP Board is a sub committee of the Trust Board which meets monthly. It will provide a monthly report to the Trust Board on progress
Equality and Diversity	There are no specific equality and diversity risks identified in this paper.
Reputation	There may be a reputational risk if the Trust does not deliver against the QIP in making effective changes that result in meeting the standards required by the CQC and other stakeholders.
Other	

This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Activities within the QIP will lead in due course to achievement of this objective.
To make LAS a great place to work	Activities within the QIP will lead in due course to achievement of this objective.
To improve the organisation and infrastructure	Activities within the QIP will lead in due course to achievement of this objective.
To develop leadership and	Activities within the QIP will support achievement of this

management capabilities	objective, over time.

Appendix A

Quality Improvement Programme Board
Progress Report to the Trust Board

TDA review of the CQC Warning Notice

1. A TDA –led review of the CQC Warning Notice was completed on 16 March 2016. The purpose of the review was to seek assurance that progress has been made against the concerns raised by the CQC in the Warning Notice issued on 1 October 2015.

2. Areas that the CQC identified as requiring significant improvement were:

    - There are insufficient numbers of frontline paramedics in the Emergency and Urgent Care and Resilience Planning services in order to provide a safe service to the population you serve.
    - There are poor systems and checks in place to ensure that medicines are managed in accordance with the Human Medicines Regulations 2012 and professional guidance.
    - The governance arrangements are inadequate and not effective in identifying and mitigating significant risks to staff and patients.

3. The audit was conducted in two parts, firstly a submission of documented evidence followed by an observational audit. Audit teams were represented by members of the NHS England, the TDA, Commissioners, Patients Forum, and the LAS.

4. The outcome following the review identified areas of good practice and those requiring further development. An overall summary includes:
    - Some good progress made
    - Acknowledgement by staff on progress made – particularly for recruitment of staff, both frontline and HART
    - Systems and processes need further review (medicines supply and tracking chain, patient records, vehicle preparedness) to maximise efficiency, to support crews and to reduce risk

5. The learning from the audit will be incorporated into future activity relating to the Quality Improvement Programme.

Progress Report

1. At the QIP Board meeting held on 15 March 2016, the Board noted key activity completed for the programme during February and they reviewed activities reporting potential delays in the upcoming months that may pose a risk to programme delivery. There are no significant concerns to be reported.

2. A full and detailed report of February activity is included in the attached progress report.

3. All activities were delivered in February, with the small exception of a review of the Health and Safety function that was due for completion. It was reported that this issue was being attended to as a priority, with a review being organised and it is anticipated this position will be recovered by the end of March 2016.

4. Significant process has been made on a number of workstreams including bullying and harassment, and training for managers on risk management.

5. A total of 350 managers attended briefings held in February to raise the profile of the Quality Improvement Programme, which resulted in the development of local action plans to support delivery of the programme.

6. A potential delay relating to progression of Equality and Inclusion activities in March was discussed, due to the absence of key members of the Equality and Inclusion team. Actions to mitigate any delay are being explored.

7. The terms of reference for the Quality Improvement Group were approved by the QIP Board.

8. The QIP Board was provided an update on the following areas:
    - Risk Management, Director of Corporate Affairs
    - TDA audit of the CQC Warning Notice, Director of Transformation & Strategy
    - The QIP communications approach , Director of Communications

9. The next phase of the communications campaign will be launched next month on ‘Making the LAS great’ to give greater visibility of the Trust vision and values.

Moving Forward Together

2016/17 QUALITY IMPROVEMENT PROGRAMME

Progress Report

February 2016

CONTENTS

Moving Forward Together

Definitions

	Project Delivery		***Project Performance***
	All scheduled activities have been completed		
	The scheduled activities are on track for completion by the due date		*Performance has been met or is over 95% towards the agreed trajectory / target*
	The scheduled activities have been delayed and are no more than 4 weeks		*Performance is between 85-95% towards the agreed trajectory / target*
	The scheduled activities are at risk and have delays over 4 weeks		*Performance is below 85% of the agreed trajectory / target*

EXECUTIVE SUMMARY
February 2016

Moving Forward Together

Progress this month

- Detailed action plans for each project have been completed for the majority of the workstreams.
- The Trust Board have provided agreement in principle for additional projects to be included in the Quality Improvement Programme, and work is underway to finalise these details before presentation to the Trust Board in March.
- A total of 350 managers attended briefings held in February to raise the profile of the Quality Improvement Programme, which resulted in the development of local action plans to support delivery of the programme.
- An initial review of programme and project risk and issues has been completed.
- A communications plan specific to the Quality Improvement Plan has been prepared and will be presented to the QIP Board for approval in March.
- Further refinement of the costs of delivering the programme has been completed.
- The progress report for January 2016 has been made available on the external LAS website.
- There is one workstream reporting a delay which relates to a review of the Trust's Health and Safety function. A specification and review has been organised and it is anticipated this position will be recoverable in the next two weeks.

	Theme	Executive Director	RAG
WORKSTREAM STATUS **February 2016**	Making LAS a great place to work	Paul Beal	
	Achieving good governance	Sandra Adams	
	Improving patient experience	Zoe Packman	
	Improving environment and resources	Andrew Grimshaw	
	Taking pride and responsibility	Fenella Wrigley	n/a

PROGRAMME SUMMARY
Forecast View

Moving Forward Together

Programme:

- The previous risk reported in January has now been resolved and the revised Bullying and Harassment policy is in the process for approval and therefore will meet the scheduled delivery date in March.
- There will be a further review undertaken with Executive Leads to rebalance the spread of activities to be delivered in Q1.
- Final details on activities and milestones for the full Quality Improvement Programme is scheduled for approval at the Trust Board meeting on 29/03/2016.
- Preparations are underway to launch the communications campaign for the Quality Improvement Programme widely across the Trust.
- A TDA led review of the warning notice issued by the CQC is scheduled for 16 March 2016, which will include a review of evidence and an observational audit.

Workstream Challenges:

- At present there is one delivery risk identified in Theme 1 due to the unavailability of key individuals to deliver activities relating to the Equality and Inclusion project. A contingency plan is being explored to mitigate this delivery risk.

		March 2016				April 2016			
Theme	**Executive Director**	Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Making LAS a great place to work	Paul Beal		8		**1**	na			
Achieving good governance	Sandra Adams		12				5		
Improving patient experience	Zoe Packman		4			na			
Improving environment and resources	Andrew Grimshaw		11				1		
Taking pride and responsibility	Fenella Wrigley		3			na			
	Total		**39**				**6**		

WORKSTREAM PROGRESS REPORTS

1| MAKING THE LAS A GREAT PLACE TO WORK

Executive Lead: Paul Beal

Moving Forward Together

HIGHLIGHTS THIS MONTH	
	• During this month, members of the Executive Leadership Team have been allocated to a sector within the Trust, and a scheduled programme of visits has been constructed. A number of the management team were also involved in the Unified Response exercise , and were engaged with various staffing groups. • 15 workshops and 12 briefing sessions were held to raise awareness about bullying and harassment across the Service. Forums have been created to raise awareness of the issue and to also hear from a cross section of staff about possible solutions. • The advisory line was transferred from the Andrea Adams Consultancy over to the Employee Assistance Programme and has been publicised across the organisation. • The recruitment pipeline for the remainder of 2015/2016 is still strong with no foreseeable implications on the projections, and work has commenced to progress the three year plan for recruitment. • Sector based management sessions relating to the delivery of the Quality Improvement Programme have taken place with over 350 people in attendance over a period of three days. All sessions were supported by the CEO and Directors of Strategy, Transformation & Workforce and Communications, and included the initial launch of the LAS brand which will undergo some further work prior to its official launch in the coming weeks. Informal feedback provided to date has indicated that the sessions were well received.

Deliverable	Executive Lead
Advert to Action (Recruitment)	Paul Beal
Bullying and Harassment	Paul Beal
Training	Karen Broughton
Equality and Inclusion	Paul Beal
Vision and Strategy	Karen Broughton
Supporting Staff	Karen Broughton
Retention	Paul Beal

Outstanding actions
There are currently no outstanding or delayed actions

February 2016		
Complete	Delayed	At Risk
n/a		
n/a		
n/a		
n/a		
1		
n/a		
n/a		

1| MAKING THE LAS A GREAT PLACE TO WORK

Moving Forward Together

Focus for next month	Key challenges
• Recruitment to the Learning and Development Manager post within the People and Organisational Development Team. • Graduate recruitment processes and packages to be reviewed and approved in time for the university open days. • Redesign and update of corporate induction content continues to progress. • Local workshops on staff behaviours and the interface with the three core LAS values have been held, and the output of these workshops will be communicated widely across the organisation.	• Electronic Staff Record (ESR) transformation project has the potential to impact the Oracle Learning Management (OLM) implementation plans and will need to be robustly managed. • Accuracy of employee relations data needs to be improved to ensure there is the functionality to report on required KPIs , and actions are in place to improve data quality. • There could be potential delays to the delivery of scheduled Equality and Inclusion activities due to the unavailability of key members of the Equalities and Inclusion Team .

Deliverable	Executive Lead	March 2016				April 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Advert to Action (Recruitment)	Paul Beal		1			n/a			
Bullying and Harassment	Paul Beal		4			n/a			
Training	Karen Broughton		2			n/a			
Equality and Inclusion	Paul Beal				**1**	n/a			
Vision and Strategy	Karen Broughton	n/a				n/a			
Supporting Staff	Karen Broughton	n/a				n/a			
Retention	Paul Beal		1			n/a			

2| ACHIEVING GOOD GOVERNANCE

Executive Lead: Sandra Adams

Moving Forward Together

HIGHLIGHTS THIS MONTH	
	• Key performance indicators have been established for incident reporting of serious incidents. • Implementation of DatixWeb continues, and training on the system has commenced. • Intensive risk management training for managers is almost complete, and ongoing training sessions will be scheduled on a quarterly basis. • Improving complaint handling is well underway with significant progress being made to raising awareness across the organisation to both internal and external stakeholders. • Duty of Candour training is currently underway for frontline clinical staff as part of the core skills refresher course and has been publicised in the Routine Information Bulletin, and is also featured on the Governance page on the Intranet site. • Two reviews have been conducted of the Emergency Operations Centre (EOC) and an options appraisal has been completed by both staff and managers within the department with suggested recommendations. This will form the basis of the business case that is currently in the process of being written.

Deliverable	Executive Lead
Risk Management	Sandra Adams
Capability and capacity of Health, Safety and Risk function	Sandra Adams
Improving incident reporting	Sandra Adams
Duty of Candour	Sandra Adams
Operational planning	Paul Woodrow / Paul Beal
Listening to patients	Zoe Packman

Outstanding actions
• Benchmarking of the Health, Safety and Risk teams has been completed for the Risk function, however this did not include Health and Safety and therefore this activity is subject to a delay. A specification is currently being drawn up using experience from other Ambulance Trusts, and it is anticipated that this delayed position should be quickly recovered.

February 2016		
Complete	Delayed	At Risk
n/a		
	1	
3		
2		
n/a		
n/a		

2| ACHIEVING GOOD GOVERNANCE

Moving Forward Together

Focus for next month	Key challenges
• Business case to be completed detailing plans for the EOC staffing strategy to be approved by the Executive Leadership Team in March 2016. • Job evaluations to be completed for the Risk function of the department in relation to additional posts. • Website updates to be implemented regarding complaints and gaining feedback. • Health and safety review to be completed. • The first Risk, Compliance and Assurance Group meeting is scheduled on 09/03/2016, and terms of reference have been drafted. If approved, these will be submitted to the Executive Leadership Team to be ratified.	• Key members of the Patient Experiences Team have been unavailable, which may impact on delivery on the listening to patients actions. • Achieving a mutually agreed rest break policy between all parties within the scheduled timeframe may be challenging as there is a dependency on the outcome of the London Package discussions and 2016/17 contract negotiations. • A strategic risk review by the Trust Board will be undertaken in April 2016 led by the new Chair.

Deliverable	Executive Lead	March 2016				April 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Risk Management	Sandra Adams		5				**2**		
Capability and capacity of Health, Safety and Risk function	Sandra Adams	n/a				n/a			
Improving incident reporting	Sandra Adams		**3**				**1**		
Duty of Candour	Sandra Adams		**2**			n/a			
Operational planning	Paul Woodrow / Paul Beal	n/a					1		
Listening to patients	Zoe Packman		2				**1**		

3| IMPROVING PATIENT EXPERIENCE

Executive Lead: Zoe Packman

Moving Forward Together

HIGHLIGHTS THIS MONTH	
	• The guidelines for managing patients with mental health issues have been reviewed and updated. These have been discussed with and agreed with Metropolitan Police (MPS) colleagues. • This guidance has also been included in the standard operating procedure for the dedicated MPS telephone line in the EOC, and we are also working towards inclusion of these guidelines into a memorandum of understanding for the MPS/LAS which is due to be published in early March. • The HAS- Pin (hospital notification system) review has been completed with a table top review taking place in February as well as site visits for user input. Recommendations are being developed following this review. • In an effort to support NHS England (London) plan to reduce handover times at the eight worst performing emergency departments across London the LAS Senior Team attended the pan-London handover workshop held on 26/02/16. • A review of the current patient waiting times for the Patient Transport Service (PTS) against contractual KPIs took place on the 17th and 23rd of February, and areas for improvement have been identified. An action plan has been developed and implementation of these have commenced

Deliverable	Executive Lead
Patient Transport Service	Paul Woodrow
Meeting peoples needs	Fenella Wrigley/ Paul Woodrow
Response Times	Paul Woodrow

Outstanding actions
There are currently no outstanding or delayed actions

February 2016		
Complete	Delayed	At Risk
1		
1		
2		

3| IMPROVING PATIENT EXPERIENCE

Moving Forward Together

Focus for next month	Key challenges
• The implementation of the action plan to address patient waiting times is already underway with communication to patients and providers planned. • A feedback process is being developed with staff to ensure they are capable of managing mental health patients. This feedback will be monitored. • Recommendations from the HAS- pin review is due to be shared. Recommendations following the workshop on hospital handover to be shared	Clarity on on-going levels of support to NHSE regarding hospital handover required.

Deliverable	Executive Lead	March 2016				April 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Patient Transport Service	Paul Woodrow		2			n/a			
Meeting peoples needs	Fenella Wrigley/ Paul Woodrow		1			n/a			
Response Times	Paul Woodrow		1			n/a			

4| IMPROVE ENVIRONMENT AND RESOURCES

Executive Lead: Andrew Grimshaw

Moving Forward Together

HIGHLIGHTS THIS MONTH	
	• Following the review of the current 'Make Ready' service completed in January, relating to vehicle equipping, cleaning, and the general preparation, it has been agreed by the Executive Leadership Team that a pilot of a revised make ready service would be conducted in the North East Sector and the funding required in addition to the existing contract was approved for the duration of the pilot. • A further review of the Make Ready service in relation to equipment tracking was completed in February, and this has resulted in an enhancement to the equipment tracking functionality . This included an upgrade in software which has extended the scanning range and also an ability to generate activity reports. A phased implementation is planned, and this work will be included as part of the pilot in the North East which goes live at the beginning of March 2016. • An options paper for the supply of blankets has been completed, however the medium to long term solution identified requires the development of a full specification and implementation plan to be agreed by key stakeholders. In the interim, disposable blankets will be purchased to supplement the supply of LAS blankets . • An options appraisal to upgrade the specifications for cleaning on stations was presented to the Executive Leadership Team and approved to proceed

Deliverable	Executive Lead
Fleet / Vehicle Preparation	Andrew Grimshaw
Information Management and Technology	Andrew Grimshaw
Infection prevention and control	Zoe Packman
Facilities and Estates	Sandra Adams
Resilience functions	Paul Woodrow

Outstanding actions
There are currently no outstanding or delayed actions

February 2016		
Complete	Delayed	At Risk
4		
n/a		
n/a		
1		
n/a		

4| IMPROVE ENVIRONMENT AND RESOURCES

Moving Forward Together

Focus for next month	Key challenges:
All activities scheduled for delivery in March and April are on track: • Review of processes relating to vehicle checks at the start of shift • Defining roles and responsibilities for all resource and equipment activities on station, and a plan developed to implement agreed changes • The business case for 140 ambulances will be submitted to the TDA in mid-March • Review the out of service vehicle maintenance coverage for both workshops and third party contractors • Reissue of guidance to staff relating to bare below the elbows, and establish monitoring mechanisms to ensure compliance • Development of an implementation plan for the new cleaning regime • HART teams to have completed training, and the development of a 2016/17 training plan for all resilience functions	• There no challenges or risk to delivery currently identified

Deliverable	Executive Lead	March 2016				April 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw		6				1		
Information Management and Technology	Andrew Grimshaw	n/a				n/a			
Infection prevention and control	Zoe Packman		2			n/a			
Facilities and Estates	Sandra Adams		1			n/a			
Resilience functions	Paul Woodrow		2			n/a			

5| TAKING PRIDE AND RESPONSIBILITY

Executive Lead: Fenella Wrigley

Moving Forward Together

HIGHLIGHTS THIS MONTH	Although there were no scheduled activities to be delivered in February, good progress has been made on activities in this workstream. • **Mental Capacity Act:** An Aide Memoire on the mental capacity act has been prepared and published on the LAS App to assist staff. In addition, training materials have been completed for use by the Clinical Education Department and tutor development materials have been completed. The Medical Directorate will be providing train the trainer sessions for core skill refresher modules for Quarter 1 2016/17. • **Clinical supervision:** Clinical Team Leaders have been trained as mentors in order for them to undertake the clinical supervision, and a review of the delivery against the abstraction plans has started. • **Medicines Management:** Work to combine policies relating to medicines management has been prioritised and is scheduled for approval by the Executive Leadership Team in March. Unannounced spot checks by Incident Review Officers are due to commence, and these will be focused on the management and storage of medicines. Station based medicines management audits have been embedded through Clinical Team Leaders, supported by the medicines management team. Medicines management issues were highlighted at the manager briefing sessions held in February, and this time was used to devise local plans that will address areas of concern. • **Safeguarding:** A standard paragraph for job descriptions has been developed (only due in March) and will be embedded in all new role profiles

Deliverable	Executive Lead
Clinical supervision	Fenella Wrigley
Consent MCA	Zoe Packman
Medicine Management	Fenella Wrigley
Safeguarding	Zoe Packman

Outstanding actions
There are currently no outstanding or delayed actions

February 2016		
Complete	Delayed	At Risk
n/a		
n/a		
n/a		
n/a		

5| TAKING PRIDE AND RESPONSIBILITY

Moving Forward Together

Focus for next month	Key challenges
• A review of IT solutions relating to the management of medicines is underway • Review of initial IRO spotchecks • Action plan based on audits and spotchecks (where required) • Medicine Management event • Review and reinforcement of the current process to capture batch numbers and to allow for reporting, monitoring and assurance of compliance	

Deliverable	Executive Lead	March 2016				April 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Clinical supervision	Fenella Wrigley	n/a				n/a			
Consent MCA	Zoe Packman	n/a				n/a			
Medicine Management	Fenella Wrigley		1			n/a			
Safeguarding	Zoe Packman		2			n/a			

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Full Quality Improvement Programme**
Report Author(s):	**Donna Fong** **PMO Manager, Quality Improvement Programme**
Presented by:	**Karen Broughton** **Director of Transformation and Strategy**
Contact Details:	
History:	**Presented to the Executive Leadership Team 16/03/2016**
Status:	**For approval**

Background/Purpose

The Quality Improvement Programme (QIP) launched in January 2016 sets out the immediate priorities to be addressed by the Trust following the CQC review. It is the intention that the programme also encompasses other strategies and action plans which the Trust has committed to deliver, so that there is one singular plan which is prioritised for delivery during 2016/17.

At the informal Trust Board meeting held on 23/02/2015, it was agreed in principal the activities that would be included in the QIP. Executive Directors were asked to further refine the projects and to define delivery dates and project leads.

Action required

This paper sets out the final additions into the Quality Improvement Plan for approval by the Trust Board.

Assurance

Assurance for delivery of these additional projects will be subject to the same governance structure and processes as currently defined for the QIP.

Key implications and risks arising from this paper	
Clinical and Quality	The QIP details activities to mitigate against clinical risks including deliverables relating to medicines management, improving patient outcomes for bariatric and mental health patient groups, and how the organisation learns from reportable incidents, risks and complaints. Additionally, the development of a Trust Quality and Clinical strategy will set the direction and organisational approach to managing clinical and quality risks.
Performance	There may be risk to Trust performance if activities within the QIP are not delivered to time, or they do not have the anticipated impact on operational functions to improve performance.
Financial	Delivery of the QIP will require dedicated funding. These requirements will be included in the 2016/17 contract negotiations with Commissioners.
Governance and Legal	The QIP Board is a sub committee of the Trust Board, and will provide a monthly report to the Trust Board on progress
Equality and Diversity	There are no equality and diversity risks identified in this paper.
Reputation	There may be a reputational risk if the Trust does not deliver against the QIP in making effective organisational change that meets the standards required by the CQC and other stakeholders.
Other	

This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Activities within the QIP will support achievement of this objective.
To make LAS a great place to work	Activities within the QIP will support achievement of this objective.
To improve the organisation and infrastructure	Activities within the QIP will support achievement of this objective.
To develop leadership and management capabilities	Activities within the QIP will support achievement of this objective.

Appendix A

Additional projects for inclusion in the Quality Improvement Programme

THEME	PROJECT	ACTIVITY	DIRECTOR	TASK OWNER	DELIVERY DATE
Making LAS a great place to work - Paul Beal	Vision and Strategy	Review the LAS 5 year strategy	Karen Broughton	Adam Levy	31/10/16
	Workforce and Organisational Development	Develop a workforce and OD strategy, and an associated workforce plan	Karen Broughton	Karen Broughton	31/10/16
		Develop an annual staff recognition and engagement plan	Charlotte Gawne	Charlotte Gawne	30/06/16
Achieving Good Governance - Sandra Adams	Blue Light Collaboration	Work in collaboration with the London Fire Brigade and Metropolitan Police to develop a business case in the area of: response, prevention, control room, estate, and back office support	Karen Broughton	Karen Broughton	31/03/17
	CQC Reinspection	To prepare the Trust for the next CQC inspection	Fionna Moore	TBC	31/12/16
	Business intelligence systems	Review the current performance management system	Jill Patterson	Jill Patterson	31/12/16
		Improve benchmarking and horizon scanning	Jill Patterson	Jill Patterson	31/12/16
	Internal Audit	Regular reporting on delivery of internal audit recommendations	Sandra Adams	Sandra Adams	31/05/16. Quarterly checks
	Policy & Guidance Review	Introduction of a monthly plan to ensure policy and guidance documents are up to date	Sandra Adams	Sandra Adams	30/06/16. Quarterly checks
Improving patient experience - Zoe Packman	Learning from experiences	Develop a patient voice strategy	Zoe Packman	Zoe Packman	31/12/16
		Improve and evidence how we learn from incidents, risks, feedback and external inquiries	Fenella Wrigley	Fenella Wrigley	31/12/16

THEME	PROJECT	ACTIVITY	DIRECTOR	TASK OWNER	DELIVERY DATE
Improving environment and resources – Andrew Grimshaw	Information Management and Technology	Agree and IM&T strategy to ensure technology supports business delivery	Andrew Grimshaw	Andrew Watson	31/12/16
	Facilities and Estates	Develop and Estates Strategy	Sandra Adams	Sandra Adams	30/09/16
	Operations Management	Review of the Operations Management structure	Paul Woodrow	Paul Woodrow	30/06/16
	Improving Operational Productivity	Deliver a reduction in job cycle time in line with the 2016/17 trajectory agreed with Commissioners	Paul Woodrow	Paul Woodrow	31/03/17
		Deliver the non emergency transport service in line with the 2016/17 trajectory agreed with Commissioners	Paul Woodrow	Paul Woodrow	31/03/17
	Cost Improvement Programme	Deliver the cost improvement programme for 2016/17	Andrew Grimshaw	Andrew Grimshaw	31/03/17
	Frontline Equipment and Uniforms	Review and improve uniforms for frontline staff	Paul Woodrow	Paul Woodrow	01/10/16
		Review and improve equipment for frontline staff	Andrew Grimshaw	Andrew Grimshaw	31/12/16
Taking Pride & Responsibility – Fenella Wrigley	Quality and clinical strategy	Develop the quality and clinical strategy	Fenella Wrigley	Fenella Wrigley	30/07/16
	Operating Model and Clinical & Education Strategy	Review of the Trust operating model to support the quality and clinical strategy	Paul Woodrow	Paul Woodrow	31/12/16
		To develop a Clinical Education and Training strategy to support the new quality and clinical strategy	Karen Broughton	Tina Ivanov	31/12/16
	Developing the 111 Service	Review 111 procurement opportunities across London as they become available and make recommendations on LAS bidding	Karen Broughton	Karen Broughton	31/03/17
		Review our existing 111 service to further improve the way we work on the cost of our service	Paul Woodrow	Paul Woodrow	31/12/16

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Assurance report from the Quality Governance Committee**
Report Author(s):	**Bob McFarland, Non-executive director and Chair of the Quality Governance Committee**
Presented by:	**Bob McFarland, Non-executive director and Chair of the Quality Governance Committee**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**1. Assurance** **2. Approval of the terms of reference of the Quality Governance Committee**

Background/Purpose

The purpose of this report is to update the Trust Board on key items of discussion at the Quality Governance Committee on 15th March 2016.
The Trust Board is asked to note that the Committee reviewed its terms of reference and membership and the final version is attached for Trust Board approval.

Action required

1. To note the discussion at the Quality Governance Committee on 15th March 2016.
2. To approve the terms of reference of the Quality Governance Committee.

Assurance

The primary focus of the Quality Governance Committee is to assure the Board on clinical governance, risk and audit through monitoring the standards of care set by the Board ensuring that the three key facets of quality – effectiveness and outcomes, patient safety and patient experience – are being met. This in turn will enhance the Board's oversight of quality performance and risk.

Key implications and risks arising from this paper	
Clinical and Quality	**X**
Performance	**X**
Financial	**X**
Governance and Legal	**X**
Equality and Diversity	
Reputation	**X**
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**X**
To make LAS a great place to work	**X**
To improve the organisation and infrastructure	**X**
To develop leadership and management capabilities	

Report from the Quality Governance Committee on 15th March 2016

There were no new issues which require the attention of the Board.

The Quality Governance committee is still concerned that the EOC staffing review which has been under investigation and consideration now for over 12 months since the problem was recognised has yet to be finalised and reported to both the Executive Leadership Team and the Trust Board. It is understood that there are significant implications if staff numbers in EOC are increased (particularly cost and space). However in view of the important safety functions and the high staff turnover in EOC an action plan needs to be decided upon and delivered soon.

C3 delays are still a concern and we await the Internal Safety Review which should be available in April.

The committee discussed the recent increase in activity which seems to be a real increase with no obvious explanation for the step change. This is occurring across all ambulance services and is not just a London phenomenon.

INTERNAL ASSURANCE

Clinical Governance
The committee was pleased to take reports from the Clinical Safety and Standards committee, the Improving Patient Experience committee and the Risk Compliance and Assurance Group.

The Medicines Management group has been active since the CQC report and it is felt that local practice has improved. Plans include a tracking barcode system in the relative short term and in the future an electronic dispensing system has advantages.

Mark Whitbread is going to review the Cardiac figures which have improved recently, to identify any relationship between the activity levels, response times and outcomes.

The Improving Patient Experience report highlighted significant improvement in the number of open complaints. There has been an improvement in the Staff Survey results and response rate although they were still not good.

The first meeting of the Risk Compliance and Assurance Group was on 8th March.

The papers for this meeting did not include the Quality Dashboard, BAF, Risk Register or SI tracker. Although we have agreed that any significant issues should be highlighted in the feeder committee reports, members felt they should still have sight of these papers if they were to be confident all issues had been properly identified and understood.

BUSINESS ITEMS

The Terms of Reference for the committee were presented and approved.

The TDA observation feedback was reviewed. It was agreed that better time management, more clarity and consistency in the format and way papers were presented and a more systematic assessment of each would improve the assurance function.
We did not feel that an increase in the number of meetings was appropriate, although Sandra Adams is going to arrange an extra meeting in April specifically so the committee can comment on the Quality Account (not available today) before it is finalised and recommended to the Board.

DEEP DIVE

Clinical Audit Workplan 2016/2017 and Clinical Audit Recommendations – Progress report.

Joanne Shaw and Rachel Fothergill presented the draft Clinical Audit work plan for the coming year and reviewed the last year's work with the majority of actions completed or due to be completed with the next few months.

The committee congratulated the team on a substantial achievement and commended the systematic approach to research and audit – both the new work undertaken as a LAS initiative and the substantial amount of work done to satisfy national reporting standards. There was also a positive discussion around the involvement of trainee and qualified paramedics in audit projects.

Date of next meeting

The next meeting of the Quality Governance Committee is on Tuesday 17th May 2016.
NOTE THE MEETING WILL BEGIN AT 1300 in order that several members can still attend the full meeting which we will aim to finish by 1600.

Subsequent meetings next year will be on 12th July, 13th September, 15th November 2016.

There will be an additional meeting arranged in April to consider the Quality Account for 2015.

Terms of Reference
March 2016
Quality Governance Committee

1. Authority

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

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

2. Purpose

2.1 The primary focus of the Quality Governance Committee will be to assure the Board on clinical governance, risk and audit through monitoring the standards of care set by the Board ensuring that the three key facets of quality – effectiveness and outcomes, patient safety and patient experience – are being met. This in turn will enhance the Board's oversight of quality performance and risk.

2.2 The Committee provides assurance to the Trust's Audit Committee on the effectiveness of the clinical risk management arrangements.

2.3 The Committee shall:

2.3.1 Offer scrutiny to ensure that the required standards are achieved and action taken to improve performance where required and to hold senior managers to account for delivery.

2.3.2 Oversee the systems and processes in place to ensure that the Trust's services deliver safe, high quality, patient-centred care;

2.3.3 Seek assurance that processes are in place and evidence is available to support a cycle of continuous improvement in the provision of high quality and safe services within the framework of the Trust's Clinical Strategy.

2.3.4 Offer scrutiny and oversight of the quality impact assessments underpinning the Cost Improvement Programme and the *Quality Improvement Programme.*

2.3.5 Seek assurance that arrangements are in place to maintain compliance with external regulatory requirements and standards including: the Care Quality Commission's Essential Standards of Quality and Safety; Monitor's *Well-led* Framework;

2.3.6 Seek assurance that organisational systems and processes are robust and embedded so that priority is given, at the top level, to identifying and managing risks to patient care.

2.3.7 Support the development by the Board of a culture that reflects NHS values as defined in the NHS Constitution:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives; and
- Everyone Counts.

2.3.8 Oversee the implementation of arrangements to address the key recommendations from reports.

2.3.9 To seek assurance on the application of the statutory Duty of Candour.

3. Quality and Safety Assurance

3.1 To ensure that the Trust has in place a Clinical ~~*Quality*~~ Strategy that drives the overall strategy and integrated business plan of the organisation.

3.2 To oversee and recommend to the Trust Board the approval of the annual Quality Account.

3.3 To assure the Trust Board that the quality dashboard and performance against key clinical quality indicators and any associated risks are being monitored and managed.

3.4 To receive reports on outcomes and effectiveness of patient treatment, care and interventions with particular reference to clinical quality indicators.

3.5 To oversee the programme for patient involvement and experience and to seek assurance that this incorporates the CQC regulatory requirements and the development of the annual Quality Account.

3.6 To ensure that the patient voice is heard at the Board table through a programme of patient stories presented to the Board with the issues and lessons reviewed by the Quality Governance Committee.

3.7 To take assurance from the outcomes and actions taken to achieve full compliance with Monitor's Well-led framework and the CQC well-led domain.

3.8 To receive assurance reports from the executive-led quality improvement group on progress against the CQC quality improvement programme and to cross-reference with the Board Quality Improvement Programme Board to understand the implications on quality and safety.

4. Clinical Risk Management

4.1 To seek assurance on the effectiveness of processes and systems for managing clinical governance, risks and audit.

4.2 To oversee the clinical risk management processes throughout the organisation including regular review of the clinical risk register and the actions in place to mitigate and manage the risks to patient safety.

4.3 To seek assurance from the clinical audit programme and how this supports clinical improvements and delivery and reflects the key strategic risks as defined in the board assurance framework.

5. Monitoring and Reporting

5.1 To receive regular assurance reports from the following committees on outcomes, effectiveness, patient safety, clinical risk and the patient experience:

- *Clinical safety and standards*
- *Improving patient experience*
- *Risk compliance and assurance*

5.2 To receive regular assurance reports from the Executive Leadership Team on workforce so as to assess any impact or risk on the delivery of high quality and safe care for patients.

5.3 To ensure that quality drives the Board agenda.

5.4 To complement the work of the Audit Committee and exchange information and reports on a regular basis.

5.5 To receive and review reports on Serious Incidents, problematic inquests and clinical negligence claims and associated action and outcomes from the Improving Patient Experience group.

5.6 To receive trend information on incidents, complaints and claims and other quality & safety data.

5.7 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include but will not be limited to any reviews by the Care Quality Commission, Health & Safety Executive or other regulators/inspectors etc; and professional bodies with responsibility for the performance of staff or functions (e.g. accreditation bodies etc).

6. Membership

6.1 The Committee shall be appointed by the Board and shall comprise the following:

Four non-executive directors, including a non-executive chair
Director of Nursing and Quality
Medical Director
Director of Corporate Affairs/Trust Secretary
Director of Operations
Deputy director, Clinical Education and Standards
Commissioning Representative

The Director of Performance shall be invited to attend all meetings of the Quality Governance Committee and shall receive papers, but will not be required to attend each meeting.

6.2 All non-executive director members and the executive (voting) clinical directors shall have voting rights.

6.3 One non-executive director shall be appointed by the Board to be the Chair of the committee and, in their absence, another non-executive director shall chair the meeting.

6.4 At least one non-executive director shall be a full member of the Audit Committee.

6.5 At least one non-executive director shall be a full member of the Finance and Investment Committee.

6.6 The Director of Nursing and Quality will be the executive lead for the Quality Governance Committee.

6.7 The Director of Corporate Affairs/Trust Secretary shall act as the executive team's link between the Quality Governance Committee and the Audit Committee.

6.8 Other senior managers should be invited to attend when the Committee is discussing areas of quality, safety and risk that are their responsibility, including:

- Consultant Midwife
- Head of Safeguarding
- Head of Infection Prevention & Control
- Head of Governance and Assurance
- Deputy director of Nursing & Quality
- Risk and Audit Manager
- Mental Health Advisor
- Head of Clinical Audit & Research

6.9 The Chief Executive will be invited to attend at least one meeting of the committee a year.

6.10 At least twice a year the appropriate Internal Auditor representative should attend the meeting.

6.11 The Committee will invite a patient representative to attend each meeting.

7. Accountability

7.1 The Quality Governance Committee shall be accountable to the Board of Directors.

8. Responsibility

8.1 The Quality Governance Committee is a formal sub-committee of the Board of Directors and has no executive powers other than those

specifically delegated in these Terms of Reference.

9. Reporting

9.1 The minutes of the Quality Governance Committee meetings shall be formally recorded by the Trust's Committee Secretary.

9.2 An assurance report will be provided to the next meeting of the Trust Board. The emphasis of the report will be to highlight the strategic and corporate risks associated with items considered by the Quality Governance Committee and provide assurance to the Trust Board relative to the mitigation. This report will be given to the Trust Board four times a year.

9.3 The Quality Governance Committee will receive a report from the Clinical Safety and Standard, Improving Patient Experience, and Risk Compliance and Assurance groups at each meeting following their meetings. The reports will provide assurance on the areas covered within the terms of reference of the committee and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these.

9.4 The Chair of the Quality Governance Committee shall draw the attention of the Board to any issues that require disclosure to the full Board or that require executive action.

9.5 The Quality Governance Committee will annually monitor the effectiveness of the committee. A report will be prepared by the Chair and the Director of Nursing and Quality and submitted to the Trust Board, highlighting areas of good practice as well as any shortfall in assurance and the action to be taken to address this.

9.6 Responsibility for monitoring action to be taken rests with the Director of Nursing and Quality.

10. Administration

10.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the agenda with the Chair of the Quality Governance Committee and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

10.2 Agenda items shall be forwarded to the Committee Secretary two weeks before the date of the committee meeting.

10.3 The draft minutes and action points will be available to Committee members within four weeks of the meeting.

10.4 Papers will be tabled at the discretion of the Chair of the Quality Governance Committee.

11. Quorum

11.1 The quorum shall be 3 non-executive director members and 2 executive

director members.

12. Frequency

12.1 Meetings shall be held six times a year with membership extended to the whole Trust Board and an invitation to attend and participate extended to all staff

12.2 Any formal member of the committee may request a meeting if they consider that one is necessary.

12.3 Committee members are required to attend at least 50% of the committee's meetings per financial year. Committee members' attendance will be recorded in the minutes of each meeting and reviewed at the end of each year to ensure that this requirement is met.

13. Terms of Reference Review

13.1 The Quality Governance Committee will review these Terms of Reference annually.

13.2 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.

