London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 29th NOVEMBER 2016 AT 09.00am – 12.00pm
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from:			
	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		HL	
	3.	**Minutes of the meeting held in public on 4th October 2016** To approve the minutes of the meeting held on 4th October 2016	Approval	HL	TAB 1
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	HL	TAB 2
	5.	**Report from the Chair** To receive a report from the Chair	Information	HL	TAB 3
	6.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	FM	TAB 4
PERFORMANCE AND ASSURANCE					
	7.	**Integrated Board Performance Report – October 2016** 7.1 To receive the integrated board performance report (including Quality, Finance, Performance and Workforce) 7.2 Performance Reporting Framework	Information	AG	TAB 5
	8.	**Quality Improvement Programme** 8.1 Medicines Management Requirement Notice	Assurance	KB FW	TAB 6
	9.	**Quality Governance Committee Assurance Report** 9.1 To receive the Quality Governance Committee Assurance Report – 15th November 2016 9.2 To approve the following annual reports for 2015/16 following recommendation by the Quality Governance Committee: • Cardiac Arrest • Stroke Care • Clinical Audit	Assurance Approval	BMc	TAB 7 TAB 8
	10.	**Finance and Investment Committee Assurance Report** To receive the Finance and Investment Committee Assurance Report - 24th November 2016	Assurance	NM	TAB 9
	11.	**Workforce Committee Assurance Report including WRES Oversight** To receive the Workforce Committee Assurance Report – 26th October and 21st November 2016	Assurance	FC	TAB 10
	12.	**Audit Committee** 12.1 To receive the Audit Committee assurance report from the meeting held on 7th November 2016. 12.2 To approve the appointment of Ernst & Young for the Trust's External Audit Service 12.3 To receive the 2015/16 annual accounts and annual report of the Charitable Funds	Assurance	JJ	TAB 11

	13.	**Board Assurance Framework and Risk Management** To receive the Board Assurance Framework and risk register – October 2016	Assurance	SA	TAB 12
BREAK					
GOVERNANCE					
	14.	**Fit and Proper Person Policy** To approve the following policy that will replace the current process	Approval	SA	TAB 13
	15.	**Strategy and Business planning** - Contracting and planning for 2017-2019 - IM&T Strategy - STPs	Discussion	AG/KB FM KB	TAB 14
	16.	**Standing Orders, Standing Financial Instructions and the Scheme of Delegation** Presented for approval following recommendation by the Audit Committee	Approval	SA	TAB 15
	17.	**Terms of Reference for Board Committees** 17.1 Audit Committee 17.2 Quality Governance 17.3 Finance, Investment and Performance 17.4 Workforce and Organisational Development 17.5 Quality Improvement Programme Board 17.6 Charitable Funds 17.7 Nominations and Remuneration 17.8 Logistics and Infrastructure	Approval	HL	TAB 16
	17.	**Report from Trust Secretary**	Information	SA	TAB 17
	18.	**Trust Board Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 18
	19.	**Questions from members of the public**		HL	
	20.	**Register of Interest** To note the register of interests	Information	SA	TAB 19
	21.	**Any other business**		HL	
	22.	**Meeting Closed** The meeting of the Trust Board in public closes		HL	
	23.	**Date of next meeting** The date of the next Trust Board meeting in public is on 31st January 2017.		HL	

London Ambulance Service NHS Trust

TRUST BOARD MEETING (PUBLIC)

DRAFT Minutes of the meeting held on Tuesday 4th October 2016 at 09.00am
in the Conference Room, 220 Waterloo Road, London SE1 8SD

Present:

Heather Lawrence	Chair
Fionna Moore	Chief Executive
Fergus Cass	Non-Executive Director
Jessica Cecil	Non-Executive Director
John Jones	Non-Executive Director
Nick Martin	Non-Executive Director
Bob McFarland	Non-Executive Director
Theo de Pencier	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
Briony Sloper	Interim Chief Quality Officer
Fenella Wrigley	Medical Director
Paul Woodrow	Director of Operations

In attendance:

Sandra Adams	Director of Corporate Governance/Trust Secretary
Karen Broughton	Director of Transformation, Strategy and Workforce
Lesley Stephen	Improvement Director, NHS Improvement
Tony Birkett	Ernst & Young LLP (for item 118 only)

Members of the Public:

Malcolm Alexander	LAS Patients' Forum
John Martin	Member of Public – left at 10am
Ross Lydall	Evening Standard
Darryl Smith	Ferno UK Ltd
Dean Spencer	NHS Improvement

Members of Staff:
Anna Macarthur

99. Welcome and Apologies

99.1 The Chair welcomed all to the meeting. There were no apologies for absence.

100. Declarations of Interest

100.1 There were no declarations of interest in matters on the agenda

101. Minutes of the Board meeting held on 26th July 2016

101.1 The minutes of the meeting held on 26th July 2016 were approved as a true record of the meeting subject to minor amendments to 78.1 and 90.6.
Action: Sandra Adams
Date: 29th November 2016

102. Matters Arising

102.1 The Trust Board reviewed the action log and noted the following:
81.6 – Karen Broughton reported that the North East London sector was of most concern regarding long term sickness levels and a summary of the issues and actions was being worked through. She confirmed this would be a targeted approach and she would provide a full summary

to the next meeting of the Workforce Committee. The Chair asked for a trajectory for reducing sickness levels with an emphasis on long term sickness, by sector.
Action: Karen Broughton/Mark Hirst
Date: 25th October 2016

81.8 – Fenella Wrigley confirmed the annual report on cardiac care was in the final stages of writing and would include STEMI on scene times. The report would be submitted to the next meeting of the Quality Governance Committee.
Action: Fenella Wrigley
Date: 15th November 2016

63.3 – Fergus Cass confirmed that the Workforce and Organisational Devgelopment Committee had discussed the staff equality and inclusion issues and the position had moved forward. Action closed.

63.5 – Melissa Berry and Mark Hirst had met with Malcolm Alexander to discuss the ethnicity of complainants. The Chair asked to see this included in future complaints reports. It was noted that the PTS issue had been followed up with Nic Daw.
Action: Briony Sloper
Date: 29th November 2016

103. Report from the Chair

103.1 The Chair added that she had also gone on a rideout with 2 Advanced Paramedic Practitioners which had been interesting and she had particularly noted delays in handover at 2 hospitals.

103.2 John Jones asked about the governance arrangements for the Blue Light Collaboration programme and the Trust Board agreed that, as this tied in with a number of procurement issues, the local programme board would report to the Finance and Investment Committee.
Action: Sandra Adams to include governance on Blue Light Collaboration in the planner for the Finance and Investment Committee and the Board governance structure:
Date: 25th October 2016

103.3 The Trust Board noted the Chairman's report.

104. Report from the Chief Executive Officer

104.1 Fionna Moore provided an overview of progress and events within the Service since the last time the Board convened. Fionna Moore responded to a question from the Patients' Forum regarding the approach to gaining consent and also the provision of information for survivors about the outcome of the trial: *When a person is unconscious due to their cardiac arrest we can't ask permission about their treatment or obtain consent in the immediate emergency situation as resuscitation must be started without delay. Due to the urgent need for treatment we are not able to ask a relative or friend, should there be anyone else on scene. If a person survives the initial cardiac arrest and is admitted to hospital they will be informed about the trial as soon as is practically possible in consultation with the clinical team caring for them. If the person is unable to consent to continuing to take part in the trial their next of kin will be informed about the trial and their agreement sought in line with legal and ethical requirements.*

The trial is expected to take around four years and is due to finish in August 2018. We will share the results of the trial with other healthcare professionals and will publish the results of the trial in medical journals. When any information from the trial is published it will not contain personal information, and it will not be possible to identify individual patients. We will endeavour to make sure the results of the trial are shared widely, including with surviving participants if they wish, once the trial is complete.

104.2 Fionna Moore reported that with effect from today NHS ambulance services would have up to 240 seconds to reach the final disposition on dispatch to a call. Red calls would not be entered into this and there was unlikely to be any impact on patients or performance.

104.3 Category C performance was improving and there was dedicated resource within the control room to ensure the welfare of patients in this category. Where there was concern that a patient's condition might be deteriorating then the call would be upgraded to a Red3 response.

104.4 Fionna Moore confirmed that all non-executive directors had viewed the NARU awareness video which provided an overview of Board responsibilities in relation to HART, MTFA and CBRN.

104.5 Fenella Wrigley reported on the recent CQC inspection of the LAS 111 service which was the first London 111 service to be inspected. The high level feedback at the end of the 2 days was positive and the CQC confirmed they had found nothing of regulatory concern. Fionna Moore acknowledged the significant amount of work undertaken by the team at LAS 111 and by Fenella Wrigley and Karen Broughton and team.

104.6 The Chair added that the Trust Board could be assured that there was no bullying and harassment culture at LAS 111. She had witnessed a good open atmosphere and good line management.

104.7 The Trust Board noted the Chief Executive's report.

105. Integrated Performance – September (August data) 2016

105.1 Andrew Grimshaw presented the Integrated Performance Report providing organisational oversight of all key areas across the Trust. He noted that the report had been consistent with previous months. Delivery of care continued to be safe but quality of service remained challenged at times.

105.2 Ten serious incidents had been declared out of 50 reviewed during the period. Two investigations were overdue the 60 day target and had been escalated to the executive leads for action.

105.3 The Trust had remained at Surge Red with 3 periods of Surge Purple Enhanced at August Bank Holiday weekend.

105.4 A8 performance ended at 67.43% against the trajectory of 67.08%. The Trust had successfully achieved above trajectory for 5 consecutive months but was failing to meet the target in September, primarily due to the high level of demand which was 8.5% above plan.

105.5 Category A activity was 7.4% above plan and it was noted that the plan included 4% growth on the previous year. Andrew Grimshaw reported that the Trust was struggling to address the increase in demand. The level of activity was impacting on the financial position due to increasing staff numbers to address earlier demands on capacity but we were unable to address current demand and were working with the clinical commissioning groups (CCGs) to: mitigate and address demand pressures; identify how productivity could be improved; and discuss the potential for any additional funding.

105.6 In terms of workforce, the vacancy rate was now based on 100% establishment and had continued to improve from 7.3% to 6.9%.

105.7 The LAS 111 service had achieved 95.9% of calls answered within 60 seconds in August against the target of 95%.

105.8 *Performance*

Theo de Pencier asked whether there was any analysis available to indicate whether the demand increase was a blip or a trend. Andrew Grimshaw responded that there had been a step change in demand and the analysis of the drivers indicated this was not uniform across London. The principle increase was from 111 services, other health care professionals and the Metropolitan Police Service (MPS). The elderly represented the largest volume of the increase in patient groups however the was also an increase in demand on 111 services for the 20-30 year old group which could indicate they were more proactively interfacing with the service. There was greater pressure in outer areas of London and the Trust had developed a set of interactive tools to drill down in particular areas of demand in CCGs. The Chair asked that a session be arranged for non-executive directors once these tools were all set up.
Action: Andrew Grimshaw
Date: 29th November 2016

105.9 Nick Martin asked to what extent the Trust could re-open discussions with commissioners to which Andrew Grimshaw responded that CCGs recognised the pressures but there were many pressures across the system and he referred to his earlier comment about the actions underway. He added that the Trust was mobilising as many staff as possible and that additional funding wouldn't necessarily help at this time.

105.10 Jessica Cecil asked whether we could use 111 to mitigate demand where we had control of the service and Andrew Grimshaw acknowledged that there was differential performance across 111 providers and some scope for improvement.

105.11 Bob McFarland challenged that the Trust should have seen this pressure coming back in April. Andrew Grimshaw confirmed that this had been seen and the Trust had been planning to meet the increased demand and had flagged this uncertainly earlier in the year. The Chair stated that these issues should be risk assessed and proactively mitigated to address them before they had impact and she cited workforce as an example. This led to discussion about understanding the true level of staffing needed and getting the planning right. The Chair asked whether the 32% abstraction rate built into rosters could be lower and whether, despite the relief rate being lower than other ambulance services, it could be lower still. The following actions were then identified for the executive to address and to inform the contracting round:

- Assess the optimum staffing levels to meet demand an plan appropriately for this taking into account the following 2 factors:
- Reduce the abstraction rate
- Reduce the relief factor
- Risk assess this
- Arrange a briefing for non-executive directors
- Check whether the turnover figures include staff moving to other posts within the Trust and if so, remove these if they shouldn't be counted.

Action: Mark Hirst/Karen Broughton/Paul Woodrow
Date: 25th October 2016

105.12 Fergus Cass summarised the position as one of capacity, cost and performance against the challenges of higher demand and not meeting the Red 1 performance target, and he asked whether there was additional third party provider capacity that we could seek and utilise to improve performance. Andrew Grimshaw confirmed that the Trust was looking at the mix of staff and how we could mitigate some of the higher cost resource in order to expand the broader response. The Chair added that we could translate hospital handover delays into freeing up LAS vehicles to improve Red 1 performance figures as part of the discussion with CCGs and our response to Winter planning. Paul Woodrow confirmed that the Trust had been working with NHS Improvement since February 2016 to hold 14 acute Trusts to account on account of hospital handover delays. It was noted however that this had now been in place for 8 months.

Theo de Pencier asked whether utilisation was still a valid measure and warranted focus, and

105.13 whether utilisation of third party providers was as high. Paul Woodrow responded that we used the latter to respond mainly to Category C calls; utilisation of ambulances was high due to the level of demand but productivity improvements would release some additional capacity.

105.14 Andrew Grimshaw stated that NHS England had asked CCGs to target a 5% reduction in demand for the rest of the year. The Chair requested a plan for this and a mitigating plan in the event that this didn't happen. Andrew Grimshaw summarised 4 areas of focus that he had outlined at the recent Finance and Investment Committee meeting:

- Demand management
- Productivity
- Optimising capacity
- Freeing up additional internal resource – the executive team would be looking at a range of options to address this.

Action: Andrew Grimshaw
Date: 25th October 2016

105.15 Fergus Cass asked whether the pressures would impact on the clinical team leader role and achievement of objectives such as undertaking appraisals. Paul Woodrow confirmed that the 50:50 role was still being met and team leaders were delivering in line with objectives.

105.16 Lesley Stephen commented that the CPI completion rate appeared to be declining and Briony Sloper confirmed that this had been a trend recently for mental health and safeguarding CPIs and she was working with clinical team leaders to ensure feedback was being given and she was also working on a range of different approaches plus the job cycle time programme would help. The Chair asked whether 95% completion would be achieved and Briony Sloper confirmed that improvements would be achieved. The Chair asked Briony to work on actions to deliver 95% in safeguarding CPI.

Action: Briony Sloper to develop actions to deliver 95% CPI completion rate in safeguarding.
Date: 31st March 2017

105.17 Theo de Pencier asked whether staff capacity could be moved to areas where there was a shortfall. Paul Woodrow responded that staff in south west London had been offered permanent lines elsewhere and the transfer register was monitored weekly. Third party and bank staff capacity was also deployed to different areas.

Quality

105.18 Fenella Wrigley drew the Board's attention to several items in the quality section of the integrated performance report: 2nd CSR had commenced and was focussed on advanced life support and ensuring everyone was trained and confident; the complaints response time was improving with fewer now exceeding 35 days; she noted thanks to Dave Fletcher, Darzi Fellow, for his work on frequent callers and that the project had now finished but would be included in contract negotiations for next year; a CPI had been introduced for identifying sepsis and there was good compliance which was being monitored plus guidance had been shared with 111 providers; and that the Trust continued to hold and attend public events which was a useful way to encourage the public to think about working for the LAS. Fenella also reported on the Warning Notice review by the CQC and the inspection of LAS 111 last month.

105.19 Lesley Stephen asked about the increase in the STEMI care bundle to 73% and the contrast with the cardiac care bundle. Fenella Wrigley reported that the Trust had pulled out of administration of analgesia as the proximity of emergency departments in London and the other drugs administered often meant patients didn't need the additional analgesia; she confirmed that LAS was reasonably comparable with other urban areas.

Jessica Cecil asked for clarification of the on scene times for stroke patients to which Fenella Wrigley explained that there was added complexity for this group of patients and work was

105.20 underway to provide guidance to crews on what needed to be done on scene and on the way to hospital in order to start moving the patient as quickly as possible and to get them to the right place within 60 minutes. Paul Woodrow added that the job cycle time programme included review of response profiles and the resources on scene.

In response to a query from Fergus Cass about cardiac arrest response times, Andrew Grimshaw agreed to clarify and amend the statement in the report.

105.21 **Action: Andrew Grimshaw**
Date: 29th November 2016

The trend in serious incidents was queried as to whether this was a result of increasing demand or more reporting or another reason and therefore of concern. The Board was told that the
105.22 serious incident group was reviewing more safety incidents as a result of increased reporting and the numbers declared felt about right. The KPI would be updated to show the number of declared serious incidents as a proportion of total activity and of the total number of safety incidents reported for the period and would be incorporated in the lessons learnt report in order to show the increased reporting and the flow of learning. Bob McFarland confirmed that the Quality Governance Committee received a quarterly report on learning and he welcomed the increase in willingness of staff to declare clinical incidents but cautioned that this should be monitored. Fenella Wrigley also gave a commitment that 90% of the outstanding actions resulting from serious incidents would be dealt with and closed by the November meeting of the Quality Governance Committee.
Action: Fenella Wrigley and Sandra Adams
Date: 29th November 2016

Fenella Wrigley reported that the role of the Advanced Paramedic Practitioner (APP) would be
105.23 included in the clinical strategy as she considered each tier of clinical support and the increase in skills and knowledge required. For example, APPs were dispatched to a cardiac arrest where additional skills or intervention may be required. The next cohort of APPs would be urgent care focussed.

Finance

Andrew Grimshaw reported that the £6.6m control total was at risk if the current pattern of spend
105.24 was maintained. Cash was under pressure and the Trust was awaiting confirmation of income lines from NHS England and commissioners.

The Chair asked whether the cost improvement plans (CIPs) had now been identified and
105.25 Andrew Grimshaw confirmed that plans for £9.5m CIPs were being finalised and he was working with the executive team on these. The Chair commented that the additional £0.5m should have been identified by now and she asked that the Board see the CIP plan and receive a paper on short term back office actions and other savings to achieve recurrent savings by the end of the year. Andrew Grimshaw would present the CIPs and quality impact assessments to the November meeting of the Quality Governance Committee. The Chair asked Fenella Wrigley and Briony Sloper if they could assure the Board that each identified individual CIP did not have an impact on quality and they confirmed this; Fenella Wrigley stated that they would need to look at the impact of all CIPs together and to review the project plans.
Action: Andrew Grimshaw, Briony Sloper and Fenella Wrigley
Date: 29th November 2016

Workforce

Karen Broughton drew the Board's attention to the key points: vacancy rates were now being
105.26 reported against 100% establishment; EOC turnover had reduced by 4% over the past year and paramedic turnover was now at 8.5% and this gave a positive indication that the position was improving particularly as turnover affected capacity and staff morale. Karen also reported that: over 50 workshops on bullying and harassment had been delivered to staff; the 3 year programme of rolling DBS checks was now in place; sickness levels remained at 5% but more

focussed work was underway to address specific areas; the number of assaults on staff had reduced in August; and the staff survey was out to staff now and would close in early December with the results available in February 2017.

105.27 John Jones asked for appraisal rates to be included in future reports; Karen Broughton confirmed that the Trust appraisal rate stood at 57% at the end of September of which the corporate rate was 89% and operations 53%. The Chair stated that 65% would still be at the lower end of the national rates and she wanted to see this increase to the levels of other ambulance trusts (67%) and to acute trusts (85%).
Action: Karen Broughton and Mark Hirst
Date: 29th November 2016

105.28 The Chair asked whether reducing turnover in EOC to <10% was part of the strategic plan and Paul Woodrow confirmed this, particularly in call handling. A clearer career structure was needed in EOC and we were seeing a number of EOC staff move onto roles in the non-emergency ambulance transport service and as trainee emergency ambulance crew.

105.29 The Trust Board noted the report.

106. Quality Improvement Programme (QIP)

106.1 Karen Broughton presented the nine-month status report outlining the delivery of the QIP together with the progress and KPI reports for August. In the 9 month period 125 actions had been delivered which equated to 67% of the programme deliverables and it was now time to consider whether to continue with the programme as currently placed and whether the actions are making a real difference as we prepare for the CQC inspection in February 2017.

106.2 The Chair recognised that a lot of work had been undertaken and that significant improvements could be seen but that it was also important this was having impact.

106.3 The Trust Board noted the reports.

107. Progress report on compliance with CQC domains

107.1 Lesley Stephen presented a paper on her assessment of progress in improving services in line with the CQC inspection recommendations from November 2015. There had been 3 focussed Board sessions recently on the QIP and the overall improvement journey over the past 9 months and there were now 5 months to prepare for inspection in February 2017. The key question was whether the executive focus would deliver enough improvement to support the Trust stepping out of special measures and to continue the improvement journey beyond this. The aim of the paper was also to help the Board focus on its role in driving strategy and holding the executive to account.

107.2 Lesley Stephen outlined the 4 areas of challenge that needed increased pace:

- Deployment and distribution of the workforce
- Vehicle preparedness
- Medicines management and tracking end to end governance of drug packs
- Learning – how different aspects are drawn together for the Board to understand hot spots and areas for focus.

107.3 The report reconciled the work programmes of the QIP, the priorities identified by the Board, and the findings from the external Clinical Review and CQC Warning Notice inspection feedback, back to the CQC domains, and highlighted the areas most at risk of a poor assessment in February 2017. These areas were Safe, Well-led and Responsive and the report summarise the main issues in turn.

Safe

107.4 Staffing, frontline numbers and retention: the combination of deployment and distribution of staff, the relief system, and progress of recruits through induction reduce the potential impact that could be achieved on performance. Agreeing the optimum staffing levels and modelling for the next year was critical in the coming weeks. The Board needed to understand the scale and scope of the proposed relief roster review. The Trust was still at risk but having more plans in place to address some of the issues highlighted would improve the position.
Action: Paul Woodrow
Date: 25th October 2016

107.5 Medicines management: the proposed audits should help to assure the Board that the tracking and governance of medicines has improved.

107.6 Vehicle preparation: the plans presented to the Board appear likely to achieve CQC requirements for improvements in cleanliness and equipment provision.

107.7 Incidents: reporting rates are below those of other ambulance services; the rate of reporting is improving but the investigation and feedback loop and trend analysis processes were yet to develop as was the process for communicating lessons from incidents. There was evidence of changes to clinical policies and core skills training as a result of lessons learned.

107.8 In conclusion, the earlier forecast that the Trust could move to Requires Improvement from September 2016 remained and the Safe domain could be achieved if the Trust can secure the necessary short term improvements in medicines management, vehicle preparation and incident reporting.

Effective

107.9 Competent staff: the variability of local leadership had been frequently raised by crews and EOC staff but this may be addressed by the new leadership programme proposed for December and January. Lesley Stephen urged the executive team not to commission a potentially costly leadership programme without being clear on the areas of focus and the individuals needing to attend. She also commented that there was no talent management programme in place. Management roles need to be well articulated and with support to discharge the role effectively otherwise there could be a lost opportunity with certain groups of staff if this wasn't determined.

107.10 Access to information: there was no agreed mobile technology or data development strategy in place and a paucity of mobile devices and modern technology such as the use of apps. Lesley Stephen encouraged the Board and Finance & Investment Committee to consider this and to give careful consideration to the independent report on IM&T.
Action: Andrew Grimshaw
Date: November FIC

107.11 In conclusion, the above issues were considered a risk area and the Trust was likely to remain at Requires Improvement for this domain.

Well-led

107.12 The CQC would look at 4 areas: strategy, leadership, culture, and staff engagement.

107.13 Strategy: this was not well articulated in the organisation and the Board would need to focus on this.

107.14 Leadership: the executive team was not yet at full capacity and Lesley Stephen recommended that where interim/acting arrangements are in place, roles are adequately backfilled.
Action: Heather Lawrence/Fionna Moore
Date: 25th October 2016

107.15 Culture: the dialogue with staff had shifted from bullying and harassment to a more latent sense of disengagement from management and frustrations at day to day issues such as poor vehicle preparation and relief shift patterns. The Trust needed to be mindful of the staff morale issue; staff communication had improved but staff engagement was still deemed low yet should be part of core responsibilities of the leaders of the organisation.

107.16 In conclusion, the Trust had made progress in areas of this domain but remained challenged in the development of local leaders and active engagement with staff. Lesley Stephen urged the Board to consider the capacity of the executive team.

107.17 Lesley Stephen was forecasting that the LAS would exit special measures in February 2017; the Board would want to assure itself on:

- The distribution of the workforce
- Vehicle preparation and delivery
- Medicines management logistics and tracking and auditing to demonstrate strong governance in this area
- Incident reporting and learning.

She concluded the report saying that the Trust was set on a longer term journey of continued improvement towards 'Good'. This was possible but there were some risks.

107.18 Fionna Moore responded that the report was comprehensive with a lot of positive aspects and work continued on areas of focus to make a difference and there was a plan in place to monitor progress.

107.19 The Chair stated that there was a renewed focus now for the 2017/18 control target and concern about cash. Deployment of staff, rosters, annual leave, and rest breaks all required a lot of engagement with staff in working differently and the Chair would be looking for a weekly trajectory on progress to address the 4 key areas together with assurance to the October QIP Board that action plans were in place to address these.
Action: Karen Broughton
Date: 11th October 2016 QIP Board

107.20 Nick Martin commented that there needed to be a longer term solution to building the workforce. He asked whether there were lessons to be learnt from elsewhere on vehicle preparation; and he commented that there had been progress with developing a career path. The Chair confirmed that the executive had looked at other services in terms of vehicle preparation, make ready, and estates.

107.21 Paul Woodrow acknowledged the potential for proactive line management and said that the expectations for Clinical Team Leaders had increased and there was a need now to consider whether to change some elements of the role thereby allowing them more time to engage with staff. The Chair asked that a Board session be held on the proposals for the Clinical Team Leader role and the implementation plan for this once the executive team had signed this off.
Action: Paul Woodrow
Date: 12th December 2016

107.22 The Chair summarised that there was a clear list of actions including assurance at the Board and recruitment to executive appointments. The strategy needed to be developed and articulated and should include sustainability and STPs, and this would need Board focus.
Action: Karen Broughton
Date: 25th October 2016

108. <u>Quality Governance Committee Assurance Report</u>

108.1 Bob McFarland presented the assurance report on the meeting of the Quality Governance

Committee meeting held on 13th September 2016. A number of the issues had already been covered in the integrated performance report item however he commented that there remained concern about an apparent disconnect between what was heard at the Board and what was actual and he cited the outstanding safeguarding actions as an example.

108.2 Bob McFarland recommended to the Trust Board for approval the Mental Health annual report 2015/16.

109. Mental Health Annual Report 2015/16

109.1 Briony Sloper presented the report which had been approved by the Mental Health and Quality Governance committees. The report had been delayed due to data quality issues where the Trust had been under-reporting in some areas, and the Mental Health lead had been absent. The Mental Health committee would sign off the 2016/17 action plan this month.

109.2 Briony Sloper confirmed that more Mental Health nurse posts had been created so there were currently more vacancies; going forward she would like to see these posts being incorporated in operational shifts and the delivery of care and training, and she was talking to the Mental Health trusts about creating rotational posts.

109.3 The Board agreed this was good report and asked Fionna Moore to consider the fall back for roles where there was only one person in post.
Action: Fionna Moore
Date: 29th November 2016

109.4 In response to the question from the Patient Forum:
Will the Board consider the development of a cadre Advanced Paramedics specialising in mental health care, to support people in a mental health crisis and people detained under s136 of the Mental Health Act?

There was currently no recognised specialist role in mental health for paramedics but should this role be developed we would be supportive. In lieu of this we have employed registered mental health nurses directly who, as well as proving expert support to patients in mental health crisis are able to provide enhanced training and support to other LAS staff. A recent survey of staff highlighted benefits as:

- 80.87% of EOC staff have found the presence of RMNs beneficial to support their interpretation and management of mental health scenarios
- 84.61% of EOC staff felt that RMNs have a key benefit including improved patient assessments and support to manage these calls effectively
- 73.03% of EOC staff felt that RMNs have improved access & communication with external agencies in relation to mental health
- 50% of EOC staff felt that RMNs have impacted on their individual learning , confidence & knowledge about MH presentations

109.5 The Trust Board approved the 2015/16 Mental Health annual report.

110. Finance Report Month 5

110.1 The Trust Board noted the Finance report taking into account the earlier discussion under the Integrated Performance Report.

111. Assurance from Finance and Investment Committee

111.1 John Jones presented the assurance report from the meeting held on 22nd September 2016 and drew the Board's attention to the cash forecast position for 2016/17 and 2017/18. If the target deficit position of £6.7m was not met then the position in 2017/18 would be difficult as we could

not afford more deficit in future years. The new control on agency spend was in place and, although tight, should be manageable. This would be monitored in the monthly finance report. The Chair commented that the Trust needed to learn to live within its resources and referred back to the earlier discussions on CIPs.

112. Resilience

112.1 Paul Woodrow presented the paper on compliance with the annual Emergency Preparedness, Resilience and Response self-assessment. The Trust had developed an action plan with support from NHS England to improve on compliance from the 2015/16 assessment of partial compliance. The 2016/17 self-assessment had been submitted on 14th September and meetings were planned for 17th October and early November with NHS England to discuss this further before submitting the final assessment in late November. The Trust was aiming to achieve substantial assurance and further work was required on the biggest risk areas of HART staffing and the estate specification to be able to realise this. Fionna Moore confirmed the self-assessment position and that we were checking number of issues with NARU and other ambulance services where there was some ambiguity of interpretation of compliance.

112.2 Fergus Cass commented that part of the assurance to the Board needed to be about the capability to respond to a major emergency and he asked whether our systems and processes would work well in such an event. Paul Woodrow confirmed that the assessment covered all elements of resilience and he could give assurance that: exercise timetables and training records were much improved; the Trust had been involved in multi-site incidents this year; the number of Gold commanders had been increased and training for silver and bronze had been updated. He would be looking to review all the evidence behind a substantial assurance assessment.

112.3 Karen Broughton suggested the development of a set of KPIs to provide the required assurance and commented that there would be time after the meetings with NHS England to take any further action before the final submission. The Chair asked whether the Deputy Director – Central Operations was absolutely clear about his responsibility and accountability in this area and Paul Woodrow confirmed that he was.

Action: Paul Woodrow to establish a set of KPIs to monitor progress with compliance against standards and provide Board assurance.
Date: 25th October 2016

113. Assurance from the Workforce and Organisational Development (Workforce) Committee

113.1 Fergus Cass reported that the planned meeting in September had been postponed due to the staff engagement work on job cycle time. As the Committee Chair he had reviewed the performance of the committee against the terms of reference and was able to give assurance on some areas but not all although he was also able to confirm that the Board received assurance from other sources as well.

113.2 The review had identified a number of areas of focus including the development of a set of workforce risks, and Fergus Cass wanted to improve the administrative support to be as well organised as other Board committees. Sandra Adams would work with HR on good practice in this area.

Action: Sandra Adams
Date: Next Workforce Committee meeting

113.3 The Trust Board noted the report from the Chair of the Workforce Committee.

114. Assurance report from the Audit Committee

114.1 John Jones presented the assurance report from the Audit Committee meeting held on 5th September 2016 and drew the Board's attention to progress with actions to mitigate BAF risk 29

since the meeting was held and from the discussions at the recent Quality Governance Committee. Attention was also drawn to the high vehicle accident rate and the Accident Reduction Group set up to oversee this. Significant assurance had been given on the recent internal audit review of data quality which was very positive. The Auditor Panel had met to discuss the specification for the appointment of the external auditors and a report would be given to the November Trust Board.

The Trust Board noted the report on the Audit Committee.

114.2 **Annual Audit Letter 2015/16**

115. John Jones reported that the Audit Committee had considered and accepted the annual audit letter presented by the external auditors and he commended this to the Board.

115.1

The Trust Board accepted the Annual Audit Letter 2015/16 and congratulate the Finance team on the outcome.

115.2

Board Assurance Framework and Trust Risk Register

116. Sandra Adams reported on progress with the actions underway to mitigate the key risks currently facing the Trust.

116.1

Paul Woodrow outlined the mitigating actions for BAF risk 20 – ring backs: ORH had been asked to update their previous assumptions on staffing levels and this was due back the following week.

116.2 The additional posts would be funded through the QIP and the number of call handlers would need to increase to meet this function. Paul Woodrow confirmed the risk needed to be reviewed and re-described.

Action: Paul Woodrow
Date: 29th November 2016

Fenella Wrigley confirmed that other processes were in place within EOC such as flags for vulnerable people if alone but if they were with someone then other instructions would be given.

116.3 There was better oversight in place for patients at risk. Fionna Moore added that she had agreed with the Deputy Director, EOC that a daily record of ring backs would be maintained.

Jessica Cecil asked whether the target date of 31st March 2017 was still realistic and Paul Woodrow confirmed that it wasn't now, given the number of staff that would be recruited.

116.4

The Patients Forum raised the following question:

What actions are being taken to mitigate risks associated with Category C1 performance (53%),

116.5 *which is resulting in long waits for vulnerable people? Are there opportunities for closer work with CCGs, community organisations and 'specialist first-response' teams to support people during these long waits?*

Paul Woodrow responded:

Category C performance is improving as our staffing levels increase month on month. The Clinical Hub has been reconfigured and now reviews all held calls and there is a dedicated

116.6 resource to oversee patients in the vulnerable person category, e.g Mental health and elderly fallers. Held calls from NHS111 providers are treated in the same way. We are working closely with all STPs to manage demand for ambulance resources for lower acuity cases to maximise our operational resource availability for the higher Category C calls and Red calls.

In response to a question about the format of the BAF, Sandra Adams confirmed that the BAF should reflect the strategic objectives and the key risks to these. There should be more focus on

116.7 the mitigating actions and the impact these were having on the risk level. The old risks on the

BAF needed a fundamental review and Andrew Grimshaw added that risks tended to be looked at on a piecemeal basis rather than looking at key objectives in key areas and understanding the risks associated with these. The Board committees could review and inform this more and in particular by asking whether we were doing well enough against some of the key objectives. Heather Lawrence commented that this reflected the earlier comment about mitigating actions and that the current risks could be interpreted as difficult issues added to the BAF and left there. Lesley Stephen added that the BAF should reflect the risks to the strategic objectives and was not the risk register itself. Further work was required on the BAF and the risks allocated to sub-committees for further review. It was agreed that the operational risks that shouldn't be on the BAF and those risks > 2 years old should be brought back to the Board.
Action: Sandra Adams
Date: 29th November 2016

117. Risk Appetite Statement

117.1 Sandra Adams presented the risk appetite statement that had been developed through the committee structure and recent Board working sessions.

117.2 Bob McFarland commented that the proposed statement suggested the Board was quite risk averse. Andrew Grimshaw responded that there was a fundamental difference between being risk averse and taking reasonable mitigation to control and manage risk. Heather Lawrence said that the statement reflected the highly regulated environment within which we operate, the NHS financial position, and the role of corporate decision-making, and acknowledged that innovation could be added.

117.3 Theo de Pencier commented that this was an excellent document on a complex area and that the fundamental flow through worked well. He said that this type of organisation would have a low appetite for risk but that didn't have to stifle innovation. Fergus Cass added that this was looking at risk after reasonable mitigation had been taken; the risk appetite would apply after mitigating action had been taken. Jessica Cecil said that innovation was an enabler and moderate risks would emerge from this.

117.4 In terms of communicating the risk appetite to managers and staff, it was important to set the frame to how we deal with risk and that, if effective, it could support people to be more autonomous and to support risk management and corporate decision-making. Sandra Adams would work on this with Communications and further develop the risk appetite statement for discussion at the November Board.
Action: Sandra Adams
Date: 29th November 2016

118. IM&T Strategy Review

118.1 Tony Birkett from Ernst & Young LLP (EY) attended the meeting to present the outcome report of the independent review of IM&T in the Trust. In summary the Trust was standing still and not taking a clear strategic view on what technology could offer going forward. He commented that the Trust had received a very good report from PA Consulting in November 2015 and he expressed the view that he would have expected the report and recommendations to have been taken forward by the executive. This would have included a forward plan, the appointment of key personnel to stabilise systems, and development of the strategy.
Following the appointment of the substantive Chief Information Officer (CIO), it would have been usual to expect a 100 day plan and development of the strategy, together with engagement of senior personnel in identifying business needs and prioritising these together with costed options for their delivery. The EY review had identified that the key appointments of two senior personnel: one to lead the CAPEX programme and any Digital Pilots, and one to build and lead the IT SLA for the business, had not been made; the target operating model (TOM) had not been developed; there was no clear strategy; and leadership needed reinforcing with the CIO owning

the business process.

118.2 The Trust needed a clear 100-day plan on tackling some of the immediate issues and then a 12 month plan, and an overall strategy and costed plan in the context of CAPEX. The Board did not feel there was the capability to do this internally at present. In response to a question from the Chair, Tony BIrkett thought this work could be completed in 4 weeks and he would be concerned about the Trust putting investment in without completing this work first. Andrew Grimshaw confirmed that an outline capital plan had been identified on the back of the PA Consulting report and was included in the 5-year plan.

118.3 Paul Woodrow commented that he was not yet assured that the critical systems were robust enough and that maintenance of current systems needed to run in parallel with the strategy development.

118.4 In summary, the Chair reported that the following needed to be taken forward:

- Develop a 100-day plan
- Draft a strategy that was linked to the overall strategy
- Maintenance of critical systems
- Developing a 21st century call centre
- Developing an urgent care hub
- Have bids ready in the event other funding sources became available.

118.5 The executive team would take forward:

- Work across the next 4 weeks to develop the 100-day plan
- Develop the strategy
- Develop the plan and costings to meet this.

Action: Fionna Moore
Date: 29th November 2016 with an update on progress to the board strategy meeting on 25th October.

119. <u>Update on the Workforce Race Equality Standard (WRES)</u>

119.1 Mark Hirst presented the update on progress against the WRES action plan. He confirmed that he and Melissa Berry had met with the Patients Forum and reassured them that the issues were being addressed. The executive team had given a commitment to the plan and had agreed additional funding to resource the work. Mark Hirst had secured funding from Health Education England for various projects including continuing professional development for BAME staff.

119.2 Heather Lawrence asked about the 6 actions agreed by the Board for prioritising and Mark Hirst confirmed these were all covered within the report. He also reported that the WRES group had met for the first time on 30th September and had discussed establishing a talent management group, BAME group, additional resources, and ring fencing places within the LAS Academy.

119.3 The Board agreed that the Workforce and Organisational Development Committee would have oversight of the WRES and progress would be reported in the monthly performance report and through the Committee Chair's assurance report.
Action: Karen Broughton
Date: 29th November 2016

120. <u>Strategy and Business Planning – NHS Operational Planning Guidance 2017 – 2019</u>

120.1 Karen Broughton presented the item and reported that the guidance included 9 'must do' priorities for 2017-2019; the national timetable was set to ensure that contracts were aligned to Sustainability and Transformation Plans (STPs) and signed by 23rd December 2016 and the LAS would need to ensure that our plans support delivery of STPs. There was an expectation that systems balance financially and this was outlined in the section on efficiency and balance. A number of issues that would have to be included in the Trust's planning were outlined towards the end of the report, and there was a timetable outlining the internal governance and assurance processes intended to enable the Board to drive expectations of what we would want to see in the contract.

120.2 Heather Lawrence asked if there would be 5 contracts, 1 for each STP across London, and Karen Broughton confirmed there would be no change to the lead contracting arrangement with Brent and this had been raised with commissioners. It was possible that the environment would evolve with authority delegated to STPs and it was recognised that there were changes emerging with buddying up for Trusts in special measures and hospitals aligning. There was a focus on Board accountability and decision-making. The LAS leads for each STP were noted as follows:

120.3 South West London: Karen Broughton and Sandra Adams
South East London: Paul Woodrow and Mark Hirst
North East London: Briony Sloper and Andrew Watson
North West London: Fionna Moore and Charlotte Gawne
North Central London: Andrew Grimshaw and Jill Patterson.

120.4 Andrew Grimshaw confirmed that the financial control total had been revised and received on 30th September:
2017/18 - £1.927m deficit including £1.94m general sustainability funding; and
2018/19 - £ 1.596m surplus including £1.94m general sustainability funding.

121. Freedom to Speak Up

121.1 Sandra Adams presented the report on implementing Freedom to Speak Up and the launch of the Speak Up campaign in October.

121.2 The Trust Board noted the report and agreed the governance route through the Workforce and Organisational Development and Quality Governance Committees.

122. Report from Trust Secretary

122.1 The report from the Trust Secretary was noted.

123. Trust Board Forward Planner

123.1 The following items would be added:

- HES report – Karen Broughton would send the report to Board members for comments on the recommendations to be sent through to the Workforce and Organisational Development Committee.
  Action: Karen Broughton/Fergus Cass
  Date: 29th November 2016
- EPRR – a quarterly assessment would be submitted to the Quality Governance Committee and then added to the agenda of the next Trust Board meeting.
  Action: Paul Woodrow
  Date: 31st January 2017

123.2 The Trust Board noted the forward planner.

124. Register of Interest

124.1 There were no changes recorded since the previous Trust Board meeting.

125. Questions from Members of the public

125.1 These had been covered in earlier discussion.

126. Any Other Business

127.1 There were no items raised.

128. Date of Next Meeting

128.1 The next meeting of the Trust Board would be on Tuesday 29th November 2016 at 09.00am in the Conference Room, Waterloo.

Signed…….

ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
Date of schedule: 5th October 2016

Meeting Date	Minute No.	Action Details	Responsibility and date	Progress and outcome
04/10/16	**103.2**	**Blue Light Collaboration – governance arrangements** Sandra Adams to include governance on Blue Light Collaboration in the Finance and Investment Committee planner and Board governance structure	**SA** **25th October 2016**	
04/10/16	**102.1**	**Integrated performance – August 2016: Complaints** Briony Sloper to include ethnicity monitoring data in future complaints reports.	**BS** **29th November 2016**	
04/10/16	**102.1**	**Integrated Performance – August 2016: Sickness levels** Mark Hirst to produce a trajectory for reducing sickness levels with an emphasis on long term sickness, by sector.	**MH** **25th October 2016**	
04/10/16 26/07/16	**102.1** **81.8**	**Integrated Performance – August 2016: STEMI** Fenella Wrigley to provide a report on scene time for STEMI patients to the next Quality Governance Committee.	**FW** **15th November 2016**	
04/10/16	**105.8**	**Integrated Performance: Demand analysis tools** Session to be arranged for non-executive directors.	**AG** **29th November 2016**	
04/10/16	**105.11**	**Integrated Performance: Workforce planning** a) Assess the optimum staffing levels to meet demand and plan appropriately for this taking into account b) and c) below b) Reduce the abstraction rate c) Reduce the relief factor d) Risk assess this e) Arrange a briefing for non-executive directors f) Check whether turnover figures include staff moving to other posts in the Trust. If so, remove if they shouldn't be in there.	**MH** **KB/PW** **29th November 2016**	

04/10/16	**105.14**	**Integrated Performance: Demand management** Plan for CCGs to reduce demand by 5% and have a mitigating plan in place in the event this doesn't happen.	**AG** **25th October 2016**	
04/10/16	**105.16**	**Integrated Performance: Safeguarding CPI completion rate** Briony Sloper to develop actions to deliver 95%.	**BS** **31st March 2017**	
04/10/16	**105.21**	**Integrated Performance: Cardiac arrest** Amend the sentence on average time from 999 call to LAS on scene was 8 minutes to read 'target time……was 8 minutes'.	**AG** **29th November 2016**	
04/10/16	**105.22**	**Integrated Performance: serious incidents and incident reporting** a) Complete 90% of outstanding actions for serious incidents by the November Quality Governance Committee b) Add to the KPI report: SIs as a % of total activity for the period and as % of total number considered in the period; and total number of safety incidents reported in the period	**FW/SA** **15th November 2016** **&** **29th November 2016**	
04/10/16	**105.25**	**Integrated Performance: CIPs** Andrew Grimshaw to: a) present the CIP plan and quality impact assessments against each to the November Quality Governance Committee b) provide a paper on short term back office actions and other savings in order to achieve recurrent savings by 31st March 2017. Fenella Wrigley and Briony Sloper to consider the impact of the totality of CIPs to assess any impact on safety and quality.	**AG** **15th November 2016** **29th November 2016** **FW/BS** **15th November 2016**	
04/10/16	**105.27**	**Integrated Performance: appraisal rates** Karen Broughton to a) add appraisal rates to the KPI report and report to the October Workforce and OD Committee b) aim to increase appraisal rates to that of acute trusts (85%)	**KB** **29th November 2016**	

04/10		**CQC Preparation**		
	107.4	a) Board to receive details on the scale and scope of the relief roster review	**PW**	**Board strategy session – 25th October**
	107.10	b) Mobile devices: Board and FIC to consider investment in mobile devices and apps	**AG**	**FIC 24th November**
	107.22	c) Develop and articulate the strategy for the LAS and ensure Board focus on this; and to include sustainability and STP work	**KB**	**Board strategy session – 25th October**
	107.14	d) Board to consider executive team capacity	**HL/FM**	**25th October**
	107.19	e) Weekly trajectory on progress on addressing the 4 key areas	**KB**	**QIP Board – 11th October**
	107.19	f) Assurance to the October QIP Board that action plans for the 4 key areas are in place	**KB**	**11th October**
	107.22	g) Complete the executive appointments	**FM**	**31st December 2016**
04/10/16	**107.21**	**Clinical Team Leader role** Arrange a Board session on the proposals and implementation plan for the future role.	**PW** **13th December 2016**	Board strategy session - December
04/10/16		**Resilience**	**PW**	
	112.3	a) Establish a set of KPIs to monitor progress with compliance against standards and provide board assurance	**25th October**	
	123.1	b) Quarterly assessment to the Quality Governance Committee for assurance to the Board	**31st January 2017**	
04/10/16	**113.2**	**Workforce and OD Committee governance** Sandra Adams to share good governance practice with HR to support this committee.	**SA** **Date of next Workforce Committee**	
04/10/16		**Board Assurance Framework**	**SA**	
	116.7	a) Identify Board committees to review the top and long running BAF risks.	**29th November**	
		b) Review and re-describe BAF risk 29	**PW**	
		c) Operations risks and risk >2 years to be brought back to the Board	**29th November 2016**	

04/10/16	**117.4**	**Risk Appetite Statement** a) Update the statement from Board feedback for the November meeting. b) Further develop the managers' and staff guides with Communications.	**SA** **25th October**	
04/10/16	**118.5**	**IM&T Strategy** a) Work across the next 4 weeks to develop the 100-day plan b) Develop the strategy c) Develop the plan and costings to meet this.	**FM**	
04/10/16	**119.3**	**Equality and Inclusion** Add WRES progress to the monthly performance report.	**KB**	
04/10/16	**123.1**	**HES Report** Circulate to Board members for comments on the recommendations for the Workforce and OD Committee to consider.	**KB/FC**	
COMPLETED ACTIONS				
31/05/16	**63.3** **63.5**	**Workforce and Organisational Development Report** Fergus Cass to report about staff aspects of Equality and Inclusion. Karen to discuss with Malcolm those issues relating to Patient Experience across the organisation.	**FC** **MH**	Discussed at the July Workforce and OD committee and the work has moved forward. Melissa Berry and Mark Hirst met with Malcolm Alexander regarding the ethnicity of complainants. The PTS element has been followed up with Nic Daw.
31/05/16	**65.5** **39.12**	**Board Assurance Framework and Corporate Risk Register** Risk appetite statement – ongoing work and would be discussed at the Board strategy review in June.	**SA**	Risk appetite session on 6th September; a further session has been scheduled for 21st September.
26/07/16	**90.6**	To further discuss the WRES action plan.	**MH/MB**	Agenda 4th October 2016
26/07/16	**92.5**	Paul Woodrow to report to the Quality Governance Committee on the risk relating to staff change over times and lack of ring backs on delayed response.	**PW**	Quality Governance Committee 13th September 2016.
26/07/16	**88.6**	Fionna Moore/Charlotte Gawne to consider whether the Minutes of the Workforce Committee and other Committees would be published on the website. To respond to the Patient Forum.	**FM/CG**	Completed.

26/07/16	**84.8**	(i) Briony Sloper to provide an update on the action plans for safeguarding and infection control. (ii) Briony Sloper to develop a consistent format for future annual reports.	**BS**	Completed.
26/07/16	**84.4**	**Quality Governance Committee Assurance Report** Briony Sloper to provide an update on DBS.	**BS/MH**	Quality Governance Committee 13th September 2016.
26/07/16	**81.6**	**Integrated Performance – April 2016** Karen Broughton/Mark Hirst to make a follow-up; re – focus on long term sickness.	**MH**	Presented to the Private Board on 6th September.
26/07/16	**77.1**	**Minutes of the Previous meeting** Sandra to amend the minutes	**SA**	Completed.

London Ambulance Service NHS Trust

Report of the Chair – 29 November 2016

1. Care Quality Commission (CQC)

- **Requirement notice issued by CQC**

The Trust received a Requirement Notice from the CQC in relation Regulation 17(2) (b): HSCA Regulations 2014 specifically in relation to Medicines Management. The Trust has now responded in full to this Requirement Notice and the actions are part of the Quality Improvement Plan and Countdown plan to the re-inspection. The Board will wish to be assured that the actions will meet CQC requirements.

2. Well-led review

Board members will be aware that NHSI have asked that we engage Deloitte's to undertake a Well-led Review in advance of the CQC re-inspection visit on 7-9 February 2017. We are required to individually complete a survey online and to have a one-to-one interview with personnel form Deloitte's. In addition there is a meeting on 19 December. 2016 with the Executive Team and NEDs are also asked to attend.

The 360° feedback session has been arranged for Tuesday 13 December 2016.

3. Non-executive Directors recruitment

Saxton Bampfylde working with NHS Appointments has attracted a wide field of candidates and interviews will be held on 16 and 22 December.

4. Update from Association of Ambulance Chief Executives' (AACE) meeting 15-16 November 2016

Key issues discussed:-

- **Band 6**

The profile for the Paramedic Band 6 has been published and clarification on funding for the implementation of this is due soon.

- **Workforce Race Equality Standards (WRES)**

AACE is asking all Ambulance Trusts to formally commit to workforce race equality standards

Background

There has been a significant amount of robust evidence that suggests that the ambulance sector does not systematically ensure the equal treatment and high quality work experiences for BME employees. Additionally, the sector has struggled to employ and retain a workforce that is reflective of the communities that they serve.

Further to the presentation from Yvonne Coghill and Byron Currie from the NHS England WRES Team to the AACE on 19 July 2016, a national ambulance sector WRES Project has been initiated, led by Tracy Myhill CEO Wales Ambulance Service/lead Chief Executive to the AACE for Equality and Inclusion, supported by Byron Currie – Senior Programme Lead – WRES IT, NHS England. The following ambulance sector staff, who have relevant expertise, have made contributions to the project.

Consultation

This paper has been discussed at the National Diversity Forum Annual meeting and also the sector HRD network during October 2016 for consultation purposes. Several key comments received via the consultation process have been integrated into the paper.

Remit of the Project

The remit of the project is to develop a suite of WRES interventions and identify good practice that address some of the key areas for WRES development within the sector, as identified within the NHS England WRES Baseline Report (June 2016) and Trusts' own WRES template reports. It is anticipated that via the AACE, all Ambulance sector Trusts will sign up to, and commit resources to supporting the delivery of the agreed interventions within their Trust. It should be noted that Trusts are encouraged to also develop and deliver on local WRES interventions.

There are several proposed interventions that focus on Trust leadership and governance arrangements. These will be set out in the first instance, followed by specific proposed interventions relating to the prioritised WRES indicators, and with a particular focus on embedding and mainstreaming race equality across the Ambulance sector.

Board members will recall that in September we invited Yvonne Coghill and Roger Kline (Co-Directors – WRES Implementation team, NHS England) to our Board Strategy Session, one of four Trusts to engage directly following the previous AACE meeting where they had presented.

I have asked that a paper is prepared for the Board to actively commit to the AACE-wide work on this.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Chief Executive's Report**
Report Author(s):	**Daryl Belsey, Staff Officer to the Chief Executive**
Presented by:	**Fionna Moore, Chief Executive**
Contact Details:	**daryl.belsey@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Information**

Background/Purpose

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

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

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

Action required

To note the report.

Key implications

The CEO report provides the overview of Trust activity in the period since the last Board meeting.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	**As discussed in the report**
Performance	
Financial	
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	**Yes**

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

The Chief Executive's report gives an overview of progress and events since the last time the Board convened. The report is presented in five sections, covering the primary areas of focus of the Trust and the Board:

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

1. Strategy

1.1 The House of Commons Health Select Committee report

The House of Commons Health Select Committee report on winter planning in A&E departments was published in November 2016: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2015/planning-for-winter-pressure-in-accident-and-emergency-departments-inquiry-16-17/.

NHS Improvement has facilitated a series of workshops targeting the 10 most challenged acute trusts where examples of good practice in improving handover times can be shared.

The committee have recommended that NHS England should urgently address the levels of variation to ensure that there is a timely handover of patients. The report also highlights NHS England's view that paramedics have huge potential could do more to keep patients out of hospitals. There is also a mention about Dispatch on Disposition and it suggests that this will pave the way for the Ambulance Response Programme (ARP).

1.2 Lord Harris report

On the 28th October Lord Toby Harris launched his significant and wide-ranging independent report into what could be done to improve London's resources and readiness to respond to a major terrorist incident.

The Mayor of London, Sadiq Khan, appointed Lord Toby Harris of Haringey to undertake this independent London-wide strategic review in his first weeks in office, following the terrorist attacks in Paris and Brussels, which were followed by an attack in Nice.

The Lord Harris review commends London's emergency services for their improved major incident readiness, with responses now substantially faster and more effective than five years ago. The quality and effectiveness of the work done by the intelligence agencies and the counter-terrorist police here is, he says, amongst the best in the world.

Lord Harris goes on to make 127 recommendations for the Mayor, the Government and other agencies to consider, including

- The Metropolitan Police to further explore the use of temporary barriers to protect against a Nice-style attack in London.
- A London-wide pilot of a new public alert technology – so Londoners can be advised of a major terrorist attack with messages sent direct to mobile devices.
- CCTV to be installed on all underground and mainline trains and more easily accessible to emergency services in an emergency.
- COBR protocol to be changed so that the Mayor always attends meetings that affect London – with greater clarity around the role of the Mayor in a major incident.
- Consideration to be given to the introduction of a new MOPAC adviser on counter-terrorism, and Mayoral Adviser for Resilience.

- The Home Office to fully fund the National and International Capital Cities Grant (NICC), which currently costs the Metropolitan Police approximately £340 million a year.
- Security measure on the river Thames to be strengthened.
- The police and security services should work with businesses, local authorities and others to provide better information on how to prevent a terrorist attack, and what to do if the worst happens.
- The Department of Health should provide extra resources to the London Ambulance Service in recognition of the additional demands placed on them as the provider of services in the capital.

Amongst the 127 recommendation made by Lord Harris there are a number specifically relating to the London Ambulance Service and NHS. They are outlined as follows:

Recommendation 53 - There should be four dedicated 24/7 Hazardous Area Response Teams in London and a similar number of Mass Casualty Vehicles. These should be strategically located around London

Recommendation 55 - The number of CBRN trained LAS staff should be reviewed with a view that it should return to the higher levels previously seen in London over the past few years.

Recommendation 57 - Personal radiation monitors, which should be available to fire, ambulance and police personnel, should routinely be used

Recommendation 58 - A full testing and exercise programme should be developed to test the readiness of the LAS Control Room, including with no-notice exercises.

Recommendation 59 - I would encourage the tri-service chiefs meetings to continue, with perhaps a greater focus on dealing with the attacks considered in this review, as well as the important matter of on-going collaboration.

Recommendation 89 - Key members of the LRF, including the police, fire and ambulance services, along with the Mayor's office should work together with London's voluntary sector to ensure they are being used effectively and that the lines of communication are sufficient in the event of an attack or other emergency. When the response to an MTFA and other terror attacks is exercised, the role of the voluntary sector should be properly rehearsed.

Recommendation 94 - There is a need to ensure that all front-line personnel are adequately trained to deal with the types of injury that might be seen in an MTFA?

The LAS is working with NHSE London to consider the recommendations detailed above to provide a response to the Lord Harris report and develop a plan to ensure appropriate action is taken to address these recommendations. This will be shared with the board for consideration.

There are a further number of recommendations for the wider London Emergency Services and London partnerships to consider jointly. The London Resilience Program Board (which has representatives from each of the London resilience partners) has meet to discuss and review the recommendation and develop a response/plan for the London Resilience Forum who will meet with Lord Harris on the 3rd December.

The Lord Harris report can be found at the following address:

https://www.london.gov.uk/press-releases/mayoral/significant-and-wide-ranging-independent-report

2. Quality

2.1 Restart a heart day

Restart a heart day was created in joint partnership with the British Heart Foundation, British Red Cross, St John Ambulance Service, the Resuscitation Council (UK) and Association of Ambulance Chief Executives. The aim of the day was to train in excess of 100,000 young people throughout the UK in CPR with every UK Ambulance Trust engaged with the campaign. The combined activity from all Ambulance Trusts was 106,479 with the London Ambulance Service assisting to train over 3,053 members of the public.

2.2 Mental Health Simulation Training

A one day simulation course for both police and paramedics who are keen to improve their knowledge and confidence in how to help, assess and manage patients presenting in a mental health crisis was delivered on 25th October and 8th November at SLAM with excellent feedback from participants. 12 more dates are scheduled up to February 2017 and have already been oversubscribed.

2.3 End of Life Care

Macmillan have funded 8 places on St Christopher's Hospice Quality End of Life Care for all (QELCA) Course running from 21-25 November 2016. It is hoped that they will continue this support with further funding for courses in 2017.

Three 'Difficult Conversations' workshops have been delivered to 50 Clinical and EOC staff in NW London throughout October/November as the final part of Health Education England, North West London (HEENWL) funded LAS End of Life Care project.

3. Delivery – performance, money and workforce

3.1 Performance

- The Category A8 minute performance measure for October ended on 66.4%, below the month's trajectory of 69.2%. However the category A 19 minute performance measure did finish above the 93% plan at 93.8%.
- Demand on the service remains very high, Category A incidents were 6.1% higher than trajectory and total incident demand was 7.2% above trajectory.
- The LAS are putting out 4.4% more patient facing vehicle hours than the October trajectory, although this does include Private Ambulance Service/ Voluntary Ambulance Service. (PAS/VAS) and excess overtime hours.
- The trajectory for overtime hours projected a decline from Jul/Aug before rising back up in Nov/Dec. This decline did not happen and overtime now sits at 50% above plan.
- PAS/VAS contribution has continued to reduce in Q3 to just over 1,000 hours a week and so substantive Patient Facing Vehicle Hours need to be able to maintain trajectory given this reduction in PAS/VAS.
- The average monthly job cycle time has been decreasing steadily since the start of the financial year, providing greater operational resource capacity. However, it remains high with October at just over 3 minutes above trajectory.
- Multiple Attendance Ratio (MAR) continues to be high after the abrupt rise in September. With the challenging reduction in JCT trajectory ahead, this will need to be monitored closely and efforts made to bring it back in line with the pre-September position.

- Month-to-date (1st – 13th November), A8 performance is sitting at 66.4%.
- At present, if the rest of the month follows our forecast, we will finish the month at 67.4%, below the November trajectory of 70.7%.
- As we go into winter, the Performance Directorate will be focusing on winter planning, and forecasting demand, capacity and performance through to the new calendar year. This is especially important given the significantly higher than planned levels of activity witnessed so far this year.

3.2 Croydon tram incident

On the 9th November we were called to reports of a tram derailment at Addiscombe Road in Croydon.

We sent 22 ambulance crews, 12 officers, and two advanced paramedic practitioners to the scene, alongside our hazardous area response team, who are trained to provide emergency medical care in hazardous areas such as confined spaces or where there may be hazardous materials. Two trauma teams from London's Air Ambulance and a command support vehicle were also dispatched. We treated a number of patients at the scene, mainly for minor injuries such as cuts and bruises, sadly there were 7 fatalities and others have suffered life changing injuries. We took 51 patients to hospital, 20 of whom were taken to St George's University Hospital and 31 to Croydon University Hospital.

3.3 Ladbroke Grove Significant Incident

On the 17th November we were called at 11.51am to reports of a road traffic collision at Ladbroke Grove, W10

We sent multiple resources to the scene, including four ambulance crews, a single responder in a car, an incident response officer and our Hazardous Area Response Team. We also dispatched London's Air Ambulance .The first of our medics arrived at the scene in under six minutes. We treated and conveyed 13 patients with minor injuries to local Emergency Departments and conveyed one patient as a priority to a Major Trauma Centre

4. Money

4.1 Financial position

The year-end financial control total of £6.7m deficit remains at risk due to the additional capacity required to meet higher than planned activity. LAS Commissioners have confirmed £2.1m for Q2 and further funding across Q3 and 4. Without this funding the £6.7m control total will not be met. Commissioners are working to help reduce demand, and LAS needs to support this position through productivity improvements. Both of these actions will help to limit the scale of the additional funds required from CCGs. LAS is also taking steps to make additional savings to support this position through the review of agency staff and additional review of all non-clinical recruitment. These actions will not be applied to clinical or patient facing roles. The procurement of 140 new ambulances is proceeding following approval of the case by NHSI.

4.2 NAO Report an Ambulance Service

The Trust is in receipt of a draft report from the National Audit Office. This is a follow-up to the report completed in 2013. The final report is expected to be published in January.

5. Workforce

5.1 Death in service

We are very sad to report that Simon Lawrence, an Emergency Medical Technician stationed at Romford, passed away suddenly and unexpectedly at home on 14th November. Condolences were paid to Simon's friends, family and colleagues during the CEO road show at Ilford.

5.2 Vacancy and Recruitment (October)

- The overall vacancy rate has improved from 5.6% to 4.7%
- The vacancy rate for front line staff has increased from 7.1% to 7.2%
- The vacancy rate for frontline paramedics has improved from 11.5% to 9.8%.

5.3 Turnover (October)

- Trust turnover has improved from 9.8% to 9.7%.
- Frontline turnover has improved from 8.9% to 8.7%
- Frontline paramedic turnover has improved from 8.6% to 8.2%.

5.4 Sickness (October)

- Overall trust sickness has remained at 5% against a target/threshold of 5.5%.
- Frontline sickness has remained at 5.4%.

5.5 Appraisals
Since April there have been 2,733 appraisals completed (63% compliance).
Corporate areas have delivered 91% against their target of 100% (31st July).
The current reporting does not accurately reflect the compliance rates in EOC (82%) and NHS 111 (96%) as they manage their appraisals on a 12 month rolling cycle. A green bar has been added to reflect this 12 month rolling figure.

5.6 Mediation Skills
Thirty staff have now been trained in practical mediation skills following sessions held in September and October. This will support staff in being able to effectively facilitate round table meetings with an aim of reducing the need to instigate formal grievances. More than 600 staff have now attended over 45 separate Bullying and Harassment Awareness workshops and the practical skills in mediation training has been as a result of staff requests to have support to enhance managing conflict more effectively at all levels within the organisation.

5.7 New appointments
Director of HR and Organisational Development
After an extensive recruitment process for the new post of Director of HR & OD the Trust has made an offer of appointment and subject to the completion of standard employment checks we anticipate being able to announce the name of the successful candidate and their start date within the next few days.

Chief Quality Officer
This position has been offered and accepted by Trisha Bain and again an early 2017 start date with the trust is anticipated.

Assistant Director of Operations and Deputy Director of Operations
A dedicated Deputy Director post has been created for our 111 service across South East London and for developing urgent care integration. Katy Millard has a great deal of experience of 111 and urgent care as part of her current role and will be transitioning into this new role by Christmas. In her new role, Katy will have full responsibility and oversight for our existing 111 service delivery and will also be responsible for the development of future 111 bids. She will work closely with the Medical Directorate on the development of the Trust's urgent care strategy going forward.

Since the last restructure of Operations, the NHS in London has reorganised itself into five Sustainability and Transformation Plan (STP) areas. We have now reconfigured our Service to reflect this, and to ensure that we are in the best position to work with our partners, by moving from seven to five areas , combining the existing East Central and North East to create a new North East sector, and North West and West into a new North West. The ADOs were asked to express their interest for the five sector posts, a project portfolio post and the DDO post for Control Services. I am pleased to confirm that, following interview, Pauline Cranmer has been successfully appointed to the post of DDO Control Services. Pauline and Katy will work closely together to ensure a smooth handover by Christmas. I am also pleased to confirm that the five sector roles have been agreed. In the South East it will be Graham Norton, South West is Lucas Hawkes-Frost, North West is Ian Johns, North East is Natasha Wills and North Central is Peter Rhodes. The transition to this five sector model will commence with immediate effect.

There will be an additional role of an ADO Operational Transformation and Stuart Crichton will be taking up this position. Peter McKenna will continue in his Deputy Director of Operations role for Sector Services.

6. Culture and Engagement

6.1 Empowering managers to engage with their staff

We know that our top 400 managers are the key people to influence change within the LAS. Managers' briefings are being held once a month to make sure all managers understand what action they need to take locally and to ensure they are up to date with plans and progress ahead of the CQC re-inspection in February.

At October's managers briefing, managers were briefed on the key issues that would be presented at staff road shows that month. Key messages were included about our preparation for the re-inspection and what staff could do to play their part.

November's briefing took managers through the details of why we were rated inadequate by the CQC, a detailed account of our progress to date and a specific "to-do" list for managers.

6.2 Engaging with staff - staff road shows

Fionna Moore, Paul Woodrow and Fenella Wrigley have led a series of CEO road shows across the Service, which have been attended by around 1,000 staff. As well as being an opportunity to update people on current issues and initiatives, the two-hour meetings included a chance for questions and for staff to feedback their own ideas and views. The meetings were well attended, with a good level of constructive discussion on all aspects of the Service.

Among the key issues raised were:

- Increasing levels of demand on the 999 system
- Frontline staff's rosters
- Career development opportunities
- Availability of appropriate care pathways (other than A&E) to take or refer patients to

Notes were taken at each meeting so that the key themes were recorded and for follow up action to be taken.
At the operational staff road shows, we gave clinicians a hand-out which details why the CQC rated the Service as inadequate, a 'to-do list' and a 'You said, we did' on progress we have made on issues staff raised last year.

6.2 Making the LAS great

We have continued with our mini campaigns to highlight 'must dos' to staff to help make the LAS great.
In September we highlighted 'Representing the Service with pride' when we focused on two key initiatives: the broadcast of the BBC documentary 'Ambulance' and promotion of Service policy on how staff should wear their uniform. October's focus was 'Speak up', when a range of communication activity encouraged staff to speak up and raise concerns through their line manager, Datix Web or the new Freedom To Speak Up Guardians.

This month we have turned our attention to medicines management, when our communications activity is aiming to explain why it is important to manage medicines properly and the impact of not doing so; explain the medicines management process and where staff fit into this; share good practice by demonstrating how easy it is to use the new drug forms and packs; and clarify the individual paramedics responsibility for medicines management. Three further mini campaigns will be run between December and February: protecting vulnerable people, looking after your equipment and keeping information safe.

6.4 BBC One documentary: Ambulance

In October, we saw the broadcast of episodes two and three of our BBC One documentary, drawing a peak audience of 4.75 million viewers. Capitalising on the conversations around the documentary, we launched a social media recruitment campaign. These messages reached over 430,000 people, encouraging over 400 applications for control room staff and paramedics during the broadcast period. We also surveyed staff - 88 per cent said that the

documentary made them feel proud to work for the Service. In addition to the measurable benefits, we saw an unprecedented outpouring of praise and gratitude for the work of our staff, with messages of support reaching us through our website, social media and even in the street. Following the series, gifts of sweets, donuts and even takeaway pizza were kindly donated by grateful members of the public.

6.5 Staff recognition
13 area winners have been announced in the latest round of the VIP Awards. All winners have been invited to a mini event on 25 November where they will meet Chief Executive Fionna Moore and be presented with their award. They will all go forward to the second round of the awards.

6.6 'Get a jab, save a life'
We launched our internal flu campaign towards the end of September to support the Service's aim to get 75 per cent of frontline staff vaccinated against flu. Posters, postcards on payslips, items in RIB, on the pulse and on LiA Facebook have encouraged staff to have a flu jab. At the end of October, over 1,700 staff had been vaccinated.

6.7 World Mental Health day
To mark World Mental Health day exhibitors from Stroke Association to Diabetes UK joined the Service for a wellbeing event on the 10th of October. The event aimed to bring together charities and information services to offer staff the knowledge of other support networks available to them. Stalls hosted by Macmillian, Alzheimer's UK, Occupational Health and MIND all offering advice and information were available throughout the day as well as taster massage and reflexology sessions.

6.8 Ceremonial Unit
Nine members of the Ceremonial Unit had the privilege of representing the Service at St Pauls' Cathedral on the 7th of November when the Garden of Remembrance was opened. Following the service, where the Mayor of London and various dignitaries planted their crosses in remembrance, the Garden was opened for the public to plant their crosses. The Ceremonial Unit also had the privilege of taking part in the Remembrance Sunday event held on the 13th of November at Whitehall.

6.9 Chief Executive Officer engagement
10th October – World Mental Health day event
10th October – Presentation of STP's to the Patients Forum
12th October – Managers briefing ahead of CEO road shows
12th October – Road show – corporate and support staff
13th October – Road show – HART team East
14th October – Road show – HART team West
27th October – Co responding meeting with London Fire Brigade
28th October – Launch of the Lord Harris review findings at City Hall
3rd November – National Association of Lesbian, Gay Bisexual and Transgender meeting
8th November – Metropolitan Police Service blue light collaboration event.
11th November – Wreath laying – Annual Service of Remembrance
14th – 22nd November – Service wide CEO road shows

7. Emerging Issues

7.1 Progress towards implementation of Band 6 for Paramedics
After securing some additional funding from our commissioners to support initial proposals to implement Band 6 Paramedics within the LAS, we commenced local discussions in August. These discussions have been extremely constructive and we were close to reaching an LAS agreement. However, in October we were advised by NHS Improvement that the national discussions to implement Band 6 were moving forward and we were asked to align our local discussions to support the national programme.
Fortunately many of the features of our local agreement are reflected in the proposed National proposal, these are currently subject to on-going negotiations. Although different,

both packages are designed to deliver significant pay progression for existing Band 5 Paramedics. The national proposal is contingent on securing funding for all Trusts nationally from commissioners. Implementation of any proposals is subject to a formal national agreement and securing additional funding. However we would like to assure you that as soon as we have confirmation of the details of the agreement, the Trust management and staff sides are committed to working together in partnership to complete the local job matching and assimilation processes as quickly as possible**.**

7.2 Rest Break arrangements
The Interim Director of Human Resources and the Director of Operations continue to meet with the union leads to negotiate the new rest break arrangements. This is however increasingly challenging given the national position with band 6 paramedics.

7.3 CQC requirement notice
On the 9th September the Care Quality Commission (CQC) formally issued the service a Requirement Notice. This notice was not acted upon until the 8th of November. Our Action Plan response to this Requirement Notice was formally submitted to CQC on the 18th of November.

7.4 CQC Re-Inspection
We received a Pre Inspection Request (PIR) on the 7th November which is due to be returned by the 5th of December.

7.5 Winter planning
Extensive work is currently underway to finalise our winter planning in order to provide assurance to the Regional Oversight Group of our capability to continue to provide a safe service during the expected winter pressures. The priority for the service is to seek to improve our Job Cycle Time with hospital delays remaining a key area of focus.

Dr Fionna Moore
Chief Executive

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Integrated Performance Report – Trust Board Executive Summary.**
Report Author(s):	**Jill Patterson**
Presented by:	**Jill Patterson**
Contact Details:	
History:	
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.

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

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

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

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

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 Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**YES**
Achieving Good Governance	**YES**
Improving Patient Experience	**YES**
Improving Environment and Resources	**YES**
Taking Pride and Responsibility	**YES**

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

NOVEMBER 2016

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

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

Delivery of care continues to be safe, but remains challenged at times. Some patients experience longer waits due to capacity constraints. YTD the financial position is on plan. The year end position of £6.7m deficit is at risk due to the additional capacity required to meet increased activity. A8 performance ended at 66.4%. This is below the LAS trajectory of 69.2%. This is an improvement on last month by 3%. Reporting against 100% of establishment, the overall vacancy rate has improved to 4.7%, down from 5.6% in September.

OUR PATIENTS

- CPI completion rates increased by 5% on last month, achieving 86% this month.
- 5 Serious Incidents were declared in October out of 34 incidents reviewed, with 4 reports overdue as of 30th October 2016.
- The Trust remains at Surge Red, with three periods of Surge Purple Enhanced throughout October.
- 91 complaints remain open, with 4 exceeding the 35 working day completion target.

OUR PERFORMANCE

- A8 Performance for October 2016 was 66.4%. This was lower than the contracted trajectory of 69.2%. This is the second month in a row that A8 performance has been below trajectory, however this was an improvement on last month by 3%.
- There were 46,890 category A incidents in October (6.1% above trajectory). Category C demand was 8.2% above trajectory. Overall demand was at 94,156 incidents, 7.2% above plan.
- Job Cycle Time for October was 84.7 minutes which was above the monthly trajectory of 81.7 minutes by 3 minutes.
- Capacity was above trajectory with patient facing vehicle hours at 4.4% above plan.
- The multiple attendance ratio was on target at 1.29 for October. This has remained steady for two consecutive months.

OUR MONEY

- Plan / Target – Year to date the position is on plan. The year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained. LAS Commissioners have confirmed £2.1m for Q2 and further funding across Q3 and 4. Without this funding the £6.7m control total will not be met.
- Year to date (YTD) the Trust reports on plan at a £5.9m deficit.
- YTD CIPs is £0.6m adverse to plan. This relates to delays in the delivery of some programmes. The full year plan of £10.5m is still seen as challenging but achievable. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.
- Capital spend is £2.7m against a revised plan of £4.4m. NHSI have approved the £4.5m of £4.9m capital underspend from 2015/16, our approved CRL is now £19.1m.
- Cash is £14.0m, £2.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from Brent CCG (£2.4m) and LAS Commissioners (£2.5m).

OUR PEOPLE

- The overall vacancy rate has improved from 5.6% to 4.7% (reporting against 100% of establishment).
- Overall turnover has improved from 9.8% to 9.7%. This remains below the Trust threshold of 13%
- The sickness percentage has successfully remained at 5%. This is below the 5.5% threshold.

The LAS 111 service delivery remains safe. During October the 111 service achieved an overall figure of 95% for calls answered in 60 seconds. The Patient Transport Service remains constant in arrival at hospital times and expected lower return for friends and family questionnaires continues.

LAS 111 (SOUTH EAST LONDON)

↔ Commissioners have indicated their intention to extend the contract with LAS as provider of the 111 service until February 2018.

↔ Workshops have taken place for the transformation of the existing South East London 111 Service into the Integrated Urgent Care Model.

↑ The LAS 111 service achieved an overall figure of 95% for calls answered in 60 seconds during October, achieving the target of 95%.

PATIENT TRANSPORT SERVICE

↑ 5,720 PTS journeys were completed in October 2016, an increase from the previous month's total of 5,564.

↓ The patient departure time KPI dropped to 94% this month from 95% last month. This is 1% below the target or 95%.

↑ The October Friends and Family Test responses have seen an increase compared to September. This is as a result of sending the questionnaire mailshots on a monthly basis.

Key Performance Indicator Report Summary

	Key Performance Indicator	Oct-16	Sep-16	Aug-16	Chart
QUALITY	Adverse Incidents (Patient)	↑	↓	↑	
	Adverse Incidents (Staff)	↓	↑	↑	
	Potential Serious Incidents referred to SI Group	↓	↓	↑	
	Serious Incidents (LAS Declared)	↑	↓	↑	
	Serious Incidents (LAS Declared) Overdue	↑	↔	↓	
	Regular Reporting of Incidents - Shared Learning	↓	↑	↔	
	Total Complaints	↑	↑	↓	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↓	↓	↓	
	Controlled Drug Incidents - Not reportable to LIN	↔	↓	↑	
	All LIN Reportable Incidents	↔	↓	↔	
	Overall Medication Errors	↓	↓	↑	
	Missing Equipment Incidents	↓	↑	↑	
	Failure of Device/Equipment/Vehicle Incidents	↑	↓	↑	
	CPI - Completion Rate	↑	↑	↓	

	Key Performance Indicator	Oct-16	Sep-16	Aug-16	Chart
111	Calls answered within 60s	↑	↓	↑	
	Calls abandoned after 30s	↓	↑	↓	
	Percentage of calls referred to 999	↑	↑	↓	

	Key Performance Indicator	Oct-16	Sep-16	Aug-16	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↓	↓	
	Vacancy Rate (Frontline)	↑	↓	↑	
	Vacancy Rate (Trust)	↓	↓	↓	
	Turnover Rate (Frontline Paramedic)	↓	↑	↓	
	Turnover Rate (Frontline)	↓	↓	↓	
	Turnover Rate (Trust)	↓	↑	↓	
	Sickness (Trust)*		↓	↔	
	Sickness (Frontline)*		↓	↑	

* Sickness KPIs are reported a month in arrears

	Key Performance Indicator	Oct-16	Sep-16	Aug-16	Chart
PERFORMANCE	A8 Performance	↑	↓	↑	
	A19	↑	↓	↑	
	R1	↓	↑	↑	
	R2	↑	↓	↑	
	Calls	↑	↑	↓	
	Incidents	↑	↓	↓	
	Cat A Incidents	↑	↑	↓	
	Cat C Incidents	↑	↓	↓	
	Patient Facing Vehicle Hours (PFVH)	↑	↓	↓	
	Full Job Cycle Time	↓	↑	↓	
	Job Cycle Time (JCT)	↓	↑	↓	
	Multiple Attendance Ratio (MAR)	↓	↑	↔	
	EOC - Call Answering Rate	↑	↓	↑	
	EOC - FRU Cat C Share	↑	↑	↓	

	Key Performance Indicator	Q1	Q2	*Q3*
FINANCE	Financial Stability Risk Rating (FSRR)			
	Capital Service Capacity			
	Liquidity Days			
	Access to PDC for Liquidity Support			

	Key Performance Indicator	Oct-16	Sep-16	Aug-16	Chart
	Cash Balance - Monthly Profile - £000s	↓	↓	↑	
	Income and Expenditure Deficit by Month - £000s	↓	↓	↑	
	Income and Expenditure Deficit Cumulative - £000s	↓	↓	↑	
	Income Variance from Plan - £000s	↑	↓	↑	
	CIP Delivery Against Plan - £000s	↑	↑	↑	
	CIP Forecast Against Plan - £000s	↔	↔	↔	
	Forecast Capital Spend Against the CRL - £000s	↑	↑	↑	

KPI Summary

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

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

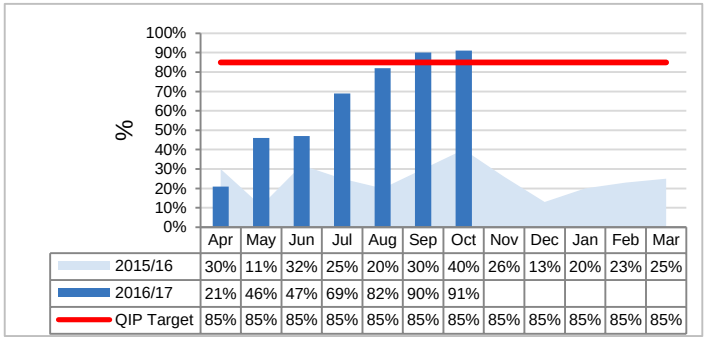
Our Patients

Section	Key Headlines
SAFE	• 5 Serious Incidents were declared in October out of 34 incidents reviewed, with 4 reports overdue as of 30th October 2016. Overdue SI's have increased on the previous month. The Trust continues to focus on these overdue reports and ensure that there is particular support and focus where a large number of reports are due for submission in a short period of time. Overdue SI's have been escalated internally to the Executive Lead for completion and an increase in throughput has been seen. • CSR2016.2 is continuing with a 76% completion rate for October. 4 International Paramedics have completed their training and mentoring programme and are now working autonomously. 49 learners completed the Emergency Ambulance Crew programme. • There was a 5% decrease in staff reported incidents in October 234, down from 247 in September. Reported patient incidents increased by 23% (239 up from 195 in September) - most notably incidents of equipment failure which increased by 25%. Missing equipment incidents have fallen compared to last month, yet are still higher than their historical average due to easier reporting of missing drug packs via Datix forms in EOC. • 90 complaints were received during October, including 4 from health or social care providers which were treated as having been made on behalf of the patient. This was a similar number to September (89), and reflects the historic trend at this time of year.
EFFECTIVE	• The number of frequent callers has remained stable in October, although the number of incidents generated by frequent callers has declined by 67 incidents. The number of local frequent caller initiatives continues to grow, improving the co-ordination of frequent caller management. This has subsequently increased the appetite for greater levels of reporting which is currently in development for distribution in December. • 97% of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF. This figure has remained the same since July 2016 data. • 29 patients with ROSC presented with a STEMI following their cardiac arrest, 28 of which were conveyed to Heart Attack Centres (HACs) in line with the pathway. 1 patient achieved ROSC that was unstable and later died on scene.
CARING	• CPI completion rates increased to 86% in September, a 5% rise compared with August. Significant increases were achieved at MRU (+64%), New Malden (+64%), St Helier (+60%), Hanwell (+42%) and Deptford (+20%) due to increased availability of Team Leaders and/or restricted duties staff. • CPI compliance, which evidences the care provided to patients with a diagnosed psychiatric problem, has reached its highest level since September 2014 at 93%. However, improved documentation of safeguarding concerns (65%) and appearance (79%) are needed across all sectors to raise compliance further. This is being addressed through the Chief Executive roadshows. • Almost 100% of frontline A&E fleet now have leaflet holders fitted and other teams (for example, Cycle Responders) are being supplied with 'Talking With Us' leaflets and internal publicity has been undertaken to increase awareness. Feedback leaflets are included with all complaint responses, to date, only 2 completed forms have been received. • 86 public events were attended by the Patient & Public Involvement team, an increase of 74 on August when schools and colleges were on holiday.
RESPONSIVE	• The Trust is currently at Pressure Level 2 – Moderate. • The Trust remains at Surge Red, with three periods of Surge Purple Enhanced in October. • There were 2,987 hospital breaches over 45 minutes during October, with 1,347 exceeding 1 hour - an increase of 404 on the previous month. Of particular note there were a number of breaches at Barnet, Princess Royal Farnborough and Royal Free hospitals. Stakeholder Engagement Managers are working locally with hospitals to find solutions to the delays and senior managers are fully engaged with NHS England to oversee this. • The LAS worked with Princess Royal and the Stroke Network to ensure adequate out of hours access to Hyper-Acute Stroke care whilst they addressed some delays in recruited staff commencing employment.

Serious & Adverse Incidents (SI)

Patient safety incidents reported on DatixWeb within 4 days of incident occurring

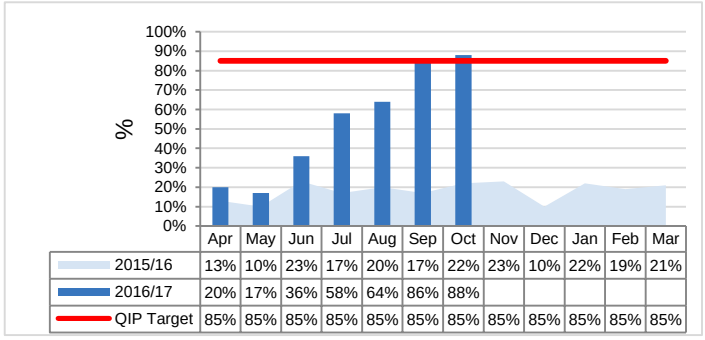
Target 2016/17	Actual	Variance	RAG
85%	91%	6%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	11%	32%	25%	20%	30%	40%	26%	13%	20%	23%	25%
2016/17	21%	46%	47%	69%	82%	90%	91%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Staff safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	88%	3%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13%	10%	23%	17%	20%	17%	22%	23%	10%	22%	19%	21%
2016/17	20%	17%	36%	58%	64%	86%	88%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Adverse Incidents

In October 2016, 8% of reported incidents were completed on paper forms, down from 18% in September and 23% in August. We estimate that 93% of all incidents occurring in October have been received.

Incidents for October are detailed below:

Patient Incidents:	**239 (+23%)**
• Failure of equipment:	35 (+25%)
• Missing Equipment:	58 (-24%)
• Medication Incidents:	18 (-18%)
Staff Incidents:	**234 (-5%)**
• Manual Handling incidents:	49 (+14%)
• Assault and Abuse:	45 (-55%)

Adverse Incidents due to items of equipment which failed or were missing

Failed in use (Top 5)

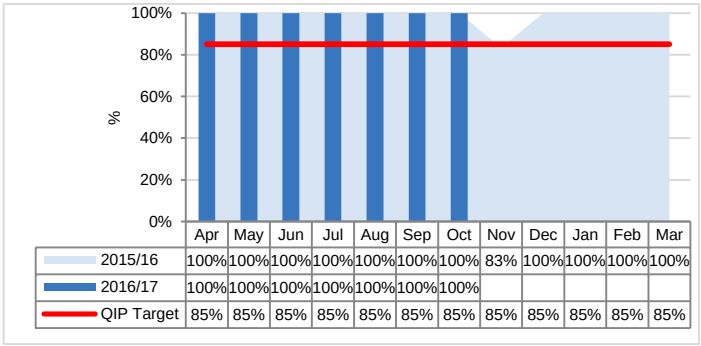
• Lifepak 15: ECG Leads	3
• Carry Chair	2
• Lifepak 15: Device	1
• Mangar Elk	1
• LUCAS Device	1

• **Missing Items (Top 5)**	
• Drug Pack (Not immediately available)	43
• Lifepak 15: Paediatric SP02 Probe	2
• Lifepak 15: ECG Leads	1
• EZIO	1
• Sharps Box	1

Serious Incidents / Governance

Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared

Target 2016/17	Actual	Variance	RAG
85%	100%	15%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%
2016/17	100%	100%	100%	100%	100%	100%	100%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Serious Incidents

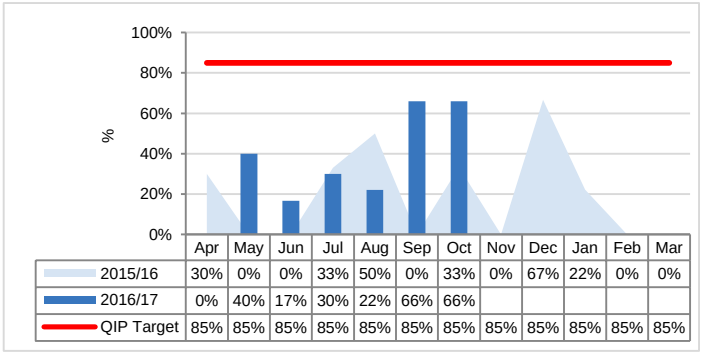
The Trust continues to meet the 100% target in reporting of Serious Incidents within 48 hours of being declared.

5 SI's were declared in October out of 34 incidents reviewed, with 4 reports overdue as of 30th October 2016. Overdue SI's have increased on the previous month. The Trust continues to focus on these overdue reports and ensure that there is particular support and focus where a large number of reports are due for submission in a short period of time.

Overdue SI's have been escalated internally to the Executive Lead for completion and an increase in throughput has been seen.

Completed investigations and reports within 60 working days of a serious incident being declared

Target 2016/17	Actual	Variance	RAG
85%	66%	19%	



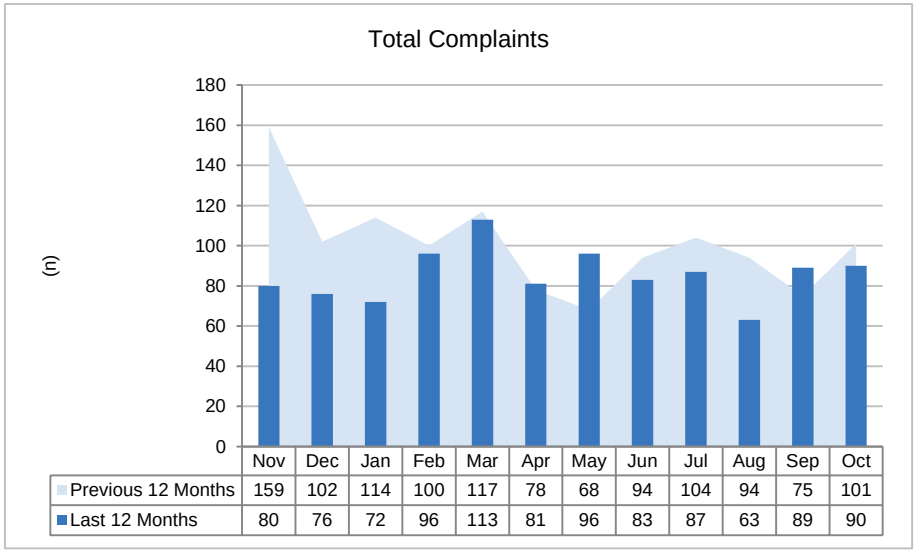
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	0%	0%	33%	50%	0%	33%	0%	67%	22%	0%	0%
2016/17	0%	40%	17%	30%	22%	66%	66%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Serious Incidents investigation reports completed within 60 days

3 SI reports were completed and submitted in October, 2 of which were within the 60 day timeline.

The percentage of reports submitted within 60 days remains constant compared to the previous month. Work is continuing to ensure that lead investigators have the tools and resources to complete investigations within the 60 day timeline. There are a number of overdue SIs expected to be completed imminently and learning from these to be shared.

Complaints – Volume & Response time



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Previous 12 Months	159	102	114	100	117	78	68	94	104	94	75	101
Last 12 Months	80	76	72	96	113	81	96	83	87	63	89	90

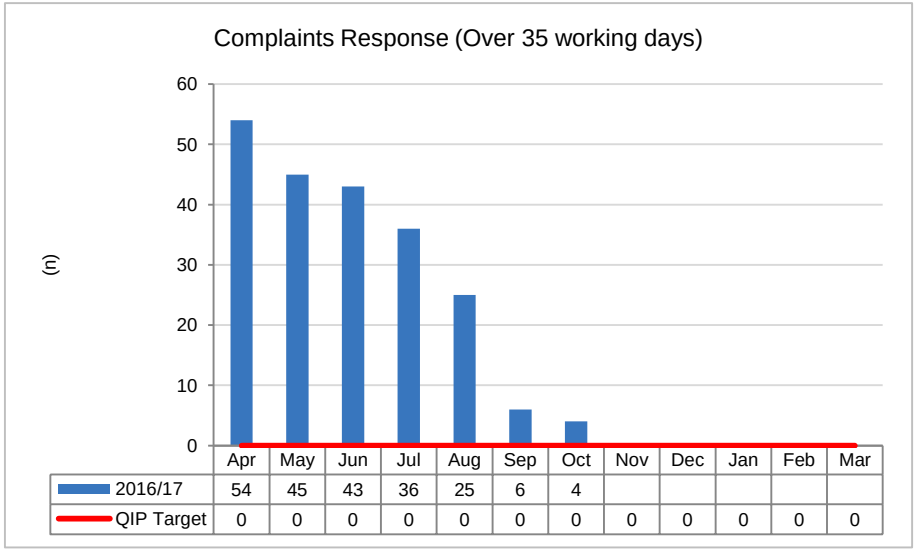
Total Complaints

90 complaints were received during October. This includes 4 from health or social care providers which were treated as having been made on behalf of the patient. This adheres to best practice guidelines.

Complaint volumes have increased slightly during October which reflects a historic trend at this time of year.

The average for delayed response complaints in 2015/16 was 47 per month compared to 32 for 2016/17.

The average for attitude and behaviour complaints in 2015/16 was 25 per month this has increased to 27 per month in 2016/17.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43	36	25	6	4					
QIP Target	0	0	0	0	0	0	0	0	0	0	0	0

KPI Report – Complaints Responses over 35 working days

The QIP KPI data reflects the number of complaints over 35 working days that remain open.

There is an overall total of 91 open complaints, a slight increase over previous months which corresponds with an increase in the numbers of complaints received.

Complaints – Volume & Response time

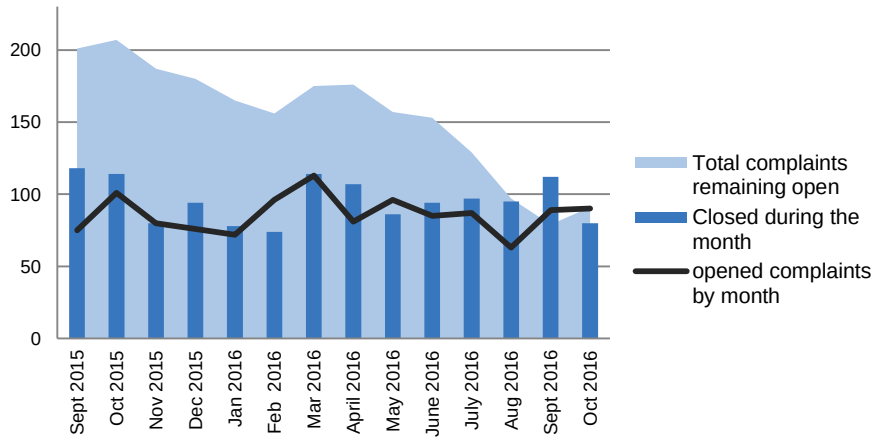
	2013/14	2014/15	2015/16	2016/17
October Complaints	125	144	101	90
Average per annum	88	117	88	84

Complaint Volumes

A number of complaints have been received regarding staff employed by the contractor engaged by Fleet. Departmental managers have been made aware.

A request has been made to change the demographic information recorded on Datix. This is to so these details can be recorded for the complainant where they are not the patient.

Complaints continue to be more complex in nature, involving numerous issues.



Complaint Volumes

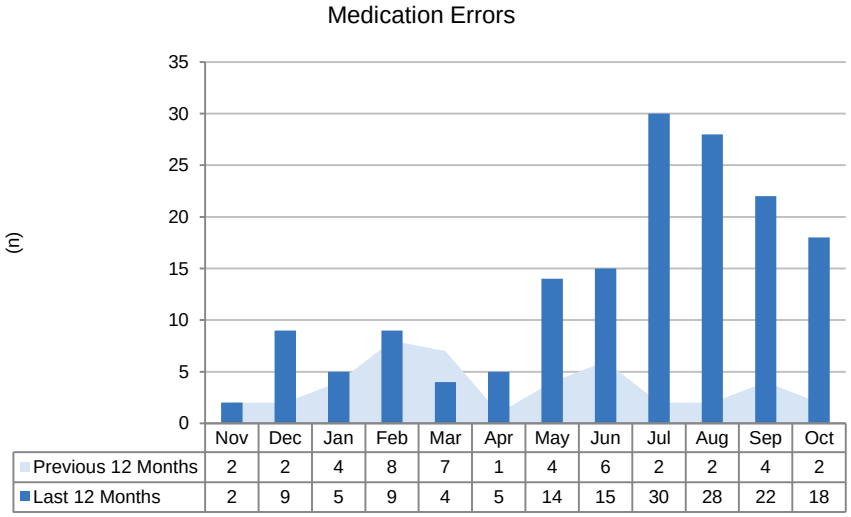
Complaint volumes have largely levelled out since the exceptional demand in 2014/15. We continue to use 2013/14 as the typical benchmark.

We are maintaining our trajectory to reduce the numbers of out of time complaints

The number of complaints closed during October 2016 was 80, against a monthly average of 85.

We continue to send out a 'Feedback on Complaints' form with every final response and will audit those received at the end of Q4 (currently only 2 have been returned).

Medicines Management



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Previous 12 Months	2	2	4	8	7	1	4	6	2	2	4	2
Last 12 Months	2	9	5	9	4	5	14	15	30	28	22	18

Medicines Management – KPI data - Controlled Drugs (CD)

There was **one** reportable Controlled Drugs (CD) Local Intelligence Network (LIN) incident in October 2016:-

- A paramedic returned to station and noted that their morphine pouch containing two ampoules for morphine was missing. Despite a search it remained unaccounted for and was reported to the Police. The Control Drugs Liaison Officers team have closed this incident.

There have been three CD incidents that are not LIN reportable. In one case a paramedic signed morphine back into the CD book but forgot to place the ampoules into the safe. In a second incident there was a discrepancy between the dose of morphine recorded on the PRF and that recorded in the CD book. Finally, a bottle of oral morphine was found loose in an ambulance side cupboard (not a schedule 2 CD).

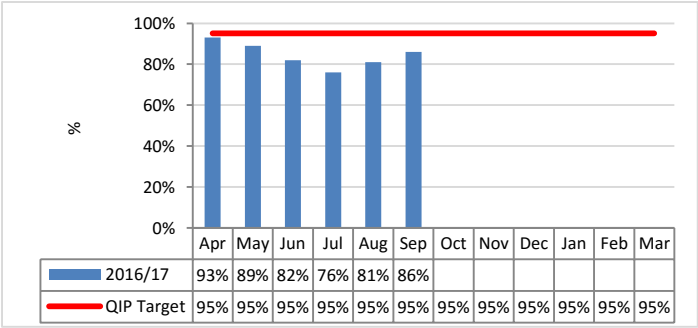
Other medicines management issues

- The Q2 Local Intelligence Network (LIN) Controlled Drugs report has been submitted to the Home Office.
- A new Trust Pharmacist has been appointed subject to pre-employment checks. The expectation is that the Trust Pharmacist will have commenced work by February 2017.
- Staffing issues at the Logistics Support Unit are hampering efforts to pack additional drugs packs for distribution within the LAS. To address this it has been suggested staff on restricted duties could be utilised to assist where possible.
- A new IM&T medicines management portal entitled ‘Medman’ has been developed which enables drugs given to patients and documented on the PRF to be reconciled with usage documented on the form contained in the sealed drugs pack enabling tracking of drugs removed from packs and given to patients.
- Medicines management leaflet was produced for distribution to all operational staff in their wage slips.

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

Number of eligible Patient Report Forms (PRFs) audited per month

Target 2016/17	Actual	Variance	RAG
95%	September: 86%	9%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	93%	89%	82%	76%	81%	86%						
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

CPI Completion

- Completion rates increased to 86% in September, a 5% rise compared with August, and 10% with July.
- Significant increases were achieved at MRU (+64%), New Malden (+64%), St Helier (60%), Hanwell (+42%) and Deptford (+20%) due to an increase in completion by Team Leaders and/or restricted staff availability.
- A decrease at Homerton (-50%) was due to restricted duties staff returning to operational duty, which along with staff sickness and annual leave, also impacted on completion at Westminster (-32%) and Greenwich (-27%). Reduction in completion at Bromley and CRU are being investigated.
- Group Station Managers receive regular reporting on CPI completion rates for their Group Stations for review and action.

CPI Compliance

- The documented care provided to patients with a diagnosed psychiatric problem has reached its highest level since September 2014 at 93%. However, improved documentation of safeguarding concerns (65%) and appearance (79%) are needed across all sectors, to raise compliance further.
- Documented care provided to those experiencing a glycaemic emergency is at a consistently high level. Recording final observations would further improve compliance which is currently at 93%.
- At 96% compliance, patients with severe sepsis receive a high standard of care. However, improvements are required in the documentation of relevant medications (87%).
- General documentation of patient care remains high (97%) and continued high quality care was delivered to patients who were discharged at scene (97%).

CPI Feedback

- Service wide, 51% of expected face-to-face feedback sessions have been delivered at this point in the financial year.
- Very few feedback sessions (1%) have been delivered to Volunteer Responder staff.
- Hillingdon (97%) has almost achieved their year to date target and are likely to provide all expected sessions for the year. Similarly, Fulham and Romford have delivered nearly three-quarters of expected feedback sessions to date.
- The Clinical Hub and New Malden exceeded their target number of face-to-face feedback sessions for September.
- CARU will continue to monitor the progress of the feedback provided to members of staff across the LAS and specifically focus on the areas where feedback sessions are considerably lower than expected.

CARU Reports - Cardiac Care (September 2016)

Cardiac Arrest

- Resuscitation efforts were commenced on **37%** of cardiac arrest patients attended by LAS crews.
- **66%** of cardiac arrest patients that were allocated a Red 1 category received an 8 minutes response.
- **32%** of cardiac arrest patients that had resuscitation commenced gained and sustained Return of Spontaneous Circulation (ROSC) until arrival at hospital and is a **7%** increase on August. **Hanwell** station group had the highest ROSC rate with 60% of their patients maintaining ROSC to hospital.
- **29** patients with ROSC presented with a STEMI following their cardiac arrest, **28** of which were conveyed to Heart Attack Centres in line with the pathway. **1** patient achieved ROSC that was unstable and later died on scene.
- An advanced airway management device was placed successfully in **87%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had End-Tidal CO_2 ($ETCO_2$) levels measured. **2** patients had no end-tidal CO_2 level documented on their Patient Record Form (PRF) nor accompanying capnography printout.
- Approximately **5%** of cases had defibrillator downloads submitted, which was a **2%** decrease from August. All of the downloads were submitted by Advanced Paramedic Practitioners on-scene. This will be improved with the roll out of mobile electronic devices.

ST Segment Elevation Myocardial Infarction (STEMI)

- **99%** of patients were conveyed to an appropriate destination. **1** patient was taken to an ED when they should have been taken directly to a Heart Attack Centre. Sector management have been informed of this case.
- Average overall on scene time have increased by **2** minutes to **44** minutes. **Edmonton** and **Fulham** station groups achieved average overall on scene times notably lower than the LAS average at **39** and **40** minutes respectively.
- Call to hospital times have increased by **3** minutes to **73** minutes.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) has increased by **9%** to **76%**. The documentation of analgesia was the element with least compliance at **81%**.
- 11 station groups provided a full care bundle to less than 80% of patients attended this month.

CARU Reports - Stroke and Major Trauma (September 2016)

Stroke

- **97%** of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF.
- Almost all FAST positive patients had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- Almost all FAST positive patients were conveyed to the most appropriate destination for their condition. However, **5** FAST positive patients (**1%**) were transported to an ED when they should have been conveyed to a Hyper-Acute Stroke Unit (HASU).
- The average time on scene is **36** minutes, which remains longer than the recommended **30** minutes. Half of LAS crews attending stroke patients who were potentially eligible for thrombolysis spent **30** minutes or less on scene.
- The percentage of patients who were potentially eligible for thrombolysis and arrived at a HASU within **60** minutes has decreased from **68%** in August to **62%** in September 2016. This has been observed across all areas and reasons for this are being investigated.

Major Trauma

- The next major trauma data for Q2 will be published in December 2016.

Our Performance

Section	Key Headlines	Oct	Sep	Aug
A8 Performance	A8 Performance for October 2016 was 66.4%. This was lower than the contracted trajectory of 69.2%. This is the second month in a row that A8 has been below trajectory, however this was an improvement on last month by 3%.			
Other Performance	Performance for A19 improved by 0.9% from the previous month to 93.8% which was above trajectory. Cat C2-C4 performances saw an increase when compared with last month and all Cat C performance was above contracted trajectory.			
Demand	There were 46,890 category A incidents in October (6.1% above trajectory). Category C demand was 8.2% above trajectory. Overall demand was at 94,156 incidents, 7.2% above plan.			
Capacity	The patient facing vehicle hours (PFVH) deployed during October were above trajectory by 4.4%. Overtime vehicle hours were above plan for October.			
Efficiency	Job Cycle Time (JCT) for October was 84.7 minutes, this is an improvement of 0.6 minutes compared to last month. JCT was 3 minutes above the monthly trajectory of 81.7 minutes. The multiple attendance ratio was 1.29 and on target.			
EOC – Call Answering	The 5 Second Call Answering for October was at 95.1%, this was 0.1% above the target of 95%. This was also a 2% increase from the previous month.			
EOC – FRU Cat C Share	FRU share of Cat C for October was 9.9%, this was 4.9% above the target of 5%.			
Resource Escalation Action Plan (REAP)	In line with the National Ambulance Resilience Unit recommendations, our REAP identifies the level of pressure the Service is under at any given time, and gives a range of options to deal with the situation. Four levels of escalation are used, which aim to help ambulance services integrate into the wider NHS surge or escalation framework. These levels are used to determine what actions are necessary to protect service delivery and supply the best possible level of service to patients with the resources available. Currently the Service is at REAP 2 (Moderate)			

Ambulance Quality Indicators (AQI) Update – September 2016

The AQIs for September 2016 were published on 10th November 2016. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

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

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

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**			
AQI Indicator Description SYSTEM INDICATORS	**Units**	**Target**	SEP	AUG	JUL	Ranked out of	SEP	AUG	JUL
The time taken to answer 95% of 999 calls in the emergency control room	(secs)	5 secs	16	4	17	11	4	2	3
The percentage of callers who have hung up before their call was answered in the emergency control room	%		0.4%	0.2%	0.5%	11	1	2	2
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	70.1%	68.7%	68.3%	8	4	5	5
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	63.3%	67.4%	63.6%	8	5	3	3
The time taken to reach 95% of Category A (Red 1) calls	(mins)		13.4	14.5	13.8	8	4	6	4
The percentage of Category A calls reached within 19 minutes	%	95%	92.9%	94.0%	93.1%	8	3	2	2
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	(mins)		19.9	18.2	19.6	8	6	4	5

Latest Publication : 10th November 2016 (Sep-16 data)
Date of next publication : 8th December 2016

Ambulance Quality Indicators (AQI) Update – June 2016

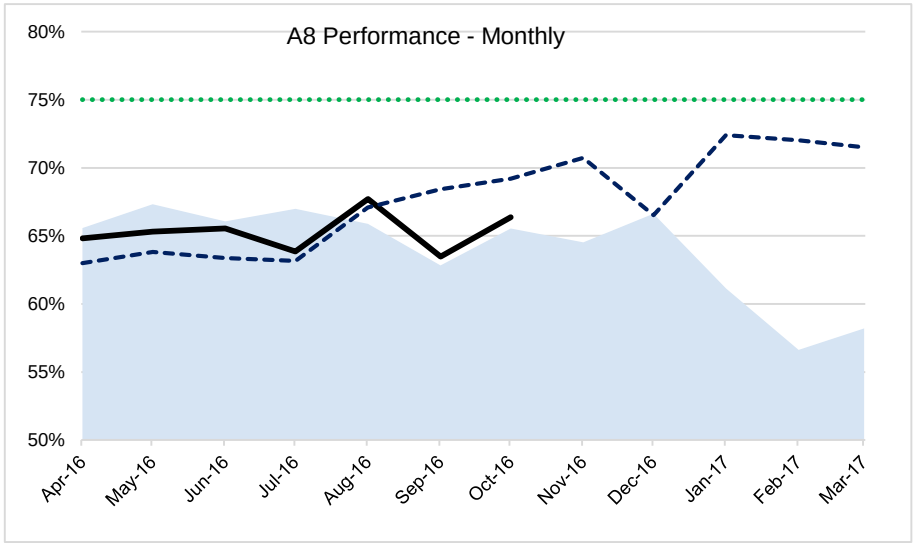
The AQIs for June 2016 were published on 10th November 2016.

The list of AQIs detailed below make up part of the Ambulance Clinical Outcome Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England. The table below details 7 of these indicators with the description and LAS performance.

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**		
AQI Indicator Description CLINICAL OUTCOMES	**Units**	**Target**	JUN	MAY	APR	JUN	MAY	APR
Cardiac Arrest out of hospital - Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall)	%	27%	33.3%	28.6%	31.1%	2	6	3
Cardiac Arrest out of hospital - Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein Comparator Group)	%	55%	62.7%	52.8%	60.0%	3	7	4
Percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call	%		92.4%	86.5%	94.8%	4	6	1
Percentage of patients suffering a STEMI who receive an appropriate care bundle	%	72%	68.2%	74.3%	69.3%	8	8	9
Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call	%	61%	63.7%	64.9%	64.6%	2	3	3
Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle	%	98%	96.5%	96.6%	95.6%	10	9	10
Cardiac Arrest out of hospital - Survival to discharge (Overall survival rate)	%		9.5%	9.8%	8.4%	4	3	5
Cardiac Arrest out of hospital - Survival to discharge (Utstein Comparator Group survival rate)	%		25.5%	27.3%	37.5%	5	5	3

Latest Publication : 10th November 2016 (Jun-16 data)
Date of next publication : 8th December 2016

A8 Performance

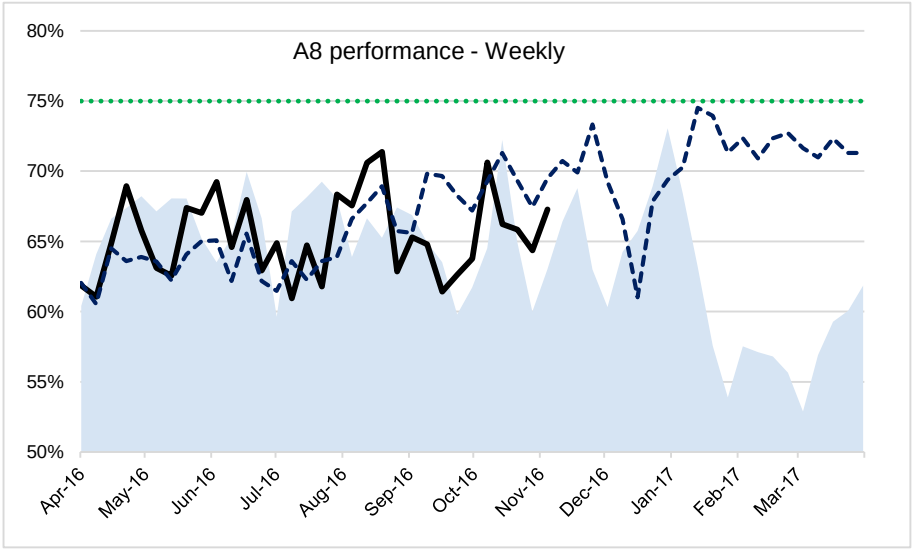


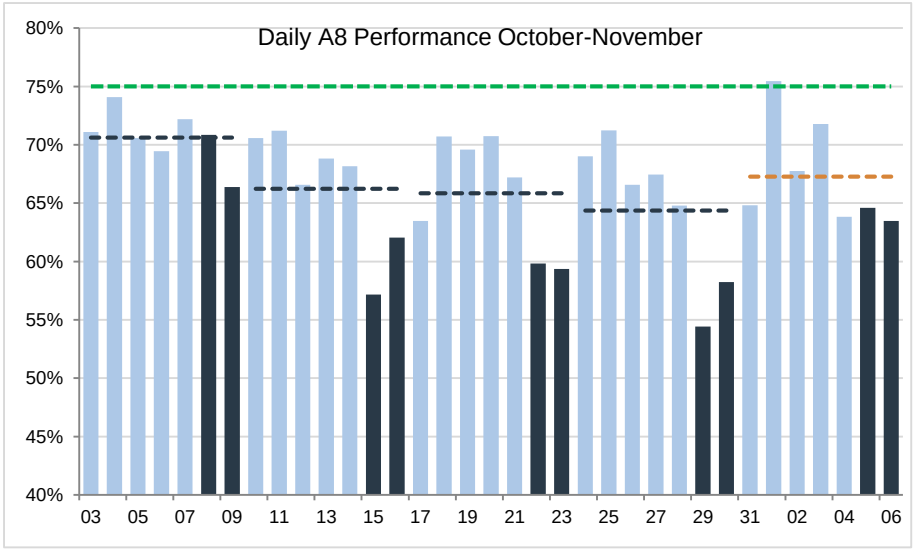
A8 Performance for October 2016 was 66.4%. This was lower than the contracted trajectory of 69.2%, for additional context, October 2015's figure was 65.5%.

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

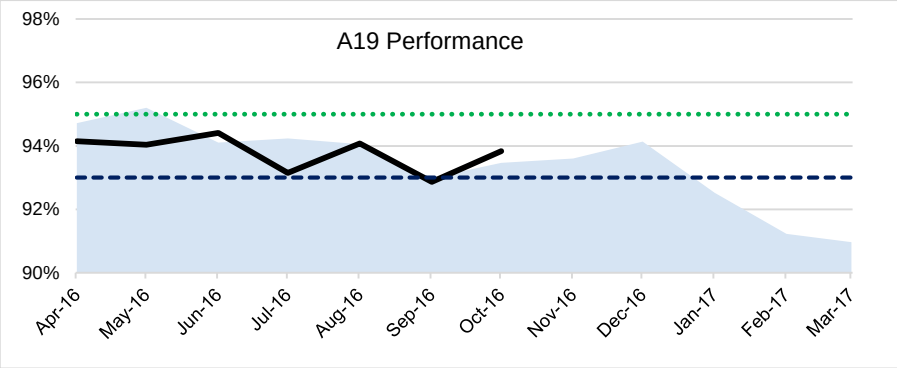
- **Demand** – Overall the number of incidents was 7.2% above plan. Cat A was 6.1% above trajectory, Cat C was 8.2% above trajectory.
- **Capacity** – Overall patient facing vehicle hours were 4.4% above plan.
- **Efficiency** - Average job cycle time was 3.05 minutes above trajectory however MAR was 1.29 and on target.

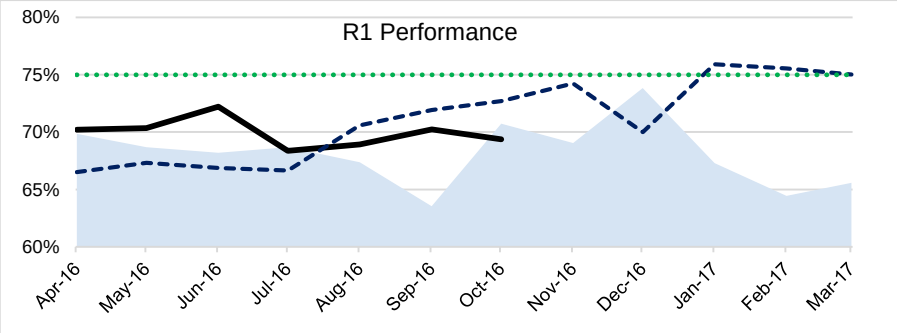
15/16 actual data
16/17 actual data
Trajectory
National target

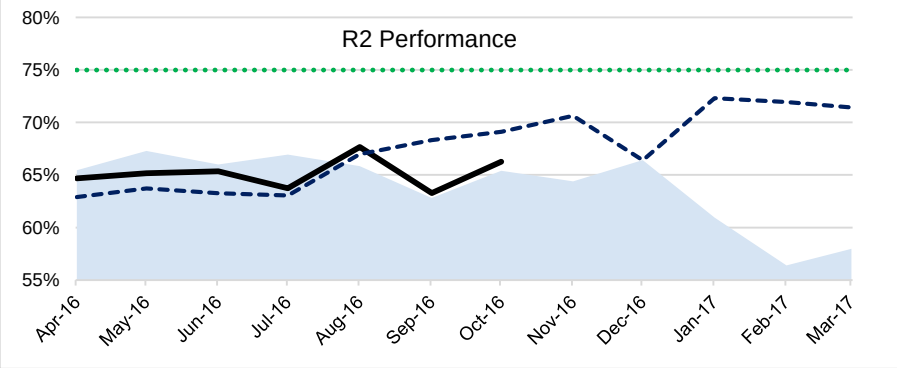




Other Performance







A19 performance in October 2016 increased by 1% compared to last month.

- Red 1 was 69.4%, below plan by 3.3%.
- Red 2 was 66.3%, below plan by 2.9%.
- A19 was 93.8%, above plan by 0.9%.

C1 performance saw a decrease when compared to last month, however C2 – C4 all saw increases compared to September's performance.

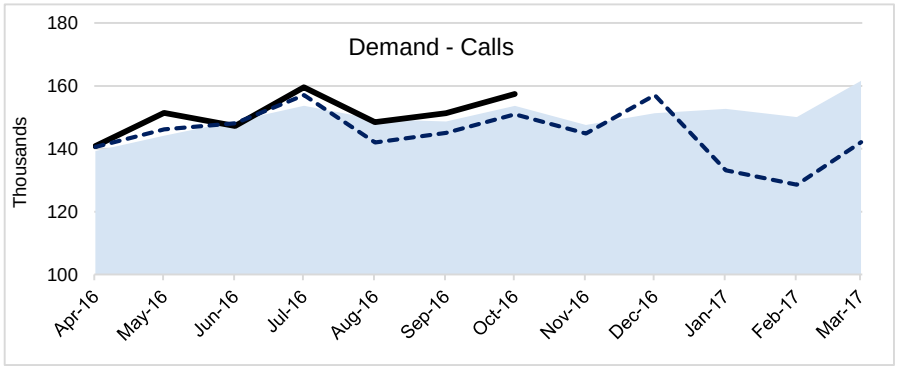
The contracted target for Cat C performance has changed for 2016-17. The new measures are:

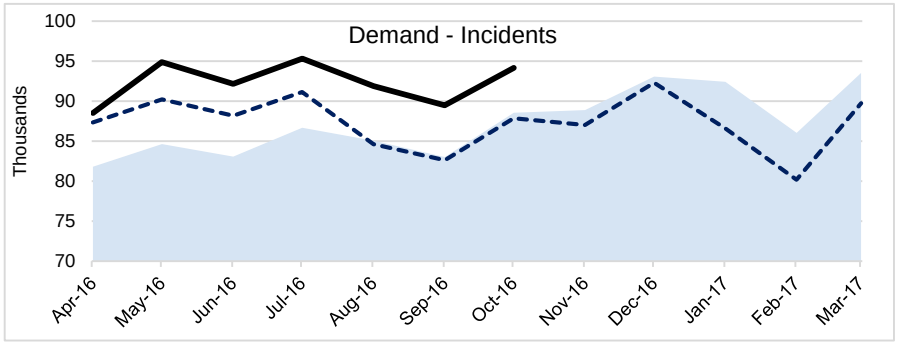
- C1 performance - 50% within 45 minutes.
- C2, C3 and C4 performance – 50% within 60 minutes.

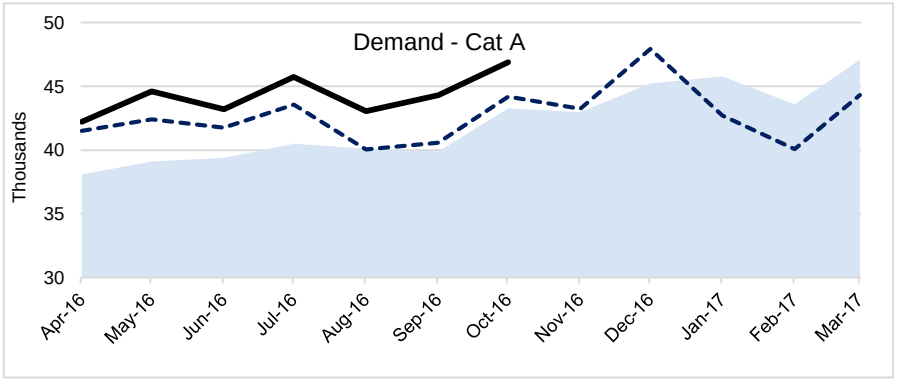
15/16 actual data
16/17 actual data
Trajectory
National target

Week ending	A8	A19	R1	R2	C1	C2	C3	C4
09-Oct	70.6	95.4	73.9	70.5	79.3	82.8	84.7	64.3
16-Oct	66.2	94.0	67.2	66.2	74.4	77.2	80.3	59.9
23-Oct	65.8	93.8	68.5	65.8	73.1	77.1	78.5	58.2
30-Oct	64.4	92.6	67.1	64.3	70.1	72.8	75.9	56.7
06-Nov	67.3	94.5	69.7	67.2	78.6	83.0	82.5	63.6
Aug-16	67.7	94.1	68.9	67.7	82.9	84.2	83.6	65.6
Sep-16	63.5	92.9	70.2	63.3	75.7	77.3	78.2	58.7
Oct-16	66.4	93.8	69.4	66.3	74.2	77.5	79.8	59.6

Demand







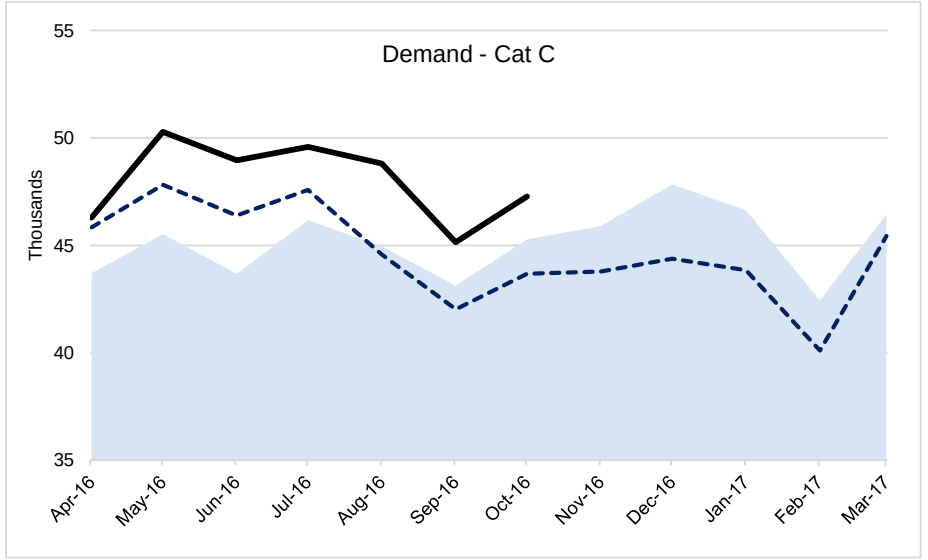
Overall demand was 7.2% above trajectory in October and 6.3% higher than October last year.

Cat A demand was 6.1% above plan and 8.4% higher than October last year.

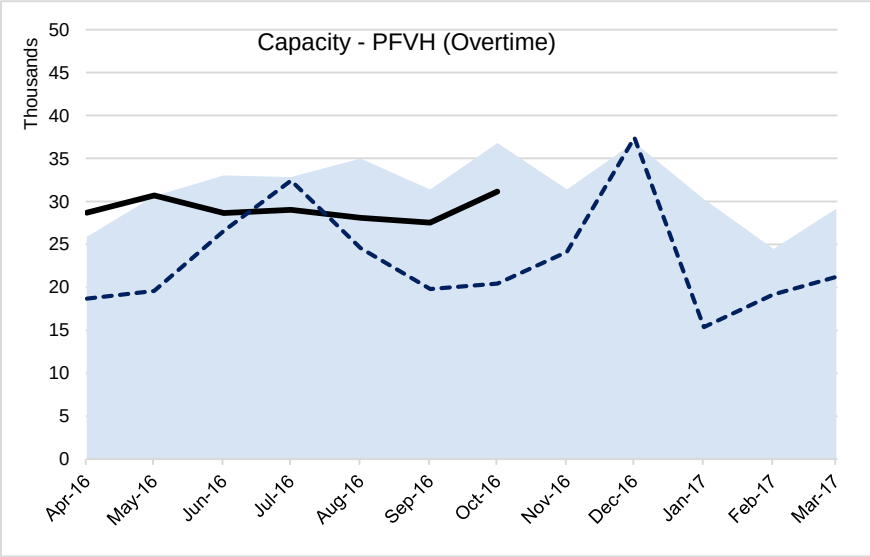
Category C incidents were above trajectory by 8.2% and higher than last year by 4.4%.

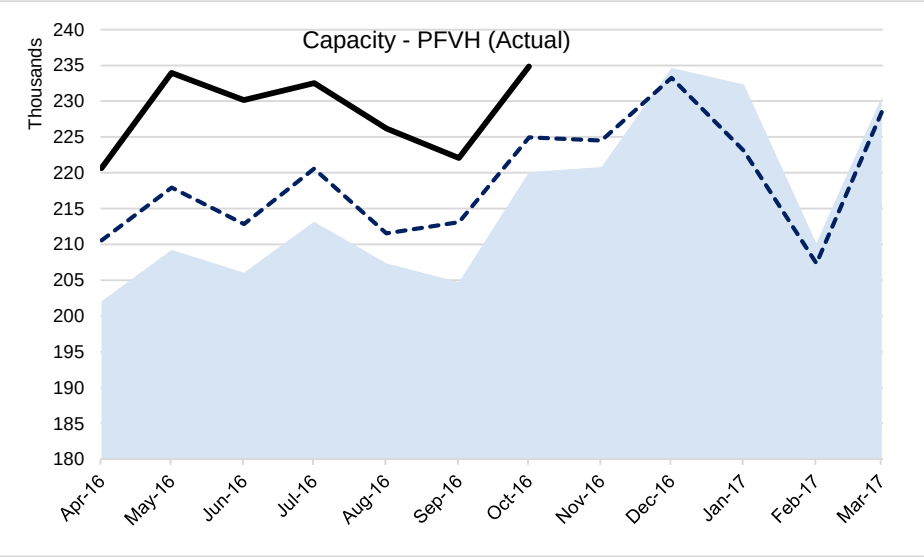
Call volumes were 4.3% above contract level for October 2016 and 2.5% higher than October last year.