Terms of Reference
March 2016

Document Profile and Control

Learning from Experience Group Terms of Reference		
Version:	**Approved by:**	**Date:**
March 2016	Quality Governance Committee	15th March 2016

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Finance Report Month 11 - Part 1**
Report Author(s):	**Director of Finance and Performance**
Presented by:	**Andrew Grimshaw**
Contact Details:	**02077832041**
History:	***ELT, Finance & Investment Committee***
Status:	***To note the paper***

Background/Purpose

Statement of Comprehensive Income

In month the position is £1.8m favourable to plan, with the year to date reporting £1.7m favourable to plan. The Trust is reporting a £5.5m deficit YTD. The year end forecast is now £4.4m deficit due to the expected receipt of system resilience funding of £2.4m.

The favourable position is driven by:

- £4.5m has been transferred from Capital to revenue as agreed with the TDA, £4.1m reported YTD.
- Income provision of £1.5m related to a >2% reduction in Cat C has been released following return to plan of CAT C activity across Q3 and 4 and agreement with CCGs.
- The Trust has now agreed a revised level of specialised services income of £2.0m. This will, however, represent a £2.3m shortfall against the original £4.3m plan.
- It should be noted that the Trust's underlying position once the non-recurrent Capital to Revenue adjustment and system resilience funding is excluded is £11.3m deficit (£4.4m plus £4.5m plus £2.4m) which would be a shortfall against the planned £9.0m deficit of £2.3m.

Statement of Position

Capital expenditure totals £6.4m to the end of M11, with spend of £3.8m expected before the end of the year. The Trust CRL was amended to reflect the recent capital to revenue transfer of £4.5m. The revised CRL is now £10.2m.

Statement of Cashflow

Cash is £17.6m this is £0.6m above plan. The Trust has received payment for some of the overdue transformation and other contract income. The year-end forecast is £18.6m which is £6.8m above plan this assumes that the CCGs pay all of the outstanding overdue debts for the SLAs and Transformation Income for periods Q1 to Q3 in March. The reason for the favourable variance is the £4.5m capital to revenue transfer and £2.4m system resilience funding.

Action required
Note the financial position reported as at Month 11 (February) 2016

Assurance
The reporting of the financial position is as follows: Timely: the report relates to the latest financial period (Month 11 – March) Accurate: The report covers all core financial statements and key issues and conforms to all accounting rules and regulations. All reports have been submitted to respective internal and external stakeholders within agreed timescales.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	**This report covers all key financial issues, risks and challenges**
Governance and Legal	
Equality and Diversity	
Reputation	
Other	

This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	
To make LAS a great place to work	
To improve the organisation and infrastructure	
To develop leadership and management capabilities	

London Ambulance Service NHS Trust
Finance Report - Part 1 – 2015/16
Month 11: February

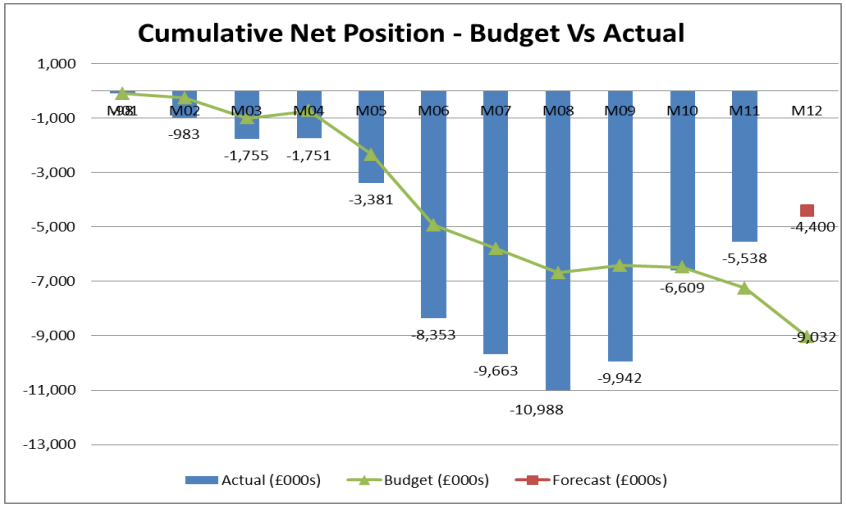
ELT Meeting – 16th March 2016
Trust Board (SRP) – 29th March 2016

Andrew Grimshaw
Finance Director

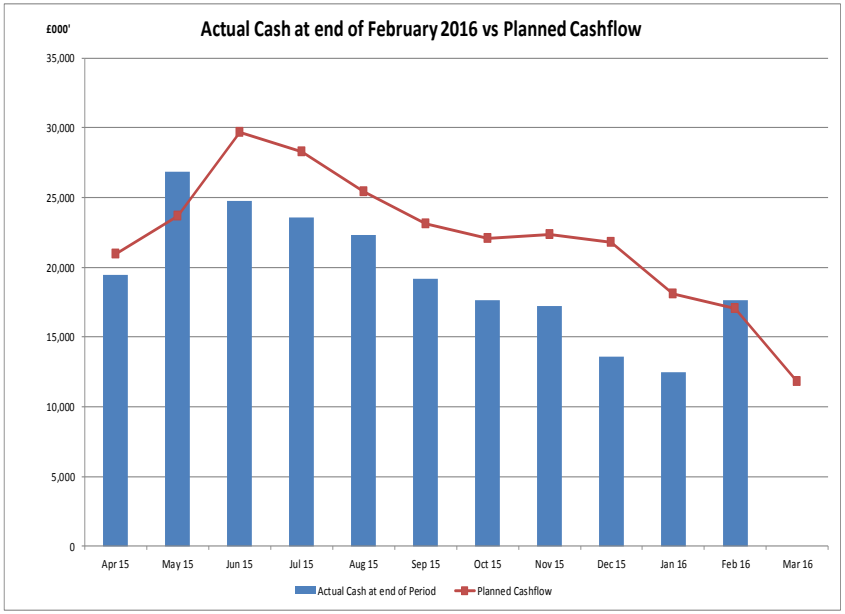
Finance Summary: M11 (2015/16)

Financial Indicator	Summary Performance	Current Month	Previous month
Surplus (Year to date)	In month the position is £1.8m favourable to plan, with the year to date reporting £1.7m favourable to plan. The Trust is reporting a £5.5m deficit YTD. The year end forecast is now £4.4m deficit due to the expected receipt of system resilience funding of £2.4m. The favourable position is driven by: • £4.5m has been transferred from Capital to revenue as agreed with the TDA, £4.1m reported YTD. • Income provision of £1.5m related to a >2% reduction in Cat C has been released following return to plan of CAT C activity across Q3 and 4 and agreement with CCGs. • The Trust has now agreed a revised level of specialised services income of £2.0m. This will, however, represent a £2.3m shortfall against the original £4.3m plan. • It should be noted that the Trust's underlying position once the non-recurrent Capital to Revenue adjustment and system resilience funding is excluded is £11.3m deficit (£4.4m plus £4.5m plus £2.4m) which would be a shortfall against the planned £9.0m deficit of £2.3m.	**AMBER**	**AMBER**
Income	Income is £3.3m favourable in Month and £2.3m favourable year to date. The key drivers for this position are: • Income provision of £1.5m related to a >2% reduction in Cat C has been released following recovery of CAT C activity across Q3 and 4 and agreement with CCGs. • The Trust agreed a revised level of specialised services income of £2.0m in Month 9. £1.8m of this has been recognised YTD. • £4.5m has been transferred from Capital to revenue, £4.1m reported YTD. Securing all the additional transformation funds is now expected and being finalised with Commissioners.	**AMBER**	**AMBER**
Expenditure (incl. Financial Charges)	In month expenditure is £1.5m adverse to plan, and year to date £0.6m adverse. The key drivers for this position are: • Frontline capacity support is reducing in line with plans across Quarter 4. Overtime rates, hours and incentives are reducing as fully operational recruits become available. However, resource remains available to support increased activity and is being targeted at FRU and week-end cover. • Partially offset by £3.9m of planned reserves released to support the position. The Trust's main cost pressures arise from additional frontline resourcing costs. There are 3 key drivers for the additional expenditure: • In Month Substantive Frontline WTEs increased due to ongoing recruitment. • Overtime spend remain high but have significantly reduced due to Increasing levels of new recruits becoming operational, reduced appetite to work overtime after busy Christmas period, rates reduced from double time to time and a half in line with plan. • Incentives remain in place for disruption and have been focused on FRU and weekend cover.	**AMBER**	**AMBER**
CIPs	Year to date CIPs are £0.3m adverse to plan. The full year plan of £8.9m is still expected to be largely achieved as benefits expected in Month 12 are realised	**AMBER**	**RED**
Balance Sheet	Capital expenditure totals £6.4m to the end of M11, with spend of £3.8m expected before the end of the year. The Trust CRL was amended to reflect the recent capital to revenue transfer of £4.5m. The revised CRL is now £10.2m.	**AMBER**	**AMBER**
Cashflow	Cash is £17.6m this is £0.6m above plan. The Trust has received payment for some of the overdue transformation and other contract income. The year-end forecast is £18.6m which is £6.8m above plan this assumes that the CCGs pay all of the outstanding overdue debts for the SLAs and Transformation Income for periods Q1 to Q3 in March. The reason for the favourable variance is the unplanned £4.5m capital to revenue transfer and £2.4m system resilience funding.	**GREEN**	**RED**

Executive Summary - Key Financial Metrics



	2015/16 - Month 11			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(776)	1,071	1,847	(7,260)	(5,533)	1,727	(9,025)
EFL				3,675	(5,424)	9,099	8,648
CRL				17,278	6,378	10,900	20,664
Suppliers paid within 30 days - NHS	95%	48%	(47.0%)	95%	70%	(25.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	78%	(17.0%)	95%	86%	(9.0%)	95%
Monitor							
EBITDA %	2.9%	8.8%	5.9%	3.1%	3.4%	0.3%	6.3%
EBITDA on plan	741	2,526	1,785	9,008	9,833	824	8,756
Net Surplus	(776)	1,071	1,847	(7,260)	(5,533)	1,727	(9,025)
NRAF (net return after financing)				(5.5%)	(4.1%)	1.4%	-6.90%
Liquidity Days				(2.11)	1.58	3.7	(10.86)
FSRR (Financial Sustainability Risk Rating)				2.0	2.0	0.0	2.0



- In Month the position is £1.8m favourable to plan while year to date the Trust is reporting a £1.7m favourable variance from plan.
- On-going pressures are:
  - Additional spend in support of performance.
  - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
  - Identification and delivery of CIPs.
  - specialised services Income £4.3m will not be received in full. The Trust will now receive £2.0m
- Cash is £17.6m, £0.6m above plan. The Trust has received payment for some of the overdue transformation and other contract income.
- The EFL variance is due to higher than planned cash balances £0.6m, planned loan of £6.0m not being drawn down and capital to revenue transfer of £2.5m.
- Monitor has replaced the existing Continuity of Service Risk Rating (CSRR) with the Financial Sustainability Risk Rating (FSRR). FSRR includes two new measures I&E Margin and I&E Margin variance from plan. The Trust would expect to score a FSRR of 2 for the YTD results based on the current Monitor metrics (maximum rating).
- CRL position – The capital plan is £10.9m behind target, of which £4.4m is due to slippage, £2.5m is due to the capital to revenue transfer and £4.0m has been deferred due to the Trust not going ahead with the £6.0m capital investment loan this year. The TDA have approved an additional capital to revenue transfer of £2.0m in month 10. The TDA has amended the Trust's CRL to £10.2m.
- The Trust has revised its plan in line with NTDA guidance and committed to additional savings of £0.5m.

Statement of Comprehensive Income

2015/16 - Month 11			Description	Year to Date			FY 2015/16
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Income				
22,885	24,699	1,813	Income from Activities	260,438	259,078	(1,360)	282,370
2,501	4,028	1,527	Other Operating Income	28,444	32,140	3,696	30,944
25,386	**28,727**	**3,341**	**Subtotal**	**288,882**	**291,218**	**2,336**	**313,315**
			Operating Expense				
19,713	18,500	1,213	Pay	214,382	213,011	1,371	234,161
4,931	7,700	(2,769)	Non Pay	65,492	68,375	(2,883)	70,398
24,645	**26,200**	**(1,556)**	**Subtotal**	**279,874**	**281,386**	**(1,512)**	**304,559**
741	**2,526**	**1,785**	**EBITDA**	**9,008**	**9,833**	**824**	**8,756**
2.9%	8.8%	5.9%	**EBITDA margin**	3.1%	3.4%	0.3 %	2.8%
			Depreciation & Financing				
1,175	1,131	44	Depreciation	12,483	11,896	587	13,657
304	319	(15)	PDC Dividend	3,342	3,504	(162)	3,646
38	6	32	Interest	443	(35)	478	481
1,517	**1,455**	**62**	**Subtotal**	**16,268**	**15,365**	**903**	**17,785**
(776)	**1,071**	**1,847**	**Net Surplus/(Deficit)**	**(7,260)**	**(5,533)**	**1,727**	**(9,029)**
(3.1%)	3.7%	6.8%	**Net margin**	-2.5%	-1.9%	0.6%	-2.9%

The overall financial position is favourable £1.7m to plan YTD. This relates primarily to the improvement in Specialised services income in December of £1.8m and a £4.1m non recurrent Capital to Revenue transfer.

Income

- Income is £3.3m favourable in Month and £2.3m favourable YTD. This relates to:
- £1.5 income reduction provision related to a >2% reduction in Category C income has been released. This provision has been released at Month 11 as CAT C activity has now returned to projected levels and agreement has been reached with CCGs.
- The Trust is now expecting to receive £2.0m of the full value of the £4.3m related to specialised services income. We have accrued £1.8m of this in February.
- A transfer of £4.5m Capital to Revenue has been agreed with the TDA with £4.1m recognised YTD.
- The Trust reduced its income by £1.4m in line with agreement with Barking, Havering & Redbridge CCG relating to prior year income.

Operating Expenditure (excl. Depreciation and Financing)

- Overall £1.8m favourable in Month and £0.8m favourable to plan YTD primarily due to:
  - Frontline capacity support is reducing in line with plans across Quarter 4. Overtime rates, hours and incentives are reducing as fully operational recruits become available. However, material additional resource is still in place to support increased activity and is being targeted at FRU and week-end cover.
  - Unproductive hours related to the Training and supervision of new recruits (EACs and International Paramedics) have been higher then expected.
  - Additional scrutiny and review are now in place for overtime and incentives to ensure robust figures in the short term. Wider system issues are now under review for longer term stability.
  - £0.5m pressure due to unidentified CIP not delivered.
  - The adverse movements are partially offset by £3.8m YTD of planned reserve releases to support the position.

Depreciation and Financing

- Overall Financial Charges are £0.1m favourable in Month and £0.9m favourable YTD due to an unwinding of discount rate benefit of £0.5m and delays in the Capital Programme.

Divisional Expenditure (excludes Income)

2015/16 - Month 11			Description	Year to Date			FY 2015/16
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Operational Divisions				
11,569	13,582	(2,013)	Core Frontline (Rostered)	136,507	148,353	(11,846)	148,147
1,283	1,261	21	Core Frontline (Non Rostered)	14,111	15,102	(991)	15,394
0	0	0	Other Frontline	0	0	0	0
1,913	1,951	(39)	EPRR	20,976	19,986	989	22,888
0	0	0	Resource Centre	0	0	0	0
2,157	1,804	353	EOC	23,726	22,140	1,586	25,883
146	159	(13)	PTS	2,194	2,415	(221)	2,340
647	469	178	NETS	5,053	3,853	1,200	5,700
578	453	125	111 Project	6,306	5,462	845	6,885
18,291	**19,679**	**(1,388)**	**Subtotal**	**208,873**	**217,312**	**(8,439)**	**227,236**
			Support Services				
2,320	2,346	(27)	Fleet & Logistics	25,301	23,754	1,546	27,620
897	805	92	IM&T	10,395	9,982	414	11,292
351	420	(68)	HR	3,866	3,717	149	4,217
0	0	0	Education & Development	0	0	0	0
812	1,041	(229)	Estates	8,905	8,492	412	9,689
19	17	2	Support Services Management	207	241	(34)	226
4,398	**4,629**	**(230)**	**Subtotal**	**48,673**	**46,186**	**2,487**	**53,044**
			Corporate				
234	410	(176)	Chief Executive & Chair	2,576	2,642	(66)	2,810
303	267	36	Corporate Services	3,332	3,273	59	3,635
0	0	0	Business Development	0	0	0	0
82	71	11	Strategic Communication	901	965	(64)	982
363	415	(52)	Finance	3,788	4,348	(560)	4,147
3	0	3	Project Management	30	9	21	33
123	126	(3)	Nursing & Quality	1,354	1,327	27	1,477
214	63	151	Transformation & Strategy	2,351	2,561	(210)	2,565
734	538	196	Clinical Education & Standards	8,074	7,559	515	8,808
244	293	(49)	Medical	2,680	2,422	258	2,924
2,299	**2,184**	**115**	**Subtotal**	**25,086**	**25,106**	**(21)**	**27,382**
			Central				
1,166	1,171	(5)	Central Corporate	13,434	8,019	5,415	14,598
7	(7)	14	Other Central Costs	77	138	(61)	84
1,173	**1,164**	**9**	**Subtotal**	**13,511**	**8,157**	**5,353**	**14,682**
26,161	**27,656**	**(1,495)**	**TOTAL**	**296,142**	**296,760**	**(619)**	**322,343**
25,386	*28,727*	3,341	*Income Memorandum*	*288,882*	*291,218*	*2,336*	*313,315*
(776)	***1,071***	***1,846***	***NET POSITION MEMORANDUM***	***(7,260)***	***(5,542)***	***1,717***	***(9,029)***

Operational Divisions

- Expenditure is currently £1.4m adverse in month and £8.4m adverse YTD
- Frontline Spend is currently £11.8m adverse due to ongoing performance pressures (and additional use of overtime and PAS) and the requirements for additional incentive rates.
- The Non-Rostered Frontline is £1m adverse to plan due to the pending allocation of staff in the Operational Management restructure. This is offset by favourable positions in other operational areas notably EOC and EPRR.
- EOC is favourable due to vacancies in the CHUB.
- EPRR is reported here as £1m favourable. EPRR is understated as no Overtime is included within the total as it is all reported into the core frontline budgets. Future statements will seek to correct this.
- NETS is favourable due to timing differences between planned and actual spend as the service is developed.
- PTS is currently showing a small negative variance (£0.2). This is however offset by a positive income variance.

Support Services

- Support Services is favourable to plan £2.5m YTD.
- Fleet is underspent £1.5m YTD mainly due to variation in maintenance spending .
- HR are overspent by £0.2m which relates to Occupational Health set up costs early in the year.
- Estates are £0.4m favourable to plan due to lower than expected utility costs.

Corporate

- Overall Corporate divisions are £0.1m adverse in month and on plan YTD.
- Finance is £0.6m overspent due to planned consultancy costs in Performance as part of the Transformation programme. The current overspend is driven by timing differences in the budget phasing.
- Transformation and Strategy is overspent (£0.2m) due to additional agency costs in the contracting team which will continue subject to an imminent restructure.
- Clinical education is underspent by £0.5m due to timing differences between Transformation programme roll out and budget phasing.
- Medical is underspent £0.3m YTD due to APP vacancies in the first half of the year, these posts have now been filled.

Central –

- Central Corporate is favourable mainly due to the release of reserves to support divisional positions.
- Planned Creditors of £3.8m have been released YTD in order to support the operational position.
- In addition £4.4m of other reserves have been released
- £3.7m of CIP remains centrally allocated which partially offsets the above.

Income

- Income is as per the Statement of Comprehensive Income (SOCI)

Statement of Financial Position: YTD

	Mar-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Feb-16		
	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000			
Non Current Assets										
Property, Plant & Equip	134,668	134,637	133,852	133,469	132,784	132,060	131,427	138,623	(7,196)	-5.19%
Intangible Assets	10,634	9,369	9,147	8,929	8,715	8,588	8,352	8,567	(215)	-2.51%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	
Subtotal	145,302	144,006	142,999	142,398	141,499	140,648	139,779	147,190	(7,411)	-5.03%
Current Assets										
Inventories	3,026	3,055	3,044	3,056	3,068	3,053	3,044	3,028	16	0.53%
Trade & Other Receivables	33,813	17,738	18,829	18,589	26,229	30,562	27,220	17,098	10,122	59.20%
Cash & cash equivalents	14,699	19,133	17,637	17,180	13,596	12,433	17,623	17,024	599	3.52%
Non-Current Assets Held for Sale	101	101	101	101	101	101	101	101	0	
Total Current Assets	51,639	40,027	39,611	38,926	42,994	46,149	47,988	37,251	10,737	28.82%
Total Assets	196,941	184,033	182,610	181,324	184,493	186,797	187,767	184,441	3,326	1.80%
Current Liabilities										
Trade and Other Payables	(39,303)	(36,551)	(36,743)	(37,167)	(39,550)	(37,539)	(39,572)	(33,069)	(6,503)	19.66%
Provisions	(7,357)	(5,154)	(4,815)	(4,453)	(4,116)	(4,116)	(6,005)	(2,005)	(4,000)	199.50%
Borrowings	0	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	(857)	857	
Net Current Liabilities)	(46,660)	(41,705)	(41,558)	(41,620)	(43,666)	(41,655)	(45,577)	(35,931)	(9,646)	26.85%
Non Current Assets plus/less net current assets/Liabilities	150,281	142,328	141,052	139,704	140,827	145,142	142,190	148,510	(6,320)	-4.26%
Non Current Liabilities										
Trade and Other Payables	0	0	0	0	0	0	0	0	0	
Provisions	(9,963)	(10,364)	(10,398)	(10,375)	(10,451)	(11,436)	(9,913)	(10,272)	359	-3.49%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	(5,143)	5,143	
Total Non Current Liabilities	(10,070)	(10,471)	(10,505)	(10,482)	(10,558)	(11,543)	(10,020)	(15,522)	5,502	-35.45%
Total Assets Employed	140,211	131,857	130,547	129,222	130,269	133,599	132,170	132,988	(818)	-0.62%
Financed by Taxpayers Equity										
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	60,016	62,516	(2,500)	-4.00%
Retained Earnings	30,746	22,392	21,082	19,757	20,804	24,134	25,205	23,523	1,682	7.15%
Revaluation Reserve	47,368	47,368	47,368	47,368	47,368	47,368	47,368	47,368	0	0.00%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	140,211	131,857	130,547	129,222	130,269	133,599	132,170	132,988	(818)	-0.62%

Non Current Assets

- Non current assets stand at £139.8m, £7.4m below plan. This is due to capital slippage.

Current Assets

- Current assets stand at £48.0m, £10.7m above plan.
- Cash position as at February is £17.6m, £0.6m above plan. This is due to higher than planned trade & other receivables, provision balances and trade & other payables.
- Within Trade & Other Receivables , Receivables (debtors) at £13.9m are £6.2m above plan , accrued income at £9.9m is £5.0m above plan and prepayments at £3.3 are £1.0m below plan. The reason for the higher than planned receivables and accrued income is that the service level agreement (SLA) for the transformation funding requires the Trust to raise invoices quarterly in arrears .

Current Liabilities

- Current liabilities stand at £45.6m, a £9.6m increase on plan.
- Payables and accruals at £35.3m are £2.4m above plan.
- The Trust has a high volume of unapproved trade payables at £3.6m.
- Current provisions at £6.0m are £4.0m higher than plan. The Trust is waiting for the final bills related to industrial action in 2014/15. Also the Trust has not incurred any redundancy costs associated with the first stages of the management restructure.

Non Current Liabilities

- Non current provisions and borrowings are £0.4m below plan.

Taxpayers Equity

- Taxpayers Equity stands at £132.2m, £0.8m lower than plan.
- Retained Earnings at £25.2m, £1.7m higher than plan. The Trust has a lower than planned year to-date deficit.

Cashflow Statement YTD

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD Move	YTD Plan	Var
	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	22,311	19,133	17,637	17,180	13,596	12,433	**14,699**	**14,699**	**0**
Operating Surplus	(3,488)	121	107	2,481	4,792	2,527	9,886	8,588	1,298
(Increase)/decrease in current assets	3,452	(1,080)	228	(7,652)	(4,318)	3,351	6,575	16,711	(10,136)
Increase/(decrease) in current liabilities	620	251	324	1,977	(2,168)	1,791	4,017	(4,094)	8,111
Increase/(decrease) in provisions	(1,189)	(316)	(397)	(273)	973	354	(1,529)	(5,166)	3,637
Net cash inflow/(outflow) from operating activities	(605)	(1,024)	262	(3,467)	(721)	8,023	18,949	16,039	2,910
Cashflow inflow/outflow from operating activities	**(605)**	**(1,024)**	**262**	**(3,467)**	**(721)**	**8,023**	**18,949**	**16,039**	**2,910**
Returns on investments and servicing finance	10	10	8	7	7	7	107	136	(29)
Capital Expenditure	(936)	(482)	(727)	(124)	(449)	(340)	(11,985)	(18,207)	6,222
Dividend paid	(1,647)	0	0	0	0	0	(1,647)	(1,643)	(4)
Financing obtained	0	0	0	0	0	0	0	6,000	(6,000)
Financing repaid	0	0	0	0	0	(2,500)	(2,500)	0	(2,500)
Cashflow inflow/outflow from financing	**(2,573)**	**(472)**	**(719)**	**(117)**	**(442)**	**(2,833)**	**(16,025)**	**(13,714)**	**(2,311)**
Movement	(3,178)	(1,496)	(457)	(3,584)	(1,163)	5,190	2,924	2,325	599
Closing Cash Balance	**19,133**	**17,637**	**17,180**	**13,596**	**12,433**	**17,623**	**17,623**	**17,024**	**599**

There has been a net inflow of cash from the Trust of £0.6m.
Cash funds at 29 February stand at £17.6m.

Operating Surplus

- The operating surplus is £1.3m higher than planned due to a lower than planned deficit.

Current Assets

- The ytd movement on current assets is £6.6m, a £10.1m decrease on plan.
- Current assets movement was lower than planned due to an increase in accrued income (£5.0m), receivables (£6.2m) and a decrease in prepayments £1.0m. The increase in accrued income is mainly due to the transformation & Q3 CQUIN income not being invoiced.

Current Liabilities

- The ytd movement on current liabilities is £4.0m, a £8.1m increase on plan.
- Current liabilities movement was higher than planned due to increases in accruals £2.8m, trade and other payables £1.2m and deferred income £4.1m.

Provisions

- The ytd movement on provisions is (£1.5m), a £3.6m above plan. The Trust is continually reviewing it's provisions and releasing from the balance sheet as required. Currently, Redundancy and Employee Tribunal spends are lower than expected and so provisions have been reduced as a result.

Capital Expenditure

- Capital cash outflow is £6.2m behind plan for the year.

Financing

- The Trust did not apply for a £6.0m capital investment loan as planned during the year.
- The Trust repaid £2.5m PDC as part of the capital to revenue transfer.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Report from the Finance and Investment Committee (FIC)**
Report Author(s):	**Director of Finance**
Presented by:	**Chair of the FIC**
Contact Details:	
History:	***This paper summarises the agenda for the FIC meeting of the 24th March for the Trust Board.***
Status:	***Assurance***

Background/Purpose

This paper details the agenda for the FIC meeting of the 24th March. It is not possible to prepare a detailed paper between this date on the Trust Board papers being issued. The Chairman of the FIC will update the Trust Board on key items discussed at the meeting and any items requiring approval.

Action required

To note the agenda for the FIC of 24th March 2016.

Assurance

This paper details the published agenda for the FIC.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	**Management of the Trust's financial position and performance.**
Governance and Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**Yes**
To make LAS a great place to work	**Yes**
To improve the organisation and infrastructure	**Yes**
To develop leadership and management capabilities	

Trust Board 29th March 2016.
Report from the Finance and Investment Committee (24th Mar 2016).

The following table summarises the agenda for the FIC meeting planned for the 24th Mar. The table details;

1. The action the FIC was requested to take for each agenda item.
2. Any potential action that the Trust Board is requested to take or note in relation to the discussion at the FIC.

The Chairman of the FIC will provide a verbal update to the Trust Board at the meeting on the 24th March.

ITEM	SUBJECT	Purpose	Potential Action for Trust Board
3.	3.1 Finance Report Month 11 2015/16 3.2 13 Week Cash Flow 3.3 Forecast 2015/16	Note Note Note	Note paper to Trust Board
4.	4.1 Development 2016/17 Financial Plan 4.2 PTS Strategy Review	Approve Approve	Note if FIC Approved
5.	5.1 Set Annual Workplan and Review 5.2 Well-Led Observation Feedback and Actions 5.3 Membership of FIC	Note Note Note	Note paper to Trust Board
6.	6.1 Technical Releases 6.2 Review of Investment Strategy	Note Note	Note paper to Trust Board
7.	7.1 Performance Management Update	Note	Note paper to Trust Board
8.	8.1 Capital Working Group (CWG) 8.2 CIP Programme Board 8.3 Estates	Note Note Note	Note paper to Trust Board

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Assurance report from the Audit Committee**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Presented by:	**John Jones, Non-executive director and Chair of the Audit Committee**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Assurance** **Approval for the amendment to the Audit Committee terms of reference.**

Background/Purpose

The purpose of this report is to update the Trust Board on key items of discussion at the Audit Committee on 15th February 2016.

Against the update on the appointment of external auditors, the Trust Board is asked to note that a separate paper is being presented with the recommendations from the Audit Committee to establish an Auditor Panel. The Board is asked to note that this will require a change to the Terms of Reference for the Audit Committee. The proposed change is included as an appendix to the assurance report.

Action required

To note the discussion at the Audit Committee on 15th February 2016.

To approve the update to the Audit Committee Terms of Reference.

Assurance

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

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Governance and Legal	**X**
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	
To make LAS a great place to work	
To improve the organisation and infrastructure	**X**
To develop leadership and management capabilities	

Report from the Audit Committee on 15th February 2016

GOVERNANCE AND RISK MANAGEMENT

Board Assurance Framework and Corporate Risk Register

The Audit Committee reviewed the updated risk register and board assurance framework (BAF), which is aligned to the 2015/16 business objectives. The BAF is a dynamic document and reflects the key issues facing the Trust, and the governance and assurance team continue to work with risk owners to ensure BAF risks and key risks are regularly reviewed and updated. Each BAF risk is owned by an executive director and where there had been increasing challenge to risk owners about the actions being taken to mitigate and control the risk. Although it was evident that there was a lot of work being undertaken on these risks the Audit Committee was concerned about the pace at which action was being taken and wanted to see an improvement in risk scores and a reduction in the number of red BAF risks particularly where these had remained red for a long period.

The Committee heard about the risk management training currently underway for managers and that the Executive team and Board would also receive training, linked to the review of the strategic risks.

Subsequent to the meeting, Audit Committee members undertook a piece of work on the management and treatment of red risks and we understand that this is now being taken forward with the Executive team.

Draft Risk Management Policy

The draft policy was presented to the Audit Committee and members had the opportunity to comment on a number of areas and in particular the current risk tolerance statement. This was to be reviewed by the Executive. The Audit Committee felt that the revised policy was much clearer and a final version would be presented to the Trust Board in March.

Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation

These were under review but had not been completed due to the high workload of the teams concerned. The Audit Committee agreed that the current documents remained fit for purpose and requested the next revision to be brought to the September meeting.

Trust Accounting Policies

The Committee agreed the changes to the accounting policies having heard that there had been little change to the previous year's review. A new class of fixed asset, previously leased ambulances with a useful life of two years, would be added to the Fixed Asset note. The financial accounts for the Charitable Funds would not be consolidated in 2015/16 as these were not material.

FINANCIAL REPORTING

Year End Timetable

The annual reporting timetable was presented and the Audit Committee noted that the Draft Annual Accounts would be presented to the meeting on 18th April and the audited accounts to the meeting on 31st May.

Losses and Special Payments

The Committee received the report for the period April – December 2015 and noted that new radios with in-built tracking were being introduced in the coming months and that actions were being taken to reduce the cost of vehicle accidents.

INTERNAL AUDIT AND LOCAL COUNTER FRAUD

Internal Audit Progress Report

The Audit Committee heard that two reports had been completed: Information Governance (significant assurance with minor improvements identified) and Flexible Working Arrangements (partial assurance with improvements identified). Internal Audit were on track against the 2015/16 Plan.

Review of progress against Internal Audit recommendations
The Committee received an update on progress against recommendations and actions. It was noted that of 31 outstanding recommendations on the tracker, 23 were not yet due for completion. Of the 8 overdue recommendations, 2 were high priority relating to Fleet Management, 3 were medium and two were low priority. The Committee expressed concern about the lack of updates on some high priority recommendations and would therefore invite the management lead to the next meeting to discuss this further if no update had been provided.

The Governance and Assurance team would work with action and risk owners to build greater consistency between the risk register and the internal audit recommendations and actions.

The Committee heard that there had been a positive management response to the recommendations arising from the Business Continuity review and it was anticipated that actions would be completed by 31st March.

Information Governance
The review was noted and an outline given of the areas of good practice, including clear information governance structures and policies and the establishment of an information governance committee.

Flexible Working Rostering Arrangements
The Committee noted that the overall assessment of 'partial assurance with improvements identified' was driven by a lack of consistent process for managing flexible working and the absence of regular monitoring and reporting of data related to flexible working; and that policy was not being followed. Two recommendations were high priority and due for completion in April. It was evident that the finance and operations teams were working together but there was a need for improvement in order to address the issues fully.

Local Counter Fraud Specialist Progress Report
The Committee noted the progress report since 9th November 2015 and received an update on cases.

EXTERNAL AUDIT

External Audit presented the plan outlining the key approach, key financial risks and the planned audit strategy to respond to those risks. The Audit Committee agreed to an overall materiality of £3m based on 1% gross expenditure which as higher than the previous year but reflected a different approach with the new auditors.

REPORTS FROM COMMITTEES

The Audit Committee noted the reports from the Finance and Investment Committee and the Quality Governance Committee on their recent meetings.

APPOINTMENT OF AUDITORS
The Audit Committee agreed to refer the recommendation to the Trust Board for approval that the Committee be nominated as the Auditor Panel for the appointment of the external auditors for 2017/18.

PRIVATE MEETING
The Audit Committee held a private meeting with the external auditors following conclusion of the main meeting.

Date of next meeting: The next meeting of the Audit Committee is on Monday 18th April 2015.

Appendix 1

Proposed amendment to the Terms of Reference of the Audit Committee

Replace:

4. External Audit

4.1 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:

4.1.1 consideration of the performance of the External Auditor;

4.1.2 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;

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

4.1.4 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;

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

With:

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 organisation's board/ governing body 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 organisation's board/ governing body on the maintenance of an independent relationship with the appointed external auditor

4.3.3 Advise (if asked) the organisation's board/ governing body 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 organisation's board/ governing body 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:

4.1.1 consideration of the performance of the External Auditor;

4.1.2 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;

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

4.1.4 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;

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

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29TH March 2016**
Document Title:	**The appointment of an Auditor Panel**
Report Author(s):	**Michael John**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andrew.Grimshaw@lond-amb.nhs.uk 020 7783 2041**
History:	**At the Audit Committee meeting on 15 February 2016 the committee agreed to act as the Auditor Panel for the appointment of the external auditors.**
Status:	**The Trust Board is asked to approve** **1. The Audit Committee to act as the Auditor Panel for the appointment of external auditors.** **2. To approve the terms of reference for the Auditor Panel.** **3. To approve the changes to the SFI to allow the Trust Board to appoint its own external auditors.**

Background/Purpose

Ernst & Young LLP were appointed external auditors to the Trust for the two years following a tender run by Public Sector Audit Appointments Limited. The Trust was informed in January 2016 that the option to extend the contract was not going to be taken.

As a consequence of this decision the Trust will have appoint its own auditors when the contract ends. The Trust will therefore have to set-up an auditor panel; this panel will appoint external auditors for the financial year 2017/18. The Department of Health guidance states that Trusts should have an auditor panel in place by March 2016 and to have appointed external auditors by December 2016.

The Trust will have to amend its Standing Financial Instructions (SFIs) to allow it to appoint its own external auditors.

The Trust will conduct a tender process starting in September 2016 to ensure that an external auditor is appointed by the December 2016 deadline.

Action required

Approve the above recommendations.

Assurance
The Auditor Panel and processes to be followed will be established in line with Department of Health guidance. The Audit Committee is recommending to the Trust Board that it forms the Auditor Panel. Amendments will be made to Standing Financial Instructions and the Terms of Reference for the Audit Committee to facilitate this.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	**Yes**
Legal	
Equality and Diversity	
Reputation	
Other	**Effective governance of the Trust**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	**X**
Increase organisational effectiveness and development	

London Ambulance Service NHS
NHS Trust

TRUST BOARD

Paper on the appointment of an Auditor Panel for 2017/18

Introduction

Ernst & Young LLP were appointed external auditors to the Trust for the two years following a tender run by Public Sector Audit Appointments Limited. The Trust was informed in January 2016 that the option to extend the contract was not going to be taken.
The Trust will have to set-up an auditor panel to appoint external auditors for the 2017/18. Trusts should have an auditor panel in place in March 2016 and to have appointed external auditors by December 2016.