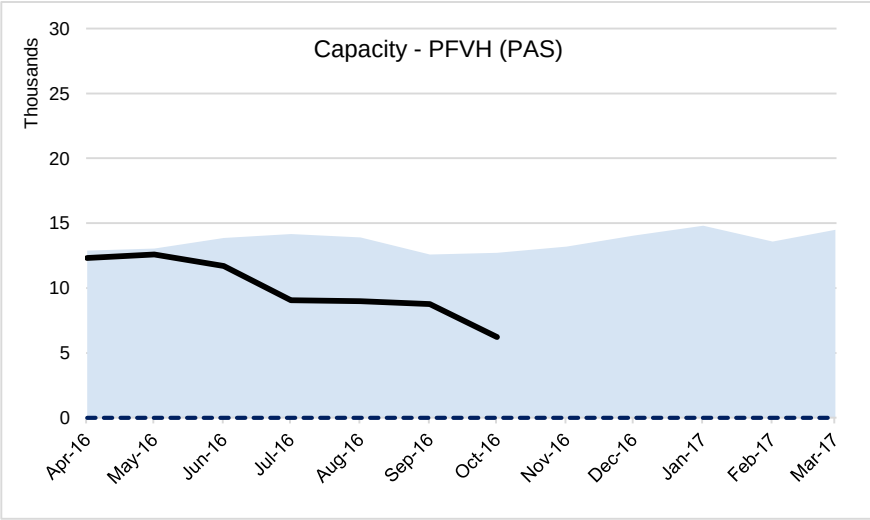
15/16 actual data
16/17 actual data
Trajectory



Capacity







Total patient facing vehicle hours were above the trajectory for October.

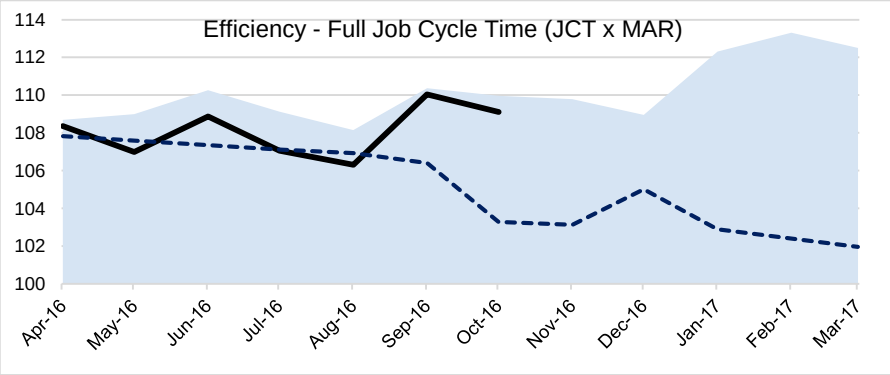
The actual hours deployed were 234,850 against a plan of 224,948 hours, a 4.4% difference.

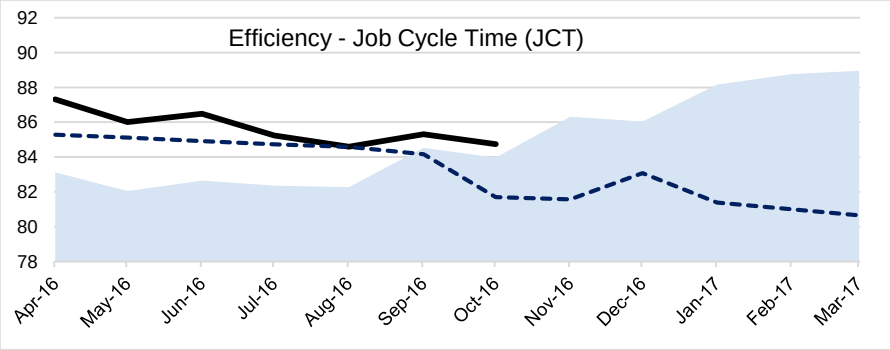
Overtime vehicle hours for October 2016 was above trajectory, at 52.4% above plan.

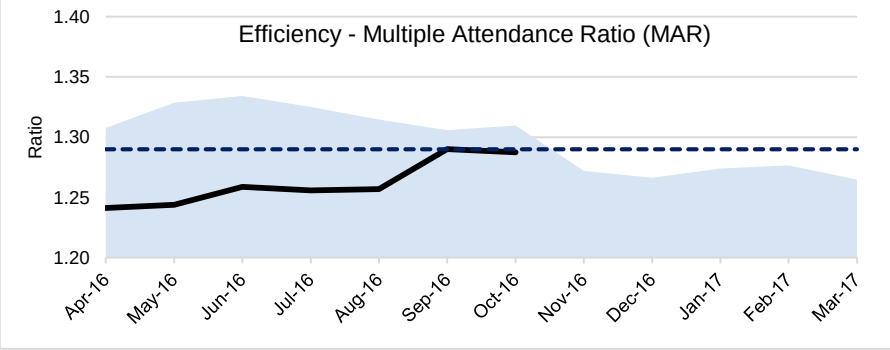
PAS/VAS hours for October 2016 are 51.05% below the level of October 2015.

15/16 actual data
16/17 actual data
Trajectory

Efficiency







Job Cycle Time for October 2016 was 84.7 minutes, above the trajectory of 81.7 by 3 minutes.

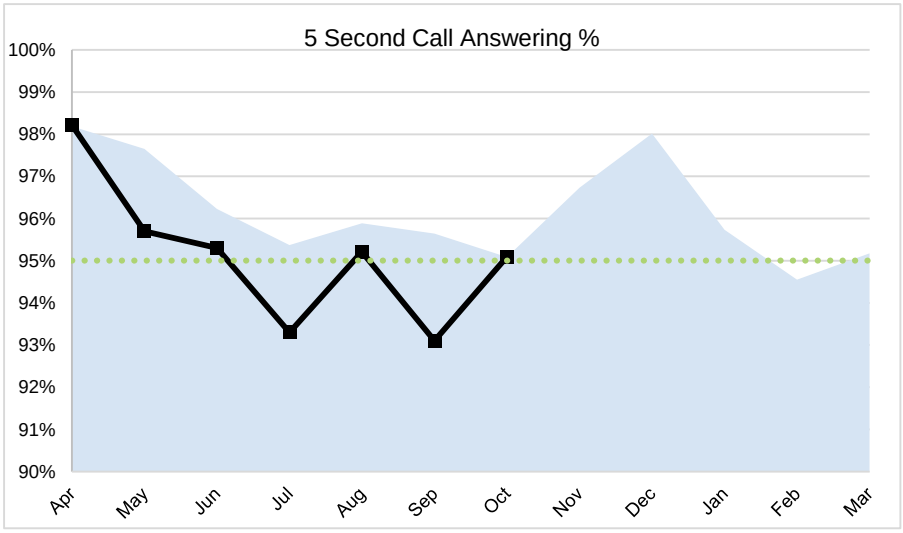
This was an decrease of 0.6 minutes from the previous month.

Full Job Cycle (JCT x MAR) was 109.1 minutes, above the October trajectory of 103.3.

The Multiple Attendance Ratio (MAR) was on target for October at 1.29. The trajectory for every month this year is 1.29.

15/16 actual data
16/17 actual data
Trajectory

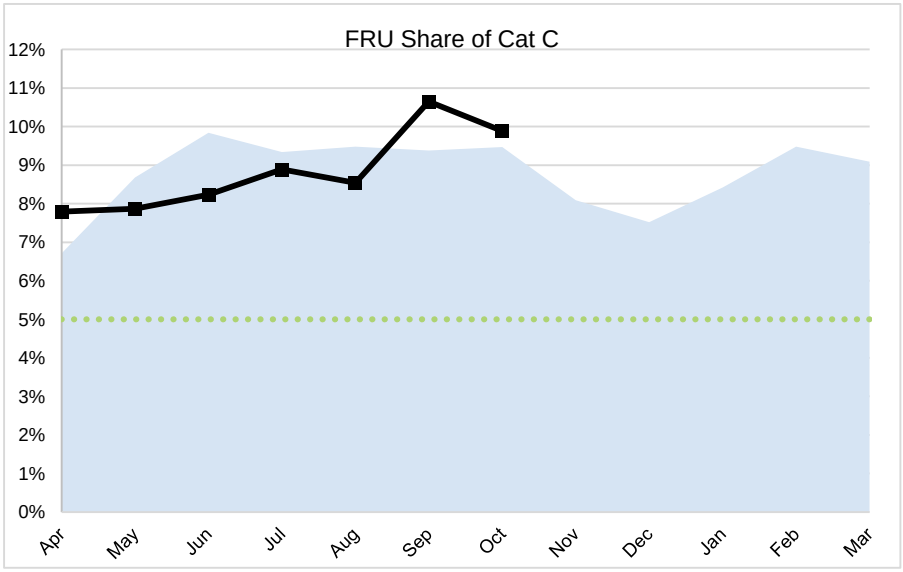
Emergency Operations Centre (EOC)



5 Second Call Answering for October was at 95.1%, which is above the 95% target.

FRU share of Cat C for October was 9.9%, this was 4.9% above the target of 5%. This was a 0.75% decrease from the previous month.

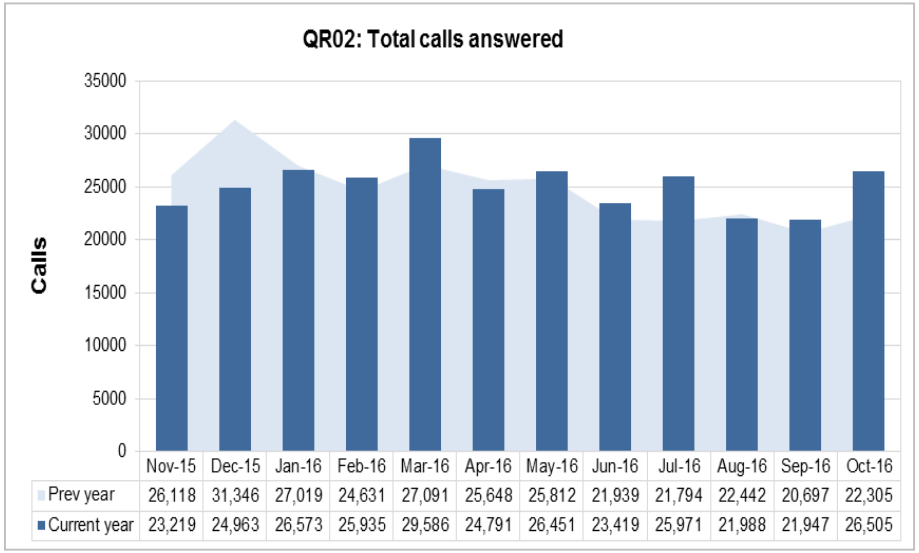
15/16 actual data
16/17 actual data
Target



Month	5 Second Call Answering %	
	2015-16	2016-17
Apr	98.19%	98.21%
May	97.65%	95.70%
Jun	96.23%	95.30%
Jul	95.37%	93.30%
Aug	95.89%	95.21%
Sep	95.64%	93.10%
Oct	95.09%	95.10%
Nov	96.73%	
Dec	98.02%	
Jan	95.73%	
Feb	94.55%	
Mar	95.18%	

Month	FRU Share of Cat C	
	2015-16	2016-17
Apr	6.71%	7.80%
May	8.68%	7.87%
Jun	9.84%	8.23%
Jul	9.34%	8.89%
Aug	9.48%	8.54%
Sep	9.38%	10.65%
Oct	9.47%	9.89%
Nov	8.09%	
Dec	7.52%	
Jan	8.42%	
Feb	9.48%	
Mar	9.09%	

LAS 111 (South East London) – Demand and Capacity



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	26,118	31,346	27,019	24,631	27,091	25,648	25,812	21,939	21,794	22,442	20,697	22,305
Current year	23,219	24,963	26,573	25,935	29,586	24,791	26,451	23,419	25,971	21,988	21,947	26,505

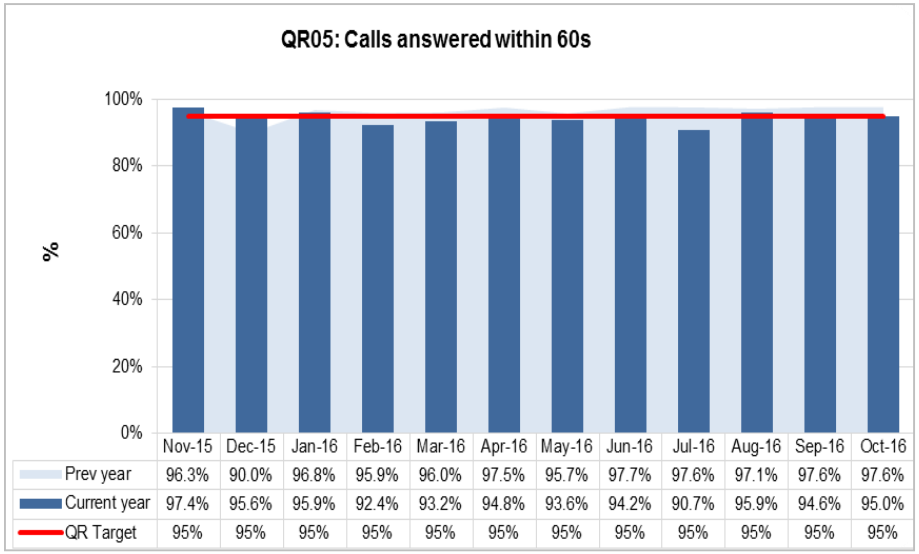
Demand: Call volumes fluctuated during October and were above the forecast on 26 days, however the recent rebalancing of calls across the week has resulted in lower levels of fluctuation and associated improvements in performance.

Capacity: The ongoing issue with recruitment of Clinical Advisors is unchanged. The Call Handler establishment is more stable. The rolling recruitment programme is now focused on recruitment for a January 2017 induction for both skill groups.

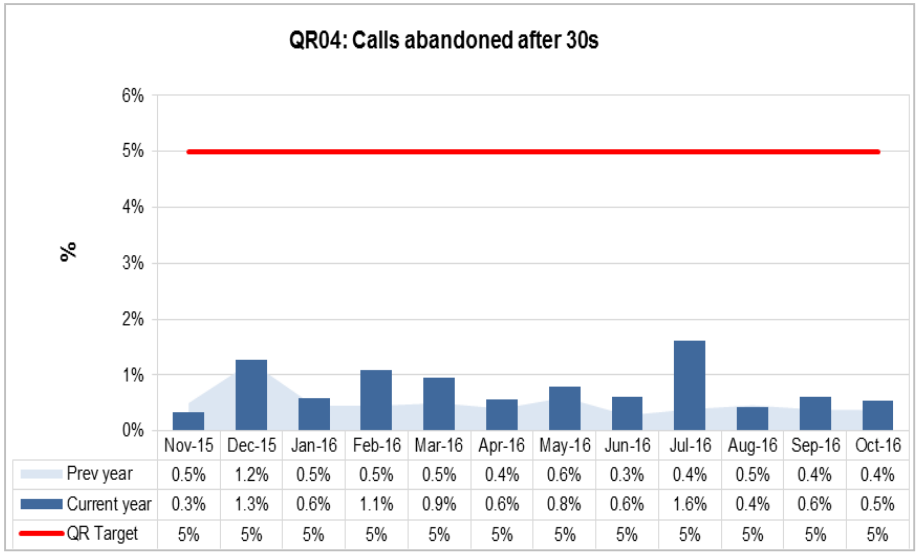
Efficiency: The percentage of calls answered in 60 seconds was 95% in October with the target achieved on 20 days.

Service Projects: Throughout October the service continued to focus on reporting issues (live and historical). Discussions with a range of suppliers for reporting solutions are in place.

The 111 service is working towards a solution for booking appointments into extended hours GP hubs. The aim is to be able to do this directly from Adastra for Bromley and Lambeth CCG patients before Christmas.

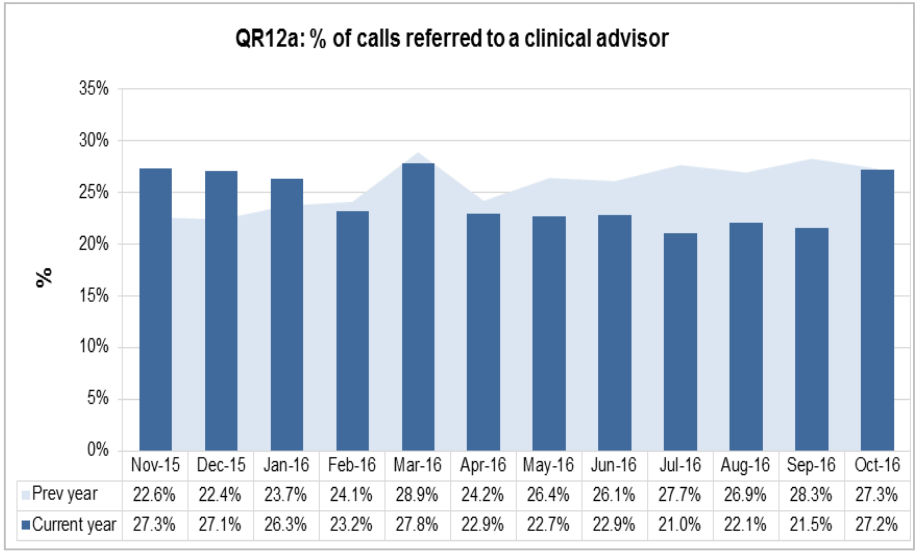


	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	96.3%	90.0%	96.8%	95.9%	96.0%	97.5%	95.7%	97.7%	97.6%	97.1%	97.6%	97.6%
Current year	97.4%	95.6%	95.9%	92.4%	93.2%	94.8%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%
QR Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	0.5%	1.2%	0.5%	0.5%	0.5%	0.4%	0.6%	0.3%	0.4%	0.5%	0.4%	0.4%
Current year	0.3%	1.3%	0.6%	1.1%	0.9%	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%
QR Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

LAS 111 (South East London) – Call Destinations

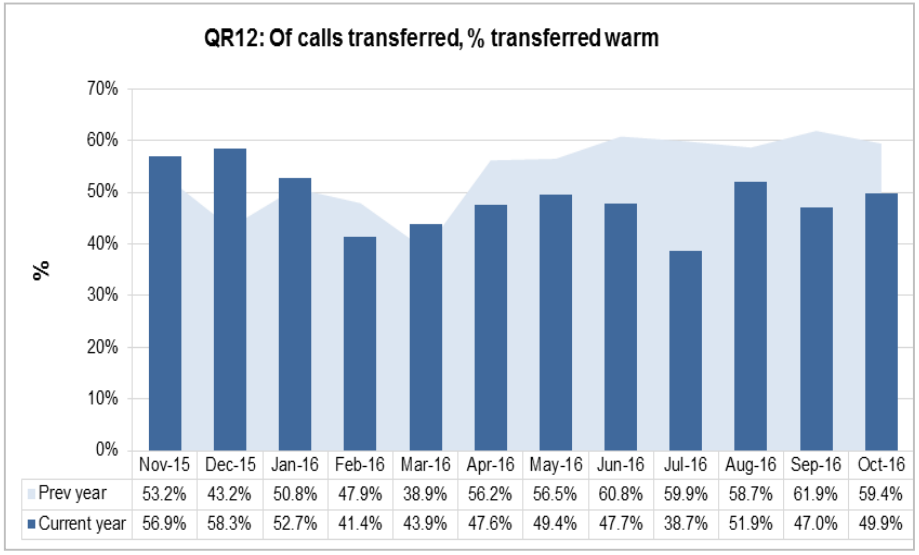


	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	22.6%	22.4%	23.7%	24.1%	28.9%	24.2%	26.4%	26.1%	27.7%	26.9%	28.3%	27.3%
Current year	27.3%	27.1%	26.3%	23.2%	27.8%	22.9%	22.7%	22.9%	21.0%	22.1%	21.5%	27.2%

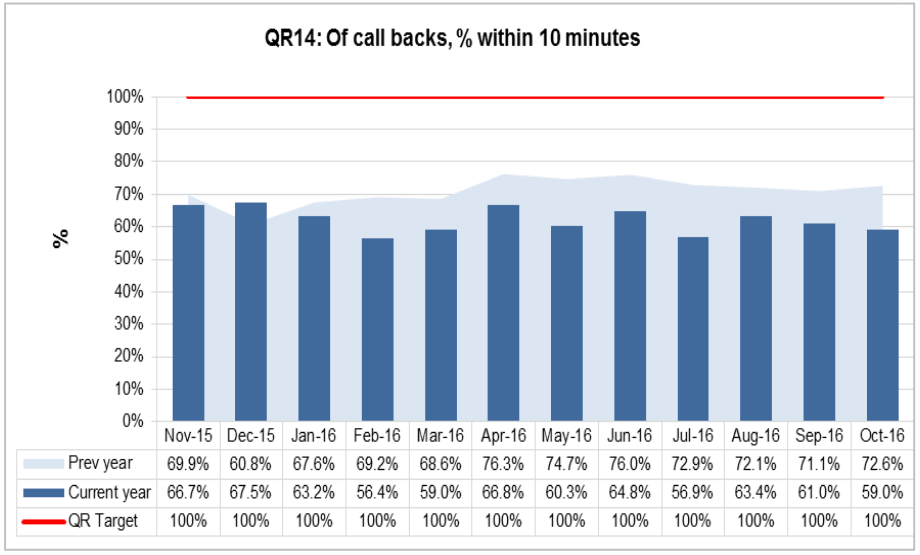
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green (lower acuity) ambulance outcomes and availability of Clinical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

Safety: There were 32 Incidents reported in Datix by the LAS 111 Team. Of these, 25% related to calls referred to an incorrect Out Of Hours Provider, 15.6% were due to system failure, 12.5% for breaches of procedure and the remaining 46.9% due to a range of 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 compliment and feedback from one Health Care Professional. There is currently one SI under investigation.

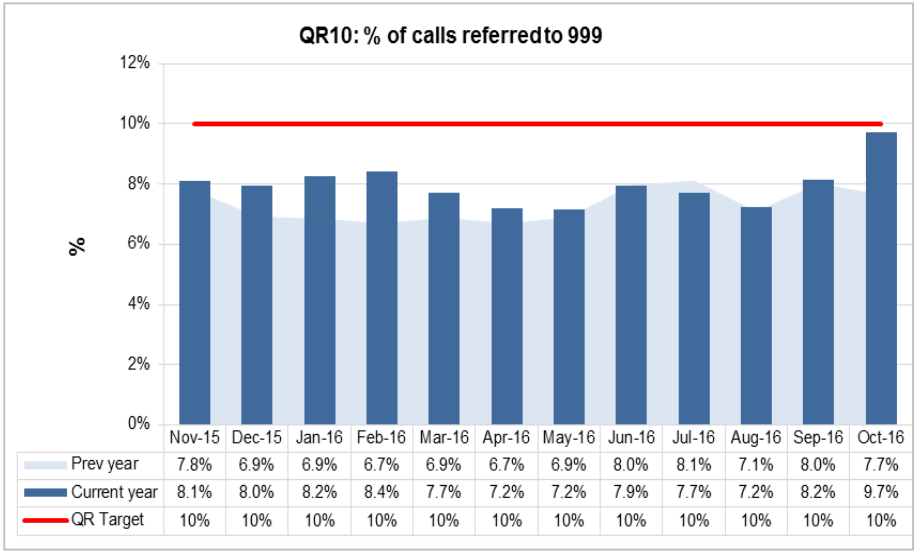


	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	53.2%	43.2%	50.8%	47.9%	38.9%	56.2%	56.5%	60.8%	59.9%	58.7%	61.9%	59.4%
Current year	56.9%	58.3%	52.7%	41.4%	43.9%	47.6%	49.4%	47.7%	38.7%	51.9%	47.0%	49.9%

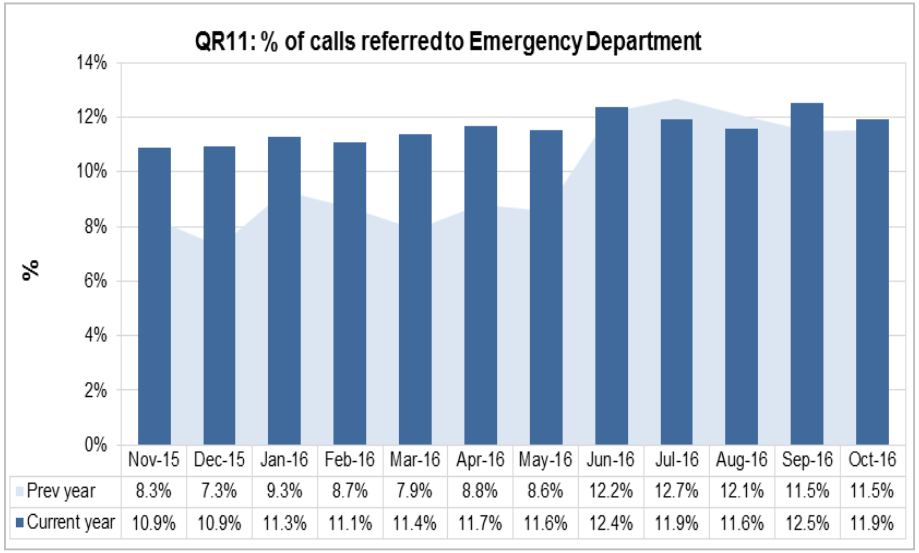


	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	69.9%	60.8%	67.6%	69.2%	68.6%	76.3%	74.7%	76.0%	72.9%	72.1%	71.1%	72.6%
Current year	66.7%	67.5%	63.2%	56.4%	59.0%	66.8%	60.3%	64.8%	56.9%	63.4%	61.0%	59.0%
QR Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

LAS 111 (South East London) – Triage destinations



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	7.8%	6.9%	6.9%	6.7%	6.9%	6.7%	6.9%	8.0%	8.1%	7.1%	8.0%	7.7%
Current year	8.1%	8.0%	8.2%	8.4%	7.7%	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	9.7%
QR Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Prev year	8.3%	7.3%	9.3%	8.7%	7.9%	8.8%	8.6%	12.2%	12.7%	12.1%	11.5%	11.5%
Current year	10.9%	10.9%	11.3%	11.1%	11.4%	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%

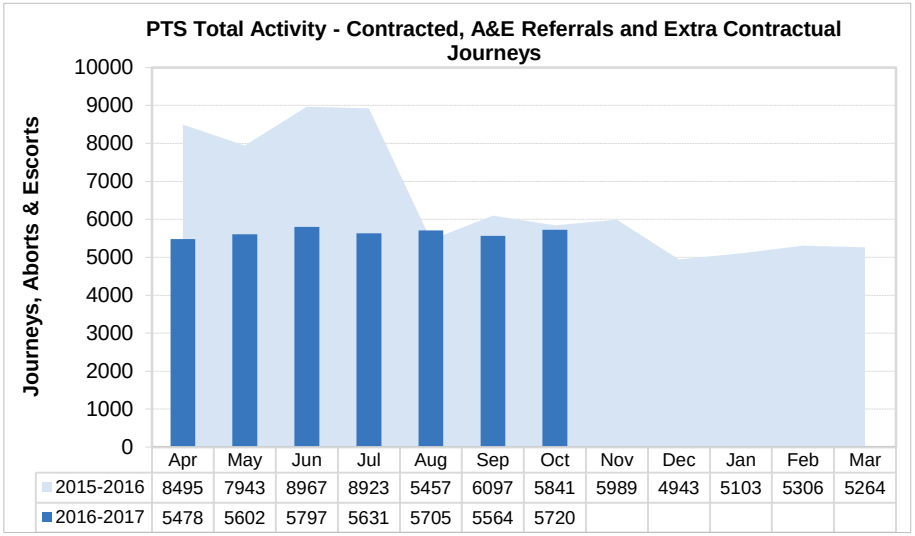
LAS 111 consistently and successfully has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for Green (lower acuity) ambulance outcomes.

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

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 is consistent when compared to other London Providers.

Clinical skills workshops have commenced focusing on asking probing questions and critical thinking skills for clinical advisors. Early indications show that those attending the workshops are successfully demonstrating a lower referral rate to urgent and emergency care services, including 999 and Emergency Departments.

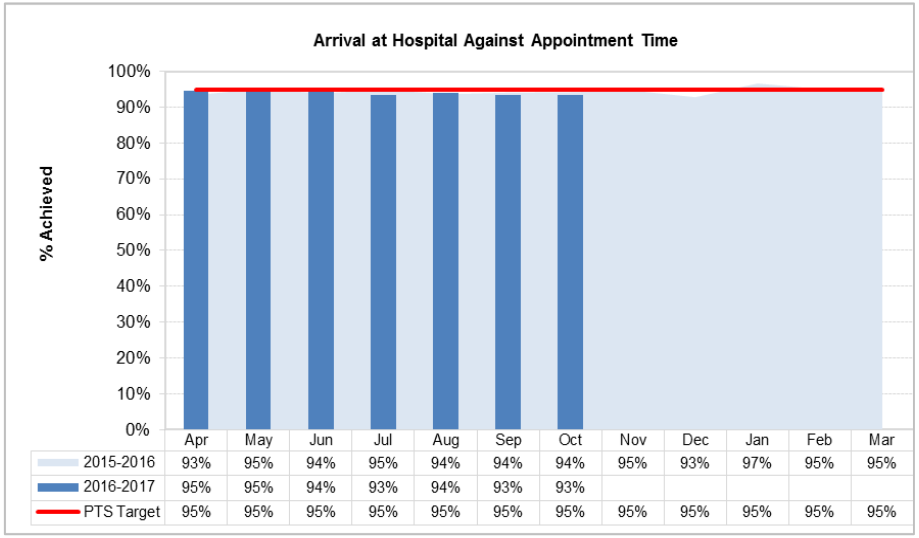
Patient Transport Service – Activity Update



5,720 journeys were completed in October 2016, an increase from the previous month's total of 5,564 journeys.

Month	2013-2014	2014-2015	2015-2016	2016-2017
Apr	15044	13227	8495	5478
May	15987	13164	7943	5602
Jun	14852	10129	8967	5797
Jul	16481	10508	8923	5631
Aug	14401	9028	5457	5705
Sep	15002	9602	6097	5564
Oct	16739	10957	5841	5720
Nov	15981	10063	5989	
Dec	13986	9250	4943	
Jan	16409	9753	5103	
Feb	15232	9787	5306	
Mar	13978	10520	5264	
Total	184092	125988	78328	39497

Patient Transport Service – KPI Update

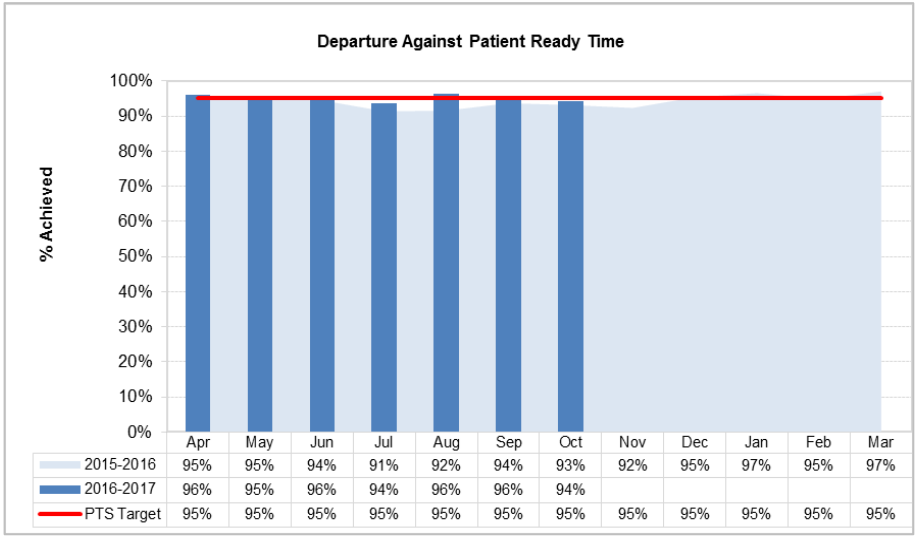


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	93%	95%	94%	95%	94%	94%	94%	95%	93%	97%	95%	95%
2016-2017	95%	95%	94%	93%	94%	93%	93%					
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

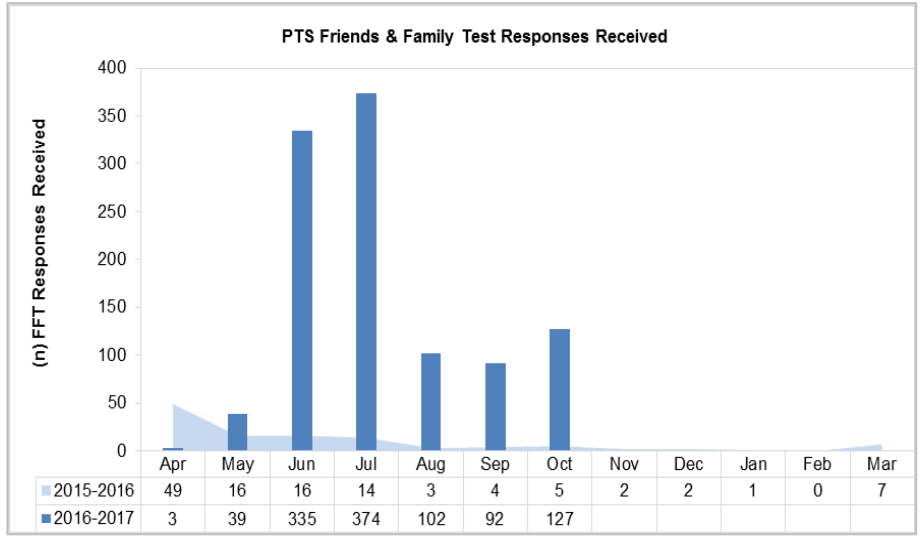
Arrival against appointment time remained at 93% in October. The patient departure KPI saw a reduction from 96% in September to 94% in October.

The Friends and Family Test (FFT) responses have increased this month following our move to a monthly mailshot, which is reflective of the increase in patient journeys in October.

In October, questionnaires were only sent to those new patients receiving PTS services. As a consequence we have seen an overall fall for the last three months in the return rate, linking to the total activity undertaken. This was expected.

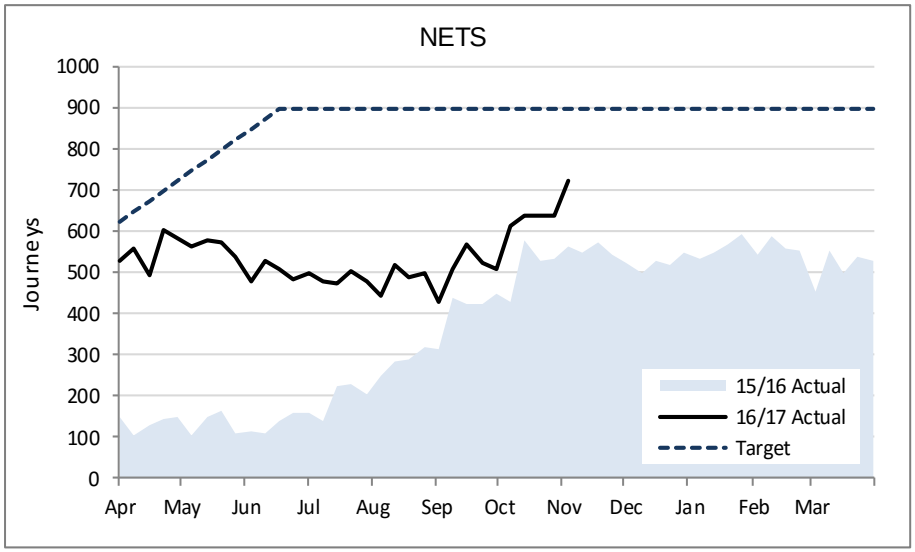


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	97%
2016-2017	96%	95%	96%	94%	96%	96%	94%					
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	49	16	16	14	3	4	5	2	2	1	0	7
2016-2017	3	39	335	374	102	92	127					

Non-Emergency Transport Service



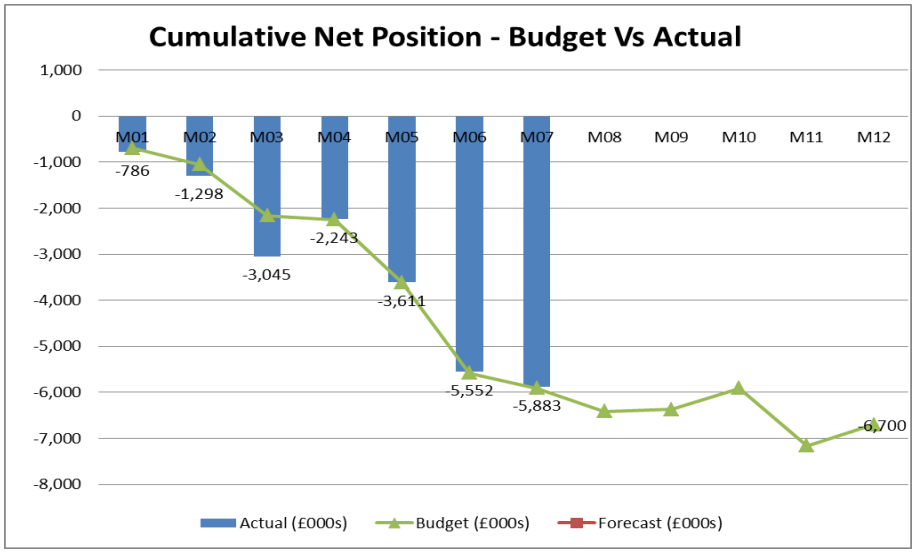
This graph shows the Non-Emergency Transport Service (NETS) incidents delivered (calls done and aborts; cancellations are not included).

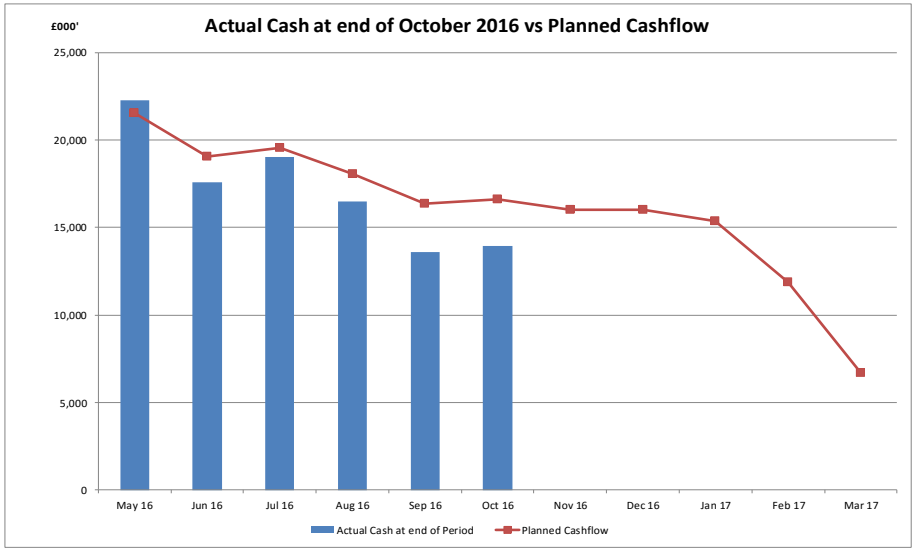
In the last four weeks we have seen a continued increase as a result of the higher number of vehicles we are now able to put out with the new intake of 24 staff.

Our Money

Financial Indicator	Key Headlines	Oct	Sep	Aug
Surplus (Year to date)	Year to date the position is on plan, The year end position of £6.7m remains at risk due to the additional capacity required to meet higher than planned activity. LAS Commissioners have confirmed £2.1m for Q2 and further funding across Q3 and Q4. Without this funding the £6.7m control total will not be met. LAS needs to support this position through demand management and productivity improvements to limit the scale of the funds required. Key issues in the position are: • Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 and Q2. Demand is currently running above contracted activity growth (circa 5% YTD). This capacity is partially funded by £2.1m agreed by LAS commissioners for Q2 due to activity above plan plus an additional £1m for overperformance in Month 7. • Across the year to date position this overspend is partly offset by underspend in other areas. This cannot be sustained across the second two quarters without a combination of additional funds, demand management and improved productivity.			
Income	Income is £1.1m favourable in month and £3m favourable YTD. • £2.1m additional income has been agreed by commissioners to support increased activity in Q2. A further £1m has been included for Month 7. Additional funds will be required if demand is not curbed and productivity gains are not delivered. • Education & Training Income is currently below the expected plan YTD by £0.4m. This could recover throughout the year if bids area successful. • 111 Income is £0.4m adverse due to continuing review of operating costs with commissioners. This is offset against reduced cost. • Non Contract PTS income is £0.3m favourable. This is offset by increased costs.			
Expenditure (incl. Financial Charges)	In month expenditure is £1.1m adverse to plan, YTD the position is £2.9m adverse to plan. The key drivers for this YTD position are: • Core frontline operational costs are £6.2m over budget. This includes £5m for PAS. • £1.7m favourable due to underspends in Operational Management etc. • £1.6m favourable in Non Core Operational divisional spend.			
CIPs	Year to date CIPs are £0.6m adverse to plan. This relates to delays in the delivery of some programmes that were due to start in Q2. The full year plan of £10.5m is still seen as challenging but achievable. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.			
Balance Sheet	Capital spend is £2.7m against a revised Capital plan of £4.4m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. NHSI have approved the £4.5m of £4.9m capital underspend from 2015/16, our approved CRL is now £19.1m.			
Cashflow	Cash is £14.0m, £2.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from Brent CCG (£2.4m) and LAS Commissioners (£2.5m).			

Executive Summary - Key Financial Metrics





	2016/17 - Month 7			Year to Date			FY 2016/17
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(328)	(327)	1	(5,908)	(5,868)	40	(6,700)
EFL				3,607	6,253	(2,646)	13,509
CRL				4,412	2,653	1,759	19,599
Suppliers paid within 30 days - NHS	95%	85%	(10.0%)	95%	80%	(15.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	88%	(7.0%)	95%	85%	(10.0%)	95%
Monitor							
EBITDA %	4.4%	4.1%	(0.4%)	2.6%	2.4%	(0.2%)	3.6%
EBITDA on plan	1,221	1,167	(54)	4,906	4,677	(230)	11,905
Net Surplus	(328)	(327)	1	(5,908)	(5,868)	40	(6,700)
NRAF (net return after financing)				(2.7%)	(2.7%)	0.0%	(2.1%)
Liquidity Days				(6.06)	(4.53)	1.5	(17.20)
Use of Resources Rating					3.0		

In-Month and YTD the Position is on plan. The year end position of £6.7m remains at risk due to the additional capacity required to meet higher than planned activity. LAS Commissioners have confirmed £2.1m for Q2 and further funding across Q3 and Q4. Without this funding the £6.7m control total will not be met.

- Key issues in the position are:
  - £2.1m additional income has been agreed by commissioners to support increased demand in Q2. A further £1m has been recognised in M7 for overperformance. Additional funds will be required if demand is not curbed and productivity gains are not delivered.
  - Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 & Q2. Demand is currently running above contracted activity growth (circa 5% year to date and 8% in August). This capacity is unfunded.
  - Further reductions in PAS (25%) and Incentives (10%) have been agreed for Q3 but further action will be required to return to a sustainable position.
- CRL position – The capital plan is £1.8m behind target. NHSI have now approved the DCA business case.
- Cash is £14.0m, £2.6m below plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from Brent CCG (£2.4m) and LAS Commissioners (£2.5m).
- In M7 the trust will be assessed against the new NHSI Use of Resources Rating. There are no budgeted figures as the basis of the rating has changed. The rating is scored 1-4 with 1 being the highest rating.
- In order to support the overall position a number of cost control measures will also be required beyond frontline productivity and demand management.

Our People

Section	Key Headlines	Oct	Sep	Aug

Vacancy and Recruitment	Reported vacancy rates have increased due to the decision made to report against 100% of establishment.
	• The overall vacancy rate has improved from 5.6% to 4.7%.
	  • The vacancy rate for front line staff has increased from 7.1% to 7.2%.
	  • The vacancy rate for frontline paramedics has improved from 11.5% to 9.8%.
				

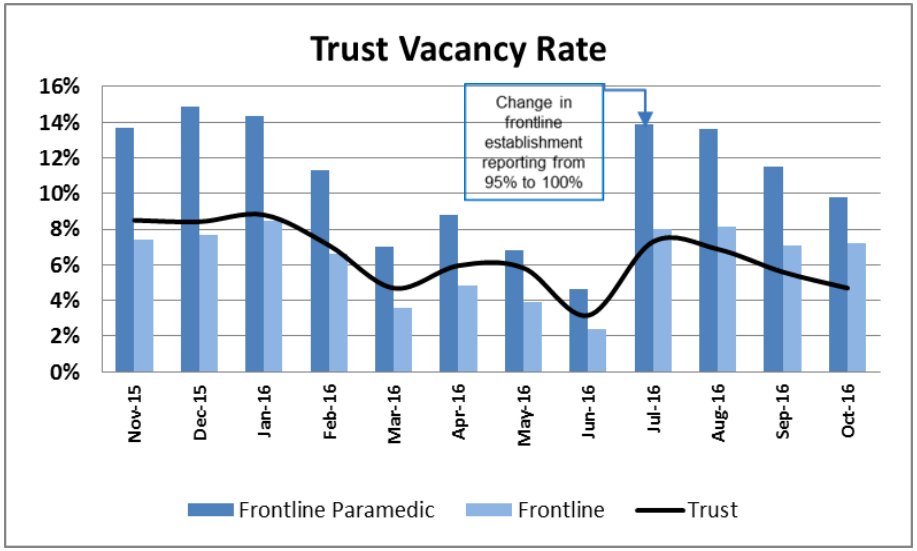
Turnover	• Trust turnover has improved from 9.8% to 9.7%.
	  • Frontline turnover has improved from 8.9% to 8.7%.
	  • Frontline paramedic turnover has improved from 8.6% to 8.2%.
				

Sickness	Sickness will be reported one months in arrears. • Overall trust sickness has remained at 5% against a threshold of 5.5%. • Frontline sickness has remained at 5.4%.			

Vacancy – Trust wide

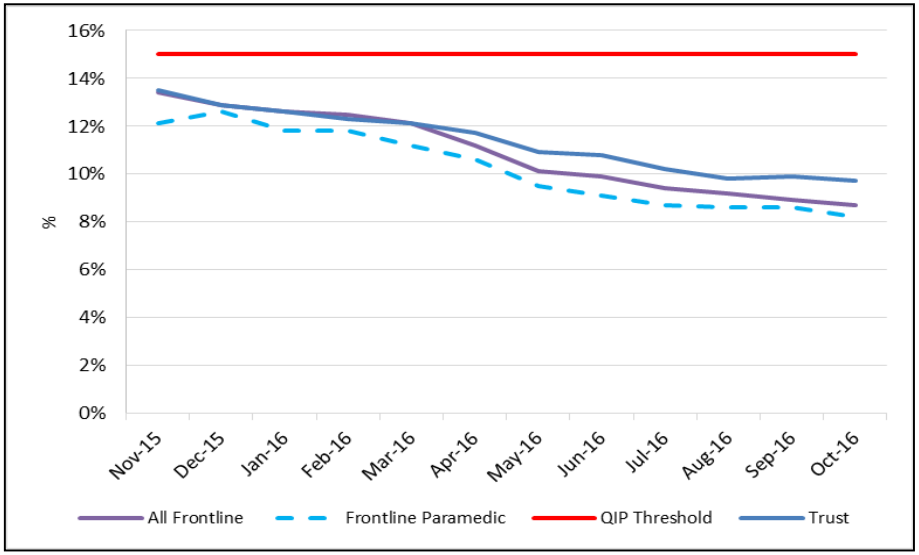
	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	5,196.8	4,953.3	243.5	4.7%
Total Frontline	3,372.7	3,128.0	244.7	7.2%
Paramedic	2,088.5	1,884.2	204.4	9.8%
Apprentice Paramedics	85.0	108.33	-23.33	-27.5%
EAC / TEAC	773.2	767.8	5.4	0.7%
EMT & support tech	426.0	367.7	58.2	13.7%
EOC	378.0	397.7	-19.7	-5.2%
Other staff	1,446.09	1,427.52	18.57	1%

- In October we had 44 frontline starters against a target of 69.
- We delivered the Trainee Emergency Ambulance Crew (TEAC) target but are behind plan for Paramedics. This is mainly as a result of the start dates for International Paramedics having slipped to Q4. We also had 15 UK candidates who withdrew at offer stage due to issues relocating to London, offers of alternative employment with other Trusts and unsatisfactory pre-employment checks.
- There are 8 International Paramedic courses starting between January and March 2017 with 125 confirmed starters to date and this will ensure we deliver to the 2016/17 target.

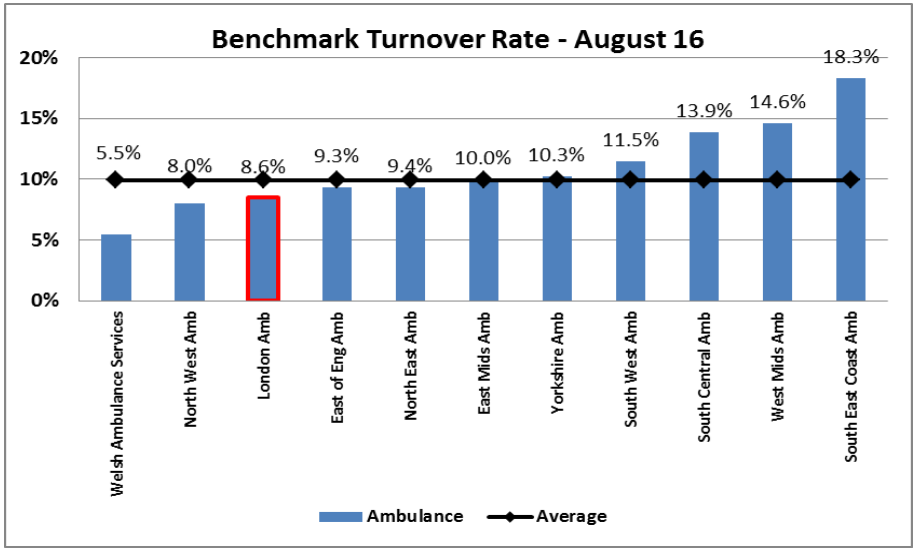


- We have met our target this month with 15 TEAC starters. We are specifically focusing on recruitment into the North West, North Central and West sectors. We are on target to deliver November and January starter targets. Additional courses are being organised in January and February with 30 places available.
- A range of activities are in progress to support the challenging target of recruiting Emergency Medical Dispatchers to the Emergency Operations Centre. This includes super Saturday events, EMD led open evenings, engagement with local recruitment providers and developing apprenticeships.

Turnover – Trust wide

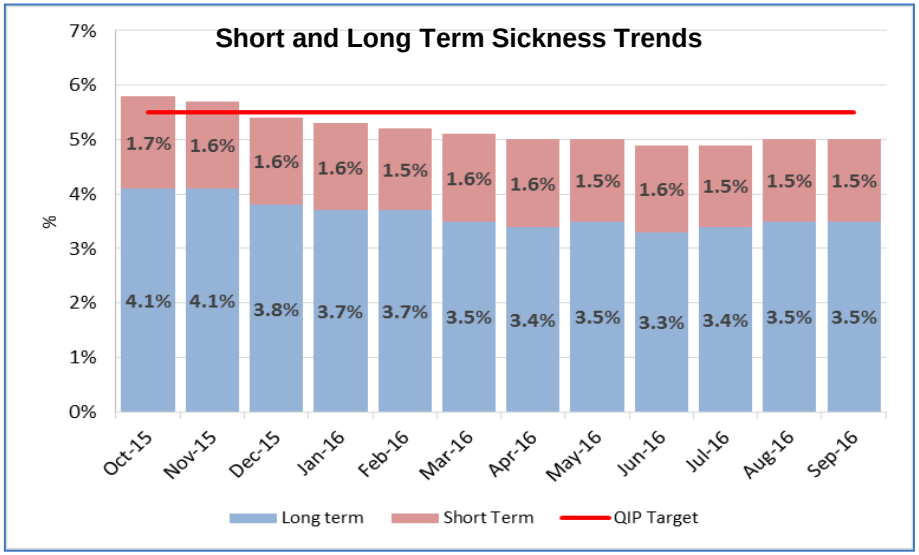


- The turnover figure for frontline paramedics has improved from 8.6% to 8.2% against a threshold of no more than 15%.
- The turnover for all frontline staff has continued to improve for the thirteenth month in a row, currently at 8.7%.
- The total Trust turnover has improved from 9.8% to 9.7% (12 month rolling figure).
- We had 24wte frontline leavers in October (13 paramedics, 5 EACs and 6 EMTs). There were 16 unplanned resignations, 4 retirements and 4 dismissals.
- The resignations were for reason of relocation (6), promotion (5), work life balance (3), child dependents (1) and other (1).

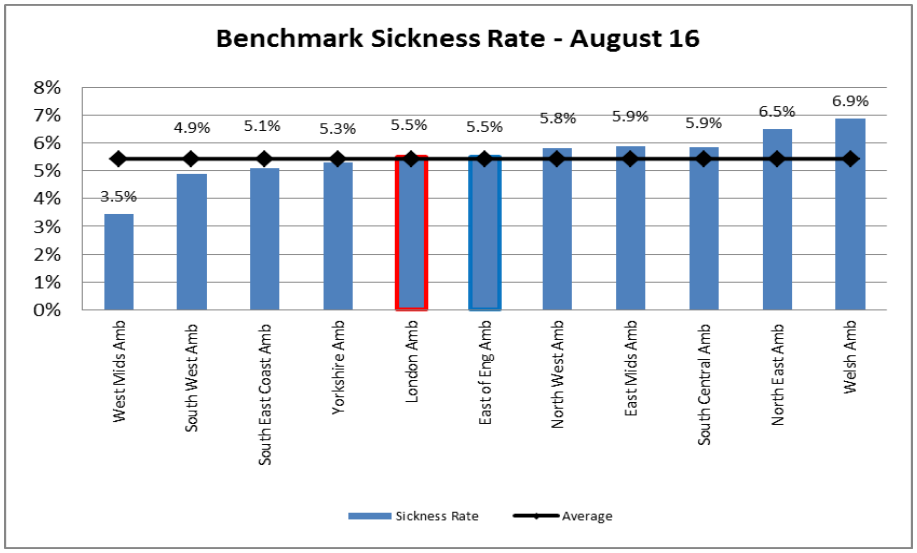


- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has the 3rd best turnover rate (4th in July) and is below the national average of 9.9%.

Sickness Absence – Trust level

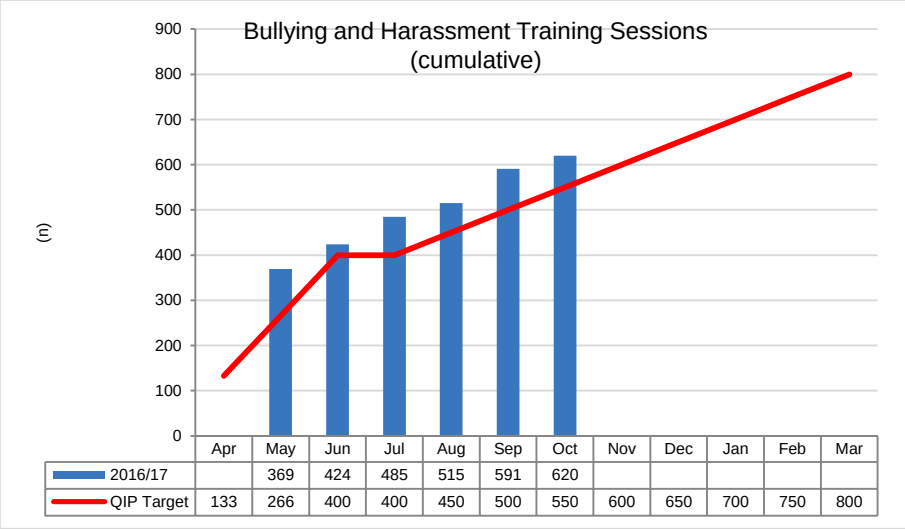


- The current Trust 12 month sickness level has remained at 5% against a threshold of 5.5%.
- A deep dive report on long-term sickness has been produced and will be presented to the Workforce Committee and ELT in November.
- The current ESR improvement programme has highlighted some process weaknesses including where sickness has not been accurately recorded. The process redesign work will address this and improve both data quality and reporting.
- Sickness is currently reported one months in arrears. An interface linking GRS and ESR is being developed (with a planned implementation in Q4) and this should enable reporting to move to one month in arrears.



- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service is joint 5th for August 2016 (4th in July).

Bullying and Harassment

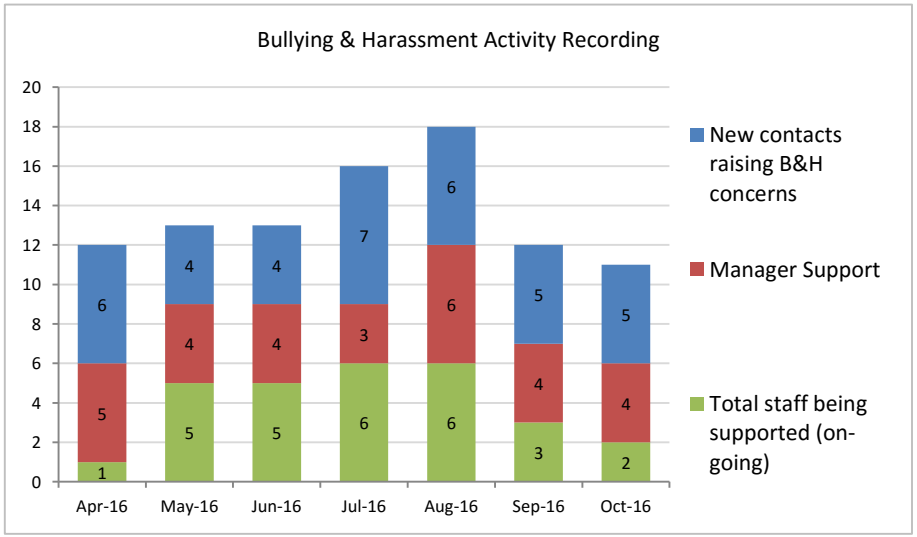


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17		369	424	485	515	591	620					
QIP Target	133	266	400	400	450	500	550	600	650	700	750	800

As at 27th October we have delivered sessions to 620 staff. Sessions to date have been open to all staff, covering a cross-section of both operational and support services staff and attendees have given feedback on the benefits of working across different teams.

- The third Practical skills in Mediation workshop took place focusing on BME staff.
- There were 5 Bullying and Harassment Workshops (currently 50 workshops have been facilitated). Focus groups took place with HART and Clinical Hub services.

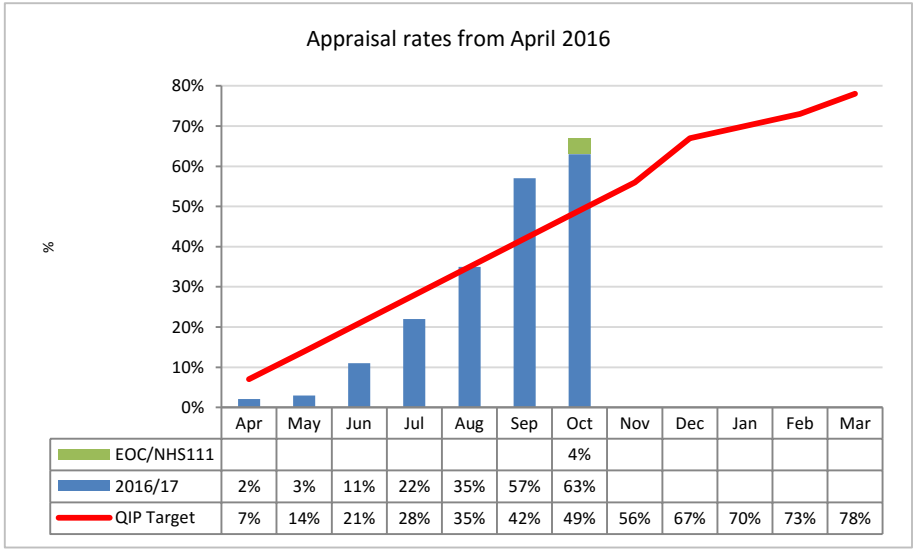
In October there were three formal bullying and harassment cases open. Two of these started in October and have not yet reached the 28 day indicator.



The Trust's Bullying & Harassment Specialist has started to capture data which reflects the significant activity they undertake to support and advise staff and managers in bullying and harassment issues. This work accounts for approximately 25% - 30% of their time and should have a positive impact in:

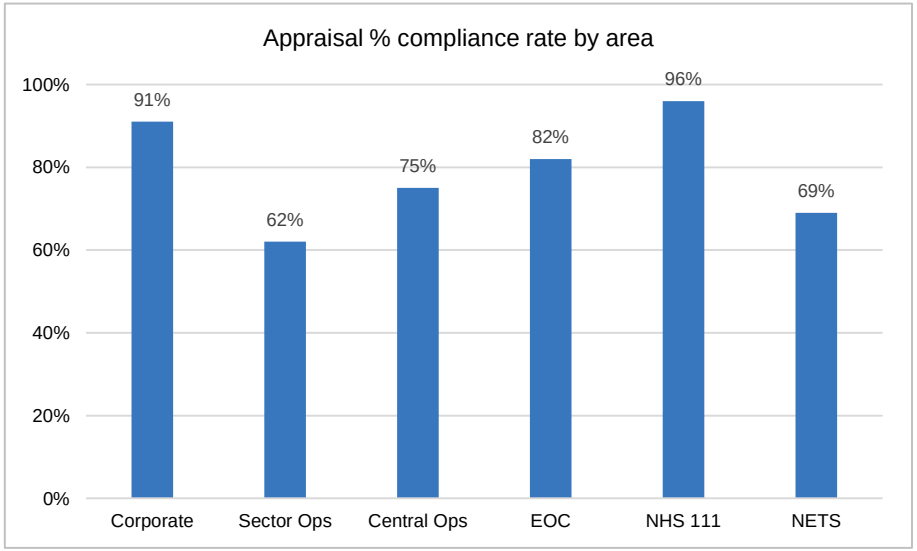
- avoiding formal cases.
- staff well-being.
- retention.

Appraisal



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EOC/NHS111							4%					
2016/17	2%	3%	11%	22%	35%	57%	63%					
QIP Target	7%	14%	21%	28%	35%	42%	49%	56%	67%	70%	73%	78%

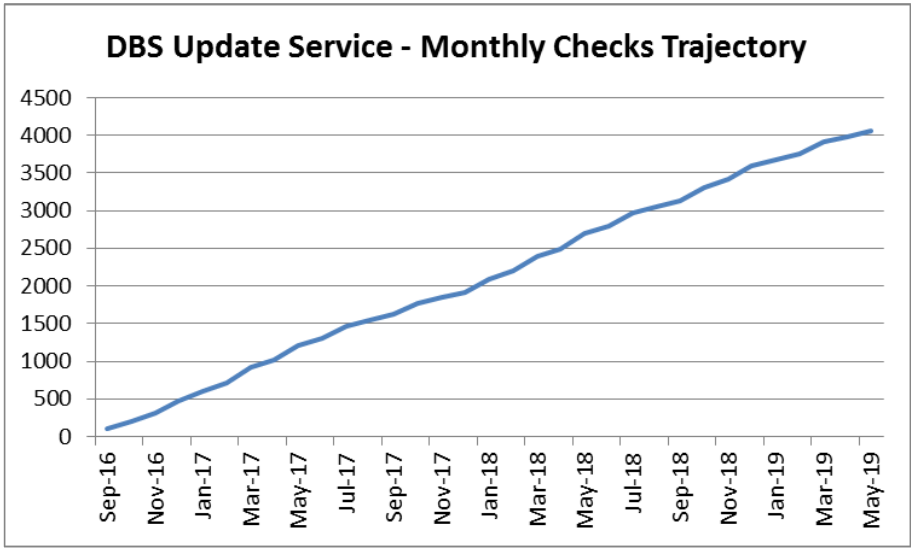
- Since April there have been 2,733 appraisals completed (63% compliance).
- Corporate areas have delivered 91% against their target of 100% (31st July).
- The current reporting does not accurately reflect the compliance rates in EOC (82%) and NHS 111 (96%) as they manage their appraisals on a 12 month rolling cycle. A green bar has been added to reflect this 12 month rolling figure.
- Please note that these figures exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS.



Sector Operations (as at 31st October 2016) have so far achieved 62% against their end of December target (64%). The sector breakdowns are as follows:

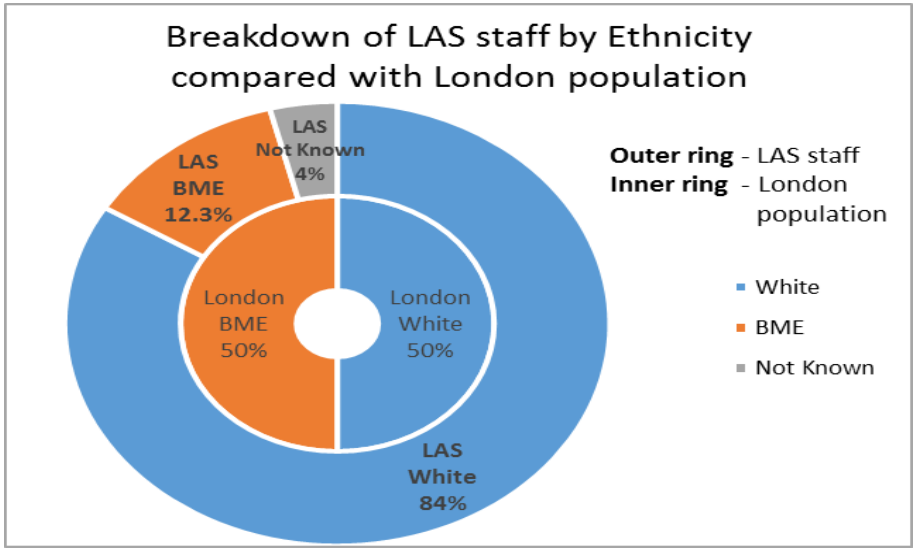
East Central	53.8%
North Central	70.5%
North East	54.0%
North West	81.7%
Ops Management	57.4%
South East	60.5%
South West	70.1%
West	47.3%

DBS and WRES



Disclosure Barring Scheme (DBS)

- DBS February 2016 Audit – 100% of checks have been completed for the original 175 employees.
- DBS rechecking - Phase One update:
  The target for December 2016 is for all Phase One staff to have an application in progress with the DBS (183 staff). As at 31st October, 63 have been cleared, 37 are in progress with the DBS and 83 have been contacted to arrange appointments with the recruitment team.
- DBS Update Service sign-up – we have asked Phase 1 staff to voluntarily sign up to the Update Service. Progress has been slow and recruitment are working in partnership with local managers to improve the compliance rate.



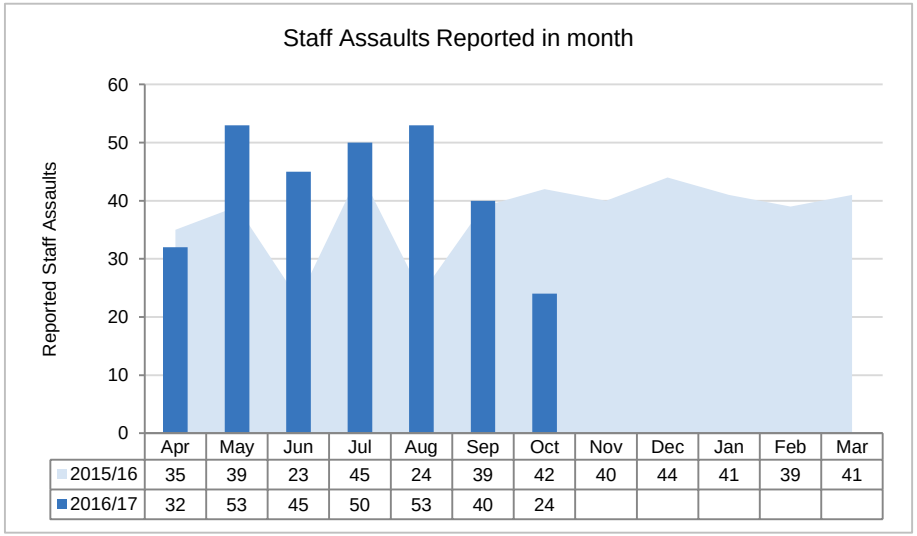
Workforce Race Equality Standard (WRES)

- This chart shows the percentage of LAS Black and Minority Ethnic (BME) staff compared with the London population.
- 12.3% of LAS staff are from a BME background compared with a London population of 50%. This data will be reported on a quarterly basis and it is recognised that change to the Trust wide position is likely to be seen over a longer period of time.

The WRES Committee met and reported on the following;

- The successful Health Education England bids
- A request for a deep dive into recruitment data, specifically the breakdown of ethnicity at application, shortlisting and offer stages
- The need to develop a system to capture Continuing Professional Development data.

Staff Assaults

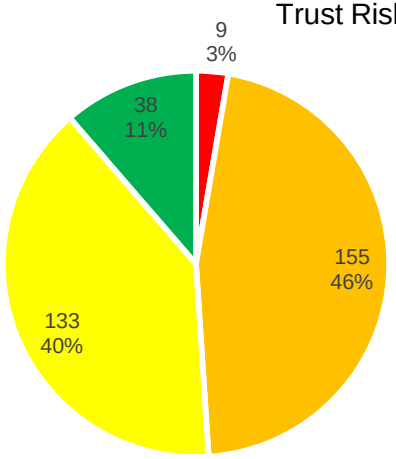


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	35	39	23	45	24	39	42	40	44	41	39	41
2016/17	32	53	45	50	53	40	24					

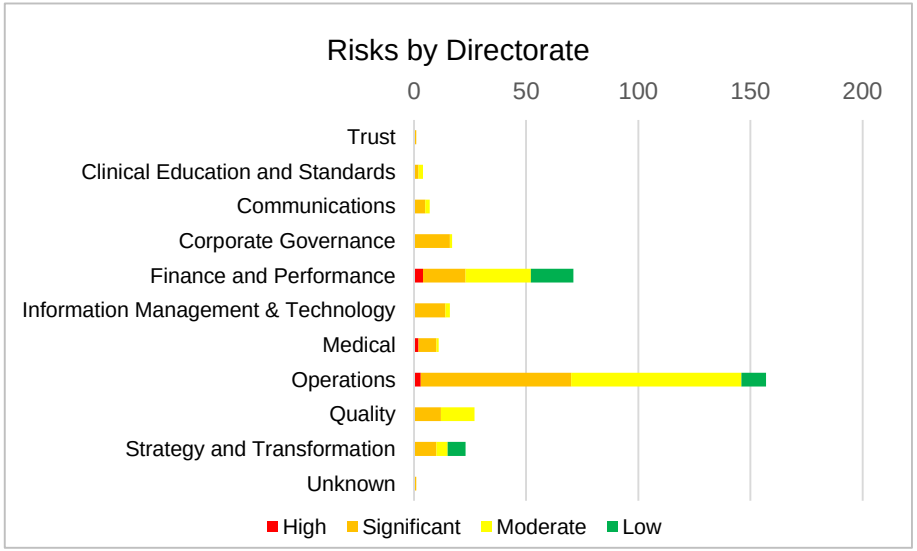
Staff Assaults

- During 2015/16 452 Staff related assaults were reported, as shown in the graph opposite.
- On average one staff member is assaulted each day in London.
- All staff are offered counselling and support following an assault. Each individual is different and the level of support required varies according to individual need. Everyone can access the same level of support, but not everyone needs it.
- We flag addresses if there is evidence of a previous assault or threat of violence against our staff. This helps to protect our staff from being sent into a potentially dangerous situation. (High Risk Register).

OUR RISKS



	Risk Rating	Risk Level	Risks	
	15-25	High	9	3%
	8-12	Significant	155	46%
	4-6	Moderate	133	40%
	1-3	Low	38	11%
		Total	**335**	



The Trust's risks are escalated via an established governance framework of committees, from local level meetings to the Trust Board. Thresholds are set for local, Trust, and Board Assurance level risks. They are reviewed and monitored at the appropriate committee meeting as set out in the Trust's Risk Assessment and Reporting Procedure (TP035).

Risks qualifying for inclusion for the Trust Risk Register (risks with a net score of 10 and above) and risks qualifying for inclusion on the Board Assurance Framework (risks with a net rating of 15 and above) need to be approved by the Risk Compliance and Assurance Group (RCAG).

The RCAG also has responsibility for approving the de-escalation of risks currently included on the Board Assurance Framework and Trust Risk Register. Compliance with management of risk at all levels is reviewed by the RCAG which is currently meeting monthly. A status report of local risk management is provided to the group and areas of non-compliance are highlighted to and escalated via the RCAG.

The Governance Team are working with areas and directorates across the organisation to embed the risk management process within their areas.

Each area has a designated contact from the Governance Team to support them. Feedback has been provided to each area on their risk registers and they have been invited to either attend a drop-in session or a meeting to facilitate their risk discussions. Drop in-sessions have been set up by the Governance Team to assist risk co-ordinators and mangers, and these will continue for the foreseeable future.

The risk register showed at 9th November;

- Just under half of the trusts risk register has a risk level of High or Significant (49%).
- Just over two thirds of the overall trusts risks sit within Operations (47%) and Finance and Performance (21%).
- There are 9 risks with a risk level of High, these sit in Operations (3), Finance and Performance (4) and the Medical (2) directorates. 3 of these risks are rated at 20 out of 25.

These charts reflect the trust risks by risk level and directorate. These are the risks rated 10 and above approved by RCAG and all other risks 9 and below as at 9th November 2016.

Our Risks

The following risks are all rated at 20 out of 25 as at 9th November 2016

Description	Controls in place	Assurance	Last review date	Directorate (Employee)	Rating (current)	Risk level (current)
There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	1. On-going recruitment to vacancies 2. Use of voluntary and private sector at times of peak demand 3. New rosters implemented successfully 4. Q1 overtime incentives have been published and target specific Sectors where staff shortfalls have been identified 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. auto-backup pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene	1. Recruitment activity/vacancy factors are reviewed fortnightly at ELT 2. Weekly Operations Group meetings with a monthly Operations Board 3. A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016 4. REAP structure has been revised and implemented 5. Workforce Committee monitors planning of recruitment	17/10/2016	Operations	20	High
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.	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.	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	22/09/2016	Finance and Performance	20	High
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.	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.	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	22/09/2016	Finance and Performance	20	High

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

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

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

Integrated Performance Report – Glossary

Other Terminology	Meaning
Green ambulance outcomes	Lower acuity ambulance outcomes

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

Other London 111 service provider	Areas Covered
London Ambulance Service (LAS)	1. South East London
Care UK	1. Hillingdon, 2. North West London
Partnership of East London Co-operatives (PELC)	1. East London & City. 2. Outer North East London
London Central & West (LCW)	1. Inner North West London, 2. North Central London
Vocare	1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Quality Improvement Programme Update**
Report Author(s):	**Janet Wint - PMO Manager, Quality Improvement Programme**
Presented by:	**Karen Broughton** **Programme Director, Quality Improvement Programme**
Contact Details:	**Janet.wint@lond-amb.nhs.uk**
History:	**Update on the Quality Improvement Programme**
Status:	**For assurance and information**

Background/Purpose

The purpose of this paper is to provide the Trust Board a status report on the monthly delivery of the Quality Improvement Programme

Action required

The Trust Board are asked to note:

- the QIP progress and KPI report (October performance)

Assurance

The Quality Improvement Programme progress update, reports on the activities delivered up to the end of October; the main concern on programme delivery in October relates to a number of strategies requiring review and ratification. These include a refresh of the current five year strategy, the Clinical Strategy and the Workforce and OD Strategy. A change request has been submitted in relation to the Workforce and OD strategy requesting this be delayed until the commencement of the new Director of Workforce and OD, although this delay will not remove the current focus on the recruitment plan for the remainder of 2016/17 and moving into 2018/19.

Key implications and risks arising from this paper	
Clinical and Quality	The QIP details activities to mitigate against identified 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 to maintain sustainability.
Financial	There are no specific financial risks identified in this paper.
Governance and Legal	The QIP Board is a subcommittee of the Trust Board which meets monthly. It will provide a report to formal Trust Board meetings 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.

2016/17 QUALITY IMPROVEMENT PROGRAMME

Progress Report & KPI Report: October 2016

November 2016

CONTENTS

	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*

Note: Information presented is up to 25th of the month. (unless otherwise stated) and is subjected to validation.
Previous months position is updated to reflect the entire month.
Please note that this report relates to performance throughout September 2016 unless otherwise stated

EXECUTIVE SUMMARY
October 2016

Progress this month

There has been steady progress of the programme during October resulting in four out of eight activities being delivered, with 50% of scheduled activities completed.

A QIP countdown action plan has been developed incorporating the current QIP plan and Board agreed priorities and compiling these into weekly action to ensure pace is maintained. This action plan includes all external requirements, planning, and internal assurance processes in place for a comprehensive inspection by the CQC in February 2017.

The activities that are delayed or reporting at risk relate to:

- The roll out pilot of pan-London process for pre-booking palliative care patients has been further delayed and is now expected to be rolled out in November.
- Implement and communicate availability of protective clothing to all staff has been further delayed. The communications package has now been completed and is due for broadcast in November.
- Review and improvement of uniforms for frontline staff was due to be delivered in October; this has been delayed due to production delays with the manufacturing company and are due to be despatched at the end of November.
- Review of the LAS 5 year strategy has been delayed to allow time for the Trust Board in conjunction with Mckinsey to revise the strategy.
- Development of workforce and OD strategy has been delayed due to the recruitment of the new HR & OD Director. A change request is due to be submitted for consideration with expected delivery date of February 2017. As stated in the change request the amended delivery date will not distract our current focus from the recruitment plan.
- Quality and Clinical Strategy has been delayed. A draft strategy has been completed awaiting feedback from ELT, with additional work being done in order to complete the Quality and Clinical Strategy in November.

OCTOBER DELIVERABLES				
Theme	**Executive Director**	**# Complete**	**% Complete**	**RAG**
Making LAS a great place to work	Mark Hirst	1/3	33%	
Achieving good governance	Sandra Adams	1/1	100%	
Improving patient experience	Briony Sloper	-	-	-
Improving environment and resources	Andrew Grimshaw	0/1	0%	
Taking pride and responsibility	Fenella Wrigley	2/3	67%	

PROGRAMME SUMMARY
Forecast View

Programme:

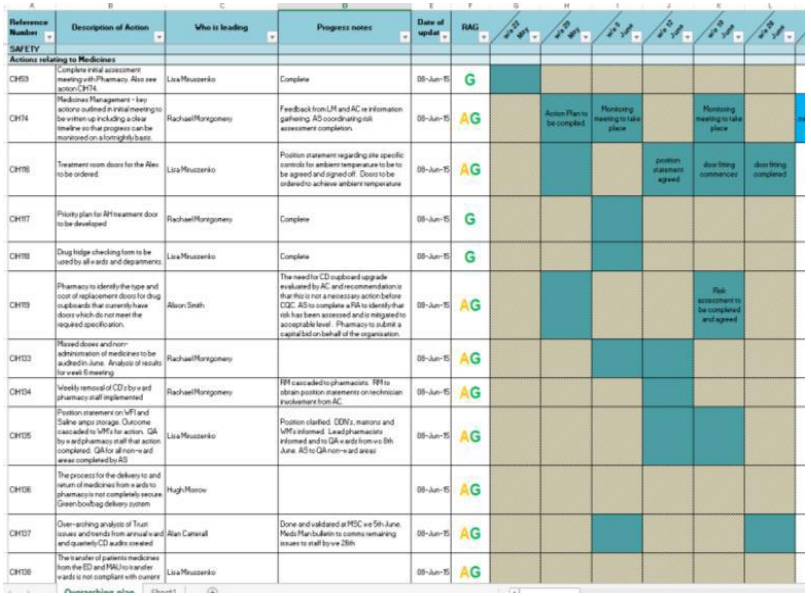
- The QIP has now moved into Phase 2 and all QIP deliverables have now been incorporated into the countdown weekly action plan. Weekly progress reports will be produced for Trust Board.

- As part of the Trust preparations for CQC inspection in February 2017; monthly managers briefings are taking place to keep managers abreast of issues and developments. Briefings will also be used to generate ideas and receive feedback from staff.

- All directorates will be required to complete a self assessment of all functions against the CQC domains. Unannounced visits to stations will also commence in November.

- CQRG have requested a deep dive review on Theme 5 – Taking Pride and Responsibility in November. The specific areas within this theme that CQRG would like the Trust to focus on is medicines management.

- Throughout November the communication team will be putting out a range of communications on medicines management including payslip postcards, articles and videos on the Pulse, Listening into Action (LiA) and sector Facebook pages.



Reference Number	Description of Action	Who is leading	Progress notes	Date of updat	RAG
SAFETY					
Actions relating to Medicines					
CM13	Complete initial assessment meeting with Pharmacy. Also see action CM14.	Lisa Mruszenko	Complete	08-Jun-15	G
CM14	Medicines Management – key actions outlined in initial meeting to be written up including a clear timeline so that progress can be monitored on a fortnightly basis.	Rachael Montgomery	Feedback from LM and AC re information gathering. AS coordinating risk assessment completion.	08-Jun-15	AG
CM16	Treatment room doors for the Alex to be ordered.	Lisa Mruszenko	Position statement regarding site specific controls for ambient temperature to be to be agreed and signed off. Doors to be ordered to achieve ambient temperature	08-Jun-15	AG
CM17	Priority plan for AH treatment door to be developed	Rachael Montgomery	Complete	08-Jun-15	G
CM18	Drug fridge checking form to be used by all wards and departments	Lisa Mruszenko	Complete	08-Jun-15	G
CM19	Pharmacy to identify the type and cost of replacement doors for drug cupboards that currently have doors which do not meet the required specification.	Alison Smith	The need for CD cupboard upgrade evaluated by AC and recommendation is that this is not a necessary action before CQC. AS to complete a RA to identify that risk has been assessed and is mitigated to acceptable level . Pharmacy to submit a capital bid on behalf of the organisation.	08-Jun-15	AG
CM23	Missed doses and non-administration of medicines to be audited in June. Analysis of results for week 6 meeting.	Rachael Montgomery		08-Jun-15	AG
CM24	Weekly removal of CD's by ward pharmacy staff implemented	Rachael Montgomery	RM cascaded to pharmacists. RM to obtain position statements on technician involvement from AC	08-Jun-15	AG
CM25	Position statement on VP1 and Saline amps storage. Outcome cascaded to WMs for action. QA by ward pharmacy staff that action completed. QA for all non-ward areas completed by AS	Lisa Mruszenko	Position clarified. DDN's, mamons and WMs informed. Lead pharmacists informed and to QA wards from w/c 8th June. AS to QA non-ward areas	08-Jun-15	AG
CM26	The process for the delivery to and return of medicines from wards to pharmacy is not completely secure. Green box/bag delivery system	Hugh Morrov		08-Jun-15	AG
CM27	Over-arching analysis of Trust issues and trends from annual ward and quarterly CD audits created	Alan Cantwell	Done and validated at MSC w/e 5th June. Meds Man bulletin to comms remaining issues to staff by w/e 26th	08-Jun-15	AG
CM28	The transfer of patients medicines from the ED and MAU to transfer wards is not compliant with current	Lisa Mruszenko		08-Jun-15	AG

WORKSTREAM PROGRESS REPORTS & KPIs

1| MAKING THE LAS A GREAT PLACE TO WORK

Executive Lead: Mark Hirst

HIGHLIGHTS THIS MONTH

EQUALITY AND INCLUSION

Work against the WRES action plan continues to be progressed. The BME network will be re-launched as Association Diverse and Minority Ambulance Staff (ADAMAS) with the first meeting due to be held on 30 November 2016.