Background

The Local Audit and Accountability Act 2014 (the Act) requires every 'relevant authority' to appoint an auditor panel to exercise functions set out in the Act (part 3, section 9). In the NHS, relevant authorities are NHS trusts and clinical commissioning groups (CCGs).
Schedule 4 paragraph 1 of the Act states that:

• The auditor panel MUST be appointed either by the Trust Board OR by the Trust Board and one or more other relevant authority.
• The auditor panel MUST be either a specially established panel OR an existing committee, sub-committee or panel.

It is for the Trust Board to decide how it appoints its auditor panel. The auditor panel must be in place in time to advise on the appointment of external auditors for 2017/18. In practice this means that the panel needs to be established early in 2016.

The attached terms of reference assume that an NHS Trust Board has decided to nominate its existing audit committee to act as its auditor panel. No other relevant authorities are involved. It is important to remember that even when this approach is followed (i.e. the existing audit committee is nominated as the auditor panel), the statutory requirements set for auditor panels must be followed. This means that the panel must have its own terms of reference (see appendix 1) and discharge its duties separately from the audit committee.

Tender Process for the selection of the external auditors

The Trust will conduct a mini tender using existing government framework. The process will take approximately 8 weeks and will start in September 2016. The evaluation panel for the tender will be the Auditor Panel. An outline of the timetable is provided below:
Advertise tender.

- 3 weeks for suppliers to submit a bid.
- 2 weeks to evaluate returned bids.
- 1 week to allow suppliers to present to the evaluation panel.

- 1 or 2 weeks to agree/finalise a recommendation.

The government framework includes all the major audit firms.

Recommendations

That the Trust Board approves:

1. The Audit Committee to act as the Auditor Panel for the appointment of the external auditors.
2. The terms of reference for the Auditor Panel.
3. The Trust Board approves the following changes to the Standing Financial Instructions to allow the Trust to appoint its own external auditors:

   Starting from the financial year 2016/17 the Trust will appoint its own external auditors.

Standing Financial Instructions

Current wording:
2.5 **EXTERNAL AUDIT**

2.5.1 The external auditor is appointed by the Audit Commission and paid for by the Trust. The Audit Committee must ensure a cost efficient external audit service. If there are any problems relating to the service provided by the External Auditor, this should be raised with the external auditor and referred to the Audit Commission if the issue cannot be resolved.

Suggested wording:
2.5 **EXTERNAL AUDIT**

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

For the audit of the accounts for 2015/16 the existing arrangements where auditors were appointed by the Public Sector Audit Appointments Ltd (PSAA) will remain in place. PSAA have taken over the role that the Audit Commission previously performed.

Appendix 1

Draft Terms of Reference for Auditor Panel

Terms of Reference

Constitution

The board body hereby resolves to nominate its audit committee to act as its auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board/governing body and has no executive powers, other than those specifically delegated in these terms of reference.

Membership

The auditor panel shall comprise the entire membership of the audit committee with no additional appointees. This means that all members of the auditor panel are independent, non-executives.
This satisfies the requirement that an auditor panel must have at least three members with a majority who are independent and non-executive members of the board.
In line with the requirements of the *Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015* (regulation 6) each member's independence must be reviewed against the criteria laid down in the regulations.

Chairperson

Either the audit committee chairperson will be appointed by the Trust Board to chair the auditor panel OR one of the auditor panel's members shall be appointed chairperson of the auditor panel by the Trust Board.

Removal/ resignation

The auditor panel chairperson and/ or members of the panel can be removed in line with rules agreed by the Trust Board.

Quorum

To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.

Attendance at meetings

The auditor panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not members of the auditor panel.

Frequency of meetings

The auditor panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit committee.
Auditor panel business shall be identified clearly and separately on the agenda and audit committee members shall deal with these matters as auditor panel members NOT as audit committee members.
The auditor panel's chairperson shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.

Conflicts of interest

Conflicts of interests must be declared and recorded at the start of each meeting of the auditor panel.
A register of auditor panel members' interests must be maintained by the panel's chairperson and submitted to the board/ governing body in accordance with the organisation's existing conflicts of interest policy.
If a conflict of interest arises, the chairperson may require the affected auditor panel member to withdraw at the relevant discussion or voting point.

Authority

The auditor panel is authorised by the board/governing body to carry out the functions specified below and can seek any information it requires from any employees/ relevant third parties. All employees are directed to cooperate with any request made by the auditor panel.
The auditor panel is authorised by the board/governing body to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the organisation's existing rules.

Functions

The auditor panel's functions are to:

• 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 Trust Board as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively
• Advise the Trust Board/ governing body on the maintenance of an independent relationship with the appointed external auditor
• 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
• Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor
• Advise the organisation's Trust Board on any decision about the removal or resignation of the external auditor.

Reporting

The chairperson of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities.

The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's chairperson. The chairperson of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action.

Remuneration

Payments to auditor panel members shall be in line with the organisation's existing approach to remuneration and allowances.

Administrative support

The organisation's secretary (or governance lead) shall be responsible for organising effective administrative support to the auditor panel. The duties of the person appointed to fulfil this role shall include:
• Agreement of agendas with the chairperson

• Preparation, collation and circulation of papers in good time
• Ensuring that those invited to each meeting attend
• Taking the minutes and helping the chairperson to prepare reports to the board/ governing body
• Keeping a record of matters arising and issues to be carried forward
• Arranging meetings for the chairperson
• Maintaining records of members' appointments and renewal dates etc
• Advising the auditor panel on pertinent issues/areas of interest/ policy developments
• Ensuring that panel members receive the development and training they need
• Providing appropriate support to the chairperson and panel members.

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Board Assurance Framework and risk management update**
Report Author(s):	**Frances Field, Risk and Audit Manager**
Presented by:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
This paper has been previously presented to:	**Risk, Compliance and Assurance Group Executive Leadership Team**
Recommendation:	**To review top level risks currently facing the Trust.**

Background/Purpose

Board Assurance Framework

The Risk and Audit Manager has continued to review the top level risks with risk owners during February and March and these updates are reflected in the Board Assurance Framework (BAF). The top level risks facing the Trust continue to present as:

- BAF risks 4 & 7: Service performance risks
- BAF risks 14 & 34: Financial risks
- BAF risks 16, 28 & 29: Clinical and quality risks
- BAF risks 24, 25, 26 and 27: Fleet risks.

The Trust Board agreed at its meeting on 2nd February 2016 to tolerate BAF risk 4 at its current level as the mitigating actions are tied into the 2016/17 planning and contracting discussions.

The Risk Compliance and Assurance Group reviewed the BAF risks on 8th March and agreed that the following risks had been treated and mitigated sufficiently to achieve the target ratings and would therefore be archived:

- BAF risk 3: turnover rates for frontline staff. Retention and recruitment levels were improving.
- BAF risk 28: quality assurance of the dispatch function. Following analysis of cases/errors, results showed that any errors made were not at a level where they had a major impact on patient safety. Agreed to archive but to keep under review.
- BAF risks 31 & 32: Performance Improvement Programme risks. Agreed to close in line with the closure of the programme and to assess any new risks as part of the Quality Improvement Programme.
- BAF risk 30: category 4 infectious diseases. Agreed to close and archive as two lower level risks have been assessed and are being managed via local risk register.

New BAF risk 35 relating to medicines management and recording usage of data. Incorporated in the March BAF and due for review after the Warning Notice review.

BAF risk 20: NHS 111 contracts. Risk reviewed by lead director and net risk rating amended to 12. This risk will be recommended to the RCAG in April for removal from the BAF but to be maintained on the risk register.

Risk management update

- Risk management training for managers: 263 trained to date and 46 remaining. Additional sessions to be arranged for this final group and then quarterly for refresher training and any new managers or staff who wish to undertake the training.
- DatixWeb is on track for implementation in the 1st quarter of 2016/17 and training is underway now. This will facilitate local risk management and better incident reporting amongst other benefits.
- Risk Management Policy has been reviewed and revised (see Board agenda)
- Quarterly Learning from Experience report draws out the key themes and issues emerging from key risk indicators such as incidents, complaints, serious incidents, and claims and inquests.
- An Executive committee focussing on risk is in place
- Risk training for Board members is provisionally scheduled for 4th May and will follow the review and approval of the 2016/17 business plan. The session will focus on the identification of the strategic risks to the achievement of that plan.

The format of the BAF is under review following the outcome of the NHS Trust Development Authority well-led assessment. The format will revert to one that presents the Trust's strategic overview in terms of objectives and then highlights the key risks to the achievement of those objectives as identified through the risk management process and risk registers. This should then move the top risks away from being operational/ day to day and towards more corporate and strategic risks managed through the BAF. With greater focus on the treatment of risk by the Executive team, the BAF will become more dynamic as will the management of the risks contained within it. The revised BAF will follow the work outlined above on the 2016/17 business plan and identification of the key strategic risks to that plan.

Action required

To review top level risks currently facing the Trust and the recent activity undertaken to treat these risks, including those mitigated to target level and archived.

Implications

This paper has the following implications and has been discussed with the appropriate director:

☒ Quality and patient engagement (Director of Nursing and Quality)

☒ Safety (Medical Director)

☒ Clinical Education (Director of Transformation and Strategy)

☒ Operations (Director of Operations)

☒ Financial (Director of Finance and Performance)

☒ Strategic (Director of Transformation and Strategy)

☒ Fleet and Logistics (Director of Finance and Performance)

☒ IM&T (Director of Finance and Performance)

☒ Human Resources (Director of Human Resources)

☒ Estates (Director of Director of Corporate Affairs/Trust Secretary)

☒ Governance (Director of Corporate Affairs/Trust Secretary)

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Quality Framework

This paper supports the following domains of the quality framework:

☒ Safety and Standards
☒ Development, Education and Enablers
☒ Effectiveness, Experience and Evaluation

LAS Objectives

This paper supports the achievement of the following objectives for 2015/16:

☒ Improve patient care
☒ Improve recruitment and retention
☒ Achieve sustainable performance
☒ Simplify our business processes
☒ Increase organisational effectiveness and development

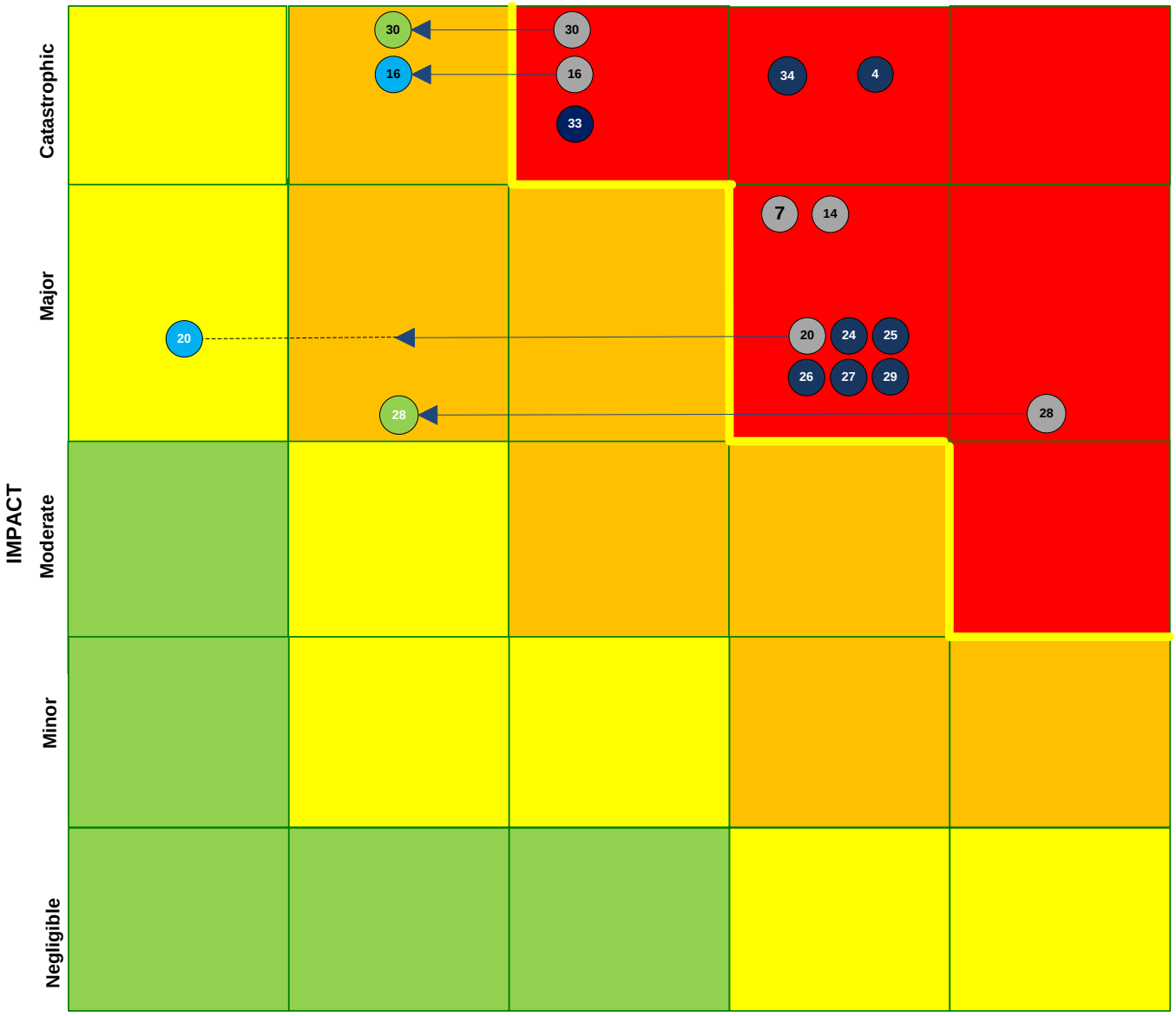
Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Board Assurance Framework – March 2016



Key:

- Gross risk assessment
- Net risk rating
- Gross risk = net risk
- Controls to mitigate are implemented and operating effectively
- Target risk rating

Risk Severity

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

Risk trajectory since November 2015

- BAF Risk 4 - RR 265 Service Performance affected by the inability to match resources to demand
- BAF Risk 7 - RR 269 Performance falls at staff changeover time
- BAF Risk 14 - RR 394 Developing and delivering cost improvements
- BAF Risk 16 - RR 410 Patient safety for category C patients
- BAF Risk 20 – RR 440 Acquiring new 111 contracts as stated in the 5 year strategy
- BAF Risk 24 - RR 441 There may be insufficient vehicle numbers to meet demands
- BAF Risk 25 - RR 442 There may be insufficient range and volume of equipment on vehicles
- BAF Risk 26 - RR 443 Availability of equipment for frontline vehicles
- BAF Risk 27 - RR 444 Condition of equipment for frontline vehicles
- BAF Risk 28 - RR 429 No routine arrangements for quality assurance of dispatch in place
- BAF Risk 29 - RR 451 Lack of ring backs on delayed response calls
- BAF Risk 33 - RR 420 EOC systems environment could be compromised by a cyber attack
- BAF Risk 34 – RR 460 Delivering a balanced financial plan for 2016/17

London Ambulance Service NHS
NHS Trust

Board Assurance Framework – Risk Trajectory

Business Objective 1:	To improve quality and delivery of our urgent and emergency response
Business Objective 2:	To make LAS a great place to work
Business Objective 3:	To improve our organisation and infrastructure
Business Objective 4:	To develop our leadership and management capabilities

	*	CRR Ref	April 2015	May 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016
PRINCIPAL RISK 4 Resources vs. demand	**1**	265	20	20	20	20	20	20	20	20	20	20
PRINCIPAL RISK 7 Performance at changeover	**1**	269	16	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 14 Delivery of cost improvement	**3**	394	16	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 16 Category C patients	**1**	410	15	15	15	15	15	15	15	15	15	15
PRINCIPAL RISK 20 Potential inability to win new NHS 111 contracts	**1, 3**	440	16	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 24 Insufficient vehicle	**1**	441	-	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 25 Insufficient volume of equipment	**1**	442	-	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 26 Availability of equipment	**1**	443	-	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 27 Effective equipment	**1**	444	-	16	16	16	16	16	16	16	16	16
PRINCIPAL RISK 28 QA for dispatch functions	**1**	429	-	-	20	20	20	20	20	20	20	20
PRINCIPAL RISK 29 Lack of ring back on delayed response calls	**1**	451	-	-	-	16	16	16	16	16	16	16
PRINCIPAL RISK 33 loss or compromise of sensitive data	**3**	420	-	-	-	-	-	-	15	15	15	15
PRINCIPAL RISK 34 delivering a balanced financial plan for 2016/17											20	20

* Business Objective reference number.

Board Assurance Framework – March 2016

BAF Risk 4: Service Performance may be adversely affected by the inability to match resources to demand.

Risk Classification: Performance

Principal Risk Description:
There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 265**	**Impact**	**5**	**5**	4
Last reviewed by Director on:	28th Feb. 2016		**Likelihood**	**4**	**4**	**3**
Date of next review	18th Mar. 2016		**Total Score**	**20**	**20**	**12**

Risk Consequences:
Patient Safety and Financial Penalties

Underlying Cause/Source(s) of Risk
Recruitment; Attrition; Growing vacancy factor; Increased demand; Patient Safety and Financial Penalties

Existing Key Controls
1. On-going recruitment to vacancies.
2. Use of voluntary and private sector at times of peak demand.
3. New rosters implemented successfully.
4. Targeted use of incentive based overtime including disruption payments.
5. Surge plan in place and has been reviewed
6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories
7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls i.e. autoback up pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene.
8. Use of agency Paramedics to enhance bank scheme. (On-going)

How are controls measured?
Vacancy factors measured fortnightly at ELT.
Workforce Committee monitors planning of recruitment.

Positive Assurance
1) Recruitment activity reviewed fortnightly at ELT 2) Weekly forecast & planning meetings 3) A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016 4) Plans for non-auto dispatch back-up have been developed and are in place 5) Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review. 6) NETS now in place with 108 staff in post. 7) Staff are being trained for FRU response to increase numbers of people who can work on a car.

Gaps in Control/Assurance
Use of private sector ambulances to be reviewed. Agreed plan in place until end of March 16 for private provision.
Targeted use of incentive based overtime and disruption payments to be reviewed. Uptake of overtime has reduced and corresponds to the reduction in disruption payments due to the financial context of the Trust.
Surge plan will be reviewed again in January 2016.
Annual leave review - a revised annual leave policy has been drafted and is awaiting agreement.
The incident management desk is not open consistently 24/7 due to sub-optimal staffing.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at January 2016 is 5%. Monitoring to continue	Target reached.
2	Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. Interviewing of paramedics who graduate from universities (summer 2016) is taking place over the weekend of 20th/21st Feb 2016. Plans are being developed to return to Australia to recruit. Recruiting to 3169 frontline staff by March 2016.	March 2016
3	Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. Current usage around 700 per week against a target of 1200. Changes to questions asked of HCPs requesting transport is soon to be implemented and an audit of C3/C4 category calls completed by AEUs undertaken to see if NETS utilization can be increased.	February 2016
4	Dispatch on disposition DH pilot. (now rolled out to four other Trusts). Effectiveness is being reviewed. part of on-going Ambulance response programme allowing additional time to make more effective decisions in the allocation of resources.	In place
5	IMD incident management desk – to manage incidents.	In place

Risk owner's update: The Trust Board are asked to continue to tolerate the current level of this risk until work has been completed by McKinsey on the restatement of funding and performance.

Risk owner: Director of Operations **Signed:** Peter McKenna **Date:** 18th Feb. 2016

BAF Risk 7: There is a risk that at staff changeover times, LAS performance falls

Risk Classification: Performance

Principal Risk Description:
There is a risk that at staff changeover times, LAS performance falls.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 269**	**Impact**	4	4	4
Last reviewed by Director on:	22nd Feb. 2016		**Likelihood**	5	4	2
Date of next review	22nd Mar. 2016		**Total Score**	20	16	8

Risk Consequences: delays in responses to patients and increased risk of adverse incidents

Underlying Cause/Source(s) of Risk
Current rest break agreement permits staff to conclude shift by up to 30 minutes early where no break given by EOC

Existing Key Controls
1. Daily monitoring of rest break allocation to resolve end of shift losses.
2. Use of bridging shifts for VAS/PAS.
3. Roster reviews/changes include staggered shifts.
4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies on sufficient EOC resourcing (ORH review).

How are controls measured & monitored?
1. By Incident Delivery Manager and Watch Manager escalating to surge levels with gold involvement.
2. New Rotas in place since Q2 14/15
3. Modernisation Programme Board minutes
4. Weekly tracking report.

Positive Assurance
New Rotas in place since Q2 14/15; Modernisation Programme Board minutes; and weekly tracking report.
Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review.
Rota changes to be implemented as result of ORH review.

Gaps in Control/Assurance
There is no allocation process to ensure loss is spread evenly across the day to manage impact. No current progress with ELT/staff side to change rest break arrangements. Without a change this risk is unlikely to be mitigated effectively. It may reduce as staffing improves.
The incident management desk is not open consistently 24/7 due to sub-optimal staffing.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Agree the process for the rest break arrangements to be implemented.	Within the QIP
2	Recruiting frontline staff to 3169 by March 2016	March 2016
3	Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015	Completed
4	On-going rigorous management of out of service. We are unlikely to meet the final target by the end of the Programme (end March 2016), however what was felt to be achievable is a target of 2.2% (vehicle element).	March 2016
5	Out of service HUB implemented.	Completed

Risk owner's update: Review the likelihood due to the daily impact on performance. Are we prepared to accept the risk at the current rating or is action to be taken to implement the key mitigating factor for this risk (action 1).

Risk owner: Director of Operations **Signed:** Peter McKenna **Date:** 22nd Feb. 2016

BAF Risk 14: Developing and delivering Cost Improvements

Risk Classification: Finance

Principal Risk Description:
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 on-going viability and solvency of the Trust.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 394**	**Impact**	**5**	**4**	**3**
Last reviewed by Director on:	18th Mar. 2016		**Likelihood**	**4**	**4**	**2**
Date of next review	30th April 2016		**Total Score**	**20**	**16**	**6**

Risk Consequences:
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 on-going viability and solvency of the Trust.

Underlying Cause/Source(s) of Risk
- Not all CIPs supported by detailed milestone plan;
- Not all CIPs not owned by relevant manager; • Not all CIPs embedded in budgets (unidentified items)
- CIPs not delivering in line with expectations.
- Capacity and capability not available to support delivery.

Existing Key Controls
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.

How are controls measured?

Report to CIP Programme Board	(Monthly)
Reporting to FIC	(On-going)
Reports to Quality Committee	(on-going)

Positive Assurance
On-going reporting to CIP Programme Board, FIC and Quality Committee.
On-going review of CIP opportunity takes place.

Gaps in Control/Assurance
As per "Underlying causes of risk

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Engage additional support to drive the CIP Programme.	30/09/15 Revised 30/04/16
2	Ensure all schemes have clear project plans.	30/09/15 Revised 30/04/16
3	Embed all CIPs in budgets. Ensure managers sign off.	30/09/15 Revised 30/04/16
4	Review current benchmarking information.	On-going Revised 30/04/16
5	Review and confirm CIP governance	31/03/16

Risk owner's update:

Risk owner: Director of Finance **Signed:** Andrew Grimshaw **Date:** 18th Mar. 2016

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BAF Risk 16: Patient safety for category C patients may be compromised due to demand exceeding available resources.

Risk Classification: Performance

Principal Risk Description:
There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 410**	**Impact**	**5**	**5**	**5**
Last reviewed by Director on:	22nd Feb. 2016		**Likelihood**	**4**	**3**	**2**
Date of next review	22nd Mar. 2016		**Total Score**	**20**	**15**	**10**

Risk Consequences:
50% total volume of calls is Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.

Underlying Cause/Source(s) of Risk
50% total volumes of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.

Existing Key Controls

1. Undertaking ring backs within set time frames for held calls
2. Fully trained workforce with 20 minute education breaks throughout shift. LAS overtime +PAS/VAS to add capacity. Focussed incentivisation to more challenged hours of the day.
3. Additional focus on safety reporting. QA – MPDS (999); QA – CHUB MTS (H&T;) – Report safeguarding incident concerns.
4. Falls care is being introduced. Flag elderly fallers on vulnerable person monitor (VP). Clear process of escalation of response process implemented.
5. Implementation of VP (mental health / elderly fallers) and CP (sickle cell / septic patients) screen to monitor higher risk patients.
6. Managing patients through use of NETS options where clinically appropriate. NETS desk and HCP lines starting 1st July which enables selected lower acuity patients to be conveyed by them instead of a frontline vehicle and reduces the wait.
7. Recruitment well underway and number of leavers significantly less than number of new starters.
8. A business case is under preparation to increase the establishment in EOC in order to staff previously unfunded systems.
9. FRU performance improvement plan in place.

How are controls measured?
Performance dashboard;
Operations;
SI group, governance group;
Monitoring SI and complaint themes.

Positive Assurance
1) Recruitment activity reviewed fortnightly at ELT. **2)** Weekly forecast & planning meetings. **3)** Medical Director and DDO (Control Services) to review surge plan as required, and plan to do again imminently. **4)** Plans for non-auto dispatch back-up have been developed and will run from 3/11/15 for 3 weeks and this should reduce MAR. **5)** Overtime disruption payments are in place until 6th January 2016

Gaps in Control/Assurance
Advert to action activity is rated red for delivery against target. Current figures are 2766 against final target for 31/03/15 of 3169. Financial position is stressed. There may not be financial capacity to incentive resource over the winter period.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Recruit to front line Establishment minus agreed vacancy factor of 5%. Details included in advert to action in improvement programme.	Q4 2015/16
2	Deliver efficiencies in full from Capacity Review and complete Roster Implementation.	Not yet started in EOC; rosters not yet full staffed
3	Recruit to establishment in the clinical hub. Band 6 is now agreed for all HUB posts.	Partially implemented but not yet fully recruited
4	Review the establishment in the CHUB (Jan 2016) and recruit into posts (March 2016). Recruitment of 40 Team Leaders, 30 band 6's and 4 Mental Health Nurses has been agreed. Currently reviewing 24/7 Mental Health Nurse coverage and adjusting the need for more band 6's and less Team Leaders.	April 2016
5	Allocate EMDs to clinical hub to assist with ring backs (when capacity allows)	Not yet complete – EOC capacity review informs this
6	Increasing taxi use. Use of an SOP with taxi booking makes the process safer.	Complete
7	Discussion with NHS111 regarding the green calls - complete. Pan London an increasing number of green calls are assessed by a clinician to ensure appropriate level of care is assigned.	Complete
8	More accurate and visible reporting of category C delays. Clinical Hub working model changed to have greater focus on geographical areas of London, now including C1 and C2 calls waiting for risk backs.	Complete
9	Surge plan review underway to be completed with ELT by end of February 2016. Change to surge plan triggers for purple enhanced agreed by ELT January 2016.	Complete

10	Actions included with BAF risk 4 relating to performance impact on the realisation of this risk.	

Risk owner's update: The Executive Team have discussed this risk and noted that consideration needs to be given to the current rating. Risk to be reviewed by Deputy Director of Operations for Control Services for further details on action completion dates and any assurance provided by the safety review against this risk. CHUB staffing levels - following recruitment of CTL and clinical advisors levels have improved. Further supported by secondments to CHUB planned for February 2016. Odd shifts remain uncovered but working towards safe cover levels.

Risk owner: Director of Operations **Signed:** Katy Millard **Date:** 22nd Feb. 2016

BAF Risk 20: LAS will not be in a position to win new NHS 111 contracts as stated in the 5-year strategy.

Risk Classification: Infrastructure/Finance

Principal Risk Description:
There is a risk that the LAS will not be in a position to win new NHS 111 contracts as stated in the 5 year strategy.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 440**	**Impact**	4	4	3
Last reviewed by Director on:	17st Mar. 2016		**Likelihood**	4	3	2
Date of next review	17th Apr. 2016		**Total Score**	16	12	6

Risk Consequences:
- Successful 111 bidders and their service can adversely affect demand for 999 service
- Negative impact on the financial position of the organisation through failure to establish competitive pricing models based on efficiencies of scale for new bids (we remain open book as the step in provider for SEL 111)
- Loss of our place in the NHS111 market which could adversely affect our future bidding success
- Ability to maintain level of income/ margin v cost post implementation
- Adverse effect if required to mobilise two or more services concurrently
- Wider commissioner intent is to commission an integrated service (111 and OoH provision), an OoH partner(s) will be required for successful bid
- Other competitors may bid and begin to get a foothold in London

Underlying Cause/Source(s) of Risk
1. There is no consistent 111 tender process or service across London. 111 contracts across London are going out to tender dependent upon the expiry of current contracts and are constructed differently across London
2. 111 growth may not be given adequate resource/attention due to current 999 performance pressures diverting attention away, particularly at a senior level.
3. LAS costs may not competitive.
4. Detailed modelling to accurately assess what areas of London we will bid for, informing the impact on services such as, estates, IM&T, clinical support, resourcing, legal services, governance arrangements etc. has is difficult due to the tendering process and restricted timelines
5. Capacity to implement , mobilise and integrate into core business function needs to be considered
6. Integrated service delivery: Unknown market for us, One specification, a single contract with a lead provider, signifying a Lead/ Subcontract arrangement
7. Mobilisation/ implementation: Operational resource - ability to recruit clinicians / staff (current delivery is heavily reliant upon agency), Resilience - business continuity and disaster recovery solutions, Multiple implementation - will add pressure to system
8. Contract management: Capacity and expertise to deliver and manage the sub-contractors, experience in managing OoH provision – clinical and operational , executive leadership, organisational focus and accountability: is currently on core business

Existing Key Controls
1. Interim Bid team established, gathering information of service requirements / KPIs / costing of service and preparing draft response.
2. Contract meetings with SEL
3. Bid team monitoring market to review local opportunities, gather intelligence around commissioning requirement and competitors
4. Long list of 'partners' drawn up and reviewed against capability and suitability to provide

How are controls measured / monitored?
1. ELT updates on NHS111 bid process, opportunities & progress

Positive Assurance
Interim Bid team established, Monitoring of market place/ on-going intelligence gathering, Indicative procurement timelines for bids across London established, Local delivery team engaged to prep/ plan bid submission, Stakeholder feedback on LAS as a provider of 111 services; 12 month extension to SEL 111 contract

Gaps in Control/Assurance
(None identified as at 30th October 2015

Further actions - plans to reduce gaps in control/Improve Assurance		Due Date
1	Understanding developed, through dialogue with, and research of111 commissioners across London, of their timeframes for tendering.	Update end of Q3
2	Work with CCGs to influence 111 system development across London	Update end of Q3
3	Bid for new 111 services as opportunities arise	Update end of Q3

2. Update reports to FIC and Trust Board	4	Local engagement, continue to develop relationship with current 111 commissioners, maintain and improve service delivery	Update end of Q4

Risk owner's update: Interim bid team established, preparation in place based on published commissioning intent/ contribution from 111 operational team, local engagement with commissioners and partnership providers continues. - SEL 111 have extended LAS contract to March 2017

Risk owner: Director of Transformation, Strategy & Workforce **Signed:** Karen Broughton **Date:** 17th Mar. 2016

BAF Risk 24: There may be insufficient vehicle numbers to meet demands

Risk Classification: Infrastructure

Principal Risk Description:
There is a risk that there may be insufficient vehicle numbers to meet demands.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 441**	**Impact**	4	4	3
Last reviewed by Director on:	18th Mar. 2016		**Likelihood**	4	4	3
Date of next review	30th Apr. 2016		**Total Score**	16	16	9

Risk Consequences:
The risk above will impact on the Trust's ability to provide adequate vehicle numbers to support operational demand leading to an adverse impact on operational performance

Underlying Cause/Source(s) of Risk

Existing Key Controls
1. Forward view of fleet requirement for next 5 years
2. Asset management plan to ensure no frontline vehicle exceeds 7 years old and that Unplanned Maintenance levels do not adversely affect Fleet Capacity and the provision of a safe environment to Operational Staff
3. Ensure capital investment is committed to support fleet volume and replacement
4. External/stakeholder support in place as required
5. Maintain a capacity plan for the Peak Vehicle Requirement (PVR) based on operational rotas and other frontline vehicle requirements agreed with operations.
6. Have an agreed vehicle specification
7. Agree and maintain adequate headroom in fleet numbers to manage variation

How are controls measured/monitored?
Fleet Strategy
Annual Plan
Business Case Approval
Fleet Management Team Meetings
Fleet Delivery Board

Positive Assurance
1. Forward view of fleet requirement in place. 2. Plan in place to move current fleet to under 7 years. 3. Capital investment requirement understood and reflected in LTFM.4 Vehicle specifications in place.

Gaps in Control/Assurance 1. The move to complex based fleet may be placing further pressure on fleet size. 2. Increasing staff in post and continued high over time are creating pressures on fleet numbers. 3. Supporting current training activities is creating further pressure on fleet numbers. 4. Improvements in Fleet utilisation reporting required.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Vehicle allocations to complex being revisited to assess against areas with excessive out of service time. Re-allocation and consideration of holding spares at Sector level to be considered	15/02/16 Revised to 31/05/16
2	Business case for 140 new ambulances being finalised for submission to TDA	Complete
3	Agree & sign off DCA & FRU specification	Complete
4	Following agreement of vehicle headroom with Operations, identify future vehicle replacement requirements and short term retention proposals.	Revised to 30/04/16
5	Draft Fleet Strategy 2017-18 and 5 years	30/09/16
6	Revised Fleet reporting to be put in place	Complete
7	Increase DCA fleet by 17 by holding back vehicles due for replacement in 2015	Complete
8	Hold back and refurbish further 20 DCA vehicles due for replacement to cover events/training	Complete
9	Review case to retain ambulances following introduction of 140 new vehicles	30/06/16

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Risk owner's update: Business Case to deliver further 140 new DCA's in 2016. (Refer to comments 2 in positive assurance)				
Risk owner:	Director of Finance	**Signed:**	Andrew Grimshaw	**Date:** 18th Mar. 2016

BAF Risk 25: Insufficient range and volume of equipment to meet demands

Risk Classification: Infrastructure

Principal Risk Description:
There is a risk that there may be insufficient range and volume of equipment to meet demands.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 442**	**Impact**	**4**	**4**	**3**
Last reviewed by Director on:	18th Mar. 2016		**Likelihood**	**4**	**4**	**2**
Date of next review	30th Apr. 2016		**Total Score**	**16**	**16**	6

Risk Consequences: Staff will not have equipment required to provide appropriate patient care

Underlying Cause/Source(s) of Risk

Existing Key Controls
1. Agreed vehicle equipment lists 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

How are controls measured/monitored?
1. Vehicle Equipment Procedure
2. Fleet management information
3. Budget reports
4. Equipment Inventory
5. Fleet management information
6. Fleet reports/Equipment group
7. Report to recommend

Positive Assurance
Progress made in agreement of core equipment and further equipment amnesty. Decontamination of equipment commenced. Analysis of asset tracking systems being undertaken.

Gaps in Control/Assurance
Ensuring equipment is available when needed continues to be a concern despite additional equipment being procured and made available. Work is being scoped to review the whole "Vehicle Make Ready" process to ensure it has sufficient capacity to support the provision of a "fully equipped" vehicle for crews at the start of a shift. This will help to reduce the role of frontline crews in the maintenance and provision of equipment.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Define and agree a "core" equipment list for DCA & FRU.	Complete
2	Agree funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution	Complete
3	Carry out pilot to assess benefits of VP proposal	Feb/April 16
4	If pilot successful agree roll out to LAS area	30 April 16
5	Undertake an equipment amnesty and physically review all stations and complexes for "retained" equipment.	Complete
6	Introduce new paper based VP VDI form	Complete
7	Review contents, responsibility and issue of "bags" Check status of any work previously carried out and agree terms of reference, and timeline with Clinical Equipment Group	30/04/16
8	Implement working group to review personal issue kit – check status of any existing work with CEG	30/05/16

Risk owner's update: Refer to comments under "Positive Assurance" .			
Risk owner: Director of Finance	**Signed:** Andrew Grimshaw	**Date:** 18th Mar. 2016	

BAF Risk 26: The equipment for frontline vehicles may not be available when required

Risk Classification: Infrastructure

Principal Risk Description:
There is a risk that the equipment for frontline vehicles may not be available when required.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 443**	**Impact**	4	4	3
Last reviewed by Director on:	26th Feb. 2016		**Likelihood**	4	4	2
Date of next review	30th Apr. 2016		**Total Score**	16	16	6

Risk Consequences:
Staff will not have equipment required to provide appropriate patient care

Underlying Cause/Source of Risk:

Existing Key Controls
1. Serial numbers on all re-usable equipment for accurate tracking.
2. Agree & set requirements for stock levels on vehicles and monitor regularly.
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. South stores for consumables implemented. North stores to be developed.

How are controls measured/monitored
Vehicle Preparation reporting
Vehicle Preparation contract monitoring
OOS policy & reports

Positive Assurance (Evidence that shows we are reasonably managing our risks and objectives are being delivered). List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.
Clinical Equipment Group; Asset tracking report; VP reports; VP Contract; Equipment Process; Project completion

Gaps in Control/Assurance 1. Equipment tracking. 2. Responsibilities for supply and maintenance of equipment not clearly defined 3. Storage of clean and used equipment not adequate on all stations. 4. Equipment volume and location within the Make Ready process subject to variation

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Complete electronic VDI pilot to provide improved reporting. Ensure all equipment has bar code or serial number.	Revised to 30 May 16
2	Roll out pilot and fully develop equipment database reports to indicate where any equipment is missing	Q2 2016/17
3.	Roll Out NE VP pilot to include secure local equipment stores and day time "Quatermaster" role	Complete
4	Roll out enhanced VP to rest of service	From April 2017
5	Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports.	Complete
6	Ensure adequate stocks of consumables and equipment are available to VP staff – south are a rolled out – NE pilot area by 1st March and rest of area by end of April 16	End Q1 16/17
7	Review current VP contract and agree any immediate changes	Complete
8	Agree essential equipment, plan and implement a process to make key items available centrally to - restock	Superseded by 6
9	Plan rollout of and implement complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided	Complete
10	Implement pilot project in NE area to provide and resupply equipment store – see 3	Complete

Risk owner's update: Significant level of work in progress. Pilot project in NE area aimed at providing local equipment store which can be used by VP to make good deficiencies on vehicles. Improved asset tracking systems being evaluated.

Risk owner: Director of Finance **Signed:** Andrew Grimshaw **Date**: 18th Mar. 2016

BAF Risk 27: The equipment for frontline vehicles may not be in an effective condition

Risk Classification: Infrastructure

Principal Risk Description:
There is a risk that the equipment for frontline vehicles may not be in an effective condition.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 444**	**Impact**	4	4	3
Last reviewed by Director on:	26th Feb. 2016		**Likelihood**	4	4	2
Date of next review	30th Apr. 2016		**Total Score**	16	16	6

Risk Consequences:
Staff will not have equipment required to provide appropriate patient care

Underlying Cause/Source(s) of Risk

Existing Key Controls
1. Agreed VP cleaning, deep cleaning and stocking service levels are set, maintained and monitored
2. Decontamination of equipment during VP, including monitoring
3. Decontamination of items left at hospital, including monitoring
4. Replacement equipment budgets in place. Process agreed and adhered to
5. Maintenance/Replacement of Kit undertaken when required

How are controls measured/monitored
Partial via VP reports
Decontamination reports
Partially monitored within Fleet & Logistics
Monitored within Fleet & Logistics

Positive Assurance
Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet reports; and OOS reports.

Gaps in Control/Assurance None identified as at 21st Jan. 2016.

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Complex based fleet to increase vehicle availability for VP	Complete
2	Monitor Decontamination of equipment trial – trial ended 1st January – evaluation paper being prepared	Trial extended to 30/05/16
3	Implement contract for decontamination – dependent on evaluation and need to tender	July 2016
4	Develop system to reintroduce equipment that gets decontaminated – system partially introduced – some equipment to feed NE pilot -	Complete
5	Establish revised process for collection of equipment left at hospital for decontamination & subsequent redistribution	April 2016
6	Review process for maintenance of equipment	Complete
7	Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports.	Complete
8	Ensure current performance against 95% deep clean within 6 weeks maintained.	End of Q1 16/17

Risk owner's update: Significant progress made on actions. Decontamination of equipment has commenced. Work being undertaken with St George's Healthcare to agree equipment maintenance trial.

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Risk owner: Director of Finance	**Signed:** Andrew Grimshaw	**Date:** 18th Mar. 2016		

BAF Risk 29: There is a lack of ring-backs on delayed response calls within EOC

Risk Classification: Clinical & Quality

Principal Risk Description:
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.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Audit Committee					
Last reviewed by committee on:	9th Nov. 2015	**Linked to Corporate Risk No. 451**	**Impact**	4	4	4
Last reviewed by Director on:	22nd Feb. 2016		**Likelihood**	4	4	3
Date of next review	22nd Mar. 2016		**Total Score**	16	16	12

Risk Consequences:
Patients are not contacted meaning their condition can deteriorate without the EOC being aware and being able to re-triage

Underlying Cause/Source(s) of Risk
1.Inability of the Service to provide resources to dispatch on calls in a timely manner. 2. Insufficient resources in EOC to carry out the ring backs. 3. Instances of serious incidents and inquests where patients have deteriorated when there has been no contact by the service for a significant period of time. 4. Increased demand vs. resource.

Existing Key Controls
1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs.
2. Additional technical support to prompt re-categorisation and contact.
3. New ring back status monitors.
4. New information within EOC to be able to properly inform patients of the likely wait time for a response.
5. Staff removed from call handling to undertake ring backs when capacity allows. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care.

How are controls measured?
The Dispatch function is reviewed through a Quality Improvement process arising from the investigation of complaints, Serious Incidents and Inquests. Issues relating to technical and individual performance are identified through this process and actioned accordingly The Quality Assurance Unit is now starting regular reviews of EMDs adherence to protocol on both the DDS (welfare ring backs) and on similar functions on Met DG. Measured daily, monthly or as required

Positive Assurance
Patients who are most at risk are flagged via the hub to focus the ring backs.

Gaps in Control/Assurance
On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high.
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.
Additional front line resources are required.(covered by BAF risk 265 and 388)

	Further actions - plans to reduce gaps in control/Improve Assurance	Due Date
1	Two call-handling courses are under way in October 2105 which will bring a maximum of 32 new staff to EOC pre-Christmas. Complete. – New training plan for 2016/17 for 12 call handling courses.	2016/17
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.	2016/17

Risk owner's update: Links to Category C risk 16 – the change to the CHUB model assists with identifying patients at highest risk receive call backs.

Risk owner: Director of Operations / Deputy Director of Operations – Control Services **Signed:** Katy Millard **Date:** 22nd Feb. 2016

Board Assurance Framework – March 2016

BAF Risk no. 33	There is a risk that the CAC (EOC systems environment) could be compromised by an external cyber attack resulting in the loss or compromise of sensitive data.

Principal Risk Description:	**Monitoring Committee:**	IM&T Senior Management Team			**Gross Risk**	**Current or Net Risk**	**Target**
The technical environment utilised by EOC is directly linked to the wider LAS IT estate which increases the possibility that external attacks could compromise this sensitive environment resulting in a loss of systems or a compromise / loss of data.	**Last reviewed by committee on:**	16th Jan. 2016	**Linked to Corporate Risk No. 420**	**Impact**	**5**	**5**	**5**
Risk Lead/Task Owner: Steve Bass, CIO	**Last reviewed by Director on:**	21st Dec. 2015		**Likelihood**	**3**	**3**	**1**
	Date of next review	16th Feb. 2016		**Total Score**	**15**	**15**	**5**

Risk Consequences:

Failures caused by external attacks within the wider LAS will be disruptive but the impact on EOC would require OP66 invocation and potentially for an extended duration affecting LAS performance.

Underlying Cause/Source of Risk

LAS, as any other business, will never be able to completely prevent external parties that have the desire / will / capability and expertise to attack our systems doing so. Current industry experts suggest around 5,000 cyber-attacks are undertaken every day in the UK alone.

By ensuring all systems are up to date with security "patches" we can limit the exposure level. Through controlling access within EOC we apply further protection. Separating the CAC environment from the wider LAS estate is the final control process available (with reasonable costs).

Existing Key Controls

1. Prevention of external access to LAS network is monitored by a system called FireEye. This was implemented in 2015 and reports generated are regularly reviewed.
2. LAS systems are, from 2015 onwards, updated with supplier generated "patches" that limited the available opportunities for external attacks.
3. Plans are developed to implement a separation of networks between EOC (CAC) and the wider LAS through a firewall device.
4. EOC based IT equipment is highly restricted and controlled to prevent unintentional access methods for external attack. Internet, for example, cannot be accessed.

How are controls measured

Preventative measures implemented in 2015 (FireEye Intrusion detection and Lumention Patching software) produce monthly reports. These are being tailored and will be evidenced to the IM&T SMT as part of the monthly Risk Review.

Positive Assurance

The existing controls have been carefully considered and applied during the past six months. Whilst the initial reporting suggests they are effective IM&T need to work on these reports to provide empirical evidence that they are collectively comprehensive.

Gaps in Control/Assurance

Reporting on successful LAS protection to be refined and issued.

Implementing a firewall between CAC and the wider LAS IT is in planning.

	Further actions - plans to reduce gaps in control/Improve Assurance	**Date**
1	Implement Firewall between CAC and LAS corporate	Mar 16
2	Monthly reporting on hacking, attacks and virus protection for ELT and Audit Committee to be defined and agreed	Complete
3	RCAG approval of report and format	Mar 16
4	Additional information, such as patches applied / outstanding to be included in subsequent reports	April 16

Risk owner's update: Monthly reviews to continue.

Risk owner: Director of IM&T **Signed:** **Date:** 18th February 2016

BAF Risk no. 34 — Delivering a balanced financial plan for 2016/17

Principal Risk Description:
The TDA expects all NHS trusts to achieve financial balance in 2016/17, 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.

				Gross Risk	Current or Net Risk	Target
Monitoring Committee:	Finance and Investment Committee					
Last reviewed by committee on:	21st Jan. 2016	**Linked to Corporate Risk No. 460**	**Impact**	5	5	5
Last reviewed by Director on:	18th Mar. 2016		**Likelihood**	4	4	2
Date of next review	8th Apr. 2016		**Total Score**	20	20	10

Risk Consequences:
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.

Underlying Cause/Source of Risk
1. Demand levels for 2016/17 yet to be agreed with CCGs 2. Productivity targets for 2016/17 to be agreed. 3. Further work required on capacity plan once demand and productivity confirmed. 4. Discussions regarding further funding from CCGS to be concluded 5. Costs associated with CQC being finalised. 6. Internal ability to deliver efficiency 7. Pressures on capital investment

Existing Key Controls
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 establishment's 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.

How are controls measured

Report to ELT	(Monthly)
Reporting to FIC	(On-going)
Reports to Quality Committee	(On-going)

Positive Assurance
1. Planning has started with CCGS regarding 2016/17 demand, capacity, productivity and funding.
2. CQC costs being developed

Gaps in Control/Assurance
As per "Underlying causes of risk

	Further actions - plans to reduce gaps in control/Improve Assurance	Date
1	Demand: Build a demand model and agree with CCGs	Complete
2	Capacity: Build an operational model to forecast staff numbers required to support given levels of performance based on a range of demand and productivity metrics	Complete
3	Productivity: Develop a clear understanding of productivity and how it can be influenced and managed. JCT deep dive	End Q1
4	Recruitment: Clear recruitment plan in place which identifies all associated costs.	Complete
5	Funding: Appropriately funded contract in place with commissioners	31/03/16
6	All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan.	31/03/16
7	Efficiency targets have scoped, stress tested and clear plans are in place to deliver.	30/04/16
8	Inflationary pressures are understood	complete
9	Local development pressures have been identified, costed, reviewed and prioritised. Areas to be progressed are agreed.	30/04/16
10	5 year capital investment plans for, funding and associated revenue implications are defined and agreed.	End Q2

Risk owner's update: Presented and agreed at January FIC

Risk owner: Director of Finance **Signed:** Andrew Grimshaw **Date:** 18th Mar. 2016

BAF Risk no. 35	Delays in reporting medicines usage data affecting the tracking of medicines

Principal Risk Description: Significant time lag (in excess of six months) in the reporting of medicines usage data captured by Management Information during the data entry and validation of PRFs may lead to LAS not being able to track usage of medicines by complex stations/ sectors/ practitioner group, call signs etc.	**Monitoring Committee:**	TBC			**Gross Risk**	**Current or Net Risk**	**Target**
	Last reviewed by committee on:	N/A (new risk)	**Linked to Corporate Risk No. 460**	**Impact**	4	4	4
	Last reviewed by Director on:	N/A (new risk)		**Likelihood**	5	4	1
	Date of next review	27th Feb. 2016		**Total Score**	20	16	4

Risk Consequences:
The LAS cannot track in a timely manner usage of medicines by Complex / Station / Sector / Practitioner Group / or clinician.
The LAS is also being asked, in common with other Ambulance Services, to report more data on drug usage to the MHRA, and National Ambulance Pharmacy Advisers Group to assist with guidelines development and replacing existing medications with different alternatives, (benzodiazepines being a current example). The LAS is only able to offer very historic data.

Underlying Cause/Source of Risk
The trust currently has a paper based system requiring manual data extraction. This is resource intensive and results in a backlog of information not being captured.
This also has implications for investigating of medicines incidents / near misses / unusual medicine usage activity etc…
Clinical Audit and Research projects directly involving medicines are also delayed by several months, meaning that the ability to influence clinical practice is more limited, due to using old data.

Existing Key Controls
1. MI capture and validate the data via the PRF scanning process
2. Drug usage statistics produced by MI - but they are several months in arrears
3. Physically isolating PRFs and then data trawling by hand if detailed analysis required. The CPI process provides limited information, but is very difficult to use for gathering service wide data..
4. Limited information can be gained by reviewing the medicine purchasing invoices

Positive Assurance

Gaps in Control/Assurance
Risk approved by SMT 27/01/16 - risk to be further discussed by IM&T and Medical Directorate to identify the root cause of the risk exploring the input quality of data (separate risk to be assessed). Actions and completion dates to be agreed once this has been scoped out further.

	Further actions - plans to reduce gaps in control/Improve Assurance	**Date**
1	Increase rate of data capture at MI	Completed Jan 2016
2	Consider options (and cost and staffing implications) for retrospectively recording the data that will be missed if MI start contemporaneous data capture.	Decision to be made by 31/03/16
3	Consider the use of technology to assist in data capture. This could include obtaining additional information off the MDT screen and / or electronic patient records	fixed to E-ambulance timescales

Risk owner's update: Risk approved by SMT 27/01/16 - risk to be further discussed by IM&T and Medical Directorate to identify the root cause of the risk exploring the input quality of data (separate risk to be assessed). Actions and completion dates to be agreed once this has been scoped out further. 26/02/16 IM&T have initiated contemporaneous recording of drug data from PRFs. This leaves a backlog of approximately 4 months of data which will need to be retrospectively recorded.

Risk owner: Vic Wynn **Signed:** **Date:**

London Ambulance Service NHS Trust
Trust Risk Register - March 2016

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	Recruitment Attrition Growing vacancy factor Increased demand Patient Safety and Financial Penalties	31-Jul-06	4	1	Safe	Operational	Major	Almost Certain	20	1. On-going recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. New rosters implemented successfully. 4. Targeted use of incentive based overtime including disruption payments. 5. Surge plan in place and has been reviewed 6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories 7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls i.e. autoback up pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene. 8. Use of agency Paramedics to enhance bank scheme. (On-going) How are controls measured? Vacancy factors measured fortnightly at EMT. Workforce Committee monitors planning of recruitment.	Paul Woodrow	22-Feb-16	Major	Almost Certain	20	1. Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at January 2016 is 5%. Monitoring to continue 2. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. Interviewing paramedics from universities who graduate (summer 2016). Recruit to 3169 frontline staff by March 2016. 3. Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. Current usage around 700 per week against a target of 1200. High level plan will be delivered by 15 January with a fuller plan delivered by 20 January 2016 5. Dispatch on disposition DH pilot. (now rolled out to four other Trusts). Effectiveness is being reviewed. part of on-going Ambulance response programme allowing additional time to make more effective decisions in the allocation of resources. 5. IMD incident management desk – to manage incidents.	1. P. Woodrow 2. K. Broughton / T. Crabtree 3.J. Goldie / K. Millard 4. K. Millard 5. K. Millard 6. K. Millard	1. Target reached 2. March 2016 3. Jan. 2016 4. In place 5. In place	1) Recruitment activity reviewed fortnightly at EMT 2) Weekly forecast & planning meetings 3) A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016 4) Plans for non-auto dispatch back-up have been developed and will run from 3/11/15 for 3 weeks and this should reduce MAR 5) Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review. 6) NETS now in place with 108	Major	Possible	12	22/02/2016: Updates provided by Peter McKenna 11/01/16 Updated by Assistant Director of Operations Sector Services. The Trust Board are asked to consider accepting the current level of this risk until work has been completed by McKenzie on the restatement of funding and performance.
429	There is a risk that there are currently no arrangements in place for routine quality assurance of dispatch functions which may affect the quality of call management and the service provided to patients. Lack of QA for dispatch resulting in an unquantifiable level of risk from poor compliance with dispatch protocols.	No real time proactive checking of dispatch regimes. Routine QA is undertaken for call handling, but the only detailed examination of the dispatch process is done arising from complaints and incidents. Although there are metrics available relating to performance we have limited information on the quality of the allocation decisions and call management within EOC. Instances of sub-optimal dispatch have been identified within Serious Incident and complaint investigations.	14-Jan-15	28	1	Safe Effective Responsive	Operational	Major	Almost Certain	20	1. Training for CP Dispatch and Allocation 2. Updated Operational procedures 3. Increased breach analysis 4. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care. How are controls measured/monitored? The Dispatch function is reviewed through a Quality Improvement process arising from the investigation of complaints Seriously Incidents and Inquests. Issues relating to technical and individual performance are identified through this process and actioned accordingly The Quality Assurance. Unit is now starting regular reviews of EMDs adherence to protocol on both the DDS (welfare ring backs) and on similar functions on Met DG. SMT Five-weekly watch reviews	Paul Woodrow (Katy Millard)	22-Feb-16	Major	Almost Certain	20	1. Introduce a QA process within dispatch (Through the investigation process, identifying technical and individual issues). QA Dept now recruited to full establishment. 2. KPI within dispatch (MI fix for quantitative measurements not yet achieved, has been given to external contractor for action, however this is not a priority, no fixed dated provided for completion) 3. Training opportunities for staff in order for them to progress further. J.Lockett provided review for training in 2015/16, plan for 2016/17 due Feb 2016 for implementation in April 2016.	1. A. Buckler 2. K. Canavan 3. J. Lockett	1. Complete 2. November 2015 To be revised 3. Feb 2016	1. QA process within dispatch 2. SMT 3. Five-weekly watch reviews	Major	Unlikely	8	2/03/16: RCAG on 08/03/16 agreed to archive. Evidence to be reviewed in April. 22/02/16: Updates provided by Katy Millard 15/01/16: J.Lockett provided update to Action 3, BAF Updated. 11/01/16 reviewed by K. Millard - risk to be quantified in terms of numbers of sub-optimal dispatch decisions identified through serious incidents. 03/12/15: BAF Updated (K Brown) 09/10/15: BAF Updated 27/08/15: BAF updates provided by B. Jordan Net rating was proposed for revision from major x possible = 12 to major x almost certain = 20 by control services on the 04/06/15.
460	The TDA expects all NHS trusts to achieve financial balance in 2016/17, 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.		17-Nov-15	34			Finance	Catastrophic	Likely	20	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.	Andrew Grimshaw	21-Jan-16	Catastrophic	Likely	20	1. Demand: Build a demand model and agree with CCGs 2. Capacity: Build an operational model to forecast staff numbers required to support given levels of performance based on a range of demand and productivity metrics 3. Productivity: Develop a clear understanding of productivity and how it can be influenced and managed. 4. Recruitment: Clear recruitment plan in place which identifies all associated costs. 5. Funding: Appropriately funded contract in place with commissioners 6. All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan. 7. Efficiency targets have scoped, stress tested and clear plans are in place to deliver. 8. Inflationary pressures are understood 9. Local development pressures have been identified, costed, reviewed and prioritised. Areas to be progressed are agreed. 10. Capital investment plans, funding and associated revenue implications are defined and agreed.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 15/02/16 2. 31/03/16 3. 31/03/16 4. 31/03/16 5. 31/03/16 6. 26/02/16 7. 31/03/16 8. 12/02/16 9. 31/03/16 10. 31/03/16		Catastrophic	Unlikely	10	21/01/16: Risk reviewed by Finance and Investment Committee to be added to BAF and Trust Risk Register

London Ambulance Service NHS Trust
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269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	7	1	Safe	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses. 2. Use of bridging shifts for VAS/PAS. 3. Roster reviews/changes include staggered shifts. 4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies on sufficient EOC resourcing (ORH review). How are controls measured & monitored? 1. By Incident Delivery Manager and Watch Manager escalating to surge levels with gold involvement. 2. New Rotas in place since Q2 14/15 3. Modernisation Programme Board minutes 4. Weekly tracking report.	Paul Woodrow	22-Feb-16	Major	Likely	16	1. Agree the process for the rest break arrangements to be implemented. 2. Recruiting frontline staff to 3169 by March 2016 3. Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015 4. On-going rigorous management of out of service. We are unlikely to meet the final target by the end of the Programme (end March 2016), however what was felt to be achievable is a target of 2.2% (vehicle element). 5. Out of service HUB implemented.	1. T. Crabtree / P. Woodrow 2. K.Broughton 3. P. Woodrow 4. P. Woodrow 5. K. Millard	1. TBC 2. March 2016 3. Completed 4. March 2016 5. Completed	New Rotas in place since Q2 14/15; Modernisation Programme Board minutes; and weekly tracking report. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review. Rota changes to be implemented as result of ORH review.	Major	Unlikely	8	22/02/16: Updates provided by Peter McKenna. 11/01/16 Reviewed by Assistant Director of Operations for Sector Services. Review the likelihood due to the daily impact on performance. Are we prepared to accept the risk at the current rating or is action to be taken to implement the key mitigating factor for this risk (action 1).
394	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.	• 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.	10-Apr-14	14	3	Well Led	Finance	Catastrophic	Likely	20	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.	Andrew Grimshaw	21-Jan-16	Major	Likely	16	1. Engage additional support to drive the CIP Programme. 2. Ensure all schemes have clear project plans. 3. Embed all CIPs in budgets. 4. Review current benchmarking information. 5. Review and confirm CIP governance	1. A. Grimshaw 2. A. Grimshaw 3. K. Hervey / A. Bell 4. A. Grimshaw 5. A. Grimshaw	1. ~~31/12/15~~ 26/02/16 2. 31/12/15 3. 30/11/15 4. 31/12/15 5. ~~31/12/15~~ 31/01/16	1-6. Report to CIP Programme Board 7. Reporting to FIC 8-9. Report to CIP Programme Board 10. Reports to CIP Programme Board & Quality Committee	Moderate	Unlikely	6	21/01/16: Updates from FIC meeting. Only updates was new due dates, some of which have passed. Due to be reviewed at FIC 21/01/16 19/11/15: Update provided from FIC agenda (meeting due 20/11/15) 26/08/15: D.Harker on behalf of A.Grimshaw - advises that all dates of action can be changed to 30/09/15. 14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading. Reviewed by FIC 21/05/15 Reviewed by A. Bell 11/03/15.
453	There is a risk that funding for the improvement programme activities is delayed or reduced as a result not achieving the agreed commissioner performance trajectories or gateways (overall programme or projects).	The 2015/16 contract built in a stepped release of funding depending on the overall (A8%) achieved in each quarter. In turn this is linked to the Improvement Programme projects. A8 performance has not seen the improvements expected because of: - Slower than anticipated increases in operationally independent frontline staff - Optimistic modelling used in the transformation business case has resulted targets being more challenging than originally anticipated - A number of actions identified in improvement programme project plans have been delivered and not had the anticipated impact on delivery	07-Oct-15	32	3		Finance	Major	Almost Certain	20	1. All projects are managed through a formal Programme Structure. The Programme Board meets regularly to hold project leads to account on progress. The Programme reports to EMT and is subject to external scrutiny 2. All projects are led by an Executive Director who is accountable for delivery. Each project also has a defined delivery team to plan and drive delivery 3. All projects have developed detailed plans for delivering against the specific targets. 4. Regular update meetings are held with the Commissioners, TDA and NHS England to discuss progress with improvement programme and other activities	Andrew Grimshaw	22-Feb-16	Major	Likely	16	1. ~~New improvement activities not in the original scope of the Programme were agreed for inclusion at the December Programme Board. Delivery of activity against scheduled timeframes will be managed robustly by the Programme Board.~~ Release of funding for 2015/16 has been agreed with Commissioners, and work is substantially underway to agree 2016/17 performance trajectories and target ~~2. The Programme Board has requested that projects that fall significantly below required targets develop an action plan that aims to recover performance to meet January trajectories.~~ ~~3. Revised funding release mechanism to be agreed with CCGs~~	1. Exec Sponsors ~~2. Exec Sponsors~~ ~~3. Andrew Grimshaw~~	1. ~~31/03/16~~ TBC ~~2. 31/01/16~~ ~~3. 31/01/16~~	1. Programme Board will monitor the progress on a monthly basis 2. EMT will take a monthly report from the Programme Board 3. Trust Board will also review progress as part of the Integrated Board reporting process 4. LAS will update commissioners regularly on programme delivery and the impacts of reducing funding.	Major	Unlikely	8	22/03/16: RCAG agreed to archive on 08/03/16. 22/02/16: D. Fong advised that the Quality Improvement Programme will replace the Improvement Programme and so Risks 453 and 454 will be replaced by new risks. Due to be reviewed at next ELT meeting (02/03/16). Updates on left. 13/01/16: P.Woodrow - A revised trajectory presented to the Secretary of State in October 2015 has been agreed to by Commissioners for specified work streams: job cycle time, non emergency transport, and multiple attendance ratio. The Programme Board and Project teams are focussed to ensure activities are aligned with achieving the revised targets. Due to be reviewed at Performance Improvement Programme Board 12/01/16 17/11/15: Risk added to Risk Register. Added to BAF due to

London Ambulance Service NHS Trust
Trust Risk Register - March 2016

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
454	There is a risk that the Improvement Programme objectives may not fully achieve the agreed levels within the expected timescales. This may be seen across a number of the relevant projects This will put at risk achievement of the Trust A8 performance trajectory	Project delivery has been impacted by: - Slower than anticipated increases in operationally independent frontline staff - Delayed communication to operational staff on project objectives as a result of delays in linked corporate communications. - Optimistic modelling used in the transformation business case has resulted targets being more challenging than originally anticipated - A number of actions identified in project plans have been delivered and not had the anticipated impact on delivery	07-Oct-15	31	3		Operational	Major	Almost Certain	20	1. All projects are managed through a formal Programme Structure. The Programme Board meets regularly to hold project leads to account on progress. The Programme reports to EMT and is subject to external scrutiny 2. All projects are led by an Executive Director who is accountable for delivery. Each project also has a defined delivery team to plan and drive delivery 3. All projects have developed detailed plans for delivering against the specific targets. **How are controls measured** All projects have developed detailed plans for delivering against the specific targets	Paul Woodrow	22-Feb-16	Major	Likely	16	1. ~~New improvement activities, currently not in scope of the Programme are being developed for consideration. Decision on inclusion will be taken at November Programme Board~~ 2015/16 Improvement Programme, management of frontline sickness through the Improving Attendance workstream will be transferred to the Workforce Committee. 2. ~~Updated delivery trajectories have been developed for most projects to confirm end point. Exec sponsors to confirm additional actions where a shortfall is identified~~ A new governance structure is currently in the process of development which will establish the Operational Performance Board. This Board will be chaired by the Director of Operations and will manage all the interdependent workstreams that have an impact on operational performance and achievement of A8 performance. Projects to be included are: FRU, OOS (People & Vehicle), and taxi. It is intention that the Operational Performance BHpard will be established by 01/04/2016, and in the interim these workstreams will continue to fall under the responsibility of the Director of Operations. 3. Development of an full Quality Improvement Plan (QIP) is underway, which coordinates all organisational strategies and actions plans, including projects which currently fall under the remit of the Improvement Programme. It is intended that the job cycle time, non emergency transport, and recruitment workstreams are transferred. The full QIP will be presented to the Trust Board at their	1. Exec Sponsors 2. Exec Sponsors 3. Exec Sponsors	1. 02/03/16 2. 01/04/16 3. 29/03/16	~~1. Programme Board will monitor the progress on a monthly basis~~ ~~2. EMT will take a monthly report from the Programme Board~~ ~~3. Trust Board will also review progress as part of the Integrated Board reporting process~~ Closure of the 2015/16 Improvement Programme will involve transfer of projects into one of three sub committees of the Trust Board. Assurance reports are provided from each of these committees to the Trust Board.	Major	Unlikely	8	22/03/16: RCAG agreed to archive on 08/03/16. 22/02/16: D. Fong advised that the Quality Improvement Programme will replace the Improvement Programme and so Risks 453 and 454 will be replaced by new risks. Due to be reviewed at next ELT meeting (02/03/16). Updates on left. 13/01/16: P.Woodrow - A revised trajectory presented to the Secretary of State in October 2015 has been agreed to by Commissioners for specified work streams: job cycle time, non emergency transport, and multiple attendance ratio. The Programme Board and Project teams are focussed to ensure activities are aligned with achieving the revised targets. Due to be reviewed at Performance Improvement Programme Board 12/01/16 17/11/15: Risk added to Risk Register. Added to BAF due to
451	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.	Inability of the Service to provide resources to dispatch on calls in a timely manner. Insufficient resources in EOC to carry out the ring backs. Instances of Serious Incidents and Inquests where patients have deteriorated when there has been no contact by the service for a significant period of time. Increased demand vs resource.	10-Jun-15	29	1		Operational	Major	Likely	16	1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs. 2. Additional technical support to prompt re-categorisation and contact. 3. New ring back status monitors. 4. New information within EOC to be able to properly inform patients of the likely wait time for a response. 5. Staff removed from call handling to undertake ring backs when capacity allows. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care. **How are controls measured?** The Dispatch function is reviewed through a Quality Improvement process arising from the investigation of Serious Incidents. **Gaps in Control/Assurance** On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high. ORH report received due to go to EMT, 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. Additional front line resources are required.(covered by BAF risk 265 and 388)	Paul Woodrow (Katy Millard)	22-Feb-16	Major	Likely	16	1. Two call-handling courses are under way in October 2105 which will bring a maximum of 32 new staff to EOC pre-Christmas. 2. ORH report received due to go to EMT, 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. Report approved at Board level and business case for funding is now under development	1. K. Millard 2. P. Woodrow	1. 31/12/15 2. ~~23/02/16~~ Complete	Patients who are most at risk are flagged via the hub to focus the ring backs.	Major	Possible	12	22/02/16: Updates provided by K. Millard 11/01/16 BAF updated by K. Millard. 09/10/15: BAF Updated 27/08/15: BAF Updates provided by B. Jordan Approved by the SMT 10/06/15
441	There is a risk that there may be insufficient vehicle numbers to meet demands. Impacting on the Trust's ability to provide adequate vehicle numbers to support operational demand impacting on operational performance for the Trust		21-May-15	24	1		Fleet and Logistics	Major	Likely	16	1. Forward view of fleet requirement for next 5 years 2. Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that Unplanned Maintenance levels do not adversely affect Fleet Capacity and the provision of a safe environment to Operational Staff 3. Ensure capital investment is committed to support fleet volume and replacement 4. External/stakeholder support in place as required 5. Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan 6. Have an agreed vehicle specification 7. Agree and maintain adequate headroom in fleet numbers to manage variation	Andrew Grimshaw	14-Jan-16	Major	Likely	16	1. Complete capacity plan and ensure it is reviewed and updated regularly, ensure this is aligned with the operational plans evolving 2. Complete business plan for next 2 years 3. Agree & sign off DCA & FRU specification 4. Calculate and agree the headroom required along with operations and finance and adapt procurement appropriately 5. Complete Medium term Fleet Strategy 2017-18 and 5 years 6. Increase DCA fleet by 17 by holding back vehicles de for replacement in 2015. 7. Hold back and refurbish a further 20 vehicles due for replacement to cover events/training	1. Hd of Fleet & Logistics / Dir of Operations 2. DoF 3. Hd of Fleet & Logistics 4. Hd of Fleet & Logistics 5. DoF 6. Head of Fleet & Logistics 7. Head of Fleet & Logistics	1. On-going 2. OBC Completed FBC with TDA 3. Complete 4. On-going 5. 31/03/16 6. Complete 7. Complete	1. Monthly statement of Fleet requirement / Monthly KPI pack / Annual specifications to Fleet board / On-going capacity plan. 2. Actions taken have reduced pressure on the fleet. Business Case to deliver further 140 new DCA's in 2016. New vehicles introduced during 2015 are reducing unplanned maintenance.	Moderate	Possible	9	14/01/16: Updates received from C.Vale, BAF updated. Business Case to deliver further 140 new DCA's in 2016. (Refer to comments 2 in positive assurance) 07/10/15: BAF Updated 26/08/15: BAF Updated Agreed at FIC 21/05/15.

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388	There is a risk that further opportunities open up for frontline staff which may result in an increase in turnover rates impacting the Trust's ability to deliver safe patient care.	• Staff - additional pressure on staff health and wellbeing, manifesting itself as increased sickness absence, increased stress and pressure, an increase in patient complaints, a reduction in patient and staff satisfaction and potentially increasing turnover further. • Patients - reduction in the response times • Financial – increased loss of cover e.g PAS/VAS & overtime • Reputation – failure to hit targets & reduced quality of service	10-Apr-14	3	1	Safe	Clinical	Major	Likely	16	1. Actively recruiting university and registered paramedics and emergency ambulance crew 2. NHS staff benefits (e.g. pensions, T&Cs, etc.) 3. LAS staff benefits (e.g. cycle scheme) 4. LAS retention actions 5. Listening into Action - to understand staff improvements. 6. Clinical support provides career progression opportunities, with on-going training development. How controls are monitored/measured 1. Recruitment activity reviewed monthly at EMT and weekly at Performance Improvement Board 2. Reports and progress reviewed at EMT & Workforce Committee. 3. Revision of the Staff Exit Surveys to provide accurate information leavers and determine action required 4. Workforce data of resignations, projected leavers, projected joiners to identify reasons for resignation and opportunity to take intervention action 5. Workforce committee to report to EMT and Finance and Improvement Committee.	Paul Beal	22-Jan-16	Major	Likely	16	1. Exit interview analysis 2. Update progress on retention objectives/actions 3. Promote learning and development opportunities & continue to bid for LETB funding 4. Recruitment drive to fill vacant established posts. 5. Develop a Health and Wellbeing Strategy 6. Staff Opinion Survey results and subsequent action plan 7. Management with Resources to look at establishment and vacancies	1. Karen Broughton 2. Karen Broughton 3. Mark Whitbread 4.Karen Broughton 5. Tony Crabtree 6. TBC 7. TBC	1. Early May 16 2. April 2016 3. Awaiting LETB response (as at 21/12/15) 4. March 2016 5. March 2016 6. April 2016 7. TBC	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for ongoing cohorts of A&E support and Paramedic staff. 5. Development of reward strategy. 6. Development of clear clinical career structure.	Major	Unlikely	8	22/03/16 RCAG agreed to reduce the target rating to 8. Risk Ownership transferred to Paul Beal HR Director. 4/02/16 email from N. Fountain. 22/01/16 reviewed and updated by K. Broughton. 21/12/15: BAF reviewed and updated by K. Broughton. Owners and/or due dates for actions 6 and 7 required. Risk to be split into two risks to address recruitment and retention separately. The Director responsible will be reviewing the likelihood of this risk and it is unlikely that it will be included in the next iteration of BAF as it will not qualify for inclusion. 30/10/15 Reviewed by K. Broughton 24/08/15 JJ: The comprehensive Retention Strategy is being monitored by the Workforce Committee – no other update
443	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care		21-May-15	26	1		Fleet and Logistics	Major	Likely	16	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	Andrew Grimshaw	14-Jan-16	Major	Likely	16	1. Agree equipment to be tracked / scanned each day and accountabilities for each item 2. Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 3. Ensure adequate stocks of consumables and equipment are available to VP staff 4. Review current VP contract and agree any immediate changes 5. Agree essential equipment, plan and implement a process to make key items available centrally to restock 6. Plan rollout of and implement complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided 7. Implement pilot project in NE area to provide and resupply equipment store.	1-3. Logistics manager 4. Head of Fleet & logistics 5. Logistics manager 6-7. Head of Fleet & logistics	1. 30/03/16 2. Complete 3. 30/12/16 4. Complete 5. 30/12/16 6. Complete 7. 29/02/16	Clinical Equipment Group; Asset tracking report; VP reports; VP Contract; Equipment Process; Project completion	Moderate	Unlikely	6	14/01/16: Updates received from C.Vale, BAF updated. Significant level of work in progress. Pilot project in NE area aimed at providing local equipment store which can be used by VP to make good deficiencies on vehicles. Improved asset tracking systems being evaluated. 07/10/15: BAF Updated Agreed at FIC 21/05/15.
440	There is a risk that the LAS will not be in a position to win new NHS 111 contracts as stated in the 5 year strategy.	1. There is no consistent 111 tender process or service across London. 111 contracts across London are going out to tender dependent upon the expiry of current contracts and are constructed differently across London 2. 111 growth may not be given adequate resource/attention due to current 999 performance pressures diverting attention away, particularly at a senior level. 3. LAS costs may not competitive. 4. Detailed modelling to accurately assess what areas of London we will bid for, informing the impact on services such as, estates, IM&T, clinical support, resourcing, legal services, governance arrangements etc. has is difficult due to the tendering process and	08-Apr-15	20	3	Well Led	Corporate	Major	Likely	16	1. Interim Bid team established, gathering information of service requirements / KPIs / costing of service and preparing draft response. 2. Contract meetings with SEL 3. Bid team monitoring market to review local opportunities, gather intelligence around commissioning requirement and competitors 4. Long list of 'partners' drawn up and reviewed against capability and suitability to provide **How are controls measured / monitored** 1. EMT updates on NHS111 bid process, opportunities & progress 2. Update reports to FIC and Trust Board	Karen Broughton	20-Jan-16	Major	Likely	16	1. Understanding developed, through routine conversations with 111 commissioners across London, of their timeframes for tendering. 2. Work with CCGs to influence 111 system development across London 3. Bid for new 111 services as contracts become available 4. Local engagement, continue to develop relationship with current 111 commissioners, maintain and improve service delivery	1. J. Nightingale 2. J. Nightingale 3. P. Woodrow & F. Wrigley 4. P. Woodrow & F. Wrigley	1. Update end of Q3 2015 2. Update end of Q3 2015 3. Update end of Q3 2015 4. Update end of Q4	2. Monthly Review	Moderate	Unlikely	6	20/01/16 updated by K. Broughton. Interim bid team established, preparation in place based on published commissioning intent/ contribution from 111 operational team, local engagement with commissioners and partnership providers continues.