VISION AND STRATEGY

The CEO Road-shows bringing together managers from, EOC and corporate functions and will be completed prior to the end of October 2016. The Road-shows were well attended and gave the opportunity for staff to directly raise questions with members of the Executive Leadership Team.

Further Road-shows are scheduled for November 2016 at various locations throughout the Trust. The Road-shows will primarily focus on reminding staff of the CEO commitments from last year along with a section on "you said… we did". They will also include updates on:

- CQC plans
- Band 6
- Rest break agreements
- Operational performance
- The new Quality & Clinical strategy

The refresh of the five year strategy is currently delayed, the Director of Transformation and Strategy in conjunction with the Chairman have been discussing the current focus with McKinsey. Further discussions have been scheduled for November to get this on track, whilst the Trust focuses on delivery the winter plan and preparing for the re-inspection in February 2017.

A change request has been submitted to amend the delivery date for the Workforce and OD strategy so that the recently appointed Director of HR and OD is able to have input into the strategic direction of the directorate. The amended delivery date will not distract the Trust from its current focus on delivering the recruitment target for the remainder of 2016/17 and in to 2017/18.

BULLYING AND HARASSMENT

The Bullying and Harassment specialist continues to deliver workshops. Specialised workshops have been conducted in conjunction with HART and the Clinical Hub in EOC which have focused on the creation of action plans in order to support developing culture change.

EOC have also interviewed for specific Dignity and Respect Ambassadors, which were recruited from individuals across all staff groups in the Directorate to help move resolution to mediation and conducting difficult conversations to address concerns as they arise rather than formal grievances if appropriate.

1| MAKING THE LAS A GREAT PLACE TO WORK

Progress – October 2016

Deliverable	Lead	Oct 2016			Outstanding actions
		Complete	Delayed	At Risk	
Advert to Action (Recruitment)	Tracey Watts				
Bullying and Harassment	Cathe Gaskell				
Training	Jane Thomas				
Equality and Inclusion	Melissa Berry				
Vision and Strategy	Karen Broughton	1	1		
Supporting Staff	Gill Heuchan				
Retention	Lindsay Koppenhol				
Workforce and Organisational Development	Karen Broughton		1		

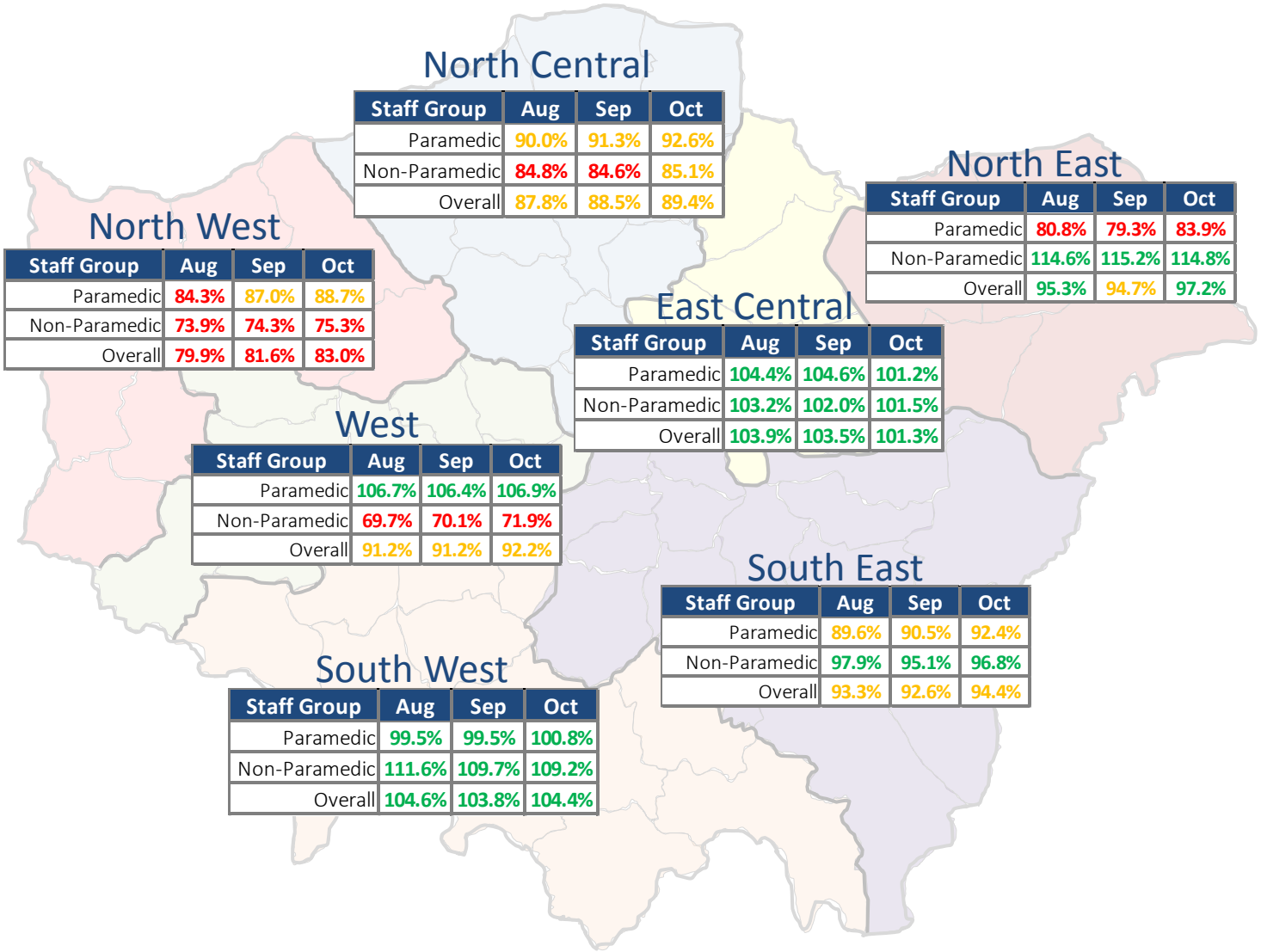
1| MAKING THE LAS A GREAT PLACE TO WORK

Forecast View

Focus for next month	Key risks and challenges
• Progressing with the OLM and ESR deliverables • Working across all directorates to ensure the trust meets the appraisal targets. • Delivering on weekly actions as part of the countdown weekly action plan.	

Deliverable	Lead	Nov 2016				Dec 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Advert to Action (Recruitment)	Julie Cook								
Bullying and Harassment	Cathe Gaskell						2		
Training	Jane Thomas								
Equality and Inclusion	Melissa Berry								
Vision and Strategy	Karen Broughton						1		
Supporting Staff	Gill Heuchan						2		
Retention	Lindsay Koppenhol								
Workforce and Organisational Development	Karen Broughton								

PEOPLE PICTURE



North Central

Staff Group	Aug	Sep	Oct
Paramedic	90.0%	91.3%	92.6%
Non-Paramedic	84.8%	84.6%	85.1%
Overall	87.8%	88.5%	89.4%

North East

Staff Group	Aug	Sep	Oct
Paramedic	80.8%	79.3%	83.9%
Non-Paramedic	114.6%	115.2%	114.8%
Overall	95.3%	94.7%	97.2%

North West

Staff Group	Aug	Sep	Oct
Paramedic	84.3%	87.0%	88.7%
Non-Paramedic	73.9%	74.3%	75.3%
Overall	79.9%	81.6%	83.0%

East Central

Staff Group	Aug	Sep	Oct
Paramedic	104.4%	104.6%	101.2%
Non-Paramedic	103.2%	102.0%	101.5%
Overall	103.9%	103.5%	101.3%

West

Staff Group	Aug	Sep	Oct
Paramedic	106.7%	106.4%	106.9%
Non-Paramedic	69.7%	70.1%	71.9%
Overall	91.2%	91.2%	92.2%

South East

Staff Group	Aug	Sep	Oct
Paramedic	89.6%	90.5%	92.4%
Non-Paramedic	97.9%	95.1%	96.8%
Overall	93.3%	92.6%	94.4%

South West

Staff Group	Aug	Sep	Oct
Paramedic	99.5%	99.5%	100.8%
Non-Paramedic	111.6%	109.7%	109.2%
Overall	104.6%	103.8%	104.4%

PEOPLE PICTURE

Sector	Group Station		Aug-16		Sep-16		Oct-16		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
North Central	Camden	*Paramedic*	2	101.9%	5	105.1%	8	108.2%					
		Non-paramedic	-13	81.8%	-13	82.3%	-13	82.3%					
		All	-11	93.3%	-8	95.3%	-5	97.1%					
	Edmonton	*Paramedic*	-23	79.1%	-21	81.4%	-20	81.8%					
		Non-paramedic	-8	90.3%	-6	92.1%	-5	93.4%					
		All	-31	83.7%	-27	85.8%	-25	86.5%					
	Friern Barnet	*Paramedic*	-6	91.3%	-8	88.4%	-8	88.4%					
		Non-paramedic	-11	80.8%	-13	77.2%	-13	77.2%					
		All	-16	86.6%	-20	83.3%	-20	83.3%					
East Central	Homerton	*Paramedic*	14	114.2%	15	114.9%	11	111.5%					
		Non-paramedic	3	103.7%	1	101.0%	0	99.6%					
		All	17	109.7%	15	108.9%	11	106.4%					
	Newham	*Paramedic*	-3	97.9%	5	105.9%	0	99.7%					
		Non-paramedic	3	102.8%	-3	94.8%	-3	94.8%					
		All	0	99.9%	2	101.3%	-3	97.7%					
North East	Romford	*Paramedic*	-24	80.8%	-26	79.3%	-20	83.9%					
		Non-paramedic	14	114.6%	14	115.2%	14	114.8%					
		All	-10	95.3%	-12	94.7%	-6	97.2%					

PEOPLE PICTURE

Sector	Group Station		Aug-16		Sep-16		Oct-16		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
North West	Hillingdon	*Paramedic*	-9	84.7%	-10	83.6%	-13	78.5%					
		Non-paramedic	-4	91.4%	-4	91.4%	-3	93.7%					
		All	-13	87.6%	-13	87.0%	-15	85.0%					
	Brent	*Paramedic*	-22	84.1%	-16	88.4%	-9	93.1%					
		Non-paramedic	-34	66.4%	-34	66.9%	-33	67.4%					
		All	-56	76.6%	-50	79.3%	-43	82.2%					
West	Hanwell	*Paramedic*	-8	92.3%	-5	95.2%	-4	96.2%					
		Non-paramedic	-16	78.5%	-16	78.5%	-17	77.2%					
		All	-24	86.4%	-21	88.1%	-21	88.1%					
	Fulham	*Paramedic*	11	113.0%	9	111.2%	11	113.7%					
		Non-paramedic	-25	60.9%	-25	60.9%	-22	65.6%					
		All	-14	90.3%	-16	89.3%	-11	92.7%					
	Westminster	*Paramedic*	13	125.3%	11	120.9%	9	117.0%					
		Non-paramedic	-11	66.3%	-10	68.7%	-9	71.8%					
		All	2	102.8%	1	101.0%	0	99.8%					

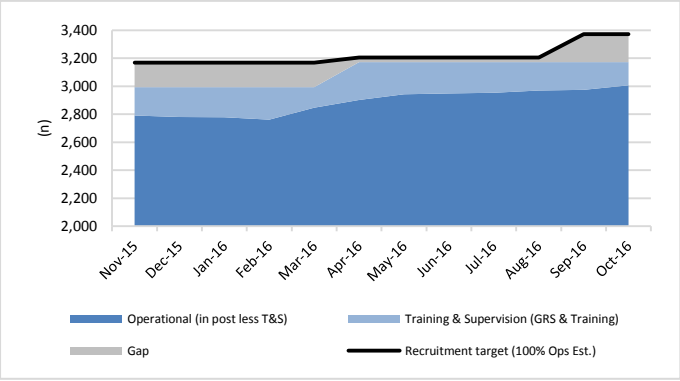
PEOPLE PICTURE

Sector	Group Station		Aug-16		Sep-16		Oct-16		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
South East	Bromley	*Paramedic*	-34	68.7%	-31	71.4%	-25	76.9%					
		Non-paramedic	1	100.9%	-1	99.0%	4	105.1%					
		All	-34	82.4%	-32	83.2%	-21	89.0%					
	Deptford	*Paramedic*	-1	99.5%	1	100.7%	3	101.6%					
		Non-paramedic	-10	92.9%	-17	88.5%	-15	89.4%					
		All	-11	96.5%	-15	95.1%	-12	96.1%					
	Greenwich	*Paramedic*	-4	95.5%	-6	94.1%	-6	93.6%					
		Non-paramedic	3	103.9%	2	103.0%	1	101.8%					
		All	-1	99.2%	-3	98.1%	-5	97.3%					
South West	Croydon	*Paramedic*	-8	86.1%	-6	89.4%	-1	98.9%					
		Non-paramedic	2	105.4%	4	108.7%	3	106.5%					
		All	-6	94.5%	-2	97.8%	2	102.2%					
	New Malden	*Paramedic*	0	100.7%	2	103.6%	1	101.8%					
		Non-paramedic	15	140.0%	11	129.6%	11	129.6%					
		All	16	116.6%	13	114.1%	12	113.0%					
	St Helier	*Paramedic*	1	101.8%	-2	96.2%	-2	96.2%					
		Non-paramedic	10	121.0%	9	118.7%	9	118.8%					
		All	11	110.0%	7	105.9%	7	105.9%					
	Wimbledon	*Paramedic*	5	107.5%	5	107.5%	4	105.8%					
		Non-paramedic	-6	88.9%	-6	88.9%	-6	88.9%					
		All	-1	99.4%	-1	99.4%	-2	98.4%					

1| MAKING THE LAS A GREAT PLACE TO WORK

1.0 Frontline recruitment

Target 2016/17	Actual	Variance	RAG
3372 wte	3172 wte	200	

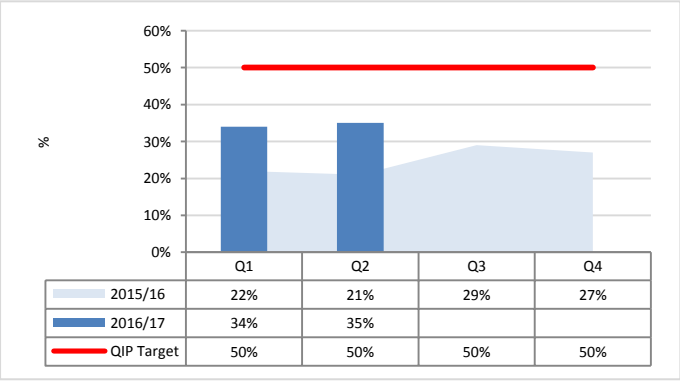


This graph shows our operational staff in-post by month, including those in training and supervision. It also now reflects the change in reporting from 95% to 100% of frontline establishment. This has changed our recruitment target from 3,193 to 3,372 wte.

The A&E Resources Group is leading work to align the staff establishment and in-post data across ESR, Finance, GRS and the People Picture. This work is progressing well and will improve the quality of reporting across all of these systems.

1.1 Staff recommending LAS as place of work on Friends & Family tests

Target 2016/17	Actual	Variance	RAG
50%	Q2: 35%	15%	



2016/17 data is shown against 2015/16 data as a baseline for the 2016/17 reporting period.

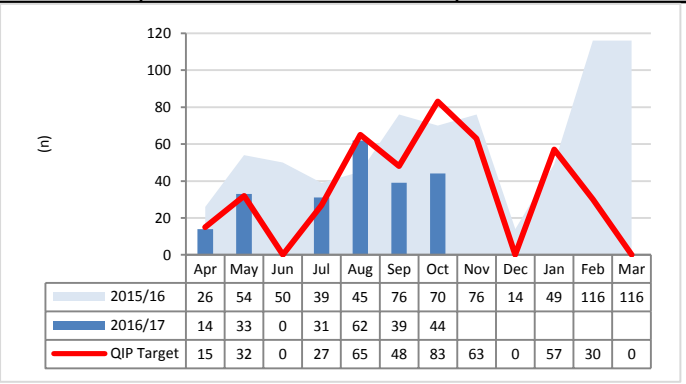
Q2 saw a slight improvement from 34% to 35% compared with Q1. There was also a slight increase of staff recommending the LAS as a place to be treated from 73% to 74%.

Note: this survey is not completed during Q3 as this coincides with the National Staff Survey which closes on 2nd December.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.2 Frontline starters

Planned – October 2016	Actual	Variance	RAG
83 wte	44 wte	39	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	26	54	50	39	45	76	70	76	14	49	116	116
2016/17	14	33	0	31	62	39	44					
QIP Target	15	32	0	27	65	48	83	63	0	57	30	0

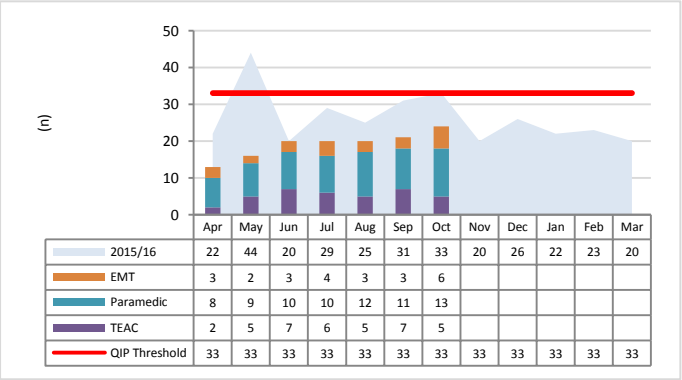
In October we had 44 frontline starters against a target of 83. We delivered the Trainee Emergency Ambulance Crew target but are behind plan for Paramedics.

This is the second month where we have not delivered to our planned target. 15 frontline paramedic candidates withdrew at offer stage due to issues of relocating to London, offers of alternative employment with other Trusts and unsatisfactory pre-employment checks.

We will be holding 8 International Paramedic courses starting between January and March 2017 with 173 planned starters to ensure we deliver to the 2016/17 target.

1.3 Frontline leavers

Target 2016/17	Actual	Variance	RAG
Below: 33 wte	24	9	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	22	44	20	29	25	31	33	20	26	22	23	20
EMT	3	2	3	4	3	3	6					
Paramedic	8	9	10	10	12	11	13					
TEAC	2	5	7	6	5	7	5					
QIP Threshold	33	33	33	33	33	33	33	33	33	33	33	33

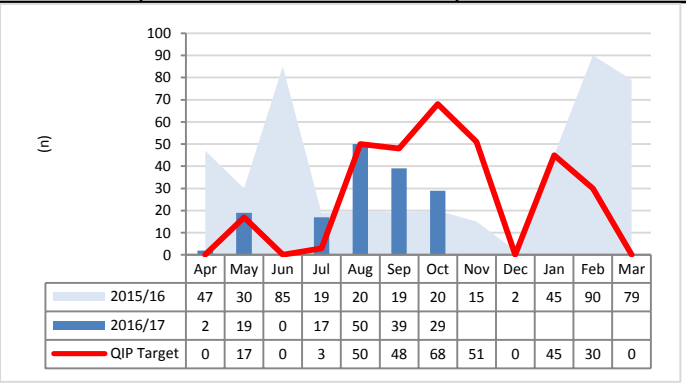
We had 24wte frontline leavers in October (13 paramedics, 5 Emergency Ambulance Crews and 6 Emergency Medical Technicians). There were 16 unplanned resignations, 4 retirements and 4 dismissals.

The resignations were for reason of relocation (6), promotion (5), work life balance (3), child dependents (1) and other (1).

1| MAKING THE LAS A GREAT PLACE TO WORK

1.4 Frontline Starters - Paramedic

Planned – October 2016	Actual	Variance	RAG
68 wte	29 wte	39	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	47	30	85	19	20	19	20	15	2	45	90	79
2016/17	2	19	0	17	50	39	29					
QIP Target	0	17	0	3	50	48	68	51	0	45	30	0

We had 29 Paramedic starters in October. 15 candidates withdrew at offer stage due to issues of relocating to London, offers of alternative employment with other Trusts and unsatisfactory pre-employment checks.

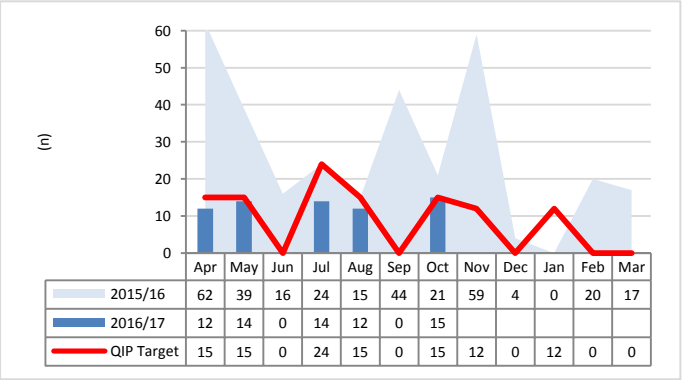
We are undertaking an analysis of the 12 paramedic candidates who withdrew at offer stage to better understand the reasons, specifically why they chose to accept offers at other Trusts. This will help to inform our recruitment strategy for future cohorts.

In our pipeline we have 7 awaiting future course dates and 3 graduates who are re-sitting exams, with their start dates deferred.

We continue to advertise monthly for both Graduate and Qualified Paramedics and hold monthly assessments and interviews.

1.5 Frontline Starters - Trainee Emergency Ambulance Crew (TEACs)

Planned – October 2016	Actual	Variance	RAG
15 wte	15 wte	0	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	62	39	16	24	15	44	21	59	4	0	20	17
2016/17	12	14	0	14	12	0	15					
QIP Target	15	15	0	24	15	0	15	12	0	12	0	0

We have met our target this month with 15 TEAC starters. From our recent TEAC advert, we have 14 candidates at interview stage and 66 candidates awaiting courses.

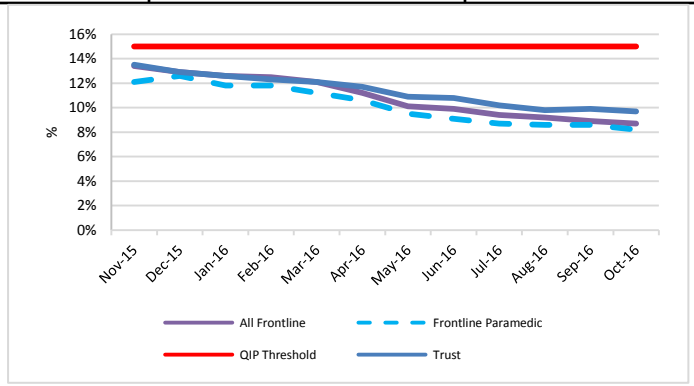
As highlighted by the people picture, we are targeting our recruitment on the North West, North Central and West sectors.

We are on target to deliver the November and January targets. Additional courses are being organised in January and February with 30 places.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.6 Staff (all) turnover to remain below 15%

Target 2016/17	Actual	Variance	RAG
Below: 15%	9.7%	5.3%	



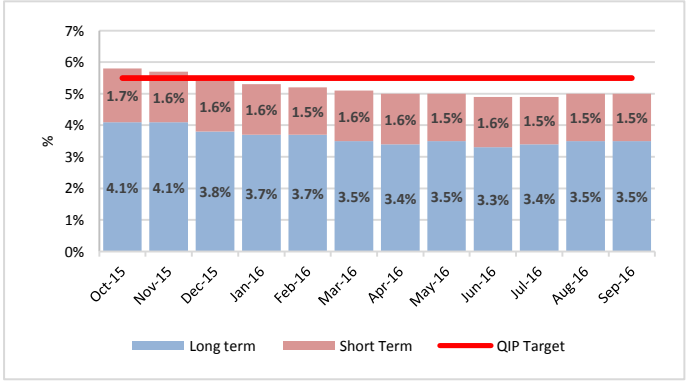
Turnover has slightly reduced from 9.8% in September to 9.7% in October.

Frontline turnover has reduced to 8.7% and frontline paramedic turnover has also reduced to 8.2%.

(Please note this is subject to change as we are not reporting the complete month).

1.7 Staff sickness to remain below 5.5%

Target 2016/17	Actual	Variance	RAG
Below: 5.5%	September: 5%	0.5%	



This KPI is reported one month retrospectively. Sickness data is currently entered into ESR at the beginning of the month for the previous month.

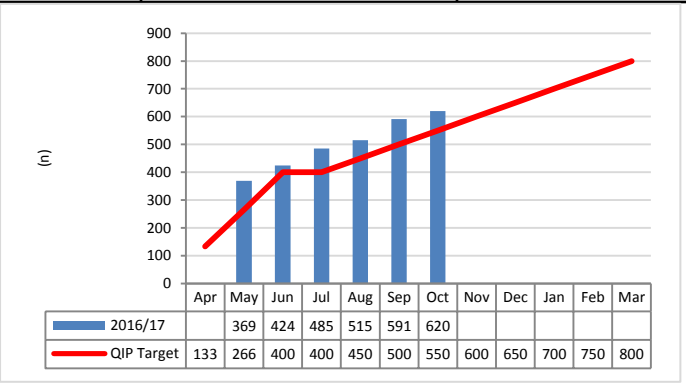
The sickness rate has remained at 5%.

A deep dive report on long-term sickness was produced for the Workforce Committee and this has been deferred to the November meeting.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.8 Bullying and harassment workshops

Target – October 2016	Actual	Variance	RAG
550	Cumulative: 620	70	

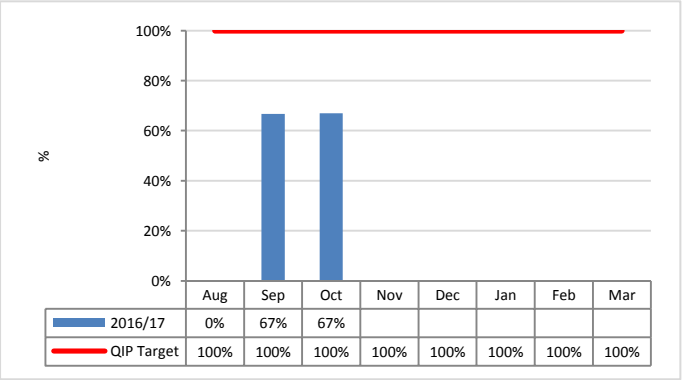


As of 27th October we have delivered sessions to 620 staff. All sessions to date to date have been open to all staff, covering a cross-section of both operational and support services staff. Attendee feedback cited the benefits of working across different teams.

The third Practical skills in Mediation workshop facilitated by TCM Group has taken place and focused on Black and Minority Ethnic staff. There have been 5 Bullying and Harassment Workshops. Focus groups have also taken place with HART and Clinical Hub services.

1.9 Bullying and harassment cases resolved within 28 days

Target 2016/17	Actual	Variance	RAG
100%	67%	33%	



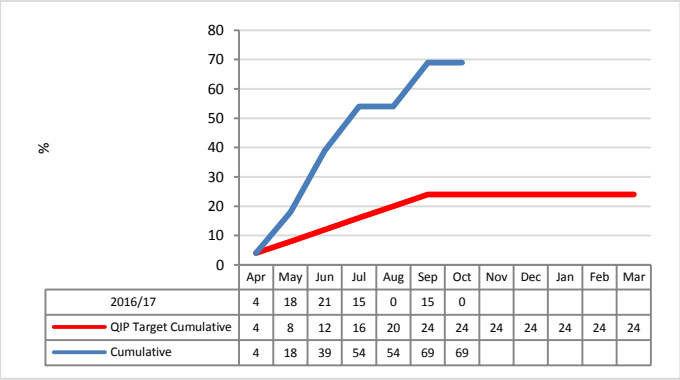
In October there were three formal bullying and harassment cases open.

Two of these started in October and have not yet reached the 28 day indicator. One has currently breached this timeframe due to the complexity of the case and we are currently awaiting the investigation report.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.10 Staff trained in bullying and harassment investigations

Target 2016/17	Actual	Variance	RAG
24	Cumulative: 69	45	

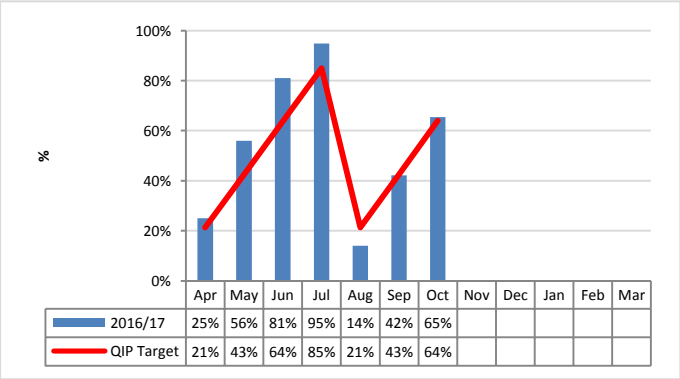


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	4	18	21	15	0	15	0					
QIP Target Cumulative	4	8	12	16	20	24	24	24	24	24	24	24
Cumulative	4	18	39	54	54	69	69					

We have delivered all the bullying and harassment investigation training to a total of 69 staff this year, exceeding the QIP target.

1.11 Clinical staff completing their Core Skills Refresher (CSR) training

Target – October 2016	Actual	Variance	RAG
64%	65%	1%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	25%	56%	81%	95%	14%	42%	65%					
QIP Target	21%	43%	64%	85%	21%	43%	64%					

We run 3 CSR courses per year and all clinical staff have to attend all 3 courses. CSR 2016.1 ended in July with a 95% compliance rate. In October, 2,050 staff attended CSR 2016.2 training and this represents 65% attendance against the monthly target of 64%.

CSR 2016.2 training modules include:

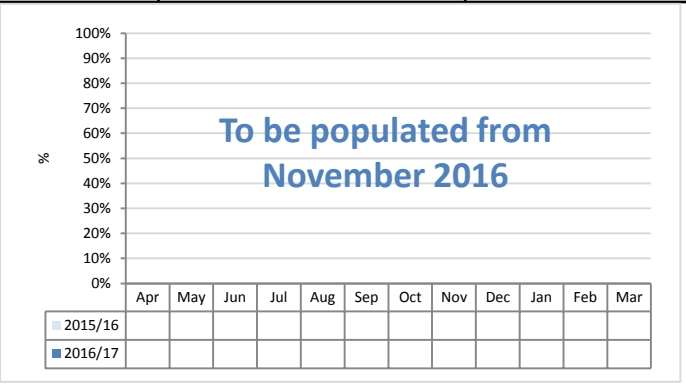
- Maternity
- Advanced Life Support
- Documentation
- Manual Handling
- Equality & Diversity

85% is the target for the four month duration of the particular CSR programme.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.12 Staff with all training recorded on an online system

Target 2016/17	Actual	Variance	RAG
100%	[NA]	[NA]	[NA]



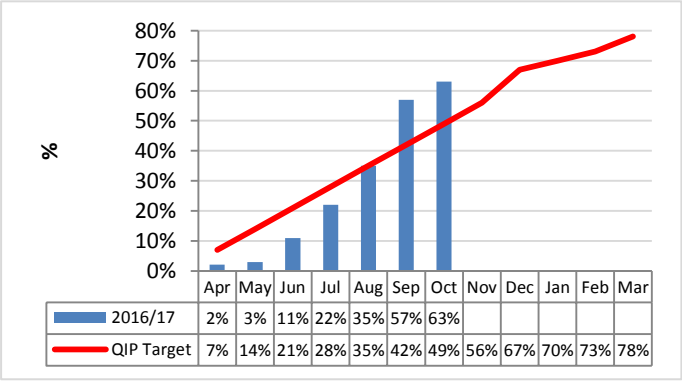
Over 100,000 training records from three different sources have been extracted, reformatted, cleansed and quality checked ready for loading into the ESR Oracle Learning Management system.

The training requirements for over 5,000 staff have been identified and these will be mapped against their ESR Positions by the 25th November

A Training Dashboard will be designed to report on Apr-16 to Oct-16 training compliance In Nov-16.

1.13 Appraisal rates from April 2016

Target – October 2016	Actual	Variance	RAG
49%	Cumulative: 63%	14%	



Since April there have been 2,733 appraisals completed (63% compliance). Operations have so far achieved 59% against their end of December target (64%).

The current reporting does not accurately reflect the compliance rates in EOC (85%) and NHS 111 (96%) as they manage their appraisals on a 12 month rolling cycle.

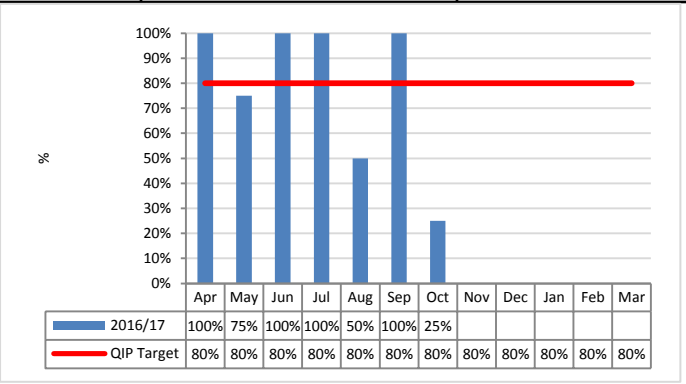
Corporate areas have delivered 90% against their target of 100% (31st July).

NB. Please note that these figures exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS.

1| MAKING THE LAS A GREAT PLACE TO WORK

1.14 Planned Director visits take place

Target 2016/17	Actual	Variance	RAG
80%	25%	55%	



The CEO together with members of the Executive Leadership Team have undertaken a number of CEO Roadshows during the month of October which has had an impact on planned director visits .

The CEO Roadshows have included service wide Senior Manager briefings, Corporate & Support Staff, EOC and HART. There will be additional sector based Roadshows in November to each of the seven sectors.

2| ACHIEVING GOOD GOVERNANCE

Executive Lead: Sandra Adams

HIGHLIGHTS THIS MONTH

IMPROVING INCIDENT REPORTING

The October monthly Newsletter was published with focus on knowing your limits with Manual Handling and the Razor Pilot. The Razor pilot was undertaken by union representatives with great success. The pilot has been designed to ensure staff are not at risk of injury due to razors being exposed within their bags by containing these sharps in a clip –lock containers. The newsletter also focussed attention on staff engagement, encouraging staff to contact the team for any concerns, queries, or suggestions for change.

OPERATIONAL PLANNING

EOC workstream leads have undertaken an evaluation of the desk functions and a review of the EOC operation model (effectiveness and efficiency) . Work continues on the development of the EOC strategy with the first draft on track to be completed in November. Environmental changes within EOC will take place in November, this includes :

- Wall Boards – with regular and relevant updates for Staff
- Repainting of the EOC (HQ-Waterloo)
- Refurbishment and additional equipment (Bow)

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2| ACHIEVING GOOD GOVERNANCE

Progress – October 2016

Deliverable	Lead	Oct 2016		
		Complete	Delayed	At Risk
Risk Management	Sandra Adams			
Capability and capacity of Health, Safety and Risk function	Sandra Adams			
Improving incident reporting	Sandra Adams	1		
Duty of Candour	Sandra Adams			
Operational planning	Paul Woodrow			
Listening to patients	Fenella Wrigley			
Blue light collaboration	Karen Broughton			
CQC reinspection	Fionna Moore			
Business intelligence systems	Jill Patterson			
Internal audit	Sandra Adams			
Policy and guidance review	Sandra Adams			

Outstanding actions

2| ACHIEVING GOOD GOVERNANCE

Forecast View

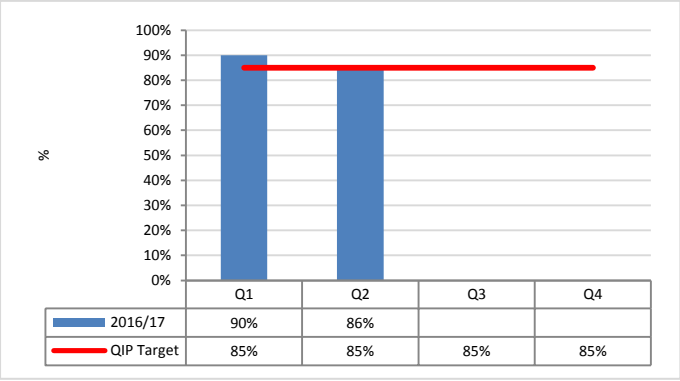
Focus for next month	Key risks and challenges
• EOC – continued focus on the quick wins with further progress made to the EOC strategy and completion of the environmental changes. • Continue to prepare the trust for the next CQC inspection • Delivering on weekly actions as part of the countdown weekly action plan	

Deliverable	Lead	Nov 2016				Dec 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Risk Management	Sandra Adams						1		
Capability and capacity of Health, Safety and Risk function	Sandra Adams								
Improving incident reporting	Sandra Adams		1				2		
Duty of Candour	Sandra Adams						1		
Operational planning	Paul Woodrow		2						
Listening to patients	Fenella Wrigley								
Blue light collaboration	Karen Broughton								
CQC reinspection	Fionna Moore						1		
Business intelligence systems	Jill Patterson						2		
Internal audit	Sandra Adams						1		
Policy and guidance review	Sandra Adams						1		

2| ACHIEVING GOOD GOVERNANCE

2.0 Updated local risk registers

Target 2016/17	Actual	Variance	RAG
85%	Q2: 86%	1%	

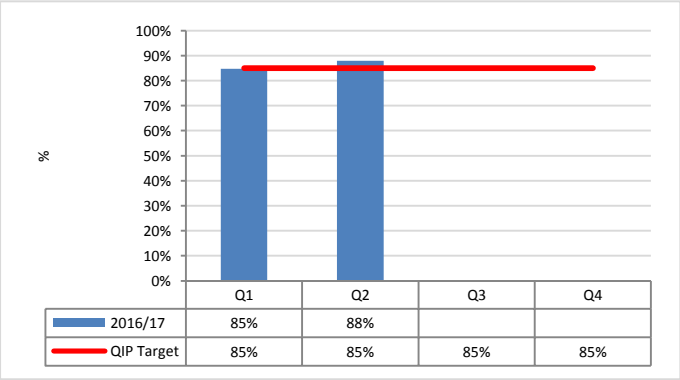


For Q2 there was a slight reduction in the number of updated local risk registers in comparison to Q1. There are a number of amber rated areas where updates are pending. The Governance and Assurance team are working with these areas to ensure they are regularly updated.

There are a series of Governance and Assurance led risk drop in sessions for Risk Coordinators to attend. This is to review and improve their local risk registers. All risk registers are now held on DatixWeb.

2.1 Managers trained in risk management

Target 2016/17	Actual	Variance	RAG
85%	Q2: 88%	3%	



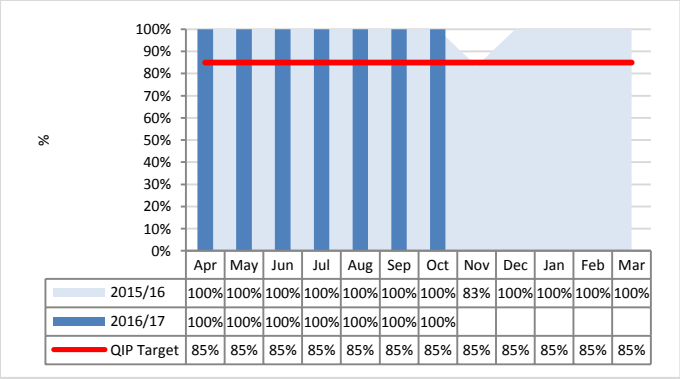
As Risk Management training for managers has become business as usual across the Trust the number of trained managers continues to increase.

In addition to formal sessions the Governance and Assurance department has put in place a number of drop in sessions for Risk Coordinators to review their risks and boost their confidence in discussing risk related issues.

2| ACHIEVING GOOD GOVERNANCE

2.2 Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared

Target 2016/17	Actual	Variance	RAG
85%	100%	15%	

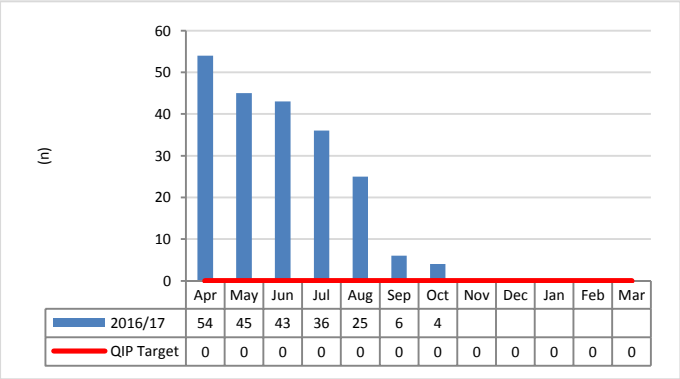


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%
2016/17	100%	100%	100%	100%	100%	100%	100%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The Trust continues to meet the target of reporting 100% of Serious Incidents within 48 hours of being declared.