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404	There is a risk that the Trust does not accurately and efficiently capture staff related incidents and process them in accordance with national guidelines and within specified internal procedures (LA52 reporting).	Insufficient recorded evidence of reported incidents (total number and quality).	09-Jul-14		2	Safe	Corporate	Major	Likely	16	1. Line manager instructed to use the incident reporting E-Mail address when completing a RIDDOR F2508 form. This is located within HS 011 This will result in a copy being received by the department from the HSE. Gap in Control: (This form is not currently being used) 2. RIDDOR F2508 forms are completed electronically, allowing reporters to save a copy as a PDF file 3. Absences due to industrial injury are recorded on GRS, allowing potential RIDDOR reportable injuries (due to absence) to be tracked and cross referenced 4. The Datix Web pilot incident reporting system is currently being used in 3 complexes. This system has inbuilt guidance regarding RIDDOR reporting, and a direct hyperlink to the RIDDOR form. This process is to be incorporated within the Incident Reporting Project Datix Web role out that is currently being reviewed. 5. LA52 packs to be kept on vehicles. 6. Incidents are placed on a file, to be reviewed with the member of staff when they are next available to receive feedback.	Tony Crabtree	03-Feb-16	Major	Likely	16	1. To ensure incidents are reported in a timely fashion, Datix will be used to capture reported incidents which will be passed to the appropriate manager for verification/review of the information provided and escalation if required. 2. Active encouragement of incident reporting to be provided to staff via information made available on the Pulse, including examples of previous incidents reported (abridged SI reports) and the learning outcomes made though the Serious Incident Reporting process. 3. To facilitate a culture change in 'no blame' when reporting risks via the Pulse? / Comms by sharing examples of near miss incidents and the learning outcomes from them.	1. Head of Safety and Risk and Head of Governance 2. Head of Governance 3. Head of Governance / Head of Safety and Risk	1. April 2016 2. Feb 2016 3. Feb 2016	By monitoring the number of LA52's and incidents raised on a monthly basis, increases will demonstrate a more open reporting culture	Moderate	Unlikely	6	03/02/16: M Nicholas: Following discussion Safety & Risk believe that a more accurate scoring of the net risk would be 12, rather than 16 and following the introduction of RIDDOR reporting by the Safety & Risk Dept, it is anticipated that this will reduce further to Major and Unlikely (8). A bulletin has been published on the Pulse regarding the change in procedure for reporting RIDDORs and this will be followed up with direct emails to management groups instructing them on the change to be followed as from 01/03/16. 19/01/16: M. Nicholas - submission of RIDDOR to be made by Safety & Risk Dept. Process of reporting to HSE to be changed so that Safety and Risk Department make the submission instead of the line managers. 08/01/16: Actions 4&5 updated by P.Nicholson
442	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care		21-May-15	25	1		Fleet and Logistics	Major	Likely	16	1. Agreed vehicle equipment lists 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	Andrew Grimshaw	14-Jan-16	Major	Likely	16	1. Define and agree a "core" equipment list for DCA and FRU 2. Logistics to take responsibility for supplying core equipment 3. Undertake an audit of available equipment 4. Undertake an equipment amnesty and physically review all stations and complexes for "retained" equipment 5. Introduce monitoring process for tracking equipment 6. Develop system to reinstroduce equipment that gets decontaminated and agree equipment to be tracked/scanned each day and accountabilities for each item 7. Review contents, responsibility and issue of "bags". Agree terms of reference and timeline. 8. Implement working group to review personal issue kit	1-2. Head of F&L 3. Logistics Manager 4. Head of F&L 5-6. Logistics Manager 7-8: Head of F&L	1. Complete 2. On-going 3. On-going 4. Complete 5. 15/02/16 6. On-going 7. 31/03/16 8. 31/03/16	Progress made in agreement of core equipment and further equipment amnesty. Decontamination of equipment commenced. Analysis of asset tracking systems being undertaken.	Moderate	Unlikely	6	14/01/16: Updates received from C.Vale, BAF Updated. Refer to comments under "Positive Assurance" . 07/10/15: BAF Updated Agreed at FIC 21/05/15.
444	There is a risk that the equipment for frontline vehicles may not be in an effective condition.Staff will not have equipment required to provide appropriate patient care		21-May-15	27	1		Fleet and Logistics	Major	Likely	16	1. Agreed VP cleaning, deep cleaning and stocking service levels are set, maintained and monitored 2. Decontamination of equipment during VP, including monitoring 3. Decontamination of items left at hospital, including monitoring 4. Replacement equipment budgets in place. Process agreed and adhered to 5. Maintenance/Replacement of Kit undertaken when required	Andrew Grimshaw	14-Jan-16	Major	Likely	16	1. Complex based fleet to increase vehicle availability for VP 2. Monitor Decontamination of equipment trial 3. Implement contract for decontamination 4. Develop system to reintroduce equipment that gets decontaminated 5. Establish revised process for collection of equipment left at hospital for decontamination & subsequent redistribution 6. Review process for maintenance of equipment 7. Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 8. Ensure current performance against 95% deep clean within 6 weeks maintained.	1. Head of Fleet & Logistics 2-5. Corporate Logistics Manager 6. Head of Fleet & Logistics 7. Corporate Logistics Manager 8. VP Manager	1. Complete 2. 29/01/16 3. 29/02/16 4. 29/02/19 5. 29/02/16 6. Complete 7. Complete 8. On-going	1-2. Partial via VP reports 3. Decontamination reports 4. Partially monitored within Fleet & Logistics 5. Monitored within Fleet & Logistics	Moderate	Unlikely	6	14/01/16: Updates received from C.Vale, BAF Updated. Significant progress made on actions. Decontamination of equipment has commenced. Work being undertaken with St George's Healthcare to agree equipment maintenance trial. 07/10/15: BAF Updated Agreed at FIC 21/05/15.
461	Significant time lag (in excess of six months) in the reporting of medicines usage data captured by Management Information during the data entry and validation of PRFs may lead to LAS not being able to track usage of medicines by complex stations/ sectors/ practitioner group, call signs etc.	Currently MI are reporting drug data usage figures that are seven to eight months old. This means that the LAS cannot track in a timely manner usage of medicines by Complex / Station / Sector / Practitioner Group / or clinician. The LAS is also being asked, in common with other Ambulance Services, to report more data on drug usage to the MHRA, and National Ambulance Pharmacy Advisers Group to assist with guidelines development and replacing existing mediciantions with different alternatives, (benzodiazepines being a current example). The LAS is only able to offer very historic data. This also has implications for investigating of	27-Jan-16				Clinical	Major	Almost Certain	20	1. MI capture and validate the data via the PRF scanning process 2. Drug usage statistics produced by MI - but they are several months in arrears 3. Physically isolating PRFs and then data trawling by hand if detailed analysis required. The CPI process provides limited information, but is very difficult to use for gathering service wide data.. 4. Limited information can be gained by reviewing the medicine purchasing invoices	Vic Wynn		Major	Likely	16	1. Increase rate of data capture at MI 2. Consider options (and cost and staffing implications) for retrospectively recording the data that will be missed if MI start contemporaneous data capture. 3. Consider the use of technology to assist in data capture. This could include obtaining additional information off the MDT screen and / or electronic patient records	? ? ?	? ? ?		Major	Rare	4	Risk approved by SMT 27/01/16 - risk to be further discussed by IM&T and Medical Directorate to identify the root cause of the risk exploring the input quality of data (separate risk to be assessed). Actions and completion dates to be agreed once this has been scoped out further.

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445	Risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence, resulting in potential adverse consequence to the health of LAS staff and that of the general public to whom they are responding.	Personal Protective Equipment (PPE) Some operational staff are at risk of infection due to: • Staff not having the equipment because they haven't been fitted with the FFP3 respirator mask. • Staff coming completing basic training having been fit tested but not having the equipment issued. • Assurance of the PAS/VAS/Community Responders status for category 4 preparedness. Patient facing staff knowledge, understanding and training Operational staff are at risk of infection due to: • Lack of knowledge and specific training regarding infectious disease processes, the use of regular and	27-May-15	30	1		Health & Safety	Catastrophic	Likely	20	1. Infection Control Workbook; standard infection prevention control training programme in place. 2. Infection Control Specialist and OHD service (not 24 hrs) 3. Task and finish group for Category 4/VHF(Ebola) assurance (chaired by EPRR) 4. Clear process for confirmed Ebola case between LAS and the Royal Free and working arrangement with Health Protection Units. 5. Regular EPRR Ebola management bulletins, including algorithms for early identification of possible cases of VHF at the call taking stage and CHUB 6. Support from the Clinical Hub and Health Protection Unit for enhanced risk assessment on suspected cases. 7. Current OHS contract does not include contract tracing– new contract from 1st April 2015 for new provider has enhanced specification 8. Waste contract in place – includes Cat A waste for incineration 9. IPC at Clinical Basic Training and CSR – requires enhancement for Ebola PPE 10. FFP3 Fit testing and provision of personal issued respirators, basic clinical training for existing staff – captured at FITFLU Programme commenced 15/10/14 11. Ebola assurance monitoring by VHF Group and at IPCC 12. National Transfer procedures agreed 13. Ongoing engagement with PHE	Paul Woodrow	18-Feb-16	Catastrophic	Possible	15	1. Develop VHF Plan – Action cards, transfer process, VHF bulletins, 2. Identify, risk assess, procure, distribute enhanced PPE: HART LAS operational staff 3. LAS Ebola VHF processes (e.g. policy and procedures) internally and externally aligned 4. Develop a set of FAQ's for all staff 5. Develop monthly compliance data and reporting for FFP3 fit testing to the IPC team for assurance 6. Share HART training package with the education and development department to ensure a consistent standard of infection control training including the use of enhanced PPE 7. Review the requirements of involvement of individuals to take part in the form working group with terms of reference for actions identified and monitoring arrangements to be put in place. 8. Enhance the decontamination process for vehicles as per national and expert guidance, to include for example hypochlorite / Bioquell, for use by all crews. 9. Procure an enhanced Category A waste disposal service Additional control measures to reduce existing level of risk: (PATIENTS & STAFF) 10. Review Incident Outbreak Policy 11. Enhance Occupational Health Service contract requirements to incorporate immediate access, contact tracing and follow up or alternative internal arrangement. New contract in place from the 1st April. 12. Identify an Incident Control Group in the event of a	1. LL VHF Group 2. L.L / ECH / HF R. Deakins A. Fulcher K. Merritt 3. S Woodmore Chris Reeves 4. Comms assisted by VHF group 5. P. Williams 6. S Woodmore I Bullamore E Hitchcock 7. L. Lehane 8. Trust Decon Lead IPC Estates 9.N. Smith ECH 10. E. Hitchcock 11. Fatima Fernandes 12. S. Lennox 13. J Downard 14. C Gawne 15. L. Lehane P Williams	1. Completed 17/03/15 2. Complete 3. Completed as part of 1 above 4. Completed in line with national guidance 17/03/15 5. Complete 6. Ongoing 7. Completed 17/03/15 8. 31/05/15 9. Complete 10. May 2015 11. Completed 12. Complete 13. Ongoing 14. Completed 17.03/15 15. Ongoing	6. M Rainey advised crews are using Clinell wipes (Green then Activated Red then Green) which is effective, however testing is due to take place for Bioquell - liaise with E Hitchcock. Hypochlorite was found to damage the metal in the ambulances. 8. Awaiting Enhanced PPE to prepare and share training package - liaise with L Lehane.	Catastrophic	Unlikely	10	22/03/16 Agreed by RCAG on 08/03/16 to archive. 18/02/16: Updates provided by K.Bate 17/11/15 K. Bate separating risk into two risks focussing on risk to HART and risk to crew to be reviewed by Infection Control Taskforce at their meeting on 19/1/15. These two new risks will not qualify for inclusion on the BAF 10/09/15 NC/MS met with M Rainey to discuss and update 19/08/15 IPC taskforce - review risk EH/LL/ Simon Woodmore / Mark Rainey / FF
410	There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	50% total volume of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.	01-Oct-14	16	1	Safe Effective	Clinical	Catastrophic	Likely	20	1. Undertaking ring backs within set time frames for held calls 2. Fully trained workforce with 20 minute education breaks throughout shift. LAS overtime +PAS/VAS to add capacity. Focussed incentivisation to more challenged hours of the day. 3. Additional focus on safety reporting. QA – MPDS (999); QA – CHUB MTS (H&T;) – Report safeguarding incident concerns. 4. Falls care is being introduced. Flag elderly fallers on vulnerable person monitor (VP). Clear process of escalation of response process implemented. 5. Implementation of VP (mental health / elderly fallers) and CP (sickle cell / septic patients) screen to monitor higher risk patients. 6. Managing patients through use of NETS options where clinically appropriate. NETS desk and HCP lines starting 1st July 7. Recruitment well underway and number of leavers significantly less than number of new starters. 8. A business case is under preparation to increase the establishment in EOC in order to staff previously unfunded systems. 9. FRU performance improvement plan in place. **How are controls measured?** Performance dashboard; Operations; SI group, governance group; Monitoring SI and complaint themes.	Paul Woodrow	22-Feb-16	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 5%. Details included in advert to action in improvement programme. Recruiting frontline staff to 3169 by March 2016. 2. Deliver efficiencies in full from Capacity Review and complete Roster Implementation. 3. Recruit to establishment in the clinical hub. Band 6 is now agreed for all HUB posts. 4. Review the establishment in the CHUB (Jan 2016) and recruit into posts (March 2016). Recruitment of 40 Team Leaders, 30 band 6's and 4 Mental Health Nurses has been agreed. Currently reviewing 24/7 Mental Health Nurse coverage, adjusting the need for more band 6's and less Team Leaders. 5. Allocate EMDs to clinical hub to assist with ring backs (when capacity allows) 6. Increasing taxi use. Use of an SOP with taxi booking makes the process safer. 7. Discussion with NHS111 regarding the green calls - complete. 80% of green calls are assessed by a clinician to ensure appropriate level of care is assigned. 8. More accurate and visible reporting of category C delays. Clinical Hub working model changed to have greater focus on geographical areas of London, now including C1 and C2 calls waiting for ring backs. 9. Surge plan review underway to be completed with ELT by end of February 2016. Change to surge plan triggers for purple enhanced agreed by ELT January 2016. 10. Actions included with BAF risk 4 relating to performance impact on the realisation of this risk.	1. K. Broughton 2. P. Woodrow 3. K. Millard 4. K. Millard 5. K. Millard / F. Wrigley 6. K. Millard / F. Wrigley 7. TBC 8. TBC 9. K. Millard 10. P. Woodrow	1. Q4 2015/16 2. Complete 3. Complete 4. April 2016 5. Complete 6. Complete 7. Complete 8. Complete 9. Complete	1) Recruitment activity reviewed fortnightly at ELT 2) Weekly forecast & planning meetings. 3) Medical Director and DDO (Control Services) to review surge plan as required, and plan to do again imminently. 4) Plans for non-auto dispatch back-up have been developed and will run from 3/11/15 for 3 weeks and this should reduce MAR 5) Overtime disruption payments are in place until 6th January 2016. **Gaps in Control** Advert to action activity is rated red for delivery against target.	Catastrophic	Unlikely	10	22/02/16: Updates provided by Katy Millard 11/01/16: BAF Updated - The Executive Team have discussed this risk and noted that consideration needs to be given to the current rating. Risk to be reviewed by Deputy Director of Operations for Control Services for further details on action completion dates and any assurance provided by the safety review against this risk. CHUB staffing levels - following recruitment of CTL and clinical advisors levels have improved. Further supported by secondments to CHUB planned for February 2016. Odd shifts remain uncovered but working towards safe cover levels. Consider risk level could be reduced. 25/11/15: BAF Updated 09/10/15: BAF Updated 21/09/15: 1) Have APPs in the control room. 2) Clinical Team
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	12	1	Effective	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from data cards. 5.LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units. 6. New Malden pilot has trialled the transmission of data from the LP15	Fionna Moore	06-Jan-16	Moderate	Almost Certain	15	1. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 2. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 3. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area. 4. Consider roll out of transmittable data from LP15 once vehicle on station. MW to source modems and establish proof of concept. 5. A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to pub into a lap top to establish the benefits that come of out of it. The evaluation of this exercise will be reviewed in February 2015. This practice is in place all of the time now Team leaders now in place 50/50 will influence the output.determine the impact of this risk review 3 months	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread	1. Complete 2. Complete 3. Complete 4. Jan 2016 pilot evaluation 5. In place	EOC briefings undertaken	Moderate	Unlikely	6	6/1/16 - C henderson. Reviewed by medical directorate. Risk owner should be moved to Medical Directorate in the absence of Director of Education and Standards. Owners should be amended to show M Whitbread and J Nevett. Spoke with M Whitbread - risk remain as current with Service development bid application for bluetooth data download facility 15/10/15 M. Whitbread provided update 26/08/15 - A.Blakely: Reviewed by Medical Directorate August 2015. Downloads remain at similar levels. Any update re: comment below? June 2015 - M. Whitbread to review with F. Moore for next course of action. Reviewed by Medical Directorate Nay 2015 - should remain.We are at 8% for defib

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420	Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services	As the CAC network does not have access to the internet or email, it is less likely that attacks will come directly from these external sources, but it may be possible to introduce an attack through infected USB drives, CD/DVDs, or other removable media (even if LAS-approved devices). Alternatively, an attacker could leverage one of the security vulnerabilities present on the other networks (external Internet facing network or Admin network) as a pivot point to launch attacks into the CAC. Patching (on the Command and Control network) Patching refers to updating software or its supporting data to help remediate known issues, such as security vulnerabilities. KPMG review has revealed that	08-Oct-14	33	3	Safe Effective	Information Governance	Catastrophic	Possible	15	1. Enterprise antivirus monitoring CAC desktops 2. Desktop ports disabled (i.e. USB, DVD) 3. No access to internet /email for CAC desktops	Steve Bass / Vic Wynn	21-Dec-15	Catastrophic	Possible	15	1. Implement Firewall between CAC and LAS corporate 2. Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed.	1. S.Bass 2. S.Bass	1. 31/03/16 2. 31/01/16	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	21/12/15: BAF Updated - Monthly reviews to continue Risk Reviewed 01/10/2015 CAD works completed and testing of EOC application suite on Windows 7 being undertaken. Target completion Nov 2015 **19/06/2015 Implementation reliant on CAD upgrade (within a planned EOC outage)- Centralised system to distribute updates (patches) being implemented and will be available by June 2015** 20/05/2015 Implementation reliant on CAD upgrade planned on 15th May (within a planned EOC outage)- still ongoing 25/03/2015 Third party (NG) still testing CommandPoint software on Windows 7 22/01/2015 The new (required)
356	There is a risk arising from no provision for protected training time for clinical and paramedic tutors. This may as a consequence cause:- ● Dilution of training skill levels ● Credibility and reputation concerns of trainers ● Impact on the validity of clinical training	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	23-Nov-11		1,2		Human Resources	Moderate	Almost Certain	15	1. All tutors have received a clinical update package. 2. All tutors have received major incident update training. 3. A clinical update training day has been provided to all clinical training staff. Additional clinical skills programmes have been run based on identified need in preparation for pre-winter 2013 Operational Support.	Mark Whitbread	28-Oct-15	Moderate	Almost certain	15	1.In conjunction with the Medical Directorate plan sufficient places in an amended format to facilitate all of the training officers / clinical tutors to attend the clinical module which is being delivered for team leaders. 2. Unable to rccruit qualified tutors therefore introduced a trainee tutor position. Therefore current vacancies are filled by trainees. 3. Need to increase Tutor numbers as currently not enough tutors to meet the current need of the training plan (increase in establishment is dependent on the workforce plan). 4. continue to rigourously pursue the provision of external support.	1. M. Whitbread 2. M. Whitbread 3. Finance - (Andrew Grimshaw) already knows 4. JThomas - Clini Educ & training Mgr - (Acting)	1.On-going continuous process. 2. On-going 3. On-going 4. On-going	Course review and feedback by Education Governance Manager	Moderate	Rare	3	J. Thomas proposed regrading net rating from moderate x likely = 12 to moderate x almost certain = 15 due to the current demands on the department due to the recruitment activity. Agreed by SMT 28/10/15.
400	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	SatNav's were originally specified and procured in 2001. The selected manufacturer was Siemens VDO, distributed in the UK by MixTelematics Ltd. Over time the unit design has evolved (CD to DVD to SDcard) but fundamentally they have remained backward compatible as far as the interface to the MDT was concerned. The device is no longer manufactured and spare parts are becoming scarce. Alternative SatNav devices from other manufacturers are not a simple retrofit and will require reengineering of the MDT interface. The impact of failures and inabilty to repair will build gradually (a rising tide) with increasing effect on fleet maintenance and availability, ultimately the	11-Jun-14	10	1	Safe	Operational	Major	Likely	16	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies. 3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available.	Paul Woodrow	10-Dec-15	Major	Possible	12	1. The current CAD Software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 and 3. 2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above. 3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process. 4. As a precaustionary measure the existing Sat Nav mapping software will beupdated to the latest version. 5. Obtain 2nd hand SatNavs from other Trusts.	1. John Downard 2. John Downard 3. John Downard 4. John Downard 5. John Downard	1. 31/03/16 2.Complete Oct 2015 3. Q1 2016 4. NFA Oct 2015 5. Complete Dec 2015	IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweight the volumeof units required. In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles.	Major	Rare	4	2/2/16 - Risk reviewed by IM&T - testing of alternative SatNav is in progress with initial encouraging results. Development of MDT3 s/w is on track. Deployment of ultimate overall solution is subject to successful testing. 27/01/16 SMT approved regrading of risk from major x likely 16 to major x possible 12. 10/12/2015 - Risk reviewed by IM&T - development work is progressing with demonstrable results and expected now to be complete in Q4. Action 3 - pre-emptive funding has been secured and framework procurement agreed. Unfortunately Action 4 has not been possible as the supplier was unwilling to provide the data. New Action 5 has been achieved and 300 units are in Telent's spares store. 01/10/15: V.Wynn proposes to regrade net rating to Major x Possible (12). To be added to

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31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02		1	Safe Effective Caring Responsive	Clinical	Major	Almost Certain	20	1. Consultant Midwife now employed substantively 3 days were week (commenced January 2015) 2. A deep dive audit was carried out which was reported to the Quality Committee in Autumn 2015. To be repeated as required. Review incidents reported through LA52's, Patient Experiences and legal Claims relating to problematic obstetric incidents. Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife. POETS e-learning programme in place. to be checked AM Drop in sessions arranged by new consultant midwife for EOC, EMD's and Clinical Hub Staff Breech Masterclasses delivered (August 2015) and to be continued around London Education Centre Advanced Life Support Bootcamp course run every 2 months, including a maternity update theory session and maternity scenario. unclear on when next dates become available Maternity update evening (external venue, attended by LAS and midwifery staff from london hospitals). Scenarios based learning. New sim-Mum purchased and delivered.	Fenella Wrigley	25-Jan-16	Major	Possible	12	1. Deputy Director of Paramedic Development & Education to directly oversaw delivery of CSR 2013/2014/Present K2 Obstetric Emergency Training software as an alternative to current POET online training. 2. Obstetric emergency decision tool to be put in place this month. 3. Obstetrics emergencies clinical update article written and will appear in the next clinical update magazine 4. Birthing Sim-manikin ordered and training is planned for January with nominated clinical tutors from around London. 5.Maternity care update articles in the Clinical Update to be completed for March 2016. 6. Pan-London Maternity Divert Policy (Updated Sept. 2013): Robust framework to limit temporary closures of maternity units and to organise redirection.to be reviewed by the current London Heads of Midwifery alongside the Obstetric Policy to look at a combinedd guideline, deadline for the project March 2016. 7. Programme of maternity simulations to be agreed with clinical tutors and education team.	1. T. Ivanovic 2. A. Mansfield 4. A. Mansfield 5. A. Mansfield 6. A. Mansfield 7. A. Mansfield	1. March 2016 2. Complete 3. March 2016 4.16 Feb. 16 5. March 2016 6. March 2016 7. April 2016	1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services. 2. Incident reporting. 3. Reports to CQSEC, SI group, Learning from Experiences 4. The six weekly maternity risk summit meeting to review collection of evidence	Major	Possible	12	22/03/16 RCAG agreed to reduce target rating to 8. Amemndment to be made. 25/01/16 A. Mansfield proposes reduce target rating from major x possible to major x unlikely = 8 due to the increased staff awareness around recognition of the deteriorating pregnant woman. Reviewed by A. Mansfield 8/12/16 no change in net rating. No longer on the BAF [NC] 26/08/15 - A.Blakely: Reveiwed by medical Directorate but should remain. August 2015. Reviewed but should remain as current rating for now. New controls also in place. Medical Directorate reviewed risk December 2014 and proposed to regrade net rating from major x likely = 16 to major x possible = 12 to go to SMT for approval January
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients.	Inappropriate non-conveyance incident	14-Nov-02		1	Safe Effective Caring	Clinical	Major	Almost Certain	20	1.Monitor level of CSR training and delivery. 2. CPIs are used to monitor the standard of assessments provided. 3. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee (CQSEC) and the Area Clinical Quality Groups. 4. The Operational Workplace Review has been reviewed and will now include ride outs. 5. A system for clinical updates is in place. 6. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 7. Introduction of Paramedic Pathfinder – an adaption of the Manchester Triage System for use pre-hospitally to safely identify the most appropriate destination for individual patients. 8. Introduction of reflective practice (as part of Module J programme). 9. Regular review of clinical incident reporting and serious incidents.	Fenella Wrigley	06-Jan-16	Moderate	Likely	12	1. Director of Paramedic Development & Education to directly oversee delivery of CSR 2015/2016. 2. The Medical Directorate will continue to monitor trends. 3. Design processes to audit and monitor the effectiveness of the pathfinder tool. 4. Development of the clinical career structure. 5. Update course for Clinical Team Leaders and Clinical managers, to enable them to update clinical staff.	1. Director of Paramedic Education and Development 2. Clinical Advisor to the Medical Director 3. Pathfinder Leader 4. Mark Whitbread/ Jane Thomas 5. Mark Whitbread / Jane Thomas	1. End of 2016 2. Ongoing 3. Commence April 2014 4. May 2014 - 2017 5. Delivered monthly	CPI reports OWRs CSDEC EMT/TB reports Learning from Experience	Moderate	Possible	9	6/1/16 - C Henderson. Medical Directorate reviewed. further discussion with MD to review this risk as ? obsolete and needs replacing with an updated risk for ?clinical supervision. To further discuss at MD risk register review meeting scheduled for February 2016. Risk discussed at SMT 25/11/15 with a view to re-grading, group proposed the net risk remains at 12. No longer on the BAF [NC] 26/08/15 - A.Blakely: Reviewed by Medical Directorate August 2015. Pathfinder training now in the current CSR which will improve decision making - to review once CSR completed to look at numbers of staff who have completed this training. Reviewed by Medical Directorate - May 2015. LA52 completion has been increasing and therefore
396	There is a risk that If the Trust does not plan effectively it will not be aware of risks and threats. These could result in significant risk to the ongoing viability of the organisation, operations and clinical safety.	• An LTFM is not in place. • Regular reports are not provided to the FIC on forward financials. • Future assessments do not take account of low level (departmental) plans or high level (organisational) issues. • Plans exclude I&E, balance sheet, capital and cash. • Future CIP plans are not scoped and where possible identified, 2-3 years ahead.	10-Apr-14		3	Well Led	Finance	Catastrophic	Likely	20	1. An LTFM is in place. 2. Regular reports are provided to the FIC on forward financials. 3. Future assessments take account of low level (departmental) plans as well as high level (organisational) issues. 4. Plans include I&E, balance sheet, capital and cash. 5. Future CIP plans are scoped and where possible identified, 2-3 year ahead.	A.Grimshaw	21-Jan-16	Major	Possible	12	~~1. Review format and frequency of reports to FIC on future planning.~~ 2. Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan. 3. Develop future CIP planning. 4. Build integrated plan encorporating CQC and required performance improvement.	1. DoF 2. DDoF 3. All executives 4. DoF	~~1. 30/11/15~~ 2. Started Oct 2015 3. 31/03/16 4. 31/03/16	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	21/01/16: Reviewed at FIC meeting, new action added. 19/11/15: Updates provided by FIC agenda (meeting due 20/11/15) No longer on the BAF [NC] 14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading. Reviewed by the FIC 21/05/15 net rating regraded from major 4 x likely 4 = 16 to major 4 x possible 3 = 12. Reviewed by A. BEll 11/03/15. FIC amended the risk description January 2015.

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433	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	All staff need time with their line manager to support them to deliver what the organisation needs them to in terms of performance improvement, better care for patients and looking after and retaining our staff.	11-Feb-15	18	2,4	Effective Well Led	Corporate	Major	Likely	16	1. Corporate communications channels reviewed and refreshed as part of communications strategy approved by the Board in June 2014. Team Talk introduced in September 2014 and now the operational management restructure is now in place – it is believed delivery and feedback will be improved. 2. Set up Workforce Committee to monitor delivery of staff engagement plan. 3. Operational restructure will improve engagement with line managers. 4. Quality Improvement Programme Governance Structure in place.	C. Gawne	26-Jan-16	Major	Possible	12	1. Performance management and appraisal of engagement objectives for line managers. 2. Regular Managers Conference 3. Communication audit to evaluate mechanisms	1. Directors 2. CTLs 50% Clinical 50% Management 3. Director of Communications	1. 31/03/16 2. bi-monthly conferences 3. 31/03/16	Management restructure now complete and new ADOs committed to and making plans for strong staff engagement. CTLs now have 50% role for supporting staff.	Major	Unlikely	8	Reviewed by C.Gawne 26/01/16 09/10/15: BAF Updated 21/08/15 C. Gawne proposed to regrade net rating from major x likely = 16 to major x possible = 12. **Approved by SMT on 28/10/15.** Approvd by C. Gawne and noted by SMT 11.02.15
434	There is a risk that that sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch). This could result in a lack of support by stakeholders: at best this would mean no support for improvement programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	ADO's and SEM's are essential for strong local stakeholder management, it cannot be done effectively centrally	11-Feb-15	19	2,4	Responsive Well Led	Corporate	Major	Likely	16	1. ADOs are developing strong relationships with key stakeholders from Aug 2015 2. New Communication Public Affairs Manager started in September 2015 supporting local stakehold engagement.	C. Gawne	26-Jan-16	Major	Possible	12	1. Provide support and training and regular stakeholder perception testing 2. Work with new Operations Directorate Stakeholder Managers to support them in their role. 3. Design process for local feedback and reporting 4. Attendance at SEM monthly meeting. 5. participation in weekly ADO call to receive feedback from stakeholders and provide advice on how to manage situations.	1-2. Director of Communications and Director of Operations 3. Communications Team 4. Monthly 5. Weekly	1. Continuous process of assistince with engagement with media 2. Ongoing 3. Dec 2015	GP survey (planned for January 2016). Stakeholder Engagement Managers are now active in their roles since August 2015. Weekly updates from communications to ADO's now in place. Public affairs in communications now appointed following restructure - this post will have a local support element.	Major	Unlikely	8	Reviewed by C. Gawne 26/01/16 25/11/15 K. Brown - ADO's and Sector Stakeholder Engagement Managers are essential for strong local stakeholder management, it cannot be done effectively centrally. 09/10/15: BAF Updated 21/08/15 C. Gawne proposed to regrade net rating from major x likely = 16 to major x possible = 12. **Agreed by SMT 28/10/15** Approved by C. Gawne and noted by SMT 11.02.15+Y8
391	Patients being placed on the Co-ordinate my Care (CMC) Database may not have their addresses flagged in a timely manner. Particularly during the out of hours period.	Initially in 2010, numbers of CMC records were low, (started off at approximately 10 records per week). The LAS were aware that this figure would rise to approximately 150 per day and this would create a problem to keep up with this number of patients. The proposed IT solution in 2011/12 was not funded but this funding has now been approved (December 2013).	12-Feb-14		1	Safe Effective	Clinical	Major	Likely	16	1. Automatic notification of CMC patients to LAS via email. 2. Staffing levels increased to support Management Information staff with the process of flagging address on the LAS Gazeteer. 3. Clinical Hub where possible monitor calls where a CMC flag has been triggered. 4. Clinical update courses run through Education and Development and internship programme which included reference to CMC and end of life care. 5. End of life care circulars regulalry on the Pulse which references CMC. 6. Attendance at CMC Steering Board, CMC Governance Committee and CMC Stakeholder Group where issues are raised and investigated as necessary."	Zoe Packman	20-Jan-16	Major	Possible	12	1. Funding has been secured to develop a web interface between the CMC database and the LAS command and control systems. Management Information are exploring with CMC an interim IT solution. 2. Following the next Command Point upgrade, Summer 2015, automated transfer of flags will be implemented. 3. A small project group, once Command Point has been upgraded, will be convened to test the automated update process and assess for any risks this may then produce in order to mitigate against them and move to full 24/7 automated CMC flags being placed Autumn 2015.	1. IM&T / MI/ Clinical Directorate 2. IM&T, MI 3. Business Development	1. Completed 2. July - Sep 2015 3. awaiting start date	1. CMC Stakeholder and CMC Steering Group meetings, (LAS have membership of both groups). Sen Clin Adv to Med Dir is LAS representative at CMC Streering Group and reports on a monthly basis to this group. 2. LAS monitoring of EOC / 111 systems. 3. LAS monitoring of clinical incidents / complaints related to EoLC and the use of CMC	Major	Unlikely	8	Reviewed at IPEC 16/02/16 Review impact of this when the system is in place. 20/01/16 M. Damiani - The new system will bring only marginal benefit in relation to this specific risk. B. Sloper update from IM&T nothing has changed other than we are being re-organised and this may involve re-prioritising and re-allocating development work. This project is still on our list, but no concrete start date has been set yet. 26/08/15 - A.Blakely: Reviewed by Medical Directorate August 2015. To remain at present, and to be reviewed once auto-flag is initiated which should reduce this risk significantly. Reviewed by B. Sloper March 2015.

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205	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system.	Capacity of Fulham Archive Store (for hard copy training records) is exhausted. Records not being available for evidencing incidents, litigation, coroners enquiries, and regulatory / awarding bodies relating to statutory training requirements	01-Jun-05		3	Effective	Corporate	Major	Likely	16	1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc. 2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system	Mark Whitbread	03-Feb-16	Major	Possible	12	1. Develop plans to move to the electronic storage of all operational training records generated within the LAS 2. Further develop the plans to create a central management hub (currently Fulham) to support and underpin the provision and quality of all Clinical Education & Development activity throughout the Trust. This will include the review of Fulham CE&S administrative staff levels, so as to ensure that sufficient capacity exists to fulfil the requirements of the new training record management system. 3. Scope the potential and options for the back scanning of existing training record documentation. 4. source sufficient estate to house all training records in one location with traceable/identifiable information	1. P.Billups 2. M. Whitbread / P.Billups 3. P.Billups 4. P. Billups	1. Completed 2. Oct 2015 3. Dec 2015 4. Dec 2015	1. Annual reaccreditation visits by IHCD external verifier 2. Title of new monitoring group tbc.	Major	Unlikely	8	3/02/16 T. Ivanov - Electronic student records are being explored via the QIP under the workstreams held with Paul Beale. A new training venue is currently being sourced to replace Lombard House and Southwark and this will have capacity for storage of paper records. It is proposed that all records move to electronic forms as part of the IM&T strategy and that previous records are archived to electronic form via an external contract with an appropriate provider. Lombard House (if lease extended) will hold all of the papers records 4/9/15. point no. 4 added to Further action required. (MSalami & JThomas). March 2015 - This project has now been included as part of the IM&T server and storage replacement programme, due to the capacities required. Gating template for the additional staff needed will be
439	There is a risk that all operational/clinical staff may not receive statutory and mandatory training appropriate to their role required to comply with legislation, meet CQC compliance and the Trust's TNA policy. This could result in the dilution of clinical skills	Lack of consistency of staff booking onto CSR places which have been provided. The Trust are not allowing stand downs for staff who haven't got Individual Learning Accounts in place to attend CSR training due to the impact of resources vs demand on performance. Non- compliance with statutory and mandatory training (The associated legislation for each requirement is referred to in the Training Needs Analysis and the Core Training Policy -TP056.)	08-Apr-15		1,3	Safe Effective	Corporate	Major	Likely	16	1. Individual Learning Accounts mitigate the impact of performance on training. 2. Complex management teams managing the training process. 3. Clinical Education and Standards monitor the uptake of course places provided (data is included on the clinical dashboard) which is reported at EMT / TB /CQSED 4. Letters have been sent out to staff reminding them to book onto courses and a Bulletin has been put in the RIB.	Mark Whitbread / K. Broughton	03-Feb-16	Major	Possible	12	1. Letters have been sent out to staff and an article has been placed in the RIB 2. ILAs need to be incorporated into all rosters when reviewed (some staff do not currently have ILAs) 3. A process needs to be put in place to monitor/review the compliance with managing the ILA process 4. Continual communication about the process i.e. routine bulletins / posters.	1. P. Cranmer 2. P. Woodrow 3. Admin Manager, Training Dept. Fulham 4. J. Thomas	1. Completed 2. TBC 3. in place / Reviewed monthly 4. In place / Continual process.	Figures are reported monthly and are overseen by the Quality Governance Committee and Trust Board	Major	Unlikely	8	3/02/16 T. Ivanov - This is being carried forward by Julia Smyth as part of the QIP under the workstreams of Paul Beale. 19/11/15: J. Thomas - GSMs are reminding staff to book onto courses and the remaining courses are now full. Further work is needed to ensure that ILAs are incorporated into the rotas. M. Whitbread 25/08/15 - current take up of CSR is down - need to remind staff to take up places to ensure we reach the 85% target escalate to Quality Safety and Standards Committee for further action. M. Whitbread reviewed 08/06/15 - proposed regrading net rating from major x likely = 12 to major x unlikely = 8 due to controls in place. FF 20/05/15 need to look at ability to capture training figures for this group of staff.
411	There is a risk that patient safety could be compromised due to the possibility of contaminated patient equipment collected from A&E departments being reused without undergoing a decontamination process. This may breach the Hygiene Code and could jeopardise continuous CQC registration	Patient equipment in ambulances is being wiped over between patients. Contaminated equipment is collected by Logistics and left in cages on sites; soiled equipment also brought back by ambulances is likewise left in cages on sites. Financial risk- Additional items are procured (reusable and single use) to ensure adequate volumes for use; without considering how the backlog of equipment can be turned around safely. Currently there is a lack of a validated decontamination service for contaminated A&E equipment and inadequate process in place to decontaminate visually soiled equipment on ambulances; there is a	08-Oct-14		1	Safe	Infection Control	Major	Likely	16	1. Education -Embedded cleaning standards into LAS daily practice - Induction, CSR training. CSR training content revised to raise awareness of need for equipment to be cleaned after each use; use of wipes and correct cleaning method for ambulance equipment. 2. IPC arranged visit with Logistics to a third party decontamination service provider (Essentia) in March 2014, with a view to a one-off clean of all equipment, and setting up of a regular service. In order to obtain a quote for the service, volumes and types of equipment from sites have to be provided.	~~Mike Evans~~ Andrew Grimshaw	04-Feb-16	Major	Possible	12	1. Third party decontamination service for A&E equipment and soiled equipment from ambulances - via St Thomas Hospital. 2. IPC training for Logistic drivers 3. LAS & Pan London A&E units working framework regarding the need to reduce bioburden/hazard on returned equipment 4. Audit of decontamination compliance to be part of AOM's objectives.? 5. Decontamination process to be included in the Management of Medical Devices Policy which is currently awaiting approval. 6. Once the Management of Medical Devices Policy is approved communication will be required with front line staff on the arrangments in place both in and out of hospital.??	1. K. Merritt / Logistics 2. IPC, Logistics, and A & E departments 3. 4. 5. External contractor 6.	1. In place 2. to be arranged 3. 4. 5. Q4 2015/16 6.	1. Decontamination Lead to oversee and report to IPCC quarterly 2. Policies - Medical Device management Policy, Decontamination Policy 3. Third Parties - Decontamination Service; Pan-London Working Framework 4. Quarterly monitoring at IPCC	Major	Unlikely	8	04/02/16 IPC Committee reviewed risk and proposed escalating to A. Grimshaw for update on actions. 03/12/15 KM reviewed and updated. Proposed these are not amalgamated good progress being made with both risks and each have separate impact areas and actions. IPC Taskforce Sep 2015 KM to assess risk of gross decontamination of vehicles IPC Tasforce 19/08/15 EH/ KM/FF to review and amalgamate risks 411 and 326 Reviewed by CEWG 10/06/15. Review again in 3 months.

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446	There is a risk that support service staff may not receive statutory and mandatory training appropriate to their role, required to comply with legislation, meet CQC compliance and the Trust's TNA policy.	Lack of commitment/capacity from managers to deliver training through the all in one and corporate induction programmes. Currently not able to monitor effectively and efficiently whether staff have undertaken required e-learning.	27-May-15		2,3		Corporate	Major	Likely	16	1. Programme of All in One training in place 2. Programme of Corporate Induction in place 3. E-learning training packages in place	Karen Broughton	19-Nov-15	Major	Possible	12	1. Monitor compliance of training received and report to the Executive Management Team by the end of May.	1. N. Fountain	1. May 2015		Major	Unlikely	8	need to include reference to not being able to capture training. 19/11/15: J. Johnson - in the process of implementing a new E-Learning system. Specification is being drawn up and this will be put to tender in Q4 2015/Q1 2016. 24/08/15 (JJ): As of May, mandatory training compliance was at 68.5% across corporate services, but still not able to effectively monitor whether staff have undertaken required e-Learning. A new e-Learning system is being introduced which will allow greater management and access to mandatory training. CQC visit already passed so not a risk from that aspect. Actions need to be identified to mitigate risk - review.
305	There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	Controlled Drugs Incidents arising from poor adherence to policy	21-Oct-08		1,3		Clinical	Major	Likely	16	1. Policy reminder to be reinforced by bulletins from Director of Operations/Medical Director. 2. Independent audits to be carried out throughout the Trust. 4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 5. Daily audit checks 6. The policy itself defines individual responsibility 7. Area governance reports to CQSEC 8. Mandatory LIN reports to CCG 9. Unannounced visits by MPS 10. Annual attendance by MMG to AO update days 11. MMG reports to EMT and Trust Board	Fenella Wrigley	06-Jan-16	Major	Possible	12	1. Medical Directorate / Medicines Management Leads to carry out spot checks on complexes / stations. 2. Continue to review feedback from spot checks made by the MPS after every visit. 3. Recommendations from outcome of spot checks to be implemented by DDO and ADO. Added to Medicines Management database and reviewed at Medicines Management Group meeting.	1. T. Edwards / Neil Thomson 2. T. Edwards 3. MMG	1. Feb 2016 2. After each visit by MPS. 3. Bi-monthly at MMG meeting.	1. Internal Audit 2. Independent Audit (MET Police carrying out spot checks) 3. LIN oversight of system 4. MMG to CQSEC, EMT and Trust Board 5. New Medicine Safety Officer will carry out unannounced spot checks and provide feedback	Major	Unlikely	8	5/1/2016 reviewed with medical directorate proposal to increase net grading from major x possible to major x likely due to regular breaches in compliance. 14/12/15 Reviewed by T. Edwards. Risk rating remains at 12. 16/09/15 - Reviewed at Medicine Management Review Meeting. Agreed Net Rating to remain at 12 (see point 4 under Further Actions and point 5 under Assurance in Place) 26/08/15 - A.Blakely: Reviewed by medical Directorate August 2015. Agree that this risk should appear on the risk register due to the number of controlled drugs incidents in the past 3 months. Risk reviewed by the Medicines Management Group 10/06/15 - proposal to unarchive risk due to recent
352	There is a risk that operational staff sustain a manual handling type injury whilst undertaking patient care. The consequence of injuries being:- -Increased staff absence through industrial injury. -Impact on service delivery. -Impact on patient care.	Staff injured whilst manual handling patients	23-Nov-11		1,2	Safe Well Led	Health & Safety	Major	Likely	16	1. Manual Handling Implementation Group and Manual handling policy 2. Manual handling awareness is provided at corporate Induction; refresher training through e-learning is available through L&OD; Education and Training dept provide training to all operational staff during initial and subsequent core refresher training; all operational ambulance vehicles are fitted with tail lifts 3. Core Skills Refresher training is monitored via the quality dash board. 4. The Corporate Health and Safety Group monitor manual handling incidents and training activity, 5. Small handling kits on all vehicles 6. BTech trained Manual Handling assessors 7. Specialist MH equipment e.g. Manager Elk 8. All A+E and PTS operational vehicles have either tail lift of ramp access 9. All A+E and PTS operational vehicles are fitted with hydraulic trolley bed 10. Generic Risk Assessments 11.All A+E Operational vehicles have access to Manager Elks 12. 3x PTS Bariatric vehicles are available by request to A+E	Paul Beal	02-Feb-16	Major	Possible	12	1. Implementation of LAS/HSE Manual Handling Improvement Programme Action Plan (i.e. tracked chair implementation) 2. Marc Rainey is leading a Bariatric Task & Finish group in respect to the idendification of suitable vehicle types 08/01/14 3. Chair Transporter Pilot: Ferno Compact 2 (tracked) chair purchase and rollout programme scheduled expected to commence December 2014 (JS Oct 2014). 4. Clinical Equipment Group - have reviwed the contents list for the response bags this has been devloped into a spefication which has been circulated to suppliers. One bag has been reviewed as suitable for trial and a number of sample bags have been ordered and are expected for delivery end Jan 2014.	1. J.Selby 2. P. Woodrow 3. J.Selby 4. M. Faulkner	1.Completed 2. TBC 3. Completed 4. On going	1. Manual Handling Implementation Group 2. Manual Handling Policy 3. Central Health and Safety Group Incident Statistics Monitor and Audit Reviews	Minor	Unlikely	4	Risk Ownership transferred to Paul Beal HR Director. 4/02/16 email from N. Fountain. 02/02/16: J. Selby - Compact 2 rollout complete 2014 Compact 2 update training completed in CSR 1 2015 Next scheduled MHIG Mtg is Mar 2016 Response bag trial closed at OPF inconclusive results Nov 2015 27/11/15: A. Street - A total of 6 responses have been received from the 10 trial bags issued. Results to be collated. Chair update training now completed on CSR 4. June 2015 trial response bags to be collected with feedback - A. Street 3. Chair Transporter - update training issue being completed on the current CSR.

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326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.	Lack of Decontamination lead Lack of a decontamination policy; in particular with regard to returned equipment from EDs which does not have an identified process for decontamination	17-May-10		1,2	Safe	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Improved cleaning programme for equipment on vehicles. 3. Detergent and disinfectant wipes for equipment being used.	~~Mike Evans~~ Andrew Grimshaw	04-Feb-16	Major	Possible	12	1. Contracted a subject expert matter to write a management of medical devices policy, which will incorporate decontamination of equipment and meet all MHRA guidance and regulations. This will then be put through the approval process before inclusion on the Pulse 2. Once Medical Devices Policy is approved communication will be required with front line staff on the arrangments in place both in and out of hospital.	1. External Contractor 2. K. Merritt	1. 1st Draft January 2016 2. Following approval of MD policy	1.Policy approved and implemented. 2. Area Governance Meetings 3. Incident reports.	Minor	Unlikely	4	04/02/16 IPC Committee reviewed risk and proposed escalatint to A. Grimshaw for update on actions. 3/12/15 KM - contracted a subject expert matter to write a management of medical devices policy, which will incorporate decontamination of equipment and meet all MHRA guidance and regulations. Reviewed by CEWG 10/06/15 to be reviewed again in 3 months time. 21/04/15CEWG to ask AG/SW to update risk. Decontamination Lead - Mike Evans; replaced by David Prince in October 2014. Draft Decontamination Policy being presented at November IPCC
385	There is a risk that the total level of financial loss due to theft and criminal damage to the organisation is anaccurately reported.	Incidents of theft and criminal damage are not reported through a single route and a result of this is that there is no central receiving department which can confidently put a total value to the financial loss suffered by the organisation.	07-Oct-13		3	Well Led	Finance	Major	Likely	16	LA 52 (Accident/ Incident Report), LA 154 (Report of Loss / Burglary / Theft), LA 41 (Digital Radio Hand Portable Terminal Theft/ Loss/ Damage Report) Logistics Asset Tracking System Annual Fixed Assets verification process Security Management Policy	Andrew Grimshaw	19-Jan-16	Major	Possible	12	1. Production of Security of Assets Policy detailing responsibilities and reporting routes. 2. Notice in RIB instructing staff how to report theft, burglary and criminal damage. 3. Finalised policy to be added to the Pulse and highlighted in the RIB.	1. M. Nicholas 2. M. Nicholas 3. M. Nicholas	1. Feb 2016 2. Completed 3. Jun 2016	1. LA 52 Data reviewed / monitored by Corporate Health and Safety Group. 2. LSMS reviews LA 52 reported data. 3. LA41 Digital Radio Hand Portable Terminal theft/loss/damage report. 5. LA154 Report of Loss/Burglary/ Theft	Major	Rare	4	19/01/16: M. Nicholas - Draft policy still underway. 19/11/15: M. Nicholas - Draft policy being amended to reflect new operational structure in place since Sept 2015. Due Feb 2016. M.Nicholas 07/04/2015 policy being amended to reflect the change of Director fulfilling the Security Management Director role. Draft policy being amended in light of feedback from comments received.
381	There is a risk that the service does not comply with DH guidance on the re-use of linen for patients and the quality of care delivered to patients may be affected which may have an adverse reputational risk to the Trust.	There is no service wide agreement for the provision and use of a sheet as a mattress protector. Blankets are re-used on patients and there is no consistent process for the swapping of blankets or sheets at hospitals. No provision for linen is currently in place. This has an impact on the quality of care delivered to patients.	07-May-13		1,3		Fleet and Logistics	Moderate	Almost Certain	15	1. Laundry contract in place for blankets (not working). 2. Some local informal arrangements for use of sheets at hospitals. 3. Additional capacity for re-usable/disposable blankets in stores. 4. Single use couch rolls in place.	Andrew Grimshaw	03-Dec-15	Moderate	Likely	12	1. Options paper to be prepared by K. Merritt to be taken forward to SMT and EMT for discussion and decision on plan of action.	1. K. Merritt / Z. Packman	1. August 15		Minor	Unlikely	4	KM provided update on risk 03/12/15 AG has formed a blanket meeting KM/EC/BS/S. Crichton / S. Woolgar. KM to take risk to next meeting to be reviewed. IPC Taskforce Sep 2015 KM organising trial of single use blankets at a couple of complexes to get staff feedback. CEWG awaiting advise from IPC regarding re-use of blankets. update with minutes of the CEWG 21/04/15. Group to ask AG/SW to update risk. risk reviewed at the IPC taskforce meeting on the 19/03/15 - recommendation single use - retest some disposable options with some of the stations. IPCC 1/07/14 Sample tape will be presented at the next CEG

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380	The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls will not be recorded. This could then impede investigations and clarification related to decisions made by control room staff and communication with patients and other agencies.	This relates to historic investigations in retrospect and clarification sought within the control room concerning the actual details of the conversation. Both Waterloo and Bow control rooms have recorders that integrate digitally with the main control room telephone system. These are set up to record the extensions within the Control rooms at each site. The absence of recording means that conversations and hence decisions made by control room staff are not recorded. This impacts on the Trust's ability to investigate patient related issues and the Control room's ability to clarify details related to recent calls from conversations between the room and	05-Feb-13		3		Information Governance	Moderate	Almost Certain	15	1. Detailed investigation by technology supplier. 2. Upgrade of Bow system to same software release as HQ (where we do not currently have the same issue) 3. Live monitoring during any event by technical staff. 4. Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2013/14.	Steve Bass / Vic Wynn	18-Jan-16	Moderate	Likely	12	1. As part of the capital plan for 15/16 proposal submitted and approved to procure a new solution to encompass all recording across the Trust, as current system is end of life. Contract awarded awaiting approval to proceed.	1. V.Wynn	1. 31/03/2016	This has been identified as the highest risk to allowing bow to going live on 27 Feb as planned, as go live cannot take place without a reliable recording system. It is under close scrutiny from the Senior Supplier & User, Project Manager and Project executive. Progress is reviewed at each Monday review meeting.	Moderate	Rare	3	18/12/15 Voice Recorder Project now has financial approval to proceed, contract was awarded but is now subject to procurement challenge Gating Template begun for Historical Archive Solution 01/10/2015 The second round of tender process ongoing –currently evaluating four responders. 18/12/15 Voice Recorder Project now has financial approval to proceed, contract was awarded but is now subject to procurement challenge Gating Template begun for Historical Archive Solution 01/10/2015 The second round of tender process ongoing –currently evaluating four responders. 19/06/2015 The tender process has begun –currently evaluating responders.
455	There is a risk that we may not be able to convey all patients detained under section 136 MHA (1983). This leads to a lack of physical health screening for these patients leading which may affect the care they receive	Limited LAS resources Increasing demand for LAS services Lack of parity of esteem between physical and mental health	22-Jul-15		1		Nursing & Quality	Moderate	Almost Certain	15	1. Section 136 figures reviewed and shared with partners at the mental health partnership board with incidents reported to the Mental Health Committee. 2. Mental health nurses in EOC provide telephone support for both officers and patients on scene and assist with upgrading calls as appropriate.	Zoe Packman	22-Oct-15	Moderate	Likely	12	1. Review of current mental health protocols and alternative resources 2. Review for transport arrangements for detained people in collaboration with NHS England and Brent CCG	1. B.Sloper / K.Dimbi 2. B. Sloper / K. Dimbi	1. 30/06/16 2. 30/06/16	1. Detailed progress will be reported in the annual report on mental health 2. Regular attendance at the Mental Health Partnership Board to review section 136 figures with partners.	Moderate	Possible	9	22/10/15: Approved at SMT
282	There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.		03-Jul-07	***	3	Safe Effective	Business Continuity	Major	Possible	12	1. The move of business information from hard drives to network drives. 2. Part of the 2010/11 audit programme will test this facility and give assurances. 3. IM&T Infrastructure Team to review and take actions as appropriate.	Vic Wynn	03-Feb-16	Major	Possible	12	1. Enterprise vault for emails deployed. 2. Full solution requires a Trust Wide EDRMS system which has been included in the IM&T Strategy for 2017. 3. Reminders and communications to all staff on the need to adequately backup data held on local devices.	1-3 V.Wynn	1. Complete 2. 1/3/16 for approval in IM&T Budget 3. Ongoing	Risk discussed and monitored by IM&T SMT	Major	Unlikely	8	RC 03/02/2016 Still in train for March completion. Exchange 2013 architecture has been signed off as acceptable by MS. Migration will start in March RC 30/11/2015 Email Archive in place - surveys to establish where local mail copies have been enabled on mobile devices have been completed. Bigger storage has been calculated, purchased and installed Program to migrate local mail data to central mail store is underway. Look to complete and then implement local mail store creation by March 2016 Risk Reviewed 01/10/2015. Further progress reliant on approval of IM&T Strategy and deployment of EDRMS. 19/06/2015 Win 7 migration project completed; Centralised e-mail archiving (enterprise vault) already in place - EDRM project will mitigate against

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Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
386	There is a risk that tail lift failures on operational ambulances will impact on patient care	Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07-Oct-13		1	Safe Well Led	Operational	Major	Possible	12	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis (Updated 11/15 – S.Westrope amended maintenance schedule for A&E – every 12 weeks). 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with Lola compliance. Additionally independent inspections by the Freight Transport Association are undertaken. These are on a 10% inspection basis. 4. Reduce age of vehicles as the tail-lift is being used past the "designed life".	Andrew Grimshaw	27-Nov-15	Major	Possible	12	1. Review of Ambulance design being undertaken in May 2014 to include tail lift. 2. Trial of alternative vehicle to be undertaken Summer 2014 with ramp in place of tail lift. 3. Alternative tail lift has been fitted to a small percentage of vehicles. 4. Training programme for workshops on fault finding to be organised for 2014/15. 5. Signage to be placed in Ambulances to indicate the type and correct operation of the tail lift in question. 6. Instructional video demonstrating the procedure to operate the tail-lift in an emergency – place on the "Pulse" June 2015 plus notes in "RIB". 7. 104 new A&E Ambulances to replace 67 x 12yr old units.	1. S. Westrope 2. C. Vale 4. L. Hyett-Powell 5. TBC 6. L. Hyett-Powell 7. Nick Pope	1. Complete 2. Vehicles in final stages of build expect delivery December 2015 with trialling to commence 2016.) 3. Complete 4. Complete 5. Ongoing 6. Complete 7. Complete	1. Motor risk management group review identified incident related to operational vehicles. 2. Corporate Health and Safety Group review all incident statistic trends. 3. Fleet management meet on a weekly basis and also review vehicle incident rate trends.	Major	Unlikely	8	27/11/15: A. Street/N. Pope - A video was uploaded on to The Pulse in Jun 2015 showing the correct way of manually lowering a tail lift. Action 2: Not complete - vehicles in final stages of build expect delivery December 2015 with trialling to commence 2016. (N.Pope) Reviewed with A. Street 08/06/15 risk still remains. S. Westrope proposed to regrade target rating to minor x unlikely = 4 and has proposed that we have now reached the target rating and therefore can archive the risk.Health and Safety Group to review 4. Traning plan had been scheduled but was deferred due to trainers long term sickness. In process of re-arranging traning for staff now trainer has returned. Expected in next month 13/03/15. LH-P has also produced a training video for operational staff on
426	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to manage the increased workload, notably Marac requests for information. This may impact on the care of vulnerable adults and children.	The Trust will fail in its statutory responsibilities to respond to safeguarding requests within time scales. There continues to be an increase in the requirement for LAS partnership involvement as Multi-Agency Risk Assessment Conferences (MARACs) these are being introduced across London and require the LAS to provide data on our involvement with indivduals over a given timescale and attendance at regular meetings. The LAS is seen as a key partner in these meetings.	10-Sep-14		1,3	Safe	Governance	Major	Possible	12	1. Local managers running own reports in absence of safeguarding officer. 2. Out of office message to manage expectations.	Zoe Packman	07-Jan-16	Major	Possible	12	1. Increase in members of safeguarding team to provide support across trust and partners (pending agreement of funding). 2. Develop an administrator post for safeguarding to cover increase workload and also support Safeguarding Officer when off (pending agreement of funding).	1. Z. Packman 2. Z. Packman	1. Resource to be agreed by EMT 2. Dependent on outcome of funding decision		Major	Unlikely	8	7/1/16 safeguarding committee agreed submission of bid for additional resources. A Taylor met with CEO to discuss safeguarding issues, CEO looking at issue. Reviewed by Safeguarding Committee 09/06/15 - proposed regrading gross and net rating from moderate x almost certain = 15 to major x possible = 12 to reflect the impact on the care and safety of vulnerable adults and children. also amend target rating to major x unlikely. Take proposal to SMT. Approval was for temporary post till Feb unfortunately authorisation received too late to write JD and advertise and train before funding disappeared. Subsequent request made for perminent staffawaiting approval to gating request submitted to Emt/SMT Feb15
435	There is a risk that Trust will not comply with all requirements within the CQC chief inspector of hospitals inspection programme for ambulance services, resulting in a less than favourable inspection report.	The CQC has introduced a new system of inspection and has recently finalised the format for ambulance services. The Trust may not be fully prepared for the new system by the time of inspection due to the focus on performance and the availability of resources across the Trust to prepare	11-Feb-15		3		Governance	Major	Possible	12	1. Focussed resource within Governance and Assurance to prepare and manage a compliance programme. 2. Quality Governance Structure in place supported by Clinical Safety Development and Effectiveness Committees. 3. Risk Register and Board Assurance Framework reviewed by the Board every quarter with oversight by Audit and Quality Governance Committees. 4. Briefing session undertaken with the Trust Board on the CQC fundamental standards.	Sandra Adams	15-Feb-16	Major	Possible	12	1. Develop and deliver a project plan to monitor and manage compliance against the five CQC quality domains which will include the review of current processes and setting up a compliance programme in line with standards set out in the Well-led framework. 2. Appointment of Quality Governance Managers in the operational management structure. 3. Appointment to key posts within Governance and Assurance.	1. D. Halliley / S. Adams 2. P. Woodrow 3. S. Adams	1. Complete - CQC SPOC 2. Q2 2015/16 3. Complete	Routine reports provided to the Quality Governance Committee. Board Assurance Framework and Risk Register. Compliance programme in place supported by evidence.	Major	Unlikely	8	Risk proposed for archive - new risk to be raised through Quality Improvement Programme. Agreed by RCAG 080316 Nov 2015: Risk under review Reviewed by S Adams and action dates updated. Risk requires review following inspection. Approved by S. Adams and noted by SMT 11.02.15

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405	There is a risk that declared serious incidents are not investigated thoroughly and within a timely manner.	Except for Serious Incidents where there is a very tangible process in relation to other incidents reported to Safety and Risk, evidence shows that the quality of the investigations undertaken are directly influenced by the limited capacity and time available to local management team. In addition to limited training and accountability related to this issue.	09-Jul-14		3		Corporate	Moderate	Likely	12	All potential serious incidents are reviewed at an internal weekly meeting (Serious Incident Group Meeting) with the Governance Team and key stakeholders for example Head of Legal, Deputy Director of Operations, Director of Corporate affairs, Director of Nursing, Director of Paramedic Education, Medical Director and the Chief Executive. A further meeting is held with the Governance Co-ordinator to ensure the necessary documentation and information has been requested and received for decision making purposes on a potential Serious Incidents. A detailed Serious Incident process 'New Ways of Working' has been developed and approved by Quality Committee on 22nd August 2014. Where appropriate internal RCA investigations are commenced for incidents not meeting the SI threshold. Active monitoring of our reporting timescale. Standing agenda item at bi-weekly Senior Management Team meetings (report up to EMT where appropriate). Weekly update on progress is sent to SIG Group. Serious incident policy in place.	Sandra Adams	08-Jan-16	Moderate	Likely	12	1. A further review of the Serious Incident Policy is required in light of the review of the 2015 framework . It has been agreed that a governance framework will be developed to give a robust foundation and all governance policies and procedures will be linked to the framework. 2. Governance to investigate options for a more structured investigation process including investigation checklist and internal deadlines. Checklist written with S.Adams, internal deadlines, working with K.Brown. 3. Increase the number and training level of lead investigators with structured trainign sessions. 1st session completed Oct 2015, number of investigators has increased.	1. P.Nicholson 2. P. Nicholson 3. P Nicholson	1. Feb 2016 2. Feb 2016 3. Jun 2016	Serious Incident Policy reviewed annually. Internal Governance audits, and external audits by accredited providers highlighting gaps in our processess Incident reporting procedure being developed	Moderate	Unlikely	6	08/01/16: P.Nicholson confirmed underlying cause should be revised as it cancels out this risk. Updates provided to actions 1,2 and 3 after review with S.Adams. Reviewed by P. Nicholson and F. Field 13/8/15. (Looking to achieve average time taken to undertake SI investigations 55 days) Reviewed by S Adams 6th July 15. Risk needs reframing and grading.
331	There is a risk that the Trust will not achieve the target of reducing its carbon footprint by 10% by 2015 (based on 2007 carbon footprint)	Underlying cause is the legal requirement on the Trust (in line with the rest of the NHS) to deliver on the commitment to reduce carbon footprint by 10% by 2015 (based on 2007/08 carbon footprint Scope 1&2).	06-May-10		3		*Finance*	Moderate	Likely	12	The Trust's five year carbon management plan has been endorsed by the Carbon Trust. The Plan outlines how the Trust will achieve reduction in carbon footprint primarily based on changes in response model - increased use of CTA, reduction in non-conveyance and Multiple Sends	Andrew Grimshaw	12-Jan-15	Moderate	Likely	12	1. An Environmental Strategy is being drafted to reflect the above two strategies and that relating to Procurement to identify how the Trust will manage and reduce its carbon footprint. 2. Changes in Operations, aimed at managing demand, should see a reduction in physical sends or unnecessary transport to A&E. In addition the implementation of Active Area Cover and the reduction of MARR should also see a reduction in unnecessary journies. All of which should result in a reduction in fuel consumption. 3. The Energy Manager is considering what additional projects may be undertaken to reduce the Trust's energy consumption e.g. the use of PVs at suitable locations. NB: as many of the projects delivered to date are as a result of 'low hanging fruit' (replace boiler, install LED lighting) the Trust will need to consider 'invest to save' approach to funding enrergy saving projects such as PVs, possibly working with Re:Fit	1. 2. P. Woodrow 3. J Smith	1.Qtr 2 14/15 2.Qtr 2 14/15 3.2014/15 4. Qtr 2/3 14/15	1. Regular reports to EMT	Moderate	Unlikely	6	12/01/15: Following departure of Director of Support Services, responsibility for this initiative was allocated to Andrew Grimshaw.
407	The potential lack of paramedic and/or technician drug bags for use by operational staff causes a risk of providing clinical care for patients due to vehicles being deficient of drugs for all or part of a shift.	Staff reporting lack of availability of paramedic and technician drug bags at the start of their shift. • Staff not following the process of booking drugs bags in at the end of their shift. • Staff not always leaving the used drug bags at the station from which they took the full drug bags, causing a problem with the 1:1 drug pack exchange process. • Staff retaining drug packs after the end of shift and not signing them back into the drug locker. • Double paramedic crews taking two drug bags. • The use of iv paracetamol may be responsible for a small increase in the number of bags coming back to Deptford. • Lack of availability of	13-Aug-14		1		Fleet and Logistics	Moderate	Likely	12	1. OPO2 The Procedure covering the issue and use of drugs by LAS Staff. 2. Local management on stations.	A. Grimshaw	14-Jan-16	Moderate	Likely	12	1. As part of 'getting the basics right' tracking systems are being looked at with a view to providing a solution to monitor the location of drug bags. (subject to agreement of funding) 2. Station Admin and Management Teams closely monitoring for adherence to OP02. 3. Review the maximum and minimum ordering checking on station. 4. identify stations where over-ordering occurs and identified the reasons for this 5. Reinforce through RIB messages and bulletines the need to comply with drugs policies and only take one paramedic drug pack per vehcile per shift 6. Instigate 'Drug Pack Amnesty' to promote return of drug packs that may have been retained by staff and are therefore not in circulation. 7. Progress trial of automated medicines management solution 8. Medicines Management Event 9. Trial of secure drug lockers to be undertaken	1. T.Edwards/ G. Ballard / K. Merrit 2. P. Woodrow 3. K. Merritt / G.Ballard 4. G. Ballard/ Tim Edwards 5. T. Edwards 6. D. Whitmore 7. T.Edwards	1. TBC 2. Ongoing 3. Aug 2015 4. Dec 2015 5. Completed 6. Nov 2015 7. April 2016 8. Completed	1. Shortages of drug bags are reported via the area governance meetings. 2. Issues regarding medicines management are monitored at the medicines management meeting and escalated where appropriate. 3. New Station Managers and Quality & Assurance Managers are in post. 4. Medicine Safety Officer will carry out unannounced spot checks.	Moderate	Rare	3	Review by MMG Chair 19/11/15 – promotional posters reinforcing medicines management regulations and associated behaviours distributed. Medicines Management Event undertaken on 11/11/15 to update on medicines management policy and procedure and undertake workshops addressing current medicines management issues. Ongoing meetings relating to automated medicines management solution involving suppliers finance and procurement. CD&PSC KM increased bag numbers on complex aligned to rotas. KM to review the number of bags per complex. Review risk with T. Edwards. 16/09/15 - Reviewed at Medicine Management Review Meeting. Agreed Net Rating to remain at 12 (see points 3 and 4 under Assurance in Place). 26/08/15 - A.Blakely:

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424	There is a risk that the lack of ownership of and responsibility for information assets will increase the likelihood of a security breach or data loss incident occurring.	There is currently no central database containing details of all information assets (systems, applications) that are in use at the Trust. Information asset management is dependent on users informing the IM&T team of the applications that they are responsible for. (highlighted by KPMG Cyber Audit - October 2013)	08-Oct-14		3		Information Governance	Moderate	Likely	12	None	Steve Bass / Vic Wynn	01-Oct-15	Moderate	Likely	12	1. Perform an exercise to identify the IT information assets owned by the Trust and assign owners to them to enable better asset management. 2. Introduce a policy to assign an owner (individual/department) to every new and existing IT information asset that is purchased at the Trust.	1. J Rathore 2. V Wynn	1. March 2016 2. June 2016	Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	Risk Reviewed 01/10/2015 IAO's to be defined and agreed through the newly formed IM&T Business Engagement Managers who will work with each business area to define the assets and ownership. This will drive into ownership of SLAS for the IAs. Once agreed IAO awareness excercise to be run by CIO and IG Manager. 19/06/2015 Awaiting update on continuing IAO excercise to add to asset DB .Ongoing discussion with CIO to arrange IAO workshops to help improve IAO culture. 20/05/2015 Awaiting update on continuing IAO excercise to add to asset DB 25/03/2015 Ongoing activity - IAO workshop expected to be delivered second quarter 2015 22/01/2015 Info Sec manager & IG
423	There is risk that the Trust could incur unnecessary expenditure replacing lost assets. The loss of such assets could also lead to reputational damage and information governance breaches (i.e lost/stolen desktop devices or other unecrypted devices)	Management of hardware assets (desktops, laptops, servers, removal media, printers & faxes) is weak at the Trust – there is no asset register which can identify responsibility to user(s) for physical IT assets. (highlighted by KPMG Cyber Audit - October 2013)	08-Oct-14		3		Information Governance	Moderate	Likely	12	1. Local asset registers held by IM&T Infrastructure Teams.	Steve Bass / Vic Wynn	01-Oct-15	Moderate	Likely	12	1. The management, recording and tracking of IT assets should be treated in the same way as all Trust key assets. An LAS wide system is required and has been planned within the IM&T Strategy for delivery in 2017/18. 2. LAS central IT assets such as servers and network components should be registered in a CMDB which can be used to assess the impact of change and provide a central library / schedule of licence renewals and software updates.	1. V Wynn 2. R. Clifford	1. Dec 2017 2. Dec 2015	Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	**Risk reviewed by IM&T 01/10/15.** **19/06/2015 Interim solutions continues to support the day to day works whilst the Service management parts continue. Still on Plan**
457	There is a risk that there may be insufficient staff to manage the three key functions of the clinical hub (1. hear and treat 2. crew queries 3. surge level). Impact will be increased demand on operational frontline with likely increase to ED departments.	Cessation of the senior paramedic programme Opportunities as CTLs in frontline operations Travel and time cost for staff going to Bow and Waterloo as opposed to more local areas. Performance may be affected potential impacting on patient care. Consideration that the CTL's in the Clinical Hub will not attract the additional £2500 awarded to Team Leaders.	17-Jun-15		1,2,3		Operational	Major	Possible	12	1. Ongoing action to maintain staffing levels 2. Accommodation of flexible hours to attract staff 3. Strong teams led by seven quality governance managers 4. All hub trained staff must do 120 hours annually to maintain their accreditation 5. New Australian nurse paramedics being allocated to Hub for 3 months. 6. Director of Operatins agreed that the Clinical Team Leaders on the HUB will receive the additional £2500 awarded to Team Leaders. 7. New job description for Clinical Advisors on the HUB banded at 6.	Paul Woodrow / Katy Millard	22-Dec-15	Major	Possible	12	1. Ensuring the 100 approximate staff out in operations book their 120 hours in a managed way 2. 50:50 split, 27 operational Clinical Team Leaders being approached to do the majority of their operational shifts in the clinical hub 3. Band 6 for Clinical Advisors 4. Review of balance of Advisors to Team Leaders	1. T. Pidgeon 2. M. Ward 3. EMT 4. K. Millard	1. Continually oversee 2. Complete 3. Agreed 4. 30/10/15	None	Major	Unlikely	8	3/12/15 reviewed by K. Millard. Risk progressing towards target level as a result of actions being progressed.
458	There is a risk that due to our inability to link safeguarding referrals and identify previous referrals made to Social Services, this will impact on our ability to escalate any continued safeguarding concerns identified, which will impact on patient care.	The Trusts ability to manage safeguarding concerns raised by staff will be questioned. Patients may not be effectively supported and safeguarded due to lack of awareness of multiple referrals. Issue identified and questioned by Social Services when Trust completed individual management review of our involvement with patients. This will affect Trust reputation.	01-May-15		1,3		Clinical	Major	Possible	12	None	Zoe Packman	05-Jan-16	Major	Possible	12	1. Introduce web based solution, confirm its ability to identify multiple calls. 2. Develop escalation policy to manage multiple referrals	1. A. Hay 2. A.Hay	1. April 2016 2. following introduction of database	None	Major	Unlikely	8	5/1/16 Safeguarding committee reviewed. Datix web is believed to be able to achieve this requirement and work is underway to introduce datix wed by April 16 22/10/15: Approved at SMT