2.3 Complaints Response (Over 35 days)

Target 2016/17	Actual	Variance	RAG
0	4	4	



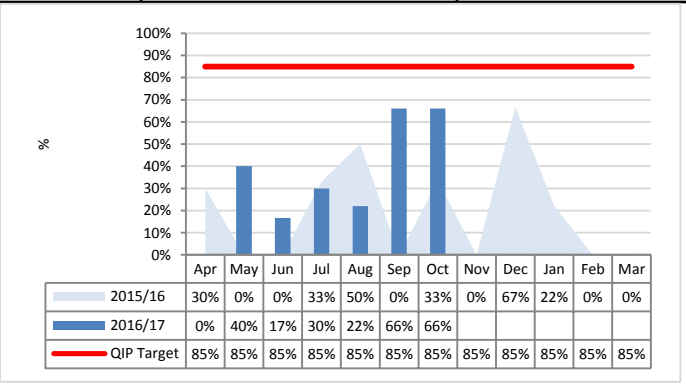
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43	36	25	6	4					
QIP Target	0	0	0	0	0	0	0	0	0	0	0	0

The remaining 4 cases represent the more complex of our complaints. Once all the relevant information is collated a clinical overview from the Medical Directorate will be required.

2| ACHIEVING GOOD GOVERNANCE

2.4 Completed investigations and reports within 60 working days of a serious incident being declared

Target 2016/17	Actual	Variance	RAG
85%	66%	19%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	0%	0%	33%	50%	0%	33%	0%	67%	22%	0%	0%
2016/17	0%	40%	17%	30%	22%	66%	66%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

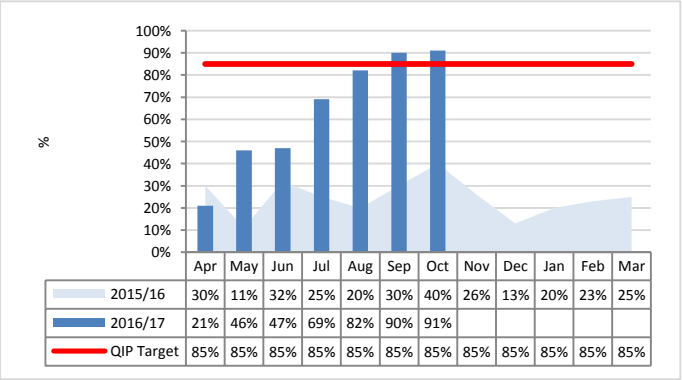
The percentage of reports submitted within 60 days in October remains constant compared to the previous month.

Work is continuing to ensure that lead investigators have the tools and resources to complete investigations within the 60 day time frame.

The number of SIs submitted within 60 days is likely to decrease in November due to the imminent completion of overdue SIs .

2.5 Patient safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	91%	6%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	11%	32%	25%	20%	30%	40%	26%	13%	20%	23%	25%
2016/17	21%	46%	47%	69%	82%	90%	91%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The Trust continues to improve the speed and efficiency of reporting patient safety incidents onto DatixWeb.

Since the implementation of DatixWeb in May 2016 the percentage of patient safety incidents reported within 4 days of the incident occurring has increased from around 20% to over 90%. This is enabling the Trust to respond to incidents quicker and allow for a more responsive SI process.

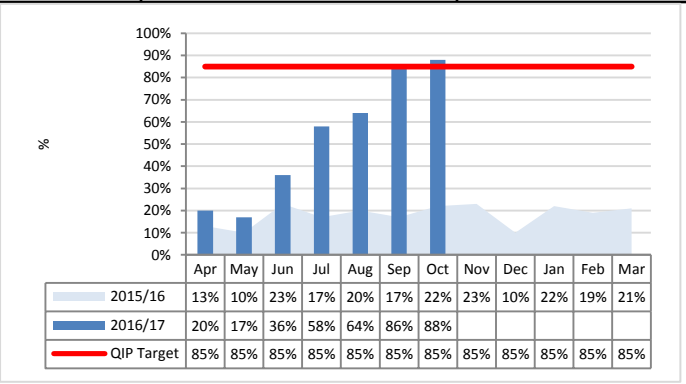
Over the last three months we have seen 242 Patient Safety Incidents reported in August, 216 in September and 207 in October.so far.

Since implementation of DatixWeb incident reporting has increased by 38%.

2| ACHIEVING GOOD GOVERNANCE

2.6 Staff safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	88%	3%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13%	10%	23%	17%	20%	17%	22%	23%	10%	22%	19%	21%
2016/17	20%	17%	36%	58%	64%	86%	88%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

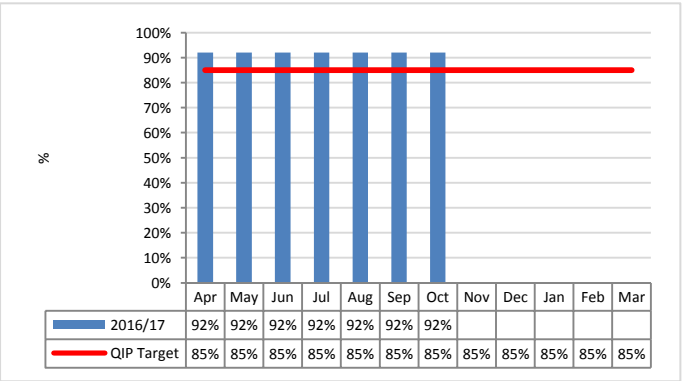
The Trust continues to improve the speed and efficiency of reporting staff safety incidents onto DatixWeb.

Since the implementation of DatixWeb in May 2016 the percentage of staff safety incidents reported within 4 days of the incident occurring has increased from around 20% to over 80%. This demonstrates the benefit of DatixWeb over paper processes.

Over the last three months we have seen 300 Staff Safety Incidents reported in August, 291 in September and 199 in October so far.

2.7 Frontline staff trained in Duty of Candour

Target 2016/17	Actual	Variance	RAG
85%	92%	7%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	92%	92%	92%	92%	92%	92%	92%					
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

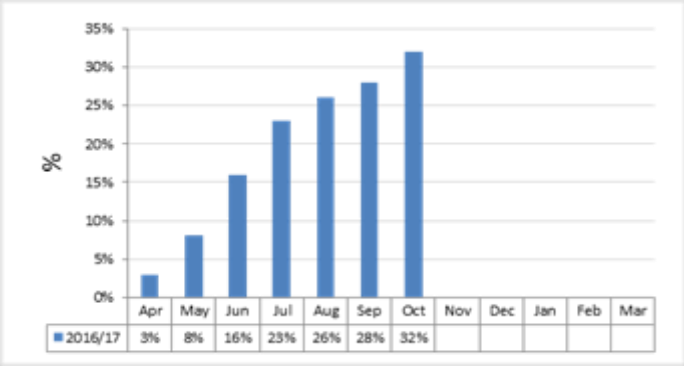
Duty of Candour training was delivered as part of the statutory and mandatory requirements for clinical staff in 2015/16. Duty of Candour training is not required on a yearly basis and therefore all of the clinical staff who completed this training are still classed as being "in date".

The actual number will change slightly each month due to leavers and starters (who receive training as part of induction).

2| ACHIEVING GOOD GOVERNANCE

2.8 Support staff trained in Duty of Candour

Actual
32%

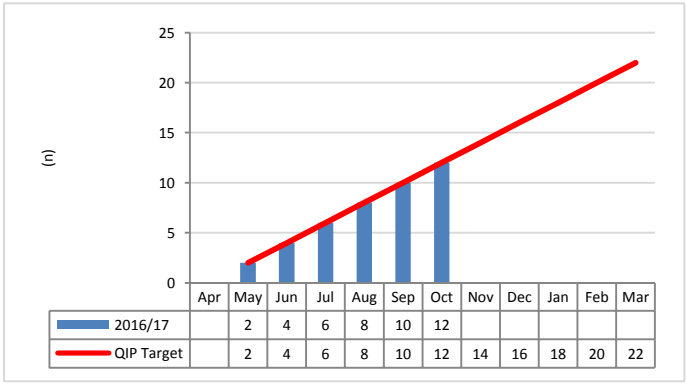


Communications have been circulated to all support services managers to place a focus on the completion of this module (as one of the statutory and mandatory elements that must be completed).

In addition to this an article has been placed in the routine information bulletin for the next four weeks.

2.9 Emergency Operations Centre (EOC) management surgeries held

Target 2016/17	Actual	Variance	RAG
22	2 (Cumulative: 12)	0	



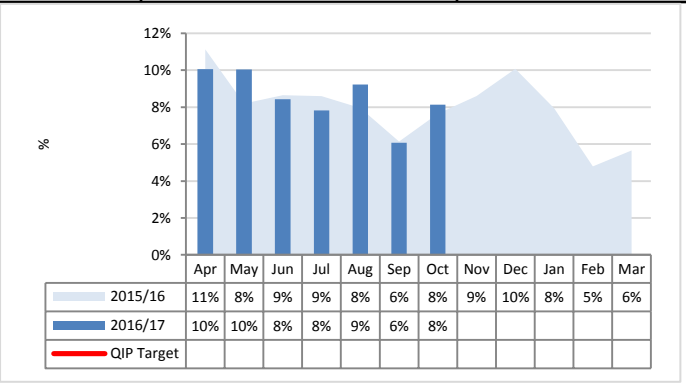
The October Surgeries were led by Alex Foundos, General Manager on 18th and 21st October. Discussions were centered around the lack of internal managerial skills courses and development programmes available via the Pulse and how to overcome this training need within the department.

In addition to this a number of staff expressed an interest in assisting with the EOC Improvement Project Workstreams.

2| ACHIEVING GOOD GOVERNANCE

2.10 Staff taking a rest break during shift

Target 2016/17	Actual	Variance	RAG
[TBC]	8%	[NA]	[NA]



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	11%	8%	9%	9%	8%	6%	8%	9%	10%	8%	5%	6%
2016/17	10%	10%	8%	8%	9%	6%	8%					
QIP Target												

The number of staff taking a rest break during their shift has increased slightly this month. The work to determine the requirements and compliance with rest breaks will be aligned with the revised rest break policy.

Discussions about the revised rest break policy are currently underway between the Director of Operations and Union representatives.

3| IMPROVING PATIENT EXPERIENCE

Executive Lead: Briony Sloper

HIGHLIGHTS THIS MONTH

NON-EMERGECY TRANSPORT SERVICE (NETS)

There has been communication with palliative care pilot site in early October which resulted in a meeting with their Head of Administration on 17th October to discuss:

- Training requirements (content and numbers of sessions);
- How it would be delivered (group or 1:1);
- Who would require training and
- Agreement on where training is to take place.
- Training is now expected to go ahead week commencing 7/11/16 with the pilot due to start immediately afterward.

MEETING PEOPLE'S NEEDS – BARIATRIC

- Work is progressing with regards to the bariatric service improvement with the preparation of the Bariatric business case.

- A paper is currently being drafted, which will be submitted to the next QIP Board. The intent of this paper is to set out the Trust's current bariatric provision, those actions already taken in terms of selecting and procuring new equipment and further investment, should it be required to increase our bariatric response.

MENTAL HEALTH

- The team continues to develop the raising Mental Health awareness campaign which was built into the World Mental Health day event. Various stalls were constructed at LAS Headquarter on 10/10/2016; this was well attended and received very positive feedback.

- Mental Health presentation was given at the Patient care conference 26/10/2016 and on going series of joint Mental Health Simulation training with Metropolitan Police Service and South London and Maudsley NHS Trust-1st session took place on 25/10/16 with positive feedback.

3| IMPROVING PATIENT EXPERIENCE

Progress – October 2016

Deliverable	Lead	Oct 2016		
		Complete	Delayed	At Risk
Patient Transport Service	Paul Woodrow	-	-	-
Meeting peoples needs	Briony Sloper/ Paul Woodrow	-	-	-
Response Times	Paul Woodrow	-	-	-
Learning from experiences	Briony Sloper	-	-	-

Outstanding actions
Complete training in early November and roll out the pilot of pan-London process for pre-booking palliative care patients.

3| IMPROVING PATIENT EXPERIENCE
Forecast View

Focus for next month	Key risks and challenges
• Deliver the pilot of pan-London process for pre-booking palliative care patients • Delivering on weekly actions as part of the countdown weekly action plan	

Deliverable	Lead
Patient Transport Service	Paul Woodrow
Meeting peoples needs	Briony Sloper / Paul Woodrow
Response Times	Paul Woodrow
Learning from experiences	Briony Sloper

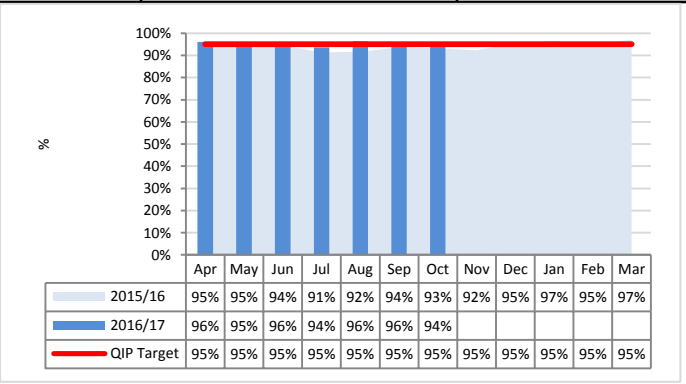
Nov 2016			
Complete	On Track	Delayed	At Risk

Dec 2016			
Complete	On Track	Delayed	At Risk
	1		
	1		

3| IMPROVING PATIENT EXPERIENCES

3.0 Patient Transport Service patients will not wait longer than the 60 min contracted departure window

Target 2016/17	Actual	Variance	RAG
95%	94%	1%	



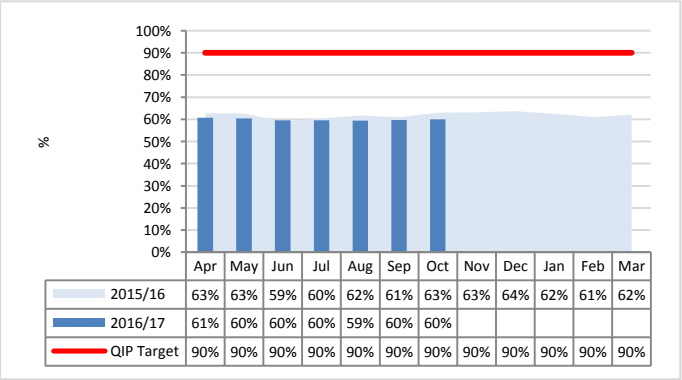
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	97%
2016/17	96%	95%	96%	94%	96%	96%	94%					
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The Patient Transport Service has seen a drop in its departure time performance against the target of 95% for this month putting in a performance of 94%.

A focus on the planning and delivery of journeys is being monitored on a real time basis and local actions taken to aid improvement.

3.1 Handover to green (ambulance conveyances/non blue calls) take place within 15 minutes

Target 2016/17	Actual	Variance	RAG
90%	60%	30%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	63%	63%	59%	60%	62%	61%	63%	63%	64%	62%	61%	62%
2016/17	61%	60%	60%	60%	59%	60%	60%					
QIP Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

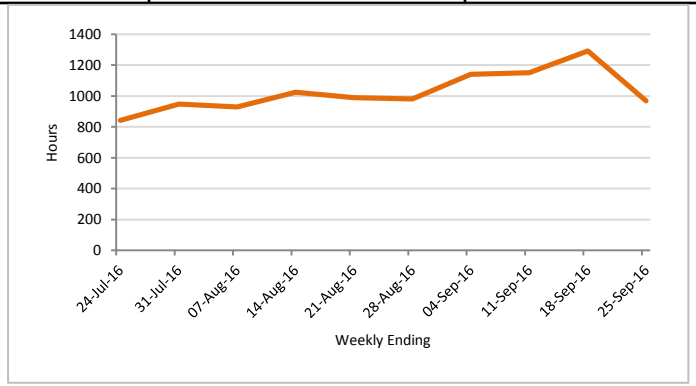
In October 2016, we achieved 60% of handovers to green within 15 minutes. An action plan has been developed to address and improve this position and continues to be implemented in Operations.

Progress against the action plan will be regularly reviewed by senior managers in the Operations Directorate as part of the newly introduced performance management framework.

3| IMPROVING PATIENT EXPERIENCES

3.2 Number of hours lost for arrival to Handovers Over 15 minutes - LAS

Target 2016/17	Actual	Variance	RAG
[NA]	968	[NA]	[NA]



Over the last 10 weeks 26.11% (2,679 hours) of the total time lost for the LAS (10,262 hours) for handovers over 15 minutes originated entirely from Kings College, North Middlesex, Princess Royal Farnborough and Royal Free.

4| IMPROVE ENVIRONMENT AND RESOURCES

Executive Lead: Andrew Grimshaw

HIGHLIGHTS THIS MONTH

VEHICLE PREPARATION / MAKE READY

- The gold roll outs have completed on time to West sector (Fulham and Isleworth) with new ways of working now being embedded.
- The silver roll out completed on time to St. Helier (first site for South West sector).
- The gold roll outs to North West sector (Brent and Hillingdon) are on track for completion in November and December respectively.
- The silver roll out to Wimbledon, to complete the silver roll out to the South West sector, on track for November.
- To date no planned roll outs behind schedule.
- Stakeholder meetings continuing. Communications plan in place for all sites, to be rolled out across November.
- Project Steering Group and Project Board meetings continuing.

INFECTION, PREVENTION AND CONTROL PERSONAL, PROTECTIVE EQUIPMENT (PPE)

- New PPE packs delivered to sites with Vehicle Preparation teams across the service to replace the protective clothing kit on vehicles. The communication package has now been completed and is due for broadcast in November.

ESTATES STRATEGY

- The Director of Finance has identified and appointed external advisors to assist the Trust to complete hypothetical model for estates. The delivery date for completion is January 2017 for submission to the January Trust Board.
- Initial meetings underway, staff engagement sessions being planned for November 2016

4| IMPROVE ENVIRONMENT AND RESOURCES

Progress – October 2016

Deliverable	Lead	October 2016		
		Complete	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw			
Information Management and Technology	Andrew Watson			1
Infection prevention and control	Fenella Wrigley			1
Facilities and Estates	Andrew Grimshaw			
Resilience functions	Paul Woodrow			
Operations Management	Paul Woodrow			
Improving operational productivity	Paul Woodrow			
Cost improvement programme	Andrew Grimshaw			
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw		1	

Outstanding actions

Information Management and Technology (September 16 Milestone)

- October update: Two handheld Cases being finalised – 1) Limited roll out of Virtual Ward, and 2) Handhelds for all frontline staff. Funding for both options being confirmed.

Infection prevention and control (September 16 Milestone) – Implement agreed protective clothing pack for staff

- October update: Anticipated delays (through to January 2017) now lifted – completion anticipated by mid-November 2016.

Facilities and Estates – Develop an estates strategy (September 16 Milestone)

- October update: Change request approved. Action re-named to 'Develop Hypothetical options model and define timeline' for completion on 20 January 2017.

Frontline Equipment and Uniforms – Review and improve uniforms for frontline staff (October 2016 Milestone)

- Soft shell jackets ordered on 07 July for October delivery. Now expected 28 November due to supplier side manufacturing delays. Jacket roll out to commence at the end of November.
- Initial epaulettes order delivered with roll out to complete by mid-November.

4| IMPROVE ENVIRONMENT AND RESOURCES

Forecast View

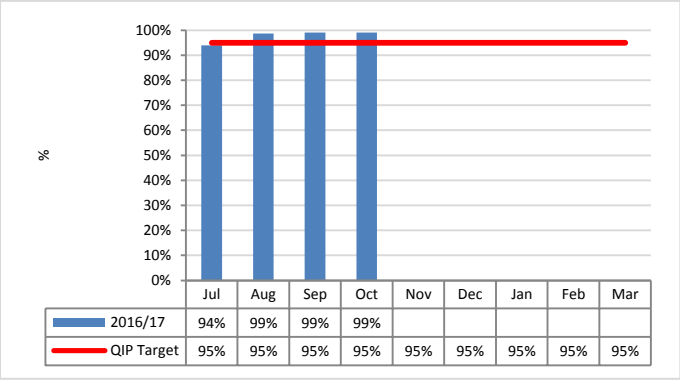
Focus for next month	Key risks and challenges
Fleet/Vehicle Preparation: Make Ready • Maintain progress against delivery timeline. • Continue stakeholder meetings with upcoming roll out sites. • Increase Trust wide communications utilising direct communications to staff on sites, the RIB and the Pulse webpage. **Vehicle Procurement** • Await approval of the business case for Double Crew Ambulance (DCA) due in November. • Delivering on weekly actions as part of the countdown weekly action plan	

Deliverable	Lead	Nov 2016				Dec 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw						1		
Information Management and Technology	Andrew Watson								
Infection prevention and control	Fenella Wrigley								
Facilities and Estates	Andrew Grimshaw						1		
Resilience functions	Paul Woodrow								
Operations Management	Paul Woodrow								
Improving operational productivity	Paul Woodrow								
Cost improvement programme	Andrew Grimshaw								
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw						1		

4| IMPROVING ENVIRONMENT AND RESOURCES

4.0 Available vehicles that enter the clean and equip process across the Trust

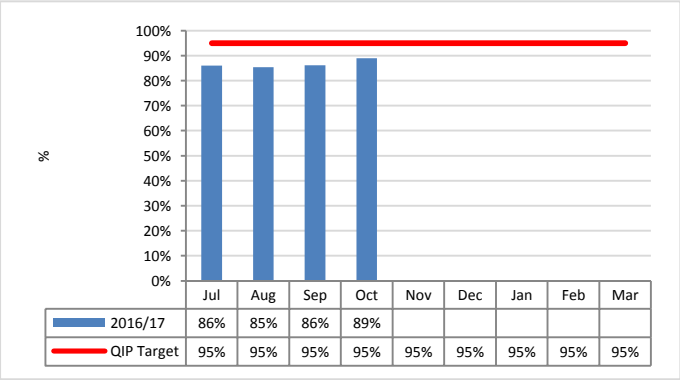
Target 2016/17	Actual	Variance	RAG
95%	99%	4%	



Resilient performance is being consistently maintained.

4.1 Available vehicles that are made ready with essential kit across the Trust

Target 2016/17	Actual	Variance	RAG
95%	89%	6%	



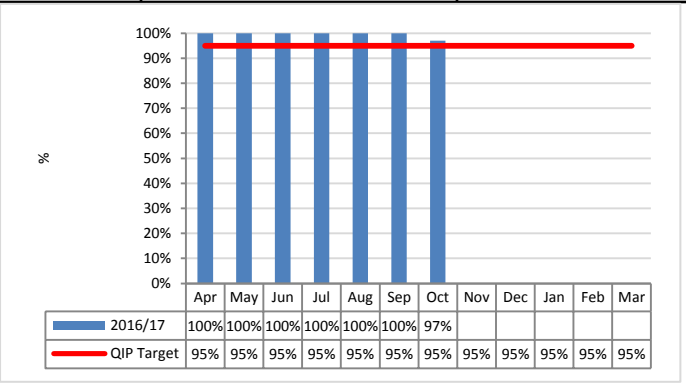
Improved performance from last month in the Vehicle Preparation contractor in obtaining 24 hour vehicles.

As the rollout of the vehicle preparation hubs continues we expect to further improvement in available vehicles made read y with essential kit across the Trust.

4| IMPROVING ENVIRONMENT AND RESOURCES

4.2 Vehicle deep clean completed as a rolling average every 6 weeks

Target 2016/17	Actual	Variance	RAG
95%	97%	2%	

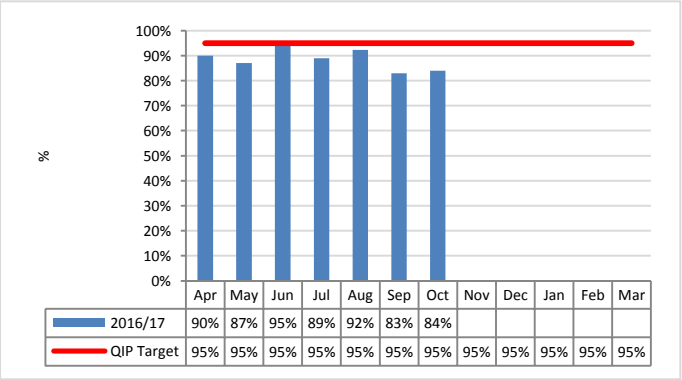


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	100%	100%	100%	100%	100%	100%	97%					
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

From April 2016, performance has consistently exceeded the target.

4.3 12 week cycle planned maintenance/servicing to be completed against schedule

Target 2016/17	Actual	Variance	RAG
95%	84%	11%	



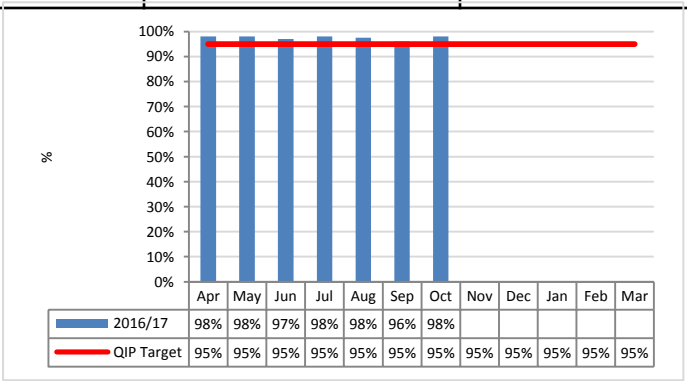
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	90%	87%	95%	89%	92%	83%	84%					
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Inadequate deliveries of vehicles on time to workshops has impacted on performance. There has been a n increased oversight of scheduling to ensure improved compliance.

4| IMPROVING ENVIRONMENT AND RESOURCES

4.4 Planned maintenance of vehicles to be completed within 48 hour target

Target 2016/17	Actual	Variance	RAG
95%	98%	3%	

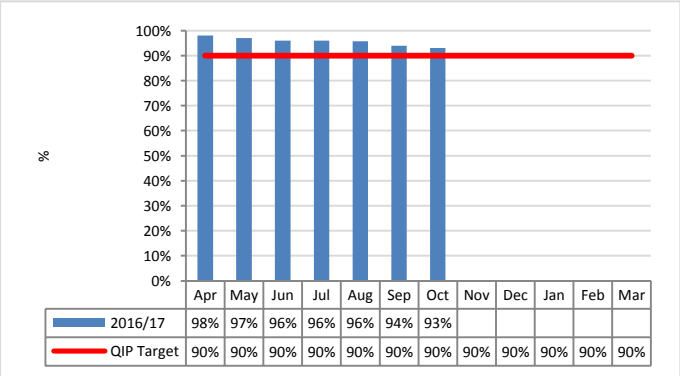


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	98%	98%	97%	98%	98%	96%	98%					
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Planned maintenance of vehicles within 48h remains above target

4.5 Unplanned jobs (defects) to be completed within 48 hours

Target 2016/17	Actual	Variance	RAG
90%	93%	3%	



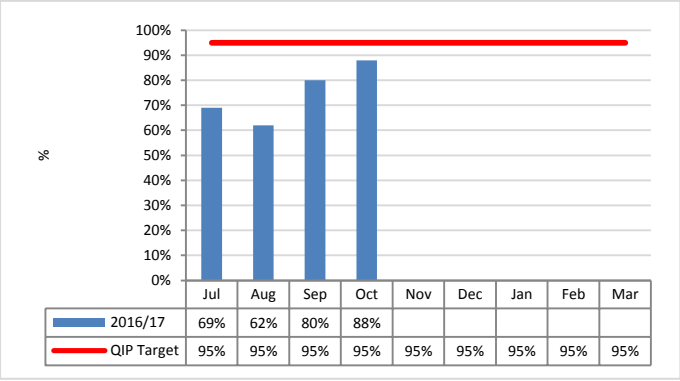
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	98%	97%	96%	96%	96%	94%	93%					
QIP Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Unplanned work continues to be completed on target.

4| IMPROVING ENVIRONMENT AND RESOURCES

4.6 Minimum of 4 blankets available at start of shift

Target 2016/17	Actual	Variance	RAG
95%	88%	7%	

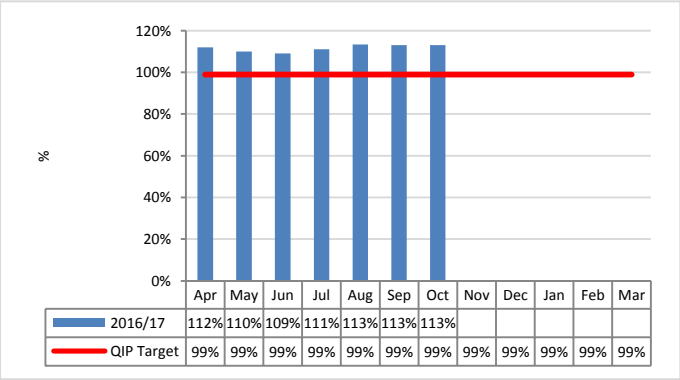


There has been an encouraging increase in blanket availability due to improved reporting and availability of stock.

There has been further negotiations with laundry services to develop a managed service that would operation via Hospitals which will improve the flow of blankets.

4.7 Number of double crewed ambulances (DCA) available against peak vehicle requirements

Target 2016/17	Actual	Variance	RAG
99%	113%	14%	

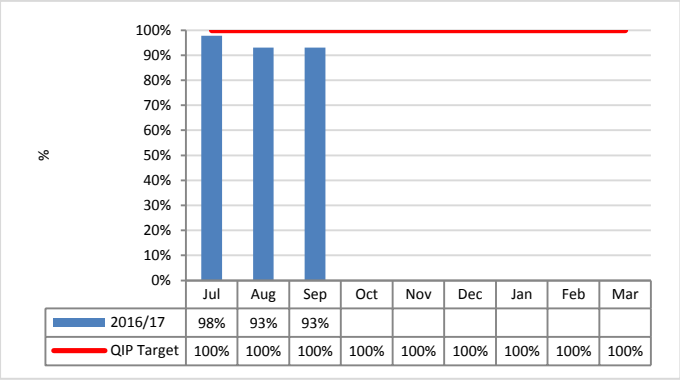


Robust Double Crewed Ambulance availability was maintained in October.

4| IMPROVING ENVIRONMENT AND RESOURCES

4.8 Number of station premises cleaning compliance audits are passed

Target 2016/17	Actual	Variance	RAG
100%	September: 93%	7%	



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	98%	93%	93%						
QIP Target	100%	100%	100%	100%	100%	100%	100%	100%	100%

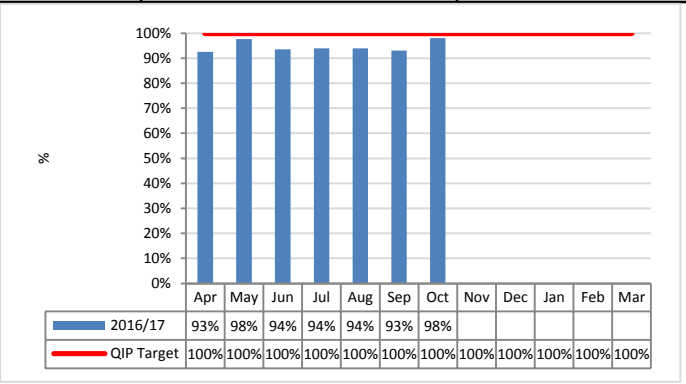
This KPI is reported one month retrospectively.

In September 2016 ,89 sites were audited by the cleaning contractor, 23 by local management and 14 by the estates department facilities manager. 126 audits were completed in total, of which 93% achieved a pass rate.

4| IMPROVING ENVIRONMENT AND RESOURCES

4.9 Hazardous Area Response Team (HART) shifts fully staffed with 6 officers per team 24/7

Target 2016/17	Actual	Variance	RAG
100%	98%	2%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	93%	98%	94%	94%	94%	93%	98%					
QIP Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

In October, we achieved 98% compliance on filling HART shifts against a target of 100%. In line with the national specification, this KPI is required to achieve 100%.

HART rosters are reviewed on a daily basis to maximise capacity as far as possible and overtime incentives are offered to fill gaps in the rosters. The gaps experienced in October were due to staff being unavailable because of annual leave and training. The HART establishment of 84 does not take into account abstractions due to training, annual leave and short term sickness, which results in HART not always being able to produce two complete HART teams of six officers, 24 hours a day. To address this issue, work has been undertaken with Working Time Solutions (a workforce optimisation company) to review HART rosters as a means of maximising cover. This work has identified that although changes to the annual leave agreement will improve roster reliability, the impact of on-day absences (such as sickness) can only be mitigated through increasing the HART establishment. The Trust undertook a review of internal capacity in order to establish the number of additional HART officers required. The Trust agreed the increase of the HART establishment to 98. There are currently 10 vacancies, the recruitment process has started with shortlisting to take place in November.

In those current instances when two full HART teams are not available, we comply with the notification protocols required by NARU and we have systems in place to notify the London Fire Brigade and the Metropolitan Police Service. Our formal agreement with South East Coast Ambulance Service (SECAMB) to provide coverage at Heathrow at times when LAS HART staffing is incomplete was signed in December 2015 and is still active.

While 2% of our HART shifts were incomplete in October, it should be noted that (as per our agreement with SECAMB) they did not have to move their HART assets on any of these occasions because our two HART teams always had more than ten officers on duty.

5| TAKING PRIDE AND RESPONSIBILITY

Executive Lead: Fenella Wrigley

HIGHLIGHTS THIS MONTH

MEDICINES MANAGEMENT

- KPMG report, shows some improvement - areas needing attention have been incorporated in the Countdown weekly plan
- Audits on going and actions reviewed by MMG and audits have better oversight by Ops. The IRO audit process has been reviewed, refined and agreed with the Operations Directorate.
- The end to end drug tracking process has been agreed and data relating to the tracking process is now available on the medman portal.
- The Pharmacist has now been recruited and a verbal acceptance of this role has been received.

Greenwich station based trial:

- Feedback has been positive and staff have engaged well with the requirements of the system along with making some suggestions for improving the forms which have been changed. Staff have reported the system as easy to use and commented that the drugs are kept in a better condition than previously where they were kept in the 02 bag.

SAFEGUARDING

- The safeguarding project manager has scoped the implications and logistics of implementing a safeguarding supervision model to provide frontline staff with the appropriate level of oversight and support in handling safeguarding concerns.
- The following staff have been trained to date:
    - 464 - total figure for EOC (Control Services, excluding CHUB/NETS)
    - 126 - EMD 1 (have already received their Safeguarding training in new entrant course)
    - 337 – Due to undertake CSR 1 (2 hour safeguarding session included)

5| TAKING PRIDE AND RESPONSIBILITY

Progress – October 2016

Deliverable	Lead	Oct 2016			Outstanding actions
		Complete	Delayed	At Risk	
Clinical supervision	Fenella Wrigley				
Consent MCA	Fenella Wrigley				
Medicine Management	Fenella Wrigley				
Safeguarding	Fenella Wrigley	2			
Quality and clinical strategy	Fenella Wrigley		1		
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton				
Developing the 111 Service	Paul Woodrow / Karen Broughton				

5| TAKING PRIDE AND RESPONSIBILITY

Forecast View

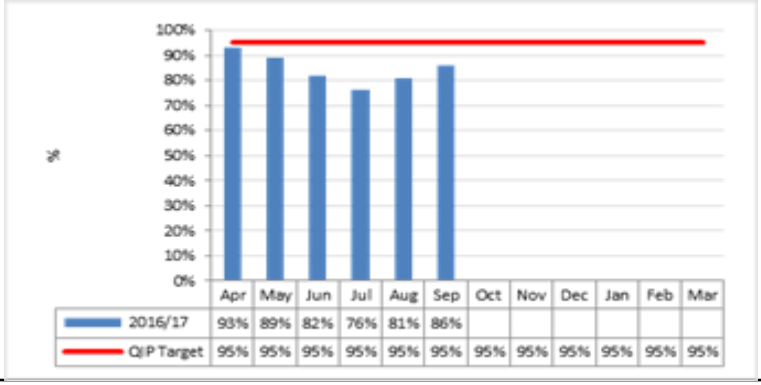
Focus for next month	Key risks and challenges
• Delivering on weekly actions as part of the Countdown weekly action plan. • Continue with ongoing audits to aid Operation Managers. promotion of good medicines management compliance. • Completing the Quality & Clinical Strategy.	

Deliverable	Lead	Nov 2016				Dec 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Clinical supervision	Fenella Wrigley						1		
Consent MCA	Fenella Wrigley								
Medicine Management	Fenella Wrigley								
Safeguarding	Fenella Wrigley								
Quality and clinical strategy	Fenella Wrigley								
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton						2		
Developing the 111 Service	Paul Woodrow / Karen Broughton						1		

5| TAKING PRIDE AND RESPONSIBILITY

5.0 Number of eligible Patient Report Forms (PRFs) audited per month

Target 2016/17	Actual	Variance	RAG
95%	September: 86%	9%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	93%	89%	82%	76%	81%	86%						
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

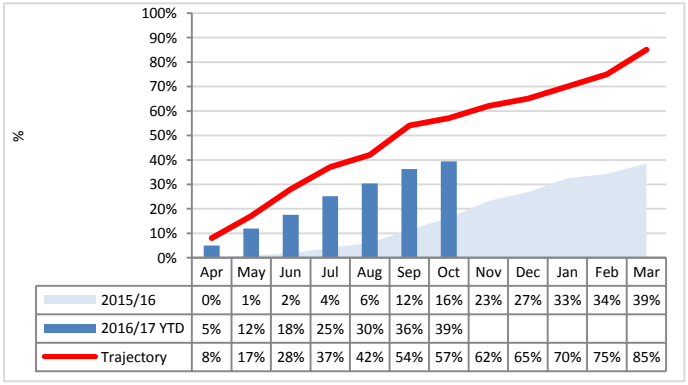
This KPI is reported one month retrospectively.

Completion has risen for the second month due to an increase in the number of CPI audits undertaken by Team Leaders however we are still below target.

Friern Barnet, HART and Hillingdon audited all PRFs for the 14th consecutive month. Similarly, the TRU have continued to maintain 100% completion this financial year. The North East and North West Sectors achieved 100% completion for the second and third months respectively. Staff sickness and annual leave affected completion rates at Greenwich and Westminster, combined with a reduction in restricted duties staff, which also had an impact at Homerton. The fall in completion rates at Bromley and the CRU are being investigated.

5.1 Frontline staff completing one operational workplace review annually

Target 2016/17	Actual	Variance	RAG
Cumulative: 57%	Cumulative: 38%	19%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	0%	1%	2%	4%	6%	12%	16%	23%	27%	33%	34%	39%
2016/17 YTD	5%	12%	18%	25%	30%	36%	39%					
Trajectory	8%	17%	28%	37%	42%	54%	57%	62%	65%	70%	75%	85%

Data shown is for a partial month in October.

A detailed review of Operational Workplace Review (OWR) completion rates was conducted at the half-year position and discussed at the Assistant Director Operations meeting on 17th October. The paper showed that two Group Stations are exceeding their OWR trajectory, whilst all others are behind. The furthest behind is Deptford Group, who need to conduct around 3 OWRs per Team Leader per month in order to catch up by the end of the financial year.

Although currently 19% off trajectory the current position sees more than a 100% improvement on the same position last year.

Recommendations made at the aforementioned meeting were:
- Local managers should produce detailed plans of OWRs to the end of the year.
- In addition to third person OWRs; one-to-one OWRs can be conducted by Clinical Team Leaders in October half-term and through December whilst working on patient-facing shifts.

5| TAKING PRIDE AND RESPONSIBILITY

5.2 Staff trained to the appropriate safeguarding level by year end

Actual
September: 259

		April	May	June	July	August	September
Level One	Induction			21	0	22	17
	E learning	48	53	71	67	55	55
Level Two	New Recruits	22	78	33	51	26	74
	EOC CSR	0	38	36	51	0	63
	EOC New staff	20	0	11	11	10	10
	PTS/NETS	0	9	58	0	23	40
	111	6	4	0	0	0	0
Specific training	Trust Board	4	3	N/A	N/A	N/A	N/A
	Local Leads	N/A	N/A	N/A	18	N/A	N/A
Total		**100**	**185**	**230**	**198**	**136**	**259**

This KPI is reported one month retrospectively.

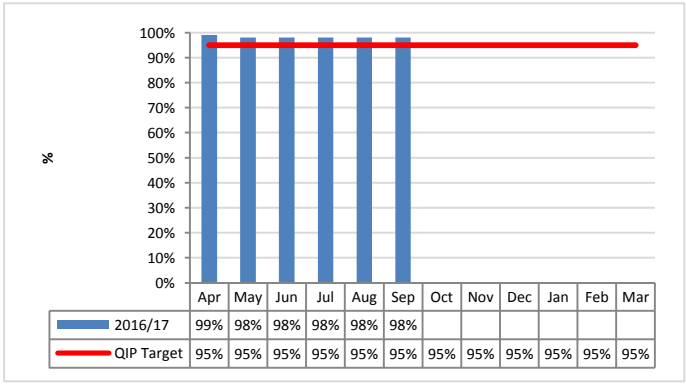
This shows the actual number who have undertaken training. It is not possible to currently provide this as a percentage.

Clinical staff will receive safeguarding training in CSR2016.3

The Trust also took part in World Anti-Slavery day on 18th October with information and educational materials provided on Pulse and in static displays across Trust.

5.3 Audited Patient Report Forms (PRFs) with drug bag numbers recorded if applicable

Target 2016/17	Actual	Variance	RAG
95%	September: 98%	3%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	99%	98%	98%	98%	98%	98%						
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

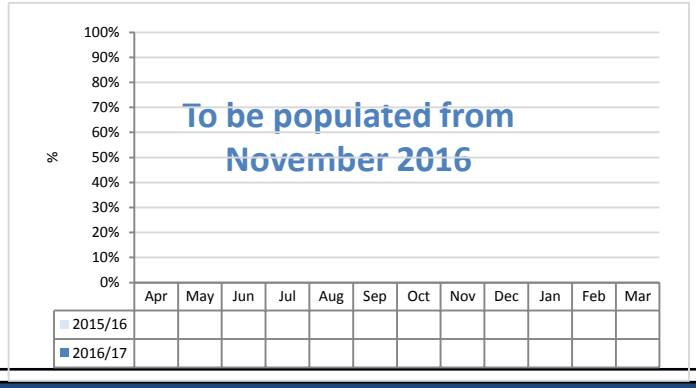
This KPI is reported one month retrospectively.