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343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		1	Safe Effective Responsive	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Practice guidance issued and supported by updates. 3. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments.	Zoe Packman	16-Feb-16	Major	Possible	12	1. Capture safeguarding practice in bi-annual Operational Workforce review. Review currently being undertaken by Operations. 2. Ensure actions included in the Quality Improvement Plan are completed. 3. Monitor the level of missed referrals and ensure follow up actions are undertaken. (to be part of new band 7 role currently done on an adhoc basis)	1. Kevin Brown 2. Alan Taylor 3. Alan Taylor	1. ? 2. Q4 2016 3. commencing April 2016	1. Safeguarding committee review referrals data - monthly. 2. Continual review of changes in statutory requirements and judicial reviews. 3. Training update - monitored centrally on scorecard by Education and Development - annually.	Major	Unlikely	8	Reviewed by A. Taylor 16/02/16 - Need to quantify the level of missed safeguarding referrals to determine when the risk will be tolerated from a quality perspective. November 2015 A. Taylor reviewed risk and suggested keeping risk at current level until post CQC review is completed. 09/06/15 - Safeguarding Committee approved regrading of risk from major x possibe = 12 to major x unlikely = 8 and agreed to archive the risk due to the controls in place. 21/05/15 A. Taylor propsal to archive risk as it has reached its target rating due to mitigating controls in place. To be managed locally. to be discussed at the Safeguarding Committee meeting on the 26/05/15 to approve. Take to SMT to approve archiving. A. Hay to look at impact on change of regulations for
459	There is a risk that the Trust is unable to meet statutory requirements of providing safeguarding supervision, by trained professionals. This will result in an impact on staff performance and welfare and the Trust will not be compliant with the Children Act and Care Act pertaining to safeguarding.	Staff support and supervision will be affected along with a possible impact on patient care due to lack of supervision and support. Currently we have no trained safeguarding supervisors, who are able to undertake this supervision. The main staff groups affected by this are Emergency Bed Service Staff Safeguarding Team Local safeguarding leads Clinical Staff We are currently providing no Safeguarding Supervision for staff, and have no trained specialists.	01-Dec-15		1		Corporate	Moderate	Likely	12	Group education/supervision provided by Head of Safeguarding. Staff have access to Linc services	Zoe Packman	25-Jan-16	Moderate	Likely	12	1. Bid submitted to NHSE for 1yr post to review best practice in supervision and national approaches and recommend and pilot supervision in LAS. 2. Source specialist safeguarding supervision training for safeguarding team. 3. Increase in members of safeguarding team by 2 officers to provide support across trust and partners. 4 Ensure safeguarding practice part of operational workplace review and appraisals for all staff.	1. A. Taylor 2. A. Taylor 3. Z. Packman 4. K. Brown	1. Completed 2. Sept 2016 3. staff in post June 2016 4. ?	Group sessions reported to Safeguarding Committee	Moderate	Unlikely	6	Reviewed by A. Taylor 25/01/16 current status -NHS England funding has been approved for safeguarding supervision post for 1 year to consider Trust requirements and implement. Approved by Safeguarding Committee in November 2015 - Discussed by SMT in November 2015 who asked for clarification of the requirments. Guidance notes were provided. Risk approved as agreed by Safeguarding Committee, chaired by Director of Quality and Nursing.
462	There is a risk that… The organisation does not accurately and effectively report incidents that have resulted in moderate, severe harm or death to the patient. A failure to do so will prevent the organisation accurately reporting to the NRLS.	Delays in LA52's being uploaded onto Datix. Level of Harm caused not recorded by LAS appropriately. Perceived low reporting levels internal and external. Access to LA52's and Datix not universal across staff groups. Inconsistent feedback loop to crews.	27-Jan-16				Corporate	Moderate	Almost Certain	15	1. Risk Systems Manager has responsibility for submitting reports to the NRLS monthly and oversee data quality via Datix. 2. New Operational structure reinforces an open reporting structure 3. Acknowledgement given to staff for reporting incidents submitted to the Serious Incident Group	Sandra Adams		Moderate	Likely	12	1. Exploring options of referring incidents over the telephone possibly via an app. This is dependent on IM&T deploying devices to all frontline staff 2. NRLS submission report to be shared with the Governance Department and Quality Governance Committee. 3. Health Safety and Risk are being tasked with bringing down the backlog of incidents reported being added to Datix. Currently dependent on resources and will be assisted by the processing of incidents via Datix when the incident module is rolled out in April 2016. 4. Benchmark level of Serious Incident reporting against other ambulance services – results shared with EMT and Quality Governance Committee. 5. Level of harm will be reviewed via the new operational structure, allowing Quality Governance Assurance managers in each sector to review the level of harm for those judged to be of at least moderate harm 6. Option for reporting incidents over the telephone/airwave is being explored 7. Deployment of Datixweb across the LAS	1. Head of Governance / EBS 2. Head of Governance 3. Head of Health and Safety and Head of Governance 4. Head of Governance 5. Head of Governance / QGAMs 6. Head of Governance / EBS 7. Head of Governance	1. Nov. 2016 2. Feb. 2016 3. Aug. 2015 / April 2016 4. Completed 5. Ongoing but training delivered in October 2015 6. Jan. 2016 7. April 2016	NRLS report summaries will be reviewed at QGC or a delegated sub committee Number of LA52s completed are published via the Learning From Experience report Datix go live in Q1 2016-17 will give access for all staff to report incidents via the pulse	Moderate	Rare	3	Approved by SMT 27/01/16

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463	Safeguarding referrals will suffer. They will be delayed, mis-referred etc; also information governance will be impacted, because EBS is unable to offer a timely and secure onward referral process. The risk impacts those patients and others who are the subject of referrals and to whom we owe statutory duties of care.	A number of Local Authorities are moving away from accepting faxed referrals, and insisting on an electronic solution. Currently the Trust cannot comply with this request and has therefore developed a work-around of scanning and then emailing each referral. This is resource-intensive. This constitutes both a potential poor quality of referral and an information governance risk due to multiple copies of referrals proliferating on local hard drives / outlook accounts	27-Jan-16				Operational	Major	Possible	12	1. Internal checking processes ensure that referrals are processed correctly. Currently this provides a good level of assurance, but could become less reliable if operational load were to increase greatly as a result of faxes being withdrawn.	Zoe Packman		Major	Possible	12	1. Move quickly to explore and implement electronic referral process	1. A. Hay	1. Q4 2015/16		Major	Rare	4	Approved by SMT 27/01/16
395	Failure to maintain an effective financial control environment could lead to poor decision making and the waste of public funds.	• SFI/So are not up to date. • SFI/SO are not understood or adhered to within the Trust. • Policies and procedures supporting the SFIs/SOs are not in place or up to date. • Budget holders are not aware of their responsibilities and do not work to adhere to them. • Performance management is not in place, at both a divisional and departmental level to ensure control is enacted. • An effective Internal Audit Plan has not been agreed which addresses risks within the control environment. • Adequate controls on financial systems are not in place. • The Finance Department does not liaise effectively with	10-Apr-14		3		Finance	Moderate	Likely	12	1. SFI/SO are current. 2. SFI/SO are understood and adhered to within the Trust. 3. Financial policies and procedures supporting the SFIs/SOs are in place and up to date. 4. Budget holders are aware of their responsibilities and work to comply. 5. Performance management is in place, both at divisional and departmental level to ensure control is enacted. 6. An effective internal Audit Plan has been agreed which addressed risks within the control environment. 7. Adequate controls on financial systems are in place. 8. The Finance Department liaises with EFLS in respect of outsourced financial systems. 9. Relationships with other core Trust systems are clear and adhered to. E.g. ESR and vacancy control. 10. An effective business case process is in place for new and developmental ideas.	Andrew Grimshaw	21-Jan-16	Moderate	Possible	9	1. Training on the meaning and role of the SFI/SO needs to be provided. 2. Budget Holder Training needs to be improved, especially if budgetary control is to become less centralised within the Trust. 3. Adherence to agreed polices and procedure needs to be improved; recruitment, secondments, placing orders for goods.	1. DDoF leading finance staff 2. DDoF 3. ? - Reported to EMT	1. ~~30/09/15~~ 31/03/16 2. 31/03/16 3. 31/12/15	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	21/01/16: Updates from FIC meeting, only update was new due date on action 1. Due date for action 3 has passed. 19/11/15: Updates from FIC agenda (meeting due 20/11/15) 14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading. Updated by FIC 21/05/15 FIC amended the risk description.
393	Failure to manage cash could result in the Trust not being able to meet its liabilities when they fall due. Ultimately poor cash management could result in the organisation and its directors acting illegally if it were to cease to be a going concern.	• Rolling 12 month cash flows not in place • Rolling 13 week cash flows not in place. • Contingencies not developed for cash management • Investment Strategy is not in place or not followed. • Robust cash reports are not provided to the FIC and Trust Board. • Senior managers across the Trust do not understand the principles of cash management. • The FRR Liquidity metric is not maintained at a minimum of a 3. • Decision making does not take into account cash management issues.	10-Apr-14		3		Finance	Major	Possible	12	1. Rolling 12 Month Cash Flow in place. 2. Rolling 13 week cash floor in place. 3. Contingencies developed for cash management in place. 4. Investment Strategy is in place and is adhered to. 5. Robust cash reports provided to the FIC and Trust Board. 6. Senior Managers across the Trust understand the principles of cash management. 7. The FRR Liquidity metric is maintained at a minimum of a 3. 8. Decision making takes into account cash management issues.	Andrew Grimshaw	21-Jan-16	Moderate	Possible	9	1. Identify cash handling contingencies and detail them to the FIC 2. Training for senior managers on cash – include in other finance training being considered above. 3. Cash impact within business cases needs improvement	1. HoFM 2. DDoF 3. DDoF	1. 31/03/16 2. ~~30/11/14~~ 31/03/16 3. 31/03/16	1-2 Training Plan Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	21/01/16: Updates provided vy FIC meeting. Only update is due date for action 2. 19/11/15: Update provided by FIC agenda (meeting due 20/11/15) Net risk proposed regrading to 12 (Moderate - 3 x Likely - 4) 14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading. Updated by the FIC 21/05/15 FIC amended the risk description.

London Ambulance Service NHS Trust
Trust Risk Register - March 2016

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
438	Management of IT Applications and services There is a risk that the Trusts IT applications, systems and infrastructure do not have the required level of resiliency and will fail causing the LAS service to be impacted or at worst unavailable. This risk includes the provision of capability and skills to manage, support and restore these services.	1. Staff capability and capacity. LAS has developed and delivers numerous innovative software solutions which collectively contribute to the efficiency of call processing and dispatch. The detailed knowledge of the software and support processes are vested with a limited number of individuals. These individuals would cause significant risk probability impact if they were to leave the trust. (IM&T Risk ID 375) 2. The resilience of the core components of the IT infrastructure is not at a level required by a high performing Trust. The current two data centres are not linked such that an automatic fail over (transfer of operations between the two data centres) can be achieved without	16-Mar-15		1,3		Information Governance	Major	Possible	12	1. Cross training of staff, creation of processes and procedures 2. Work commenced following an external review in January 2014. Key areas of resilience addressed and plans to enhance infrastructure in place with procurement completed in March 2015. 3. Review of IM&T structure and responsibilities conducted and required re-alignment planned.	Steve Bass Vic Wynn	10-Dec-15	Moderate	Possible	9	1. New posts created and staffed from 2014. Cross training ongoing and a review of IM&T structure, roles and responsibilities concluded. Required re-structure planned for June 2015. 2. CAD infrastructure replaced during 2014/15 with completion scheduled for June 2015. Voice Recorder replacement procurement approved and will be implemented by June 2015. 3. Service desk procedure that includes incident management guidelines reviewed and approved by IM&T SMT. All service desk staff are required to attend information governance training ; service desk staff briefed about the changes to the above procedure. Service Management Team lead monitoring. 4. Business Engagement management and Enterprise Architecture roles to be defined, agreed and staffed from June 2015. A full and complete restructure of IM&T, including but not limited to management roles and responsibilities to be undertaken.	1. V. Wynn 2. R. Clifford 3. R. Clifford 4. S. Bass	1. 30/06/15 2. 30/06/15 3. 30/03/15 4. 30/06/15	1. Monthly risk review through IM&T SMT. 2. Infrastructure replacement project tracking through IM&T SMT. 3. Incident management reporting to IM&T SMT. 4. Interim CIO appointed in March 2015.	Moderate	Unlikely	6	Risk Reviewed 10/12/15 1: Interim structure implemented 01/12/15 4: Interim structure implemented 01/12/15 including Business engagement roles and a Design Authority function 01/10/15 JT propose regrading net rating from moderate x likely = 12 to moderate x almost certain = 16 due to the current demands on the department due to the recruitment activity. Agreed by SMT 28/10/15 4/9/15. Net rating reviewed to match the discussion on 02/04/2015 . Also added points 3 & 4 on the 'Further action column. (Msalami + JThomas) April 2015 - M. Whitbread proposed to increase net rating from moderate x possible to moderate x likely due to the shortage of the availability of tutors due to the recruitment programme.
392	There is a risk that the Trust fails to manage its financial position compromising the agreed financial plan and ultimately presenting a challenge to the solvency of the organisation. Managing expenditure within budget	Budgets not agreed by budget holders. Budgets to not reflect expected patterns of spend (establishments, current run rates). CIPs are not embedded in budgets. No effective performance management process in place. Budget holders are inadequately trained. Management information for Budget Holders is inappropriate, late and inaccurate. Reserves are not in place. The Trust Board has not approved the budget.	10-Apr-14		3		Finance	Major	Possible	12	1. Budgets agreed by budget holders. 2. Budgets reflect expected patterns of spend (establishments, current run rates). 3. CIPs are embedded in budgets. 4. Effective performance management process in place. 5. Budget holders are adequately trained. 6. Management information for BHs is appropriate, timely and accurate. 7. Reserves are in place (2014/15). 8. The Trust Board has approved the budget (2014/15).	Andrew Grimshaw	21-Jan-16	Moderate	Possible	9	1. Ensure all Budgets signed off. 2. Ensure all CIPs are embedded. 3. Establish an integrated performance management regime. 4. Review format, take-up and refresher financial training. 5. Review management information provided to budget holders to ensure it is adequate and appropriately focused.	1. DDoF 2. DDoF 3. Interim Director of Performance 4. DDoF 5. DDoF	1. 31/03/16 2. 30/11/15 3. Completed 4. 31/03/16 5. 31/03/16	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	21/01/16: Updates from FIC meeting, no changes 19/11/2015: Updates from FIC Agenda (meeting due 20/11/15)
449	There is a risk that the Trusts IT infrastructure and applications would be severely compromised by external parties undertaking a cyber attack on LAS.	1. There is risk that a malware outbreak or a hacking attack originating from LAS admin network is propagated to the CAC network area. This could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services. (IM&T Risk ID 418) 2. There is a risk that the Trust might fail to meet forensic readiness requirements; it will not be possible to pursue a variety of information security incidents due to unavailability of security logs. (IM&T Risk ID 414) 3. There is a risk that some application /plugins (either then Microsoft office packages) are not patched ; failure to patch these applications could	27-May-15		3		Information Governance	Major	Possible	12	1. IM&T IS Security Manager reviewed existing Security Policy and updated. 2. External penetration testing conducted by HSCIC 3. Implementation of a "firewall" between CAD and other LAS systems planned for deployment in May 2015. Implementation of additional tools to apply patches to non Microsoft products being deployed in March 2015. 4. Information Security Policy approved by IM&T SMT and passed to IGG for approval. Once approved this policy will need sign off by SMT. 5. HR processes do not currently advise IM&T in a timely manner of the departure of contractors.	Vic Wynn	19-Jan-16	Moderate	Possible	9	1. The implementation of a firewall (a control point between network areas) between CAD and other LAS systems was tested in May 2015. Further work involving external suppliers is ongoing and traget date is now DEc 2015. This is will be delivered during a controlled DR test of EOC. 2. Security log management reviewed in Sept 2015 and recommendations made for budget and deployment in 2016. 3. Tools procured to apply patches to non Microsoft products. Deployment plan agreed. Complete. 4. information Security Policy approved 5. HR systems review required and planned in IM&T strategy for 2017/18	1. R. Clifford 2. E Beqiri 3. Complete 4. Complete 5. V Wynn	1. 30/12/15 2. 30/05/16 3. Complete 4. Complete 5. 30/12/17	Monthly risk review through IM&T SMT Firewall implementation project tracking through IM&T SMT Security log management proposals to IM&T SMT in October 2015	Moderate	Unlikely	6	19/01/16 Two actions completed others planned but longer term 1) Awaiting revised plan for firewall implementation after failed implementation 2) recommendations made for budget and deployment in 2016. 3) Non MS patches being deployed: ongoing activity to monitor capacity for variance from the estimates. 4) IS Policy approved 5) HR processes planned for completion 2017/18 (soem mitigation earlier) 14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading. Updated by FIC 21/05/15

London Ambulance Service NHS Trust
Trust Risk Register - March 2016

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
223	There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process.	Unable to produce sufficient capacity to meet current and ongoing demand levels	12-Jun-06		2,3,4		Operational	Moderate	Likely	12	1. Demand management strategies deployed to reduce overall activity. 2. Use of third party capacity at times of peak demand. 3. Jason Killens has arrange to visit all 7 sectors between December '14 and January '15 to update and brief staff on operational matters. Colleagues from the Medical Directorate also to attend to give a clinical update. 4. There were 2 similar sessions held in November '14 to update clinical team leaders.	Paul Woodrow	01-Oct-15	Moderate	Possible	9	1. Recruitment to establishment. 2. Implement modernisation programme. 3. work to reduce utilisation. 4. Moving towards a 50/50 split of team leaders time (a ratio of 1:16 team leaders to front line staff where 50% of the team leaders time is spent on managing the front line staff and 50% is spent on front line clinical duties). 5. The CEO and the Director of Operations are pllaning a visit to all complexes during April and May.	1. K. Broughton 2. P.Woodrow 3. K. Broughton?? 4. P. McKenna 5. P. Woodrow	1-3. Q3/4 2. Completed 3. Ongoing 4. March 2015 5. April/May 2015		Moderate	Unlikely	6	Risk Reviewed 1/10/2015, updates made including completion of Microsoft Patching software and Info Sec Policy. Approved by SMT 27/05/15
164	There is a risk that staff do not adhere to policies and procedures.	Lack of staff awareness due to insufficient training and front-line staff inability to access information remotely.	04-Jan-05		1,3,4		Corporate	Moderate	Likely	12	1. Incidents and serious incidents where policy has not been followed and action is required is monitored by the SMT. 2. All new policies and procedures and significant amendments are announced in the RIB.	Sandra Adams	02-Feb-16	Moderate	Possible	9	1. Review of TP001 to emphasise that all policy and procedure owners have a responsibility to raise awareness with appropriate staff regarding their policy or procedure. 2. Introduce interactive policies and an electronic system such as MetaCompliance to ensure that staff have read and understood policies and procedures. (IM&T 5 Year Strategy).	1. S. Moore 2. IM&T (Responsible person to be identified)	1. Complete 2. End 2018	NHSLA level 1 Review of incidents and complaints to ascertain any breach of policy. The SI action plan is reviewed and updated by the SMT.	Moderate	Rare	3	02/02/16: S.Moore - Action 2 is long term and within IM&T 5 year strategy. Demonstration of MetaCompliance solution to Head of Governance and IG Manager. 20/11/15: S. Moore confirmed action 1 (review of TP001) is complete. 09/09/15: S.Moore advised new risk wording, underlying cause and actions. Approved by S.Adams March 2015 - Propose amend wording to There is a risk that staff do not adhere to policies and procedures. New risk to be proposed to replace this risk.
437	There is a risk that some patients in the Paramedic 2 trial will experience worse outcomes than others in cardiac arrest, depending on which arm of the trial they are randomised into - adrenaline or saline placebo.	Adrenaline is a current standard treatment in cardiac arrest and has been used for decades, despite the fact that there is little evidence to support it. Recent evidence has shown much uncertainty around the effectiveness of adrenaline in resuscitation, and in fact some studies have suggested that it may actually be doing patients harm. This is particularly in relation to data that may show patients experiencing poorer neurological outcomes when they have received it. As such, in a randomised placebo-controlled trial, there is a risk to patients in either arm (adrenaline or placebo). Clinical evidence is very uncertain - it may suggest that adrenaline might increase chances	11-Mar-15		1		Clinical	Moderate	Possible	9	1. The clinical evidence has been reviewed by the International Liaison Committee on Resuscitation, and this authoritative body has determined that a randomised placebo-controlled trial is needed. The clinical risk to patients depending on which arm of the trial they are randomised into is justified by the therapeutic and public health benefits that are anticipated to be achieved by the study. 2. A Data Monitoring Committee is in place who will perform interim analyses of the data every 3 months for safety. They will advise the Trial Steering Committee if, in their view, the randomised comparisons have provided both (i) 'proof beyond reasonable doubt' that for all, or some, the treatment is clearly indicated or clearly contra-indicated and (ii) evidence that might reasonably be expected to materially influence future patient management. 3. The study will begin as a pilot in a smaller subsection of west London. This will mean that any adverse effects seen when the DMC analyses the initial data will have affected a much smaller group of patients than if it were pan London. Particularly, the first sets of data would most likely show any effects on ROSC rates fairly quickly, and this will therefore be monitored closely.	Fenella Wrigley	06-Jan-16	Moderate	Possible	9	No further action.	NA	N/A	1. Research team review of trial procedures for adherence. 2. Feedback from Data Monitoring Committee & Trial Steering Committee. 3. Regular meetings with LAS and Warwick.	Moderate	Possible	9	6/1/16 C Henderson. Reviewed by the Medical Directorate. Risk has been reworded to include the name of the trial. The trial Data Monitoring Committee has met and deemed that the trial can continue to roll out. Risk is still current as trial is still active. 26/08/15 - A.Blakely: Reviewed by the Medical Directorate August 2015 - should remain - this is a known risk with the trial. ? consider re-word of the risk as it doesn't state the name of the trial. Reviewed by Medical Directorate May 2015 but should remain with no changes. The patients who will be enrolled in this trial are already in cardiac arrest, so their outcome is likely to be poor anyway. Current survival rate in London after cardiac arrest is just 10.3%. By answering the question about adrenaline

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Risk Management Policy (TP05)**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary and Frances Field, Risk & Audit Manager**
Presented by:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**Risk Compliance and Assurance Group Executive Leadership Team**
Status:	**Presented for ratification**

Background/Purpose

The systems and processes for risk management in the LAS are governed through two key documents: the Risk Management Policy (TP05) and the Risk Assessment and Reporting Procedure (TP035). Both have been reviewed and updated in recent months to reflect change within the Trust. TP05 sets the risk management strategy and framework for the LAS.

The Risk Management Policy has been fully reviewed to take into account changes within organisation and committee/governance structures, the CQC Chief Inspector of Hospitals inspection report, and good practice and good governance, for example the Audit Committee Handbook (HFMA), The Healthy NHS Board (NHS Leadership Academy), and The Foundations of Good Governance (NHS Providers), and North West Ambulance Service NHS Trust Risk Management Policy.

The Policy was approved by the Risk Compliance and Assurance Group and the Executive Leadership Team in March and is presented to the Trust Board for information and ratification purposes.

Board members should in particular note the roles and responsibilities of the Board, individual Board members/lead executives, and committees. The Executive Leadership Team will review the risk appetite statement currently highlighted in the Policy and this will be taken forward with the Board when reviewing the strategic risks in the coming months. Executive leads are being asked to review the red risks within a framework described within the Policy, including the re-stated risk appetite statement, and within the context of a specific piece of work initiated by the Audit Committee.

The revised Risk Management Policy will be implemented from April 2016 and completes one of the actions under the Quality Improvement Programme Workstream for Achieving Good Governance.

Action required
Presented for information and ratification.
Assurance
The Policy has been revised to reflect good governance practice and exemplars within the NHS. Achievement of action 2.3 of QIP Workstream 2 is achieved once the Policy is published.

Key implications and risks arising from this paper	
Clinical and Quality	The Policy sets the framework and governance structure for the identification and treatment of risks across all categories.
Performance	
Financial	
Governance and Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Through the identification and treatment of risks.
To make LAS a great place to work	Dedicated risk management training for managers. Publication of the Policy and promotion of risk identification through internal communications to support staff awareness and when raising concerns.
To improve the organisation and infrastructure	Better identification of risks facing any aspect of the organisation.
To develop leadership and management capabilities	Risk management awareness raising and training for all managers.

London Ambulance Service NHS Trust

Risk Management Policy

DOCUMENT PROFILE and CONTROL

Purpose of the document: To define the LAS approach to risk management.

Sponsor Department: Governance and Assurance

Author/Reviewer: Risk and Audit Manager. To be reviewed by September 2016

Document Status: Final

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. 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.

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
February 2016	9.2	Director of Corporate Affairs	Major review and revision including updated committee/group terms of reference.
September 2015/January 2016	9.1	Risk and Audit Manager	Update including changes to groups.
19/11/14	8.1	IG Manager	Document Profile and Control update, formatting and minor change to S.7.
08/09/14	7.8	Risk and Audit Manager	Added SMT Terms of Reference.
13/05/14	7.7	Director of Corporate Affairs	Review and revision with changes to the executive team and the role of the senior management team
24/03/14	7.6	Risk and Audit Manager	Major review and revision including updated committee/group terms of reference.
23/01/13	7.5	Audit and Compliance Manager	Update to includes changes to groups and committees and update risk reporting process
24/09/12	7.4	Governance and Compliance Manager	Updated committee/group terms of reference (Appendix 2)
27/07/12	7.3	Governance and Compliance Manager	Reformat
19/06/12	7.2	Audit and Compliance Manager	Updated monitoring table. Minor amendments to S.4.12.6, S.6.7 & S.9.2
24/01/12	7.1	Director of Corporate Services	Approved by SMG and Trust Board subject to the updates within this version
29/12/11	6.9	Director of Corporate Services	Review and update for RCAG and the SMG approval in January 2012
20/12/11	6.3	Director of Corporate Services and Audit and Compliance Manager	Major review and revision

	6.2	Audit & Compliance Manager	Addition of monitoring table
20/09/10	6.1	Governance and Compliance Manager	Reformat and updated related documents
03/06/10	5.3	Head of RM & BC	Revised Appendix 2: CQSE & LfE ToR
02/06/10	5.2	Head of RM & BC	New Gov Committee chart added
20/05/10	5.1	Director of Corporate Services	Updated to include the final terms of reference for key committees
02/02/10	4.2	Director of Corporate Services	Updated to reflect changes to risk committee structure and responsibilities of committees.

01/10/09	4.1	Head of Governance	Updated to reflect role changes. Interim policy pending major revision by March 2010.
21/10/08	3.2	Head of Governance	Amendments to Risk Management Structure and Details of Committee Membership
20/10/08	3.1	Head of Governance	Amendments to ToR for SMG.
18/09/08	2.5	Chair of CGC, Chair of SBH group	Amendments to ToR for both
11/09/08	2.4	Head of RM & BC	Amendments from RCAG & new ToR details
28/08/08	2.3	Head of Governance(MB)	Include new ToR for Liability Claims Group. Amendments to Audit Committee entries
13/08/08	2.2	Head of RM & BC	Revision incl. addition of ToR.
05//08	2.1	Head of Governance & Head of RM & BC	Revision
03/07	2	Head of Governance & Head of RM & BC	Major revision
12/06	1	Head of Governance	Replaced Risk Management Strategy

For Approval By:	**Date Approved**	**Version**
ELT	16/03/2016	9.0
RCAG	08/03/2016	9.0
SMT	10/09/14	8.0
ADG/SMG	January 2012	7.0
SMG	09/06/10	6.0
RCAG	08/02/10	5.0
SMG	10/03/10	5.0
SMG	21/10/08	4.0
SMG	17/09/08	3.0
Chief Executive	03/07	2.0
Chief Executive	01/02	1.0
Ratified by Trust Board (If appropriate):		
	29/03/2016	9.0
	24/1/2012	7.1
	30/03/10	5.0
	25/11/08	4.0
	30/09/08	3.0

Published on:	Date	By	dept.
The Pulse	21/11/14 (v8.1)	Governance Administrator	G&A
The Pulse	27/07/12	Governance Administrator	GCT
LAS Website	21/11/14 (v8.1)	Governance Administrator	G&A
LAS Website	27/07/12	Governance Administrator	GCT
Announced on:	**Date**	**By**	**Dept.**
The RIB	25/11/14	IG Manager	G&A
The RIB	15/06/10	Records Manager	GCT

EqIA completed on	By
For review March 2016	
03/06/10	EqIA team (see doc)
Staffside reviewed on	**By**
	Staffside Representative

Ref. No.	Title
TP/035	Risk Reporting and Assessment Procedure
H&S/011	Incident Reporting Procedure
TP/013	Claims Policy
TP/004	Complaints and Feedback Policy
TP/034	Being Open and Duty of Candour
HR/07/22	Whistle Blowing Policy & Procedure
TP/006	Serious Incident Policy
TP/023	Driving and Care of Service Vehicles
H&S/001	Health and Safety Organisation – Policy Statement
TP/054	The Investigation and Learning from Incidents, PALs, Complaints and Claims Policy

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are neither controlled nor substantive.

1. Policy Statement

The Trust Board (the Board) recognises that risk management is an integral part of good management practice and to be most effective risk management should become part of the Trust's culture. The Board is, therefore, committed to the identification, evaluation and treatment of risk as part of a continuous process aimed at identifying threats and driving change. Risk management is a fundamental part of both the operational and strategic thinking of every part of the Trust's business including clinical, non-clinical, corporate, business and financial risk. The management of risk underpins the achievement of the Trust's objectives and is a key component of the Trust's Strategy, Caring for the Capital.

This Policy applies to all employees of the Trust and the implementation of its content will require active input from managers at all levels to ensure that risk management is a fundamental part of a total approach to quality, corporate and clinical governance and the Trust's annual Governance Statement. The Trust acknowledges that the provision of appropriate training is central to the achievement of this aim.

The Risk Management Policy represents a developing and improving approach to risk management achieved by building and sustaining an organisational culture which encourages risk taking, effective performance management, and accountability for organisational learning. The Trust strategy *Caring for the Capital* is the means by which the London Ambulance Service NHS Trust (LAS) will ensure its vision, aims, goals and organisational objectives are continually assessed and managed to ensure appropriate risk taking and effective performance management are in place and part of the organisational culture.

The Risk Management Policy will be communicated to all staff in every location of the Trust. This will be made available through 'the Pulse', the LAS's Intranet portal.

2. Purpose and Scope

The LAS Risk Management Policy underpins the Trust's reputation and performance and is fully endorsed by the Board. It provides the framework by which the Trust seeks to ensure risks are mitigated appropriately according to their threat to the Trust.

The Trust accepts that due to the nature of the core business there will be risks present in our activities. Through recognised and accepted risk management processes the Trust will determine acceptable risk levels and ensure that through monitoring and review processes, further measures are implemented to reduce and mitigate risks as a result of changes in practices, standards and legislation.

3. Aims and Objectives

Risk management ***identifies threats and drives change.***

3.1 The Board recognises that implementation of an effective Risk Management Policy and process is key to the delivery of the Trust's strategic and corporate objectives and the development of a positive learning environment as well as developing a risk awareness culture. In order to achieve this we will continue to develop and coordinate a systematic and auditable process of identifying, assessing, monitoring and reducing all risks that are faced at every level within the organisation.

The key objectives of this Policy are to provide a framework that ensures:

- The integration of risk management with the Trust's planning processes, aims and objectives, at all levels
- The establishment of a systematic process for the identification, assessment and elimination of risks wherever possible; and the introduction of controls for risks that cannot be eliminated; and for the management and monitoring of identified risks
- The provision of a safer environment together with working policies and procedures and practice which takes into account assessed risks
- That patients and people who use the Trust's services are cared for and treated by staff who practice safe clinical care at all times
- That an environment is created where staff are committed to developing and changing practice and systems in light of research, good practice, evidence-based clinical care, and new standards
- That all adverse incidents are reported as part of an 'open and fair' culture and that any lessons learnt from good and poor practice are shared and implemented where appropriate
- That all employees are informed of the Risk Management Policy and are appropriately trained and competent to ensure that they can fully comply with its requirements
- That all employees are made aware of and accept their personal responsibility to manage risk and communicate with the Trust using the appropriate reporting mechanism – the Risk Reporting and Assessment Procedure (TP035) – in the event they become aware of new risks or changes to existing risks; and in the event of changes in the control of existing risks
- The development of Trust-wide, Directorate, and local risk registers, with clearly defined management responsibility at each level
- That the Board Assurance Framework (BAF) is linked to the risk register process, developed through the Trust's corporate objectives, and that identified risks are linked to the CQC registration requirements
- That the BAF is reviewed and updated at least six times a year by the Risk Compliance and Assurance Group and reviewed at least six times a year by the Board
- The establishment of the Risk Compliance and Assurance Group reporting to the Executive Leadership Team and providing assurance to the Board through the Audit Committee on an effective system of risk management

- The Risk Compliance and Assurance Group will ensure robust systems and processes are in place to effectively monitor the application of risk management across Trust Directorates
- That an organisational Risk Management training needs analysis is in place which identifies which groups of staff require which levels of associated risk management training.

4. Learning Lessons from Risk Management

4.1 The Risk Management Policy will be used as a platform to drive organisational learning and feedback on the lessons learned through risk management and mitigation. The Risk Compliance and Assurance Group will have oversight of lessons learned through the quarterly report on Learning from Experience. Other Board and Executive Committees will review lessons learnt and emerging trends as appropriate and will use the opportunities these present for organisational learning from the management of risk. These committees will also seek action and/or assurance on progress with embedding risk management across the organisation.

4.2 The Trust must actively review risk occurrences and ensure that where appropriate these are adequately reported and recorded. The following may be considered during the review:

- What happened
- How and why the risk occurred
- What action has been taken (if any) since the risk occurred
- The likelihood of the risk occurring again
- Any additional responses or steps taken; and
- Key learning points and who and how these are to be communicated.

5. Risk Management Responsibilities

5.1 Trust Board

The Trust Board has corporate responsibility for the Trust's system of internal control and for robust risk management. The Trust Board is responsible for setting the strategic direction and corporate objectives for the Trust. It discharges its functions through a delegated structure (Appendix 3) designed to ensure effective risk management.

Preparation and dissemination of risk management policy	**Identification, evaluation and reporting of risk**	**Risk reduction**	**Contribution to the Board Assurance Framework (BAF)**
Review and approve the Policy. Ensure appropriate Trust-wide dissemination. Ensure the Trust has a fully functioning Committee structure so	Identify and review the risks that may affect the achievement of strategic and corporate objectives identified in *Caring for the Capital* and the business planning process *Moving Forward Together.*	Ensure that adequate controls are implemented and monitored to manage these risks. Approve the measures to be implemented to give assurances on the effectiveness of these	Review and revise the BAF in line with the Risk Management Policy. Ensure the full review of all Trust risks in line with the Risk Management Policy on a biannual basis.

that the business of risk management within the LAS can be transacted appropriately – see Appendix 3. **Approve** appropriate risk appetite for the LAS.	Provide direction and guidance regarding 'acceptable risk'. Regularly review key indicators relating to risk management and their effectiveness. Review the external environment key indicators to risk management: - CQC CIH Inspection TDA Well-led HSE Other	controls. Ensure that weaknesses in any controls or assurances are resolved and corrective action is taken. Ensure appropriate systems are in place for organisational learning from risk events. Ensure appropriate arrangements are in place for staff statutory and mandatory training and continuous professional development.	Ensure all significant risks arising from *Moving Forward Together* have appropriate assurances.

5.2 Chief Executive

The Chief Executive, as Accountable Officer, has overall accountability for having a robust risk management system in place and an effective system of internal control, which is embedded within the Trust.

Preparation and dissemination of risk management policy	**Identification, evaluation and reporting of risk**	**Risk reduction**	**Contribution to the Board Assurance Framework (BAF)**
Review the Risk Management Policy. Support appropriate Trust-wide dissemination. Ensure the Risk Management Policy is fit for purpose in that it enables the LAS to meet all of its statutory requirements and adhere to governance guidance. **Set** the appropriate risk appetite for the LAS.	Ensure that the Executive Leadership Team, as Directors of the Trust, practice robust risk management by developing and maintaining effective identification, evaluation and reporting systems within their areas of responsibility.	The Chief Executive has responsibility for reviewing the effectiveness of internal control systems by: • Ensuring appropriate mitigation and controls are in place for the Trust's strategic and corporate objectives • Ensuring that appropriate systems are in place through the committee structure to mitigate Trust risks • Supporting arrangements for organisational learning from risk events • Supporting arrangements for staff statutory and	Ensure Executive level review of the BAF on a monthly basis. Receive internal and external audit opinions on the overall arrangements for gaining assurance through the BAF and on the controls reviewed through their audit work.

		mandatory training and continuous professional development.	

5.3 Audit Committee

The Audit Committee reviews the corporate risk register and the Board Assurance Framework and is responsible for providing assurance to the Trust Board that there are effective systems and processes in place for the identification, management and mitigation of risks to the goals and objectives of the organisation.

5.4 All Directors

Each executive director has delegated responsibility for managing the strategic development and implementation of risk management pertaining to their remit.

Preparation and dissemination of risk management policy	**Identification, evaluation and reporting of risk**	**Risk reduction**	**Contribution to the Board Assurance Framework (BAF)**
Ensure that the Risk Management Policy is implemented and communicated effectively within their own directorate. All executive Directors are responsible for ensuring that staff within their directorates are given adequate information and training appropriate to their responsibilities, to enable safe working.	The strategic management of risks affecting their own directorates, departments and staff and ensuring they have effective systems in place to ensure the management of risks assigned to them. Ensure that risk management is an integral part of business planning and strategy or policy development. Full participation in the activities of the Risk Compliance and Assurance Group. Ensure that identified risks are appropriately identified, mitigated against, recorded, and reviewed on a regular basis. Implement and monitor any identified control measures within their directorate.	Ensure that the risks of not achieving objectives relating to their own areas of responsibility within the business plan are identified and assessed to ensure that appropriate risk treatment solutions are in place. Ensure that adequate resources are made available to provide safe systems of work and compliance with internal and external risk management standards. Ensure that any new high level risks that are not adequately controlled are brought to the attention of the Risk Compliance and Assurance Group, ELT, and the Trust Board. Ensure appropriate systems are in place for organisational learning from risk events. Ensure appropriate arrangements are in place for staff to undertake statutory and	Review and revise risks aligned to strategic objectives in a timely manner. Ensure major changes or new and emergent risks are highlighted to the Board in good time. Evaluate the content of the BAF on a regular basis through the Risk Compliance and Assurance Group and ELT and other Board and executive committees as appropriate.

		mandatory training and continuous professional development.	

5.5 Delegated Executive Responsibilities

5.5.1 Director of Finance

The Director of Finance is the designated Executive Director with overall responsibility for risk management pertaining to finance and/or performance (any element of risk containing financial implications in whole or in part), Fleet & Logistics; Procurement; and Information management & technology.

5.5.2 Director of Nursing and Quality

The Director of Nursing and Quality is the designated Executive Director with overall responsibility for strategic development and implementation of risk management relating to Quality; public and patient involvement & education; Infection Prevention and Control (IPC); Safeguarding; Complaints & Patient Advice & Liaison Service (PALS), Nursing leadership; and Mental health.

5.5.3 Medical Director

The Medical Director is the designated Executive Director with overall responsibility for strategic development and implementation of risk management relating to Clinical safety; Clinical Audit & Research Unit (CARU); clinical education and development; and medical & clinical advice. The Medical Director leads on medical equipment and medical devices, medicines management, clinical audit and research and risk responsibilities relating to the role and remit of the Trust's Caldicott Guardian.

5.5.4 Director of Corporate Affairs & Trust Secretary

The Director of Corporate Affairs & Trust Secretary is the designated Executive Director with overall responsibility for strategic development and implementation of risk management relating to Governance; Serious Incidents; Trust Board; corporate risk management; Corporate governance; Estates & Facilities; Freedom of Information (FOI); and Information Governance. The Director of Corporate Affairs has overall responsibility for ensuring that corporate risk processes and controls are in place.

5.5.5 Director of Strategic Communications

The Director of Strategic Communications has delegated responsibility for strategic development and implementation of risk management relating to Reputation management; Stakeholder management; Staff engagement; and Media relations.

5.5.6 Director of Transformation and Strategy

The Director of Transformation and Strategy has delegated responsibility for strategic development and implementation of risk management relating to Transformation & Organisational Development; Business Development; Strategy & business planning; clinical education and development; and contracting & relationship management.

5.5.7 Director of Performance

The Director of Performance has delegated responsibility for strategic development and implementation of risk management relating to Performance monitoring & reporting; and Performance recovery initiatives.

5.5.8 Director of Operations

The Director of Operations is the designated Executive Director with overall responsibility for strategic development and implementation of risk management relating to Frontline service delivery; frontline workforce; Emergency Preparedness, Resilience and Response; Emergency Operations Centre (EOC); Hazardous Area Response Team (HART); PTS; Non-Emergency Transport Service; and NHS111.

5.5.9 Director of Human Resources

The Director of Human Resources has delegated responsibility for strategic development and implementation of risk management relating to Human Resources; recruitment; health and safety; and equality and inclusion.

5.6 Risk Management leads

Other roles which have a specific risk management element include the following: Head of Governance and Assurance, Senior Health, Safety and Risk Advisor, Head of Patient Experiences, Head of Legal Services, and Risk and Audit Manager. These managers and heads of services are responsible for the development, implementation and management of the policy and processes for ensuring compliance with the Risk Management Policy.

5.7 All Managers

All managers are responsible for the management of risk locally and for day to day implementation of the policy and strategy within their own area.

Preparation and dissemination of risk management policy	Identification, evaluation and reporting of risk	Risk reduction	Contribution to the Board Assurance Framework (BAF)
Ensure that the Risk Management Policy is implemented and communicated effectively within their departments and teams.	Identify and assess risks and develop a local risk register for regular review and monitoring. Escalation through the agreed local governance route of the risks which exceed the local level of delegated authority or have an impact across a number of LAS departments or functions. Report all risks arising from reported incidents in accordance with the	Ensure that risk assessments are undertaken in their own areas of operation and reviewed regularly. Identify and act upon any significant hazard or risk; and reporting to their senior manager any risk that they cannot adequately control. Implement control measures arising out of their local risk registers. Ensure adverse incidents are reported	Contribute to or participate in internal and external reviews and audits. Contribute to the actions undertaken to mitigate or eliminate high level risks.

	Trust's Incident Reporting Procedure (HS 011) and ensure that corrective actions are implemented and monitored.	through the appropriate channels. Ensure appropriate systems are in place for local learning from risk events. Ensure appropriate arrangements are in place for staff to undertake statutory and mandatory training and continuous professional development.	

5.8 All Employees and workers

All Employees and workers have the duty to take reasonable care of themselves and others whilst carrying out the Trust business. It is the duty of all employees to familiarise themselves, and comply, with the Trust Risk Management policy and strategy.

Preparation and dissemination of risk management policy	Identification, evaluation and reporting of risk	Risk reduction	Contribution to the Board Assurance Framework (BAF)
Be aware of the Risk Management Policy and familiarise themselves with key sections.	Carry out dynamic risk assessments as part of their everyday duties and responsibilities. Identify and report any actual or potential hazards/risks in the work environment. Report all incidents to staff and patient safety as defined by the Incident Reporting Procedure (HS 011).	Be personally responsible for not undertaking any risk or action which would knowingly cause unnecessary risk to themselves, others or to the LAS. Take immediate action to minimise risk where it is reasonably practicable to do so. Attend statutory and mandatory training and undertake continuous professional development.	Contribute to or participate in internal and external reviews and audits. Contribute to the actions undertaken to mitigate or eliminate high level risks.

6. Organisational Structure Relating to Risk Management

The LAS committees and groups with responsibility for managing risk are as below.

6.1 The Trust Board and Chief Executive

6.1.1 The Trust Board and Chief Executive require that consideration of risk and systems of internal control are fully embedded within the culture of the Trust, whilst ensuring a coordinated and holistic approach and maintaining clear lines of accountability. The Trust's organisational structure has been designed to reflect this and is detailed at Appendix 2. The terms of reference for all the groups detailed below can be found on 'the Pulse', the Trust's Intranet portal.

6.2 The Committees

The Terms of Reference for the committees listed below can be found on 'the Pulse' (The Trust's Intranet).

6.2.1 The Quality Governance Committee

The Quality Governance Committee provides assurance to the Trust Board on clinical, corporate, information governance and compliance matters ensuring high quality care to patients. Key agenda items would include seeking assurance on clinical safety and standards, professional education and development, and effectiveness and experience, as well as compliance with the CQC regulatory outcomes and other regulatory or mandated standards such as Monitor's Quality Governance Framework, within the context of well-led; seeking assurance from within the organisation that patient safety is being managed effectively; and that effective processes are in place to manage and monitor hygiene/infection control and safeguarding.

6.2.2 The Audit Committee

The Audit Committee provides assurance to the Board that the organisation has sufficient controls in place to manage the significant risks to achieving its strategic objectives and that these controls are operating effectively.[1]

6.2.3 The Finance and Investment Committee

The Finance and Investment Committee has delegated authority from the Trust Board to consider the medium-term financial strategy and performance and this includes strategic financial risks.

6.2.4 The Risk Compliance and Assurance Group

The Risk Compliance and Assurance Group manages and monitors all risk management processes and activities within the Trust, ensuring that the objectives of the Risk Management Policy are achieved; the group is responsible for the delivery of a systematic and action-oriented approach to the management of all known and foreseeable risks within the Trust.

6.2.5 Executive Leadership Team (ELT) manages strategic and operational risk on behalf of the Trust Board. The ELT ensures that systems, structures and management

[1] NHS Audit Committee Handbook, HFMA

processes are in place for monitoring and reviewing all forms of risk throughout the Trust. The ELT has responsibility for identifying risks to the delivery of the strategic objectives and priorities and for top-down risk identification, management and mitigation.

6.3 Reporting Groups

Reporting groups will include the review, monitoring and oversight of risks within specific workstreams. Details of reporting groups are shown in Appendix 3 & 4.

7.0 The Risk Management Process

The Board, on an annual basis and through the relevant committees, will ensure that a framework is in place that identifies risks associated with all its activities. This will be an on-going process in the achievement of its strategic and operational objectives. The LAS will achieve its aims by implementing the risk management process as detailed in TP035 – Risk Reporting Assessment Procedure.

The Board will annually review all risks that may prevent it from achieving its principal objectives as detailed in the BAF. The Board will delegate the management of corporate risk to the directorate or operational division affected to assess the controls to mitigate the risk and this is subsequently recorded in both the local and corporate risk registers**.**

7.1 Risk Register

Core to this Risk Management Policy will be the provision and maintenance of a well-founded risk register, for all activities of the Trust. The risk register will be maintained on the Trust's risk reporting and management system in accordance with the Trust's Risk Assessment and Reporting Procedure (TP/035).

A Risk Register is one of the basic building blocks of risk management and provides a unified repository for the recording and monitoring of risks at both the local and corporate level within the Trust.

The business planning process will be used to identify key risks to the organisation and individual objectives will be set for all levels of staff to reflect this.

The Risk Management Policy will ensure a process (TP035) that follows accepted good risk management practice which involves identification, assessment and control of risk.

8. Implementation of the Risk Management Policy

The Trust recognises the value of the whole systems approach in preventing, analysing and learning from errors and will continually aim to implement the management of risk in a structured way. Risk registers are used to record and monitor risks at both a local and corporate level within the Trust. Interaction with the risk register occurs at all stages of the risk management process from risk identification, assessment, through to risk response development and monitoring.

The generic risk management process is detailed in the Trust's Risk Assessment and Reporting Procedure (TP035).

Owners of risks and further action will be identified on the Trust's Risk Reporting and Management System. Owners have responsibility to actively manage and prioritise risks in their areas, reviewing risk response actions and the critical risk areas wherever possible.

Figure 2

Risk Colour	Risk Level	Remedial Action	Decision to accept risk	Risk register level
Green 1 to 3	**Low**	Line Manager	Station/Department Manager	Area/ Department Manager
Yellow 4 to 9	**Moderate**	Station/Department Manager	Area/Department Manager	Assistant Director/ Head of Department
Orange 10 to 12	**Significant**	Assistant Director/ Head of Department	Director	Directorate/Risk Compliance and Assurance Group/Executive Leadership Team
Red 15 to 25	**High**	Director	Executive Leadership Team	Trust Board

When risk owners cannot complete actions necessary to treat risks because they may not have the required level of authority, they need to escalate the risk to a higher level to ensure that the risk is allocated to the most appropriate person capable of handling. This process is set out in the Risk Assessment and Reporting Procedure (TP/035).

The level at which risks will be managed or assigned priorities for remedial action will be determined by the colour bandings and risk ratings as set out in Figure 3 below.

9.0. Risk Treatment

Risk Treatment involves a cyclical process of assessing control measures then deciding whether residual risk levels are tolerable, if not, generating new control measures and then assessing the effectiveness of these measures. Control measure options are not necessarily mutually exclusive or appropriate in all circumstances. The options can include:-

- Avoiding the risk by deciding not to start
- Continue with the activity that gives rise to the risk
- Taking or increasing the risk order to pursue an opportunity
- Remove the risk at source
- Changing the likelihood or consequences
- Share the risk with another party or parties; and

• Retaining the risk by informed decision.

Risk treatment and subsequent review of the implemented measures in a timely manner is fundamental to the effective management of risk. The review schedule has been split into six sections dividing each of categories Red Amber and Green into two. See figure 3 below.

Figure 3

Risk review matrix			Owner of risk	Review schedule
Major	**20-25**	Unacceptable level of risk exposure which required immediate corrective action to be taken	CEO/ELT	Monthly
	15/16/12	Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	Director	Monthly
Moderate	**10**	Acceptable level of risk exposure subject to frequent active monitoring measures	Deputy director	Monthly
	8-9		Head of/Senior Manager	Quarterly
Low	**4/5/6**	Acceptable levels of risk subject to regular passive monitoring levels	Sector manager	Bi-annual
	1/2/3	Acceptable levels of risk subject to periodic passive monitoring measures	Manager	Annual

10. Risk Grading

Acceptable risk **- Low risk (Green):** Risks scored 1, 2 or 3 will be considered acceptable risk and subject to periodic passive monitoring measures and should be reviewed at least annually by relevant management team.

Acceptable risk **- Low risk (Green):** Risks scored 4, 5 or 6 will be considered acceptable risk and subject to subject to regular passive monitoring levels and should be reviewed at least bi-annually by Sector Manager or equivalent.

Acceptable risk **- Moderate risk (Amber):** Risks scored 8 and 9 will be considered acceptable risks and be subject to regular active monitoring levels and be reviewed at least quarterly by a Head of Service or equivalent.

Acceptable risk **- Moderate risk (Amber):** Risks scored at 10 and 12 will be considered acceptable risks and be subject to Frequent active monitoring levels and be reviewed at least quarterly by a Deputy Director or equivalent.

Unacceptable risk **- High risk (Red):**Risks scored at 15 and 16 will be considered unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure, reviewed monthly by a Director.

Unacceptable risk **– High risk (Red):** Risks scored at 20 and 25 will be considered unacceptable level of exposure which requires immediate corrective action to be taken by the Chief Executive or Executive Leadership Team, with mitigating actions reviewed monthly.

11. Acceptable Risk and Risk Appetite Statement

The Trust recognises that it is impossible, and not always desirable, to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits.

11.1 Acceptable Risk

One of the most important roles for LAS Trust Board is to determine LAS's risk tolerance. Risk tolerance is the limit on risk which has been pre-determined by the Trust, above which LAS (as a healthcare organisation) will not accept.

Acceptable Risks are those risks which have been identified and measured according to the risk-grading tool and for which risk mitigation action plans have been developed. Such risks are deemed to be acceptable according to the risk appetite of the Trust as determined by a delegated committee e.g. the Risk Compliance and Assurance Group or the Executive Leadership Team, depending on the nature and grade of the risk.

Acceptable risks should be monitored, reviewed and entered onto the appropriate risk register. By this definition an unacceptable risk/zero tolerance risk is one where such a risk is rated above the risk appetite of the Trust.

In addition, a risk appetite can be described as the level or amount of risks which a healthcare organisation is willing to take in pursuance of its objectives.

11.2 Risk Appetite Statement

LAS "...goal is to deliver safe, high quality care that meets the needs of our patients and commissioners, and which makes our staff proud." In keeping with this goal, LAS will not accept any risks associated with patient safety, safeguarding, workforce, reputational risk and information governance. The Trust has no appetite for fraud/financial risk and zero tolerance for regulatory breaches.

As a general principle the Trust will seek to eliminate and control all risks which have the potential to:

- harm its staff, patients, visitors and other stakeholders
- have a high potential for incidents to occur, would result in loss of public confidence in the Trust and/or its partner agencies
- have severe financial consequences which would prevent the Trust from carrying out its functions.
- materially impact on the quality and delivery of our urgent and emergency response.

The Executive Leadership Team commits to review the risk appetite statement on an annual basis.

12. Monitoring Compliance with the Policy

The Trust Board will receive reports at each Board meeting in respect of all actions of risk considered high and significant until such actions reduce the level of risk below these levels. This reporting is undertaken by the Audit Committee and Quality Governance Committee.

The Audit Committee will also receive reports from Internal Audit at each of its meetings and the Quality Governance Committee will receive reports on a timely basis covering:

- incident reporting systems, including analysis and feedback
- complaints and PALS reporting systems, including analysis and feedback
- claims reporting systems, including analysis and feedback
- risk register / assessment reporting systems, including analysis and feedback
- compliance with CQC registration, and other appropriate standards and audits
- risk management training initiatives
- sickness and absence statistics analysis
- clinical performance indicator checks
- number of road traffic collisions and cost of claims on vehicle damage.

The Risk Compliance and Assurance Group will help to provide central support and encourage the uptake of good practice. As the central point for the receipt of risk register information, RCAG will compare the data and approaches being taken by individual groups for consistency across the organisation. RCAG will keep the main risks under strategic review and share information on how to address these risks, as well as maintaining and disseminating up-to-date risk management guidance for managers and policy makers.

Trust board committees will have a standing agenda item on risk, where the top risks from the corporate risk register will be discussed and escalated/communicated to the Board, as appropriate.

Changes in the Trust and the environment in which it operates will be identified and appropriate changes made to systems. Regular audits of policy and standards compliance will be carried out and standards of performance will be reviewed to identify opportunities for improvement. Any changes in guidance, best practice and legislation will be considered as the need arises and incorporated appropriately into the Risk Management Policy, which will be reviewed every two years as a minimum and approved by the Trust Board.

13. Dissemination, implementation and access to this document

Following approval of this policy by the ELT, it will disseminated to all members of staff through their departmental managers, heads of department or other line management structure.

The strategy will also be introduced to all new and existing staff and other relevant risk management training identified through Training Needs Analysis during induction programme.

The previous version of this policy will be archived in accordance with TP01 ‘Policy & Procedure for the Development & Management of Procedural Documents’.

14. References

This policy is linked to the following:-
LA 167: Risk assessment and reporting form
TP035: Risk Reporting Assessment Procedure

Appendix 1 Implementation Plan

IMPLEMENTATION PLAN				
Intended Audience	All LAS staff.			
Dissemination	Available on Pulse to all staff and on the LAS Website for the public.			
Communications	Revised policy to be announced in the RIB and a link to be provided to the document.			
Training	Training will be provided to all relevant staff as part of the mandatory training programme.			
Monitoring: **(also see section 10)**				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
The organisation's risk management structure, detailing all those committees and groups which have some responsibility for risk including duties of the key individuals for risk management activities:				
How the board or high level risk committee(s) review the Trust-wide risk register	Review of Trust-Wide Risk Register Corporate Risk Register (15+) – at each Board meeting	Governance and Assurance Team report to the Risk Compliance and Assurance Group Governance and Assurance Team report to the Audit Committee	Risk Compliance and Assurance Group	Dissemination of learning in accordance with source of risk i.e. learning from risk highlighted through the quarterly Learning from Experience report or individual serious incident action plans.
How risk is managed locally	Quarterly Review of Local Risk Registers	ADOs for each operational sector report to sector governance committees Corporate Heads of Department report to Departmental Meetings	Risk Compliance and Assurance Group	

Appendix 2 Measuring Risk Compliance

Method	Application	Performance Indicators	Monitoring	Independent Assessment
Care Quality Commission: Registration Requirements	Individual Directors accountable with lead responsibility delegated to key senior managers Performance managed through Board committees and the Board. Action plans feeding and linking into business plans (objectives) and risk register (assurance framework).	Robust assurance evidences compliance against Regulatory outcomes	Assurance from the Quality Governance Committee; Compliance & action plans monitored by Compliance monitored by Committee with updates at each meeting. Quarterly reports to the Trust Board Executive Leadership Team	Internal Audit NHS TDA NHSE CQRG
Clinical Governance	Clinical Audit Plan. Clinical Performance Indicators Complaints and Serious Incidents JRCALC	Local and national clinical audits. PRF compliance audits against CPIs. Complaints audit	Quality Governance Committee Clinical Safety and Standards Clinical Audit and Research Group	CQC Internal Audit NHSE CQRG

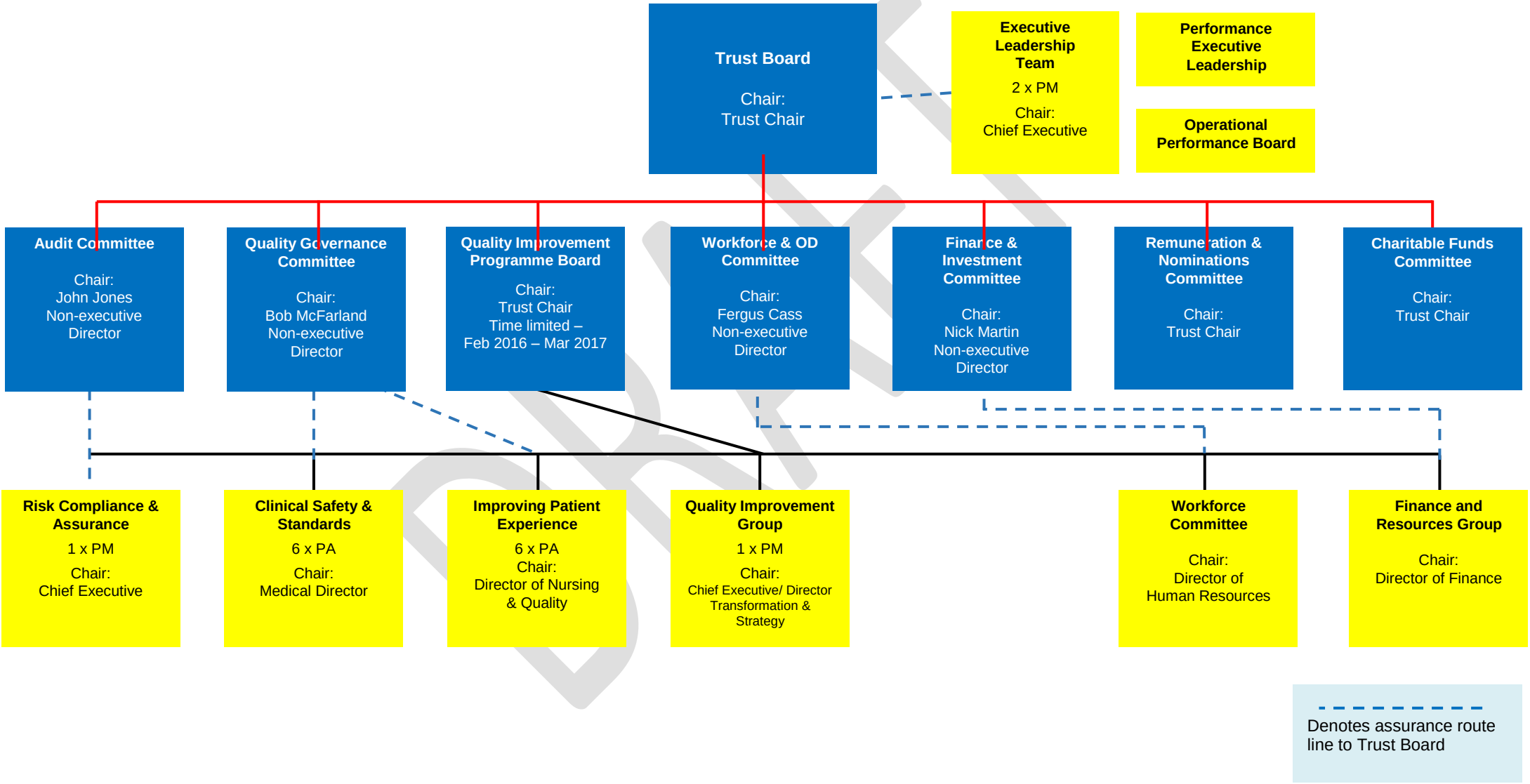
Risk Management Process	Applied on an ongoing basis through day to day working activities. Risks identified can be recorded onto the risk register. Working groups committees, business planning and project teams apply the risk management process and provide risk information to the relevant risk register.	Risks treated (i.e. reducing in risk level). Numbers of high and extreme risks.	Executive Directors Trust Board Quality Governance Committee Audit Committee Risk Compliance and Assurance Group Internal audit actions	Internal Audit HSE NHSE CQRG

Method	Application	Performance Indicators	Monitoring	Independent Assessment
Information Governance	Senior Information Risk Owner (SIRO) and Director of Corporate Affairs / accountable with responsibility delegated to key managers. Actions required to reach and maintain levels required by IG Toolkit	Number of Serious Information Incidents. IG Toolkit shows level of compliance.	Information Governance Group	NHS TDA Internal Audit

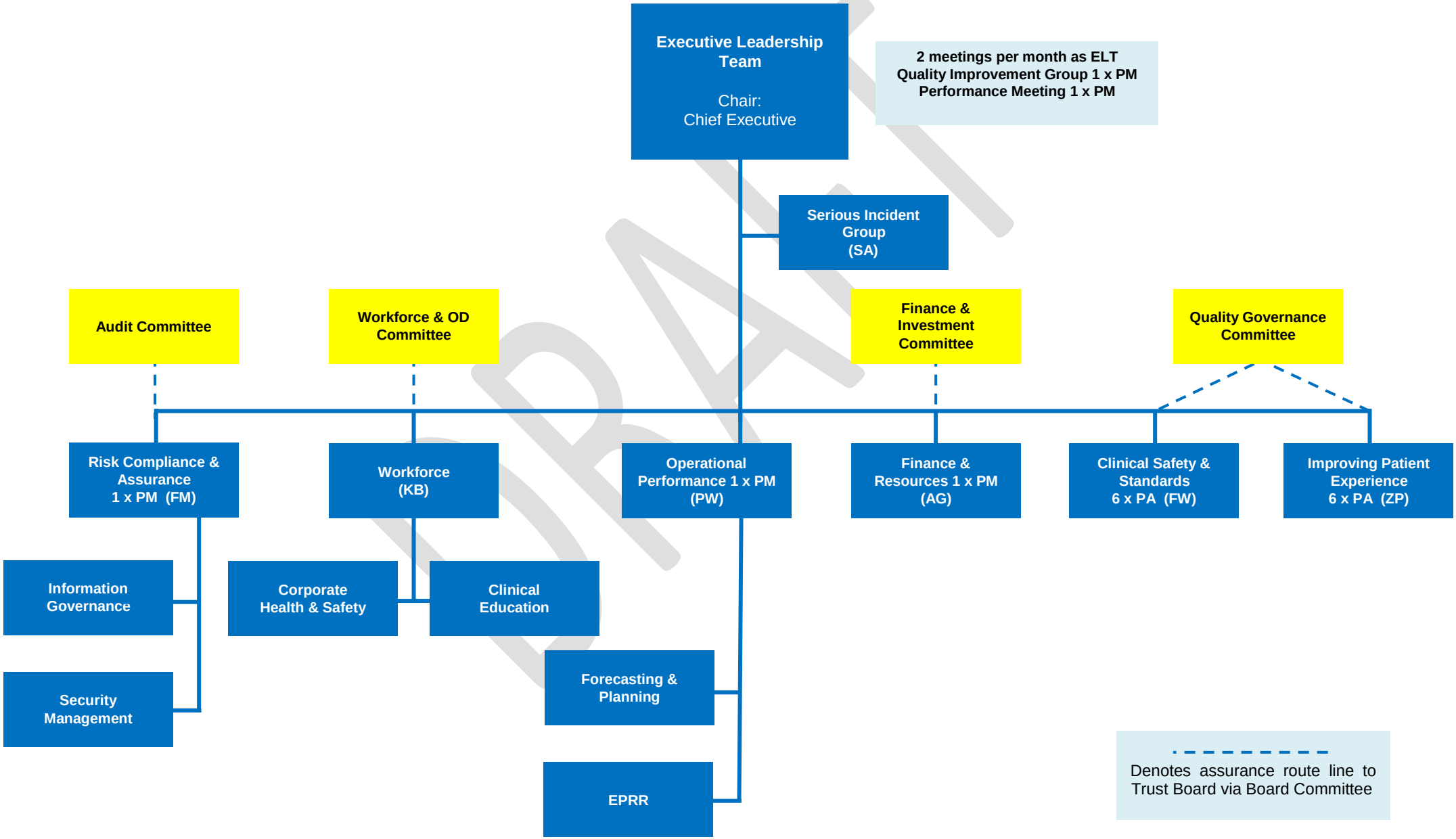
Internal Risk Assessment Process	The Risk and Audit Manager and the Governance & Assurance team oversee an ongoing programme of formal risk assessment and reporting. Line managers carry out and/or request risk assessments. Controls in place via safe systems at work. Working groups, committees, business planning and project teams feed into the programme. Risks identified are placed on the relevant risk register	Numbers, type and severity of patient safety incidents, serious incidents, staff accidents, complaints and claims. Progress against the Risk Assessment Programme. Examples of learning from incidents.	Trust Board Executive Directors Risk Compliance and Assurance Group Corporate Health and Safety Group Health and Safety Annual Report Annual patient experiences (complaints) report Quarterly integrated risk report.	Internal Audit HSE NHS TDA
Method	**Application**	**Performance Indicators**	**Monitoring**	**Independent Assessment**
Emergency Planning and Business Continuity	Major incident planning – in collaboration with other emergency services. Business continuity and internal disaster recovery planning. Testing of the above systems	Number of untoward incidents arising during a major incident or internal disaster. Compliance against emergency planning element of CQC standard. Benchmarking	Trust Board Executive Directors ELT	Internal Audit NHSE

Health and Safety Workplace Inspections	Carried out quarterly at each site to identify health and safety issues and hazards. Annual audit by the Safety and Risk Department. Outstanding issues are logged.	Number of premises inspected. Key issues identified (trends).	Executive Directors Risk Compliance and Assurance Group Corporate Health and Safety Group	Internal Audit HSE

GOVERNANCE STRUCTURE
FEBRUARY 2016



EXECUTIVE LEADERSHIP TEAM
GOVERNANCE STRUCTURE
FEBRUARY 2016



London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Operating and Financial Plans 2016/17**
Report Author(s):	**Andrew Grimshaw, Director of Finance**
Presented by:	**Andrew Grimshaw, Director of Finance**
Contact Details:	**02077832793**
History:	**Executive Leadership Team and Finance & Investment Committee**
Status:	**To note progress in developing these plans and the areas yet to be finalised. To provide delegated authority to the Chair and Chief Executive to approve the plans for submission to the TDA in April.**

Background/Purpose

This paper summarises progress in agreeing Operating and Financial plans for 2016/17.

The Operating Plan

- Based on current expectations of demand, available capacity and run rate productivity the Trust is forecasting **performance of 65.2% across 2016/17**. This remains unchanged from the presentation to the Trust Board in February.
- The London Regional Oversight Group (ROG) have accepted this position as the start point for 2016/17 performance discussions, but have indicated they wish to see **steady and ongoing improvement** against this trajectory.
- There are four major areas of work have been requested by the ROG to help achieve this:
    - **Demand**, actions to control demand have had limited impact. This is being led by the CCGs.
    - **Productivity**. The key element of productivity, JCT continues to increase for reasons. A deep dive into JCT will be undertaken
    - The **impact from CQC actions**. While not directly supporting performance some benefit can be expected.
    - Focused use of overtime during periods of high demand and high annual leave.

There will be ongoing discussion on these actions and the Board will be kept informed.

The Financial Plan

1. Work has been progressing on the financial plan for the Trust.
2. The main outstanding issue is the level of additional investment CCGs are willing to make in support of the QIP plan to address the recommendations of the CQC action plan.
3. The outcome of this has material impact on both 2016/17 and beyond.
4. LAS Commissioners are working with CCG Chief Officers to define the level of funding as they are also working to conclude their plans for 2016/17. An update will be provided to the Trust Board on the 29th March.
5. The Trust is required to submit a financial plan on the 08th April 2016.

Action required
In order to conclude the these plans it is proposed that: a. The Board review and approve the positions outlined in this paper. More detailed versions of this are being presented to both the ELT and FIC. b. The Board agree to provide delegated authority to the Chair and Chief Executive to approve the final version of the plans. c. The Chair and Chief executive will engage the full Board if there are material issues that emerge between the 29th March and the 08th April. d. A further presentation will be made to the April Trust Board detailing the final plan position submitted
Assurance
Progress is being made in agreeing the operating and financial plans for 2016/17.

Key implications and risks arising from this paper	
Clinical and Quality	**Yes**
Performance	**Yes**
Financial	**Yes**
Governance and Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**Yes**
To make LAS a great place to work	**Yes**
To improve the organisation and infrastructure	**Yes**
To develop leadership and management capabilities	**Yes**

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th March 2016**
Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Presented by:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**For information**

Background/Purpose

Since the Trust Board meeting on 2nd February 2016, the following entries have been made to the Tender book and to the Register for the use of the Trust Seal.

Tenders received
One new tender was received and opened on 18th February 2016 pertaining to the sale of the Lambourne End and Shooters Hill transmitter sites. These were dealt with as one tender.

Use of the Trust Seal
There have been 9 new entries to the Register for the use of the Trust Seal.

Action required

To be advised of the tenders received and entered into the tender book and entries to the Register for the use of the Trust Seal since 2nd February 2016 and to be assured of compliance with Standing Orders and Standing Financial Instructions.

Assurance

Compliance with Standing Orders and Standing Financial Instructions.

Key implications and risks arising from this paper	
Clinical and Quality	None
Performance	None
Financial	Controls and mitigations against any risk: compliance with Standing Orders and Standing Financial Instructions; 2015/16 financial plan
Governance and Legal	Controls and mitigations against any risk: compliance with Standing Orders and Standing Financial Instructions;
Equality and Diversity	None
Reputation	None
Other	Controls and mitigations against any risk: compliance with Standing Orders and Standing Financial Instructions;
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Yes
To make LAS a great place to work	Yes
To improve the organisation and infrastructure	Yes
To develop leadership and management capabilities	N/A

Trust Secretary Report

Trust Board

29th March 2016

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

Tenders received
One new tender was received and opened on 18th February 2016 pertaining to the sale of the Lambourne End and Shooters Hill transmitter sites. These were dealt with as one tender. Details are set out below of tenders received:

Ashaar.A.Shaikh
R.C.T Construction
Blakes Leisure Ltd
Kristian De Havilland
Philip Giles
Scott Dockerill
Michael Wilkinson
Paurav Chudasama.

Use of the Trust Seal
There have been 9 new entries to the Register for the use of the Trust Seal:

18/2/16: Renewal of lease for Barnet Fire Station: London Fire and Emergency Planning Authority.

1/3/16: Lease of 5th Floor, Southern House, Wellesley Grove, Croydon: Whittles Properties Croydon Limited

1/3/16: Licence for alterations relating to 5th Floor, Southern House, Wellesley Grove, Croydon: Whittles Properties Croydon Limited

1/3/16: Licence relating to car parking spaces at Southern House, Wellesley Grove, Croydon: Whittles Properties Croydon Limited

1/3/16: Supplemental underlease (engrossments) for County House, 221-241 Beckenham Road, Beckenham: Secretary of State for Health

1/3/16: Deed of surrender of Part County House: Secretary of State for Health

1/3/16: Deed of covenant, County House: Secretary of State for Health

1/3/16: Deed of variation – contract for provision of the 111 service in South East London: London Ambulance Service NHS Trust and Bromley Clinical Commissioning Group

1/3/16: Call option agreement relating to 5th floor, Southern House, Wellesley Grove, Croydon: Bromley Clinical Commissioning Group.

Trust Board Register of Interest - March 2016

Name	Date	Nil declaration	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Richard Hunt	04/03/2015		✓	Director of Maven Executive Coaching and Mentoring	Director of Attan Partners Ltd				
Jessica Cecil	25/02/2015		✓				On the advisory board of IntoUniversity, a charity aimed at getting disadvantaged young people to university	One sister is an NHS physiotherapist who also sees patients privately; another sister is a public health reseracher at Imperial College.	
John Jones	04/02/2015	✓							
Fergus Cass	04/03/2015		✓	Book Aid International - Charity - Trustee; Hospices of Hope - Charity - Trustee; Hospices of Hope Trading Limited - Charity related chain of shops - Chair Melton Court Parking Limited: company managing parking spaces at block where I live: Director			As noted above, I am a trustee of Hospices of Hope, a charity supporting hospice care in Romania and neighbouring countries		
Nicholas Martin	24/02/2015		✓	Cambridge Guarantee Holdings (Director); A2Dominion Housing Association (Director)			Chair, City of Westminster College		
Robert McFarland	05/02/2015	✓					Trustee and Chair of the European Doctor's Orchestra.		
Theo de Pencier	04/03/2015		✓	Non-executive directorat Transport Focus					
Sandra Adams	04/02/2015	✓							
Karen Broughton	05/02/2015	✓							
Andrew Grimshaw	05/02/2015		✓	Director of LSO Consulting Ltd.					
Charlotte Gawne	17/03/2015		✓	Director – Vannin Consulting (currently a dormant IT consultancy)					
Fionna Moore	05/03/2015		✓	Medical Director, Location Medical Services.			Member Executive Committee, Resuscitation Council (UK)		
Paul Woodrow	10/02/2015	✓							
Zoe Packman	09/03/2015		✓					Honorary senior clinical fellow, Kingston University and St George's University of London	
Jill Patterson	18/02/2016		✓	Tall Poppies Management Ltd	Tall Poppies Management Ltd	Tall Poppies Management Ltd			
Fenella Wrigley	14/02/2015		✓				Regional Professional Lead for Doctors - St John Ambulance London Region		Expert Clinical Advisor to UKBA; Consultant in Emergency Medicine, Barts Health NHS Trust