The number of PRFs which include a drug pack code following drug administration remains high, with slight variation between sectors each month.

5| TAKING PRIDE AND RESPONSIBILITY

5.4 Compliance with completion of drug pack forms

Target 2016/17	Actual	Variance	RAG
100%	-	[NA]	[NA]

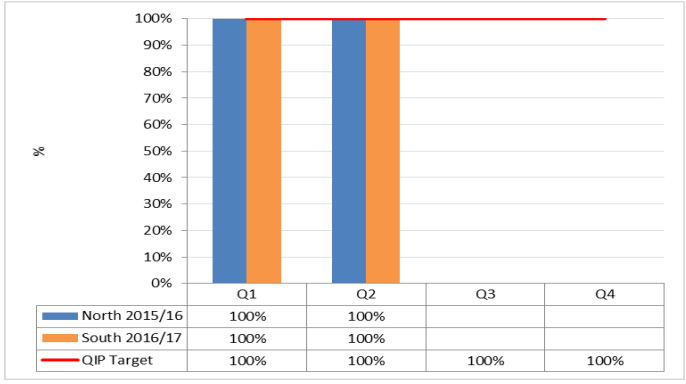


Further work has been carried out to ensure that the data submitted to IMT will provide accurate information on drug pack compliance.

Ongoing audits continue across station sites with audit results aiding operations managers promotion of compliance.

5.5 Percentage compliance of drug code changes

Target 2016/17	Actual	Variance	RAG
100%	Q2:100%	0%	



Drug locker codes are changed regularly by local managers to ensure compliance. They are checked as part of unannounced audits.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November, 2016**
Document Title:	**Sustainability and Transformation Plans**
Report Author(s):	**Nikki Fountain, Transformation and Strategy Lead** **Karen Broughton, Director of Transformation and Strategy**
Presented by:	**Karen Broughton, Director of Transformation and Strategy**
Contact Details:	**Nikki.fountain@lond-amb.nhs.uk**
History:	**A summary paper has been taken to the Strategy, Review and Planning Group**
Status:	**For information**

Background/Purpose

In December 2015, the NHS outlined a new approach to ensure that health and care services are built around the needs of local populations.

Multi-year Sustainability and Transformation Plan (STP) have been developed across London to show how local services will evolve and become sustainable over the next five years, ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

This paper summarises STPs in London and how the London Ambulance Service is contributing to their development.

Action required

The Trust Board are asked to take note of the contents of the paper

Key implications and risks arising from this paper	
Clinical and Quality	n/a
Performance	It is important that LAS responds to local need but that this does not impact on our ability to deliver national response targets, or create financial or staffing pressures that cannot be managed.
Financial	
Workforce	
Governance and Well-led	n/a
Reputation	n/a
Other	n/a
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

LONDON AMBULANCE SERVICE TRUST BOARD

29 NOVEMBER 2016

Sustainability and transformation plans for London

1. Background

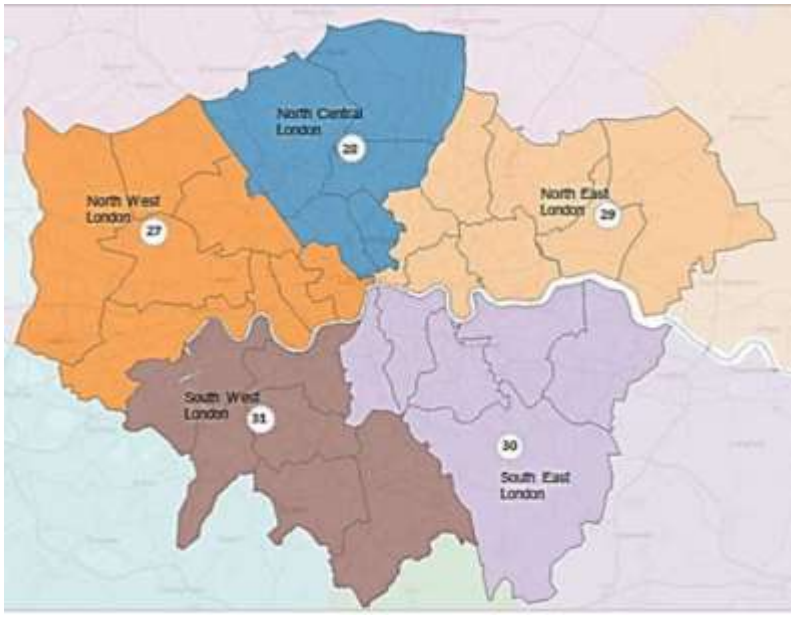
In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England is required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within these geographic footprints have worked together to develop STPs which will help drive sustainable transformation in patient experience and health outcomes. The London Ambulance Service NHS Trust aligns to the five London STPs.

The NHS Operational Planning and Contracting Guidance 2017-19 reinforces this collaboration, focusing on planning at whole system level and contracting. It also moves to a two year contracting model as part of the aim to support longer term planning.

This paper summarises STPs in London and how the London Ambulance Service is contributing to their development.

2. London's Sustainability and Transformation footprints



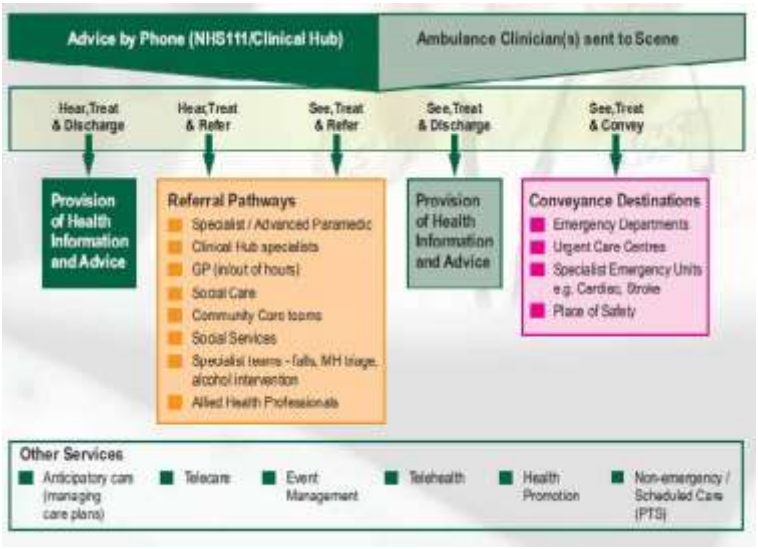
- North West London
- North Central London
- North East London
- South East London
- South West London

The table below summaries for each STP the lead officer, the locations covered and the Lead Director from the LAS to work alongside them. Dr Fenella Wrigley works across the whole of London on STPs as the Clinical Lead.

STP	Lead Officer	London Boroughs	Lead Director
North West	Dr. Mohini Parmar, Chair NHS Ealing CCG	Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, West London and City of Westminster	Dr Fionna Moore
North Central	David Sloman, CEO The Royal Free NHS Foundation Trust	Barnet, Camden, Enfield, Haringey and Islington	Andrew Grimshaw
North East	Jane Milligan, Chief Officer, NHS Tower Hamlets CCG	Barking and Dagenham, City and Hackney, Newham, Redbridge, Tower Hamlets and Waltham Forest	Briony Sloper
South East	Amanda Pritchard, CEO Guy's and St Thomas' Foundation Trust	Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark	Paul Woodrow
South West	Kathryn Magson, Chief Officer, NHS Richmond CCG	Richmond, Kingston, Croydon, Wandsworth, Merton and Sutton	Karen Broughton

3. Setting priorities

The diagram below shows nationally outlined key clinical/service models to transform the way ambulance services operate. The London Ambulance Service currently undertake the full range of activities described below.



Hear, treat & discharge: when 999 calls are completed without despatching an ambulance vehicle by providing clinical advice.

Hear, treat & refer: when 999 calls are completed without despatching an ambulance vehicle by providing clinical advice and referral to an onward service.

See, treat & refer: when a clinical assessment is conducted at the patient's location followed by immediate treatment and referral to onward services.

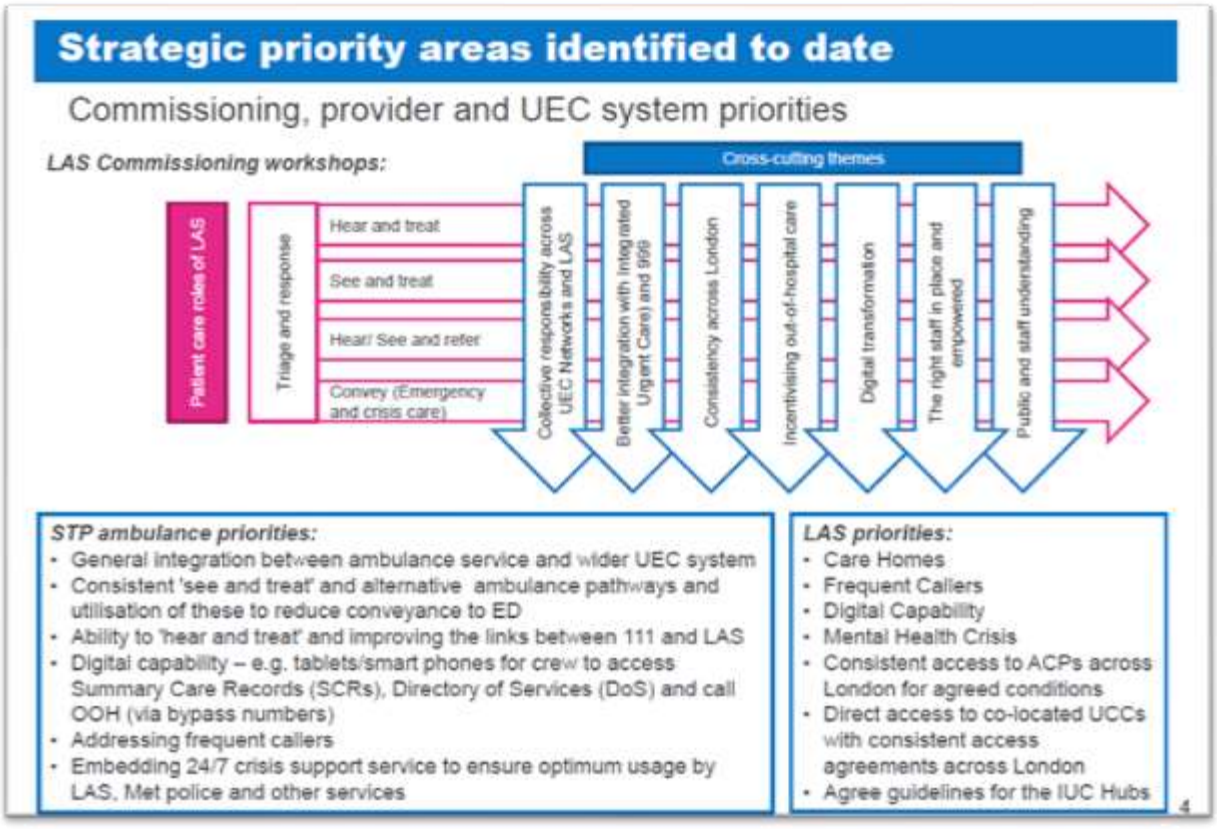
See, treat & discharge: when a clinical assessment is conducted at the patient's location followed by immediate treatment and discharge

See, treat & convey: when (rapid) transportation of patients with illness or injury, couple with treatment in transit, is provided.

The ultimate aim of the range of models is to ensure that each patient receives the right care, with the right resource, in the right place, at the right time – every time. To achieve this, it is stated that ambulance services must move from being a transport service to a central coordination hub for the provision of clinical advice and a mobile urgent healthcare provider. This will allow a shift in the balance away from acute hospitals to delivering care at home or in community settings.

4. Joint strategic aims

Although each STP will have unique challenges and local population variations to contend with, pan-London joint strategic aims were agreed with all 32 Clinical Commissioning Groups (CCGs) and Urgent and Emergency Care Networks (UECs).



These joint strategic aims were taken forward by each STP and refined for their particular population needs. The table below shows the ambulance priorities by STP.

Ambulance priorities by within individual STPs

SWL	**Ambulance Pathways** • Improving the skill mix of paramedic staff to facilitate 'see and treat' and 'hear and treat' • Identification of frequent callers and development of care plans and escalation plans to reduce avoidable call outs • Streamlining of the ambulance pathway **'Hear & Treat' and 'See & Treat'** • Providing patients with timely advice via telephone access to a GP or other appropriate health professional with clinical specialists in NHS 999 & 111 clinical hub call centres, or treatment at the scene via an improved skill mix of LAS paramedics **Psychiatric Decision Unit** • Provision of an alternative pathway for patients accessing EDs and other services, such as the police and ambulance services. **Directory of Services (DoS)** • Increased service information on the DoS to support 111 in making referrals to clinical pathways leading to reductions in the number of ambulance call-outs and conveyances to hospitals.
SEL	**Mental health** • Identification of MH patients and streaming pathways improved for LAS and the Police - Consider approaches for MH screening to be carried out during the ambulance journey and enabling the police to better recognise mental health needs and being able to refer to mental health services rather than bringing patients to the ED, including 136s. **A&E conveyance** • Working to reduce ambulance conveyance to emergency departments through improved integration and the development of new models. • Improve ambulance conveyance rates through the establishment of a Clinical Hub with experienced clinicians who are operating the Hear and Treat service.
NEL	• Across NEL working to roll out 3 integrated **paramedic / community models** and to share evaluation and best practice • **Access to Integrated Urgent Care**, to include at a minimum SCR, clinical hub and 'bookability' for GP content; with mental health crisis response in hospital and part of the Ambulance Response Programme.
NCL	• Where possible, people will be appropriately **supported and treated at home by the community services and ambulance services**. For those people who do require ambulance transfer, the ambulance services will be able to utilise any part of the UEC system that meets the patient's need.
NWL	• Embed our **24/7 crisis support service**, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS) LAS, Metropolitan police and other services – meeting access targets • Patient flow: Implement system level initiatives in areas such as: improving access to GPs, **better management of increasing volumes of ambulance attendances**, integrated discharge processes from hospital and best practice A&E processing of patients.

5

5. Final STP plans for London

On the 20th October 2016, all 5 London STPs submitted their Sustainability and Transformation Plans.

6. In conclusion

In December 2015, the NHS outlined a new approach to ensure that health and care services are built around the needs of local populations.

Multi-year Sustainability and Transformation Plan (STP) have been developed across London to show how local services will evolve and become sustainable over the next five years, ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

The London Ambulance Service has representatives on each of the 5 STP Boards in London and will now work with system partners to deliver the transformation outlined in each plan.

Karen Broughton
Director of Transformation and Strategy

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Assurance report from the Quality Governance Committee**
Report Author(s):	**Bob McFarland, Non-executive director and Chair of the committee**
Presented by:	**Bob McFarland**
Contact Details:	
History:	**N/A**
Status:	**Assurance report from the meeting held on 15th November 2016 and approval of annual reports**

Background/Purpose

The Quality Governance Committee is a Board committee with oversight of quality and safety. The committee meets bi-monthly and this is the assurance report from the meeting held on 15th November 2016. The Committee is also recommending the following annual reports for 2015/16 to the Trust Board for approval:

- Cardiac Arrest
- Stroke Care
- Clinical Audit

Action required

To receive assurance from the committee and to note any areas of concern.
To approve the 2015/16 annual reports listed above.

Key implications

The Trust Board takes its assurance from Board committees and needs to consider any areas of concern raised and take assurance that these are being addressed.

Key implications and risks arising from this paper	
Clinical and Quality	**The committee has oversight of clinical governance and will bring to the attention of the Board areas of good practice and areas of concern and any potential risks.**
Performance	**The committee considers the impact/implications of performance issues on the quality and safety of services for patients.**
Financial	**The committee seeks assurance during the year on the quality impact of cost improvement programmes.**
Workforce	**The committee considers workforce issues in relation to the provision of safety and quality of services to patients.**
Governance and Well-led	**Providing assurance on quality governance.**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	**Yes**

Report from the Quality Governance Committee on 15th November 2016

The Quality Governance Committee met on 15th November 2016. Please note the issues around Medicine Management, the new risk around power supply to both Waterloo and Bow EOC and the results of our deep dive into cardiac outcomes.

Clinical Governance

The Clinical Safety and Standards Committee reported the actions to address CQC concerns around ***Medicines Management*** were on trajectory however significant action was still required on the logistics side which was being addressed with full commitment from the Deputy Director of Logistics. The Trust has appointed a full-time pharmacist having recognised the need for more expert support than previously – the committee recognised the work which the part-time pharmacist has undertaken supporting LAS over several years and in particular since the CQC report was published. Whilst there has been significant improvement the recent Internal Audit by KPMG and our own "spot checks" have shown that consistency remains an issue and assurance reports show there are still frequent lapses of security and good practice in management of medicines (including Controlled Drugs) and medical gases. There is no clear link to stations or shifts; a station may exhibit exemplary practice one day and be deficient on the next.

This is a disappointing finding after a year of determined work around these issues. It seems unlikely that further exhortation will produce the necessary improvement (posters, bulletins, roadshows etc.). There are still systemic issues to address, with supply and traceability of drugs, but there is a clear requirement to ensure that all staff have clearly understood their professional responsibilities with regards to medicines and management.. There was a discussion around the need for individual monitoring (such as placing all medicines in one place on ambulance stations and making access via the use of swipe cards and CCTV in drug rooms) – it was recognised that the operational management teams need to have clear guidance about the management of failures to comply and that disciplinary procedures may be invoked if deviance from policy is observed. It was also agreed that Station managers should be accountable for staff behaviour in their area. An updated medicines management action planner has been agreed which will see focus on the areas where improvement is still required – action delivery will be overseen by the Medical Director and all three key directorates (medical, logistics and operations) will report twice weekly.

RCAG reported new risks added to the register. There is a new risk concerning management of controlled medicines, one on the recognition and management of fine ventricular fibrillation, and an EOC / IT risk relating to the inability to make sure that that voice recordings remain available for three years which is required not only for legal purposes but to quality assure call handling and answer queries relating to incidents and complaints.

The Board should note the new risk that both Waterloo and Bow are at critical full power supply capacity and that currently there is no proposal to solve this critical issue regarding power to the Emergency Operations Centres.

The report from the Improving Patient Experience Committee was received. We still have not seen the Mental Health Action Plan for 2016/2017. We were also concerned that although there is a plan to institute DBS checks starting in December there is still uncertainty around which of our current staff had ever been checked. This will be followed up in the Workforce committee as it is primarily an HR issue.

We noted that NHSE had asked all STPs to include a forum for the better management of Frequent Callers in their plans.

Serious Incidents – Despite a high number of SI declared in August (10) the number of overdue reports has not increased. Responsibility lies with named members of SMT and ELT. There has been a reduction in the number of overdue actions from previous months (was 47|% but now 80% completed) and work will continue to provide assurance that lessons are always learned and implemented promptly. We expect to have an updated trend analysis at the next meeting and a clear plan for those areas requiring action.

Cost Improvement Programme – Andrew Grimshaw presented the Quality Impact Assessment for the CIP for 2016/2017. In the main, cost improvements are targeted away from areas of clinical risk and the three items which had required a quality assessment had been reviewed appropriately.

Annual Reports

Gurkamal Virdi, Emily Cannon and Rachael Fothergill attended to present the ***Cardiac Arrest Annual Report, Stroke Annual Report and Clinical Audit Annual Report for 2015/2016.*** The Committee wishes to commend the CARU for the detailed and consistently high standard of work which has, for example, produced a number of research papers and presentations, completed a number of audits which have changed both our practice and on occasion national guidelines, and also managed the regular service quality reporting efficiently. We are pleased to report that our outcomes for both Stroke and Cardiac Arrest patients are good. All three reports are recommended for approval by the Board.

During 2015/2016 the London Ambulance Service attended 10116 patients in out of hospital cardiac arrest and attempted resuscitation in 4389. Survival Rates remained the same as 2014/2015 with (9% survival to discharge from hospital – all patients; 31.5% Utstein patients). These results are above average when compared to other ambulance trusts. Success in Resuscitation (ROSC) sustained to hospital handover is slightly down in both groups from best results in 2013/2014 (All patients 31.2, 31.4, 29.9%; Utstein patients 58.5, 55.1, 53.4% in 2013/14,2014/5,2015/6 respectively). This is probably within statistical variation but will be monitored.
Public access defibrillators were used on 88 patients.

Deep Dive - Cardiac Outcomes.

At the request of the Medical Director CARU and the Trust Cardiac lead have undertaken a deep dive into cardiac outcomes to provide assurance to Trust Board. CARU have undertaken a “deep dive” on all cardiac arrest patients seen between April and August 2015. Overall survival was 10.6%.

There was no difference in survival percentage between those attended in less than eight minutes and those in more than eight minutes. The conclusion is that eight minutes is not a critical time point for cardiac survival. There was no significant difference between those attended when the Surge level was Purple Enhanced rather than Red. This would suggest these patients are still being prioritised appropriately when the service is under pressure.
Patients triaged to Red 1 had a less good outcome than those triaged to Red 2 – this is likely to be due to the longer period of arrest before intervention as the patient is not in arrest when the 999 call is first taken.

We would suggest that a response time of much less than eight minutes would be necessary to materially improve on these results and increased public access defibrillators and bystander CPR will both support this improvement.

The committee also discussed a short paper by Non-Executive Director Fergus Cass looking at our nationally reported outcomes month by month from April 2013 to March 2016 to see if there is a relationship between outcomes with our response time performance. As reported

above there has been a steady improvement in results over the years with our best reported outcomes in 2013.There is a dip in outcomes in the autumn months of 2014, recovering by the end of the year and sustained to date, still above average for England but not quite regaining the best levels of 2013. Of course, we know that Autumn 2014 was the time of greatest pressure on the service and this is evidenced by a fall in Red1 performance over those months which is now better but which has still not regained the national target level.
An apparent correlation does not necessarily imply causation. These outcomes are multifactorial and we have a number of mitigations to keep patients safe and prioritise the sickest patients when demand is high. However it does seem likely that when demand exceeds the resource we have available there may be clinical consequences.

Date of next meeting

The next meeting of the Quality Governance Committee is on Tuesday 10th January 2017.
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.

London Ambulance Service NHS Trust

Cardiac Arrest Annual Report: 2015/16

November 2016

Produced by:

Gurkamal Virdi, Scott Picton, Rachael Fothergill and Mark Whitbread

✉ CARU.Enquiries@lond-amb.nhs.uk

Clinical Audit and Research Unit, Clinical and Quality Directorate, London Ambulance Service NHS Trust, 8-20 Pocock Street, London, SE1 0BW.

Contents

Key findings

- During 2015/16, the London Ambulance Service NHS Trust (LAS) attended 10,116 patients in out-of-hospital cardiac arrest and attempted to resuscitate 4,389 of these.
- Survival rates remained consistent with the previous year with 9.0% of all patients where resuscitation was attempted surviving to hospital discharge and 31.5% surviving amongst the Utstein comparator group. These rates reflect the commitment of our staff in the pre-hospital management of cardiac arrest, as well as those of our colleagues at hospital.
- For patients whose arrest was witnessed by LAS clinicians (n=745), the overall Return of Spontaneous Circulation (ROSC) sustained to hospital and survival to discharge rates increased to 37.4% and 18.4% respectively (from 36.5% and 16.8% in 2014/15).
- Survival to hospital discharge rates for those conveyed to a Heart Attack Centre as part of a specialist pathway remains high at 48.9% (n=149/305).
- ROSC and survival to discharge rates when an APP was in attendance for a select group of patients (n= 1,289) were 34.2% and 11.3% respectively.
- A small reduction in ROSC sustained to hospital of 1.5% (to 29.9%) was observed for all patients who had resuscitation attempted and 1.7% (to 53.4%) within the Utstein comparator group.
- An initial shockable arrest rhythm was present in 19.3% of patients; a slight increase of 0.6% on the previous year.
- The average response time was 7 minutes and 47 seconds.
- 59.6% of those allocated a Red 1 category received a response within 8 minutes.
- Presumed cardiac aetiology remained the most prevalent cause of cardiac arrest (81.4%).
- The proportion of arrests with bystander initiated cardiopulmonary resuscitation (CPR) remains high at 62.2%. This is a slight reduction of 0.9% from the previous year and is the first time that the rate of bystander CPR has decreased since the LAS cardiac registry was established in 1998.
- Public access defibrillators were used to deliver at least one shock to 88 patients. Of these patients 73.9% sustained ROSC to hospital and 57.3% survived to be discharged from hospital.

1. Introduction

From 1st April 2015 to 31st March 2016 the London Ambulance Service NHS Trust (LAS) attended 10,116 patients who had suffered an out-of-hospital cardiac arrest. LAS clinicians attempted to resuscitate 4,389 (43.4%) patients. Resuscitation efforts were not undertaken on 5,727 (56.6%) patients, the vast majority of whom (n=4,687) were recognised as deceased on arrival of the LAS. 1,040 patients had a Do Not Attempt CPR (DNA-CPR) order, advanced directive or similar equivalent in place, or the patient's death was expected.

Data were sourced from the LAS cardiac arrest registry, which captures information from a range of clinical and operational sources including: Patient Report Forms (PRFs), vehicle Mobile Data Terminals (MDTs), 999 call logs and defibrillator data. Survival to hospital discharge information was collected using hospital patient records and national databases.

Appendix 1 presents patient demographic and outcome information for the area in which the cardiac arrest occurred. Survival figures for each receiving hospital can be found in Appendix 2. Appendix 3 is dedicated to the specific group of patients that were conveyed to a Heart Attack Centre (HAC) following successful resuscitation. Finally, Appendix 4 focuses on those under the age of 35.

A glossary of abbreviations and terms are included on page 11 for readers unfamiliar with the terminology used.

This report presents information regarding our clinical care and the outcomes of the 4,389 patients where resuscitation was attempted.

2. Overview of all patients where resuscitation was attempted

Table 1 (overleaf) provides an overview of patient demographics, clinical presentation, call and response information, and interventions provided by the LAS for patients where resuscitation was attempted.

The largest proportion of cardiac arrests patients were male (64.8%, n=2,845). The average age was 65, with males being on average 7 years younger than females (62 vs. 69). Three-quarters of cardiac arrests occurred in a private location, with the vast majority occurring at home.

In line with previous reports, two-thirds of arrests were witnessed: 49.1% (n=2,154) by a layperson/bystander and 17.1% (n=745) by LAS clinicians. Bystander CPR was performed on 62.2% (n=2,267) of patients, which was a slight decrease of 0.9% on the previous year's figure of 63.1%.

The average response time for all cardiac arrest patients was 7 minutes and 47 seconds. Nearly two-thirds (n=2,860) of patients were allocated a Red 1 response, 59.6% of whom received a response within 8 minutes.

Recognition of Life Extinct was undertaken on-scene by LAS staff or other Healthcare Professionals in 41.9% (n=1,840) of arrests. The remaining 58.1% (n=2,549) of patients were conveyed to hospital either with a cardiac output or with ongoing CPR.

Gender	
Male	64.8%; n=2,845
Female	35.1%; n=1,542
Unknown	0.1%; n=2

Age mean (median) in years	
Overall average	65 (68)
Male average	62 (65)
Female average	69 (74)

Race^□	
White	60.4%; n=2,649
Asian	7.6%; n=333
Black	7.3%; n=322
Mixed	0.2%; n=9
Other	4.3%; n=187
Unable to obtain	18.1%; n=794
Not documented	2.2%; n=95

Peak occurrence	
Time of day (hours)	08:00-11:59 22.3%; n=978
Day	Sunday/Monday 14.9%; n=653
Month	January 9.5%; n=419

Chief complaint (top 3)	
Cardiac arrest	50.9%; n=2,236
Unconscious/fainting	15.1%; n=661
Breathing problems	8.4%; n=368
Other	25.6%; n=1,124

Response times (mins)	
999 call - scene	07:47
999 call - CPR[#]	09:42
999 call - defibrillation[◊]	12:23

Response time by category (mins)□	
R1	65.2%; n=2,860
R2	28.9%; n=1,268
C1	1.2%; n=52
C2	3.0%; n=130
C3	1.3%; n=56
C4	0.5%; n=22

** Airway management refers to the application of an advanced airway intervention by LAS staff or other Healthcare Professionals.*

□ *The total percentages do not equal 100% due to rounding.*

Location	
Private	76.0%; n=3,336
Public	24.0%; n=1,053

Private location breakdown	
Home	90.4%; n=3,015
Care home	9.6%; n=321

Public location breakdown	
Street	46.5%; n=490
Work	9.6%; n=101
Healthcare facility	8.5%; n=89
Public transport	6.3%; n=66
Social venue	5.3%; n=56
Shop/bank	4.8%; n=51
Park/Wood/River	4.2%; n=44
Hotel/Hostel	3.5%; n=37
Leisure centre/sports club	3.3%; n=35
Airport	2.5%; n=26
Other	5.5%; n=58

Witnessed□	
Bystander	49.1%; n=2,154
LAS	17.0%; n=745
Unwitnessed	33.8%; n=1,482
Not documented	0.2%; n=8

Bystander CPR (excl. LAS Witnessed)[#]	
Yes	62.2%; n=2,267/3,644
No	37.8%; n=1,377/3,644

Mechanical CPR□	
By APP	15.7%; n=690
By Team Leader/ other	8.3%; n=366
No	75.9%; n=3,333

Airway management*	
Airway placed	89.5%; n=3,928/4,389
ETT success rate	86.1%; n=1,411/1,639
SGA success rate	92.4%; n=3,142/3,401
$ETCO_2$ measured	98.3%; n=3,862/3,928

Resuscitation terminated on scene	
Yes, by LAS	39.7%; n=1,742
Yes, by other Healthcare Professional	2.2%; n=98
No	58.1%; n=2,549

~ Response category is not available for one case.

^View with caution as information is not reliably obtainable.

Table 1 – Overview of all cases where resuscitation was attempted (n=4,389).

3. Return of Spontaneous Circulation (ROSC) and Survival

3.1. Overall ROSC and survival rates

ROSC was sustained to arrival at hospital for 29.9% (n=1,311/4,389) of patients who had resuscitation was attempted. This figure represents a slight (1.5%) decrease from the previous year (see Figure 2). When compared to other English Ambulance Services our level of ROSC sustained to hospital is within the top 3 in the country (see Figure 4).

ROSC sustained to hospital	
Yes	29.9%; n=1,311
No	70.1%; n=3,077
Not Documented	0%; n=1

Table 2 – ROSC sustained to hospital where resuscitation was attempted.

The 9.0% rate of survival to hospital discharge has been maintained from 2014/15. Figure 4 shows that this rate is comparable to other English Ambulance Services and above the national average.

Survived to discharge [+]	
Yes	9.0%; n=388/4,317
No	91.0%; n=3,929/4,317

[+] *Denominator excludes patients with unknown survival outcomes (n=72).*

Table 3 – Survival to hospital discharge where resuscitation was attempted.

3.2. Utstein comparator group

The Utstein survival calculation[1,2] examines patients where resuscitation was attempted and where: the arrest was of a presumed cardiac aetiology, bystander witnessed, and in a shockable rhythm (VF/ VT) on arrival of the LAS.

Figure 1 shows that ROSC was sustained to hospital for 53.4% (n=299/560) of patients; a decrease of 1.7% from 55.1% reported in the previous year (see Figure 2). Again, the ROSC rate remains above the national average.

The survival to discharge rate has remained stable from the previous year with 31.5% (n=171/542) of patients in the Utstein group surviving to leave hospital alive (see Figure 1&3). The LAS performs favourably in comparison to other English Ambulance Services with only two other Services exceeding a 30% survival rate (see Figure 4).

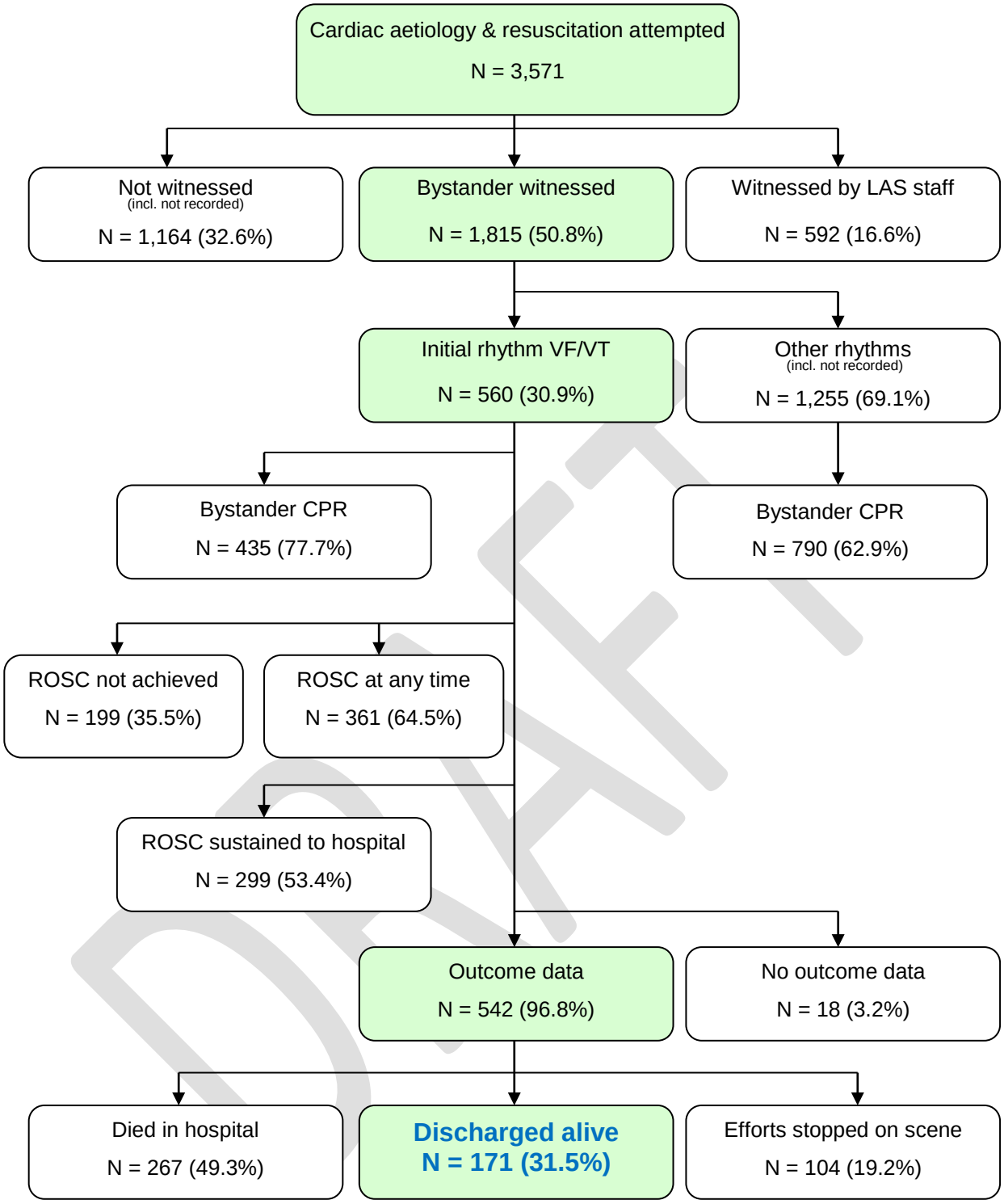


Figure 1 – Outcome for the Utstein comparator group

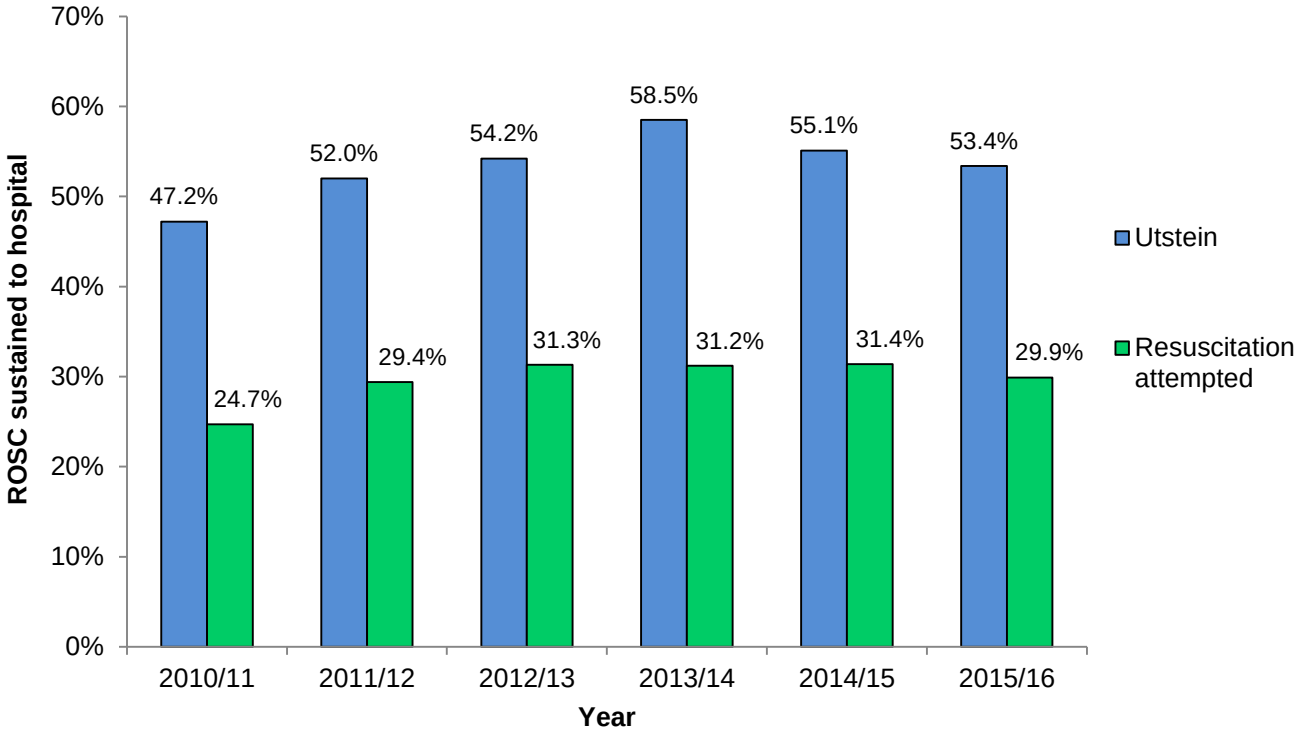


Figure 2 – ROSC sustained to hospital for the Utstein comparator group and all resuscitation attempted patients by year.

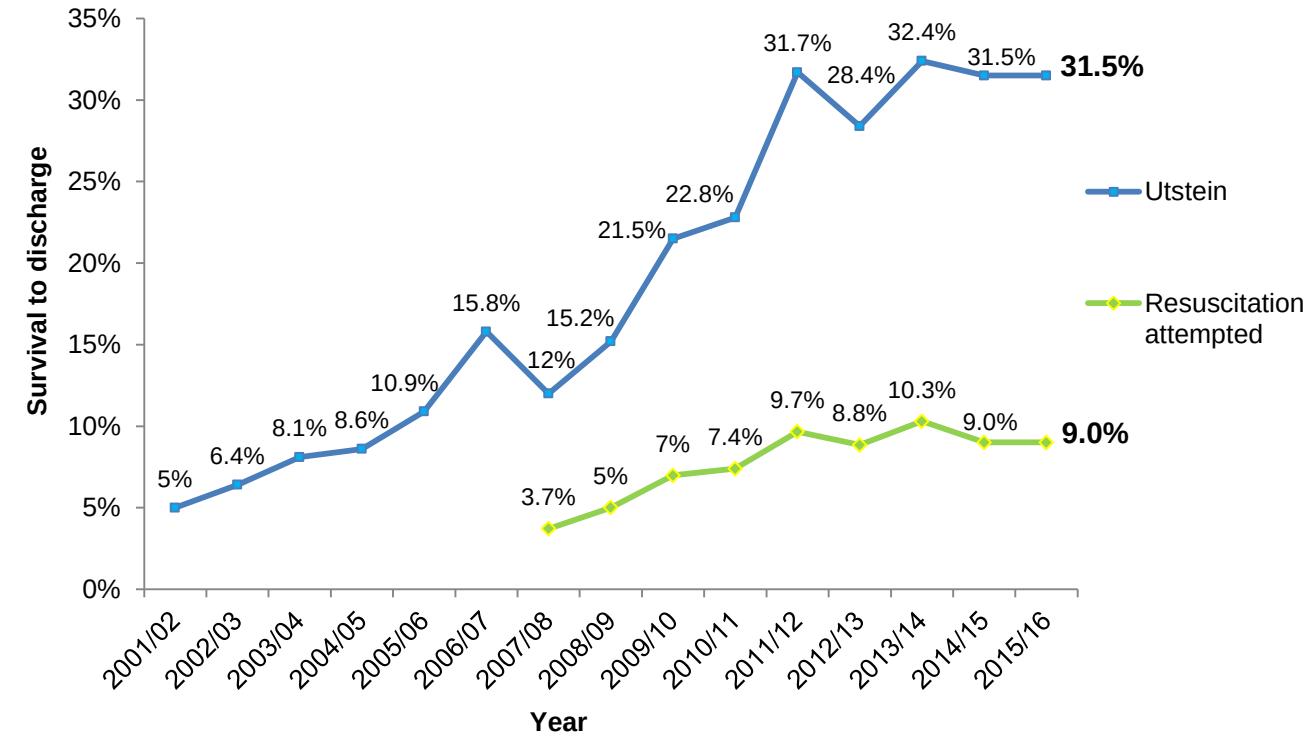


Figure 3 – Survival to discharge for the Utstein comparator group and all resuscitation attempted patients by year.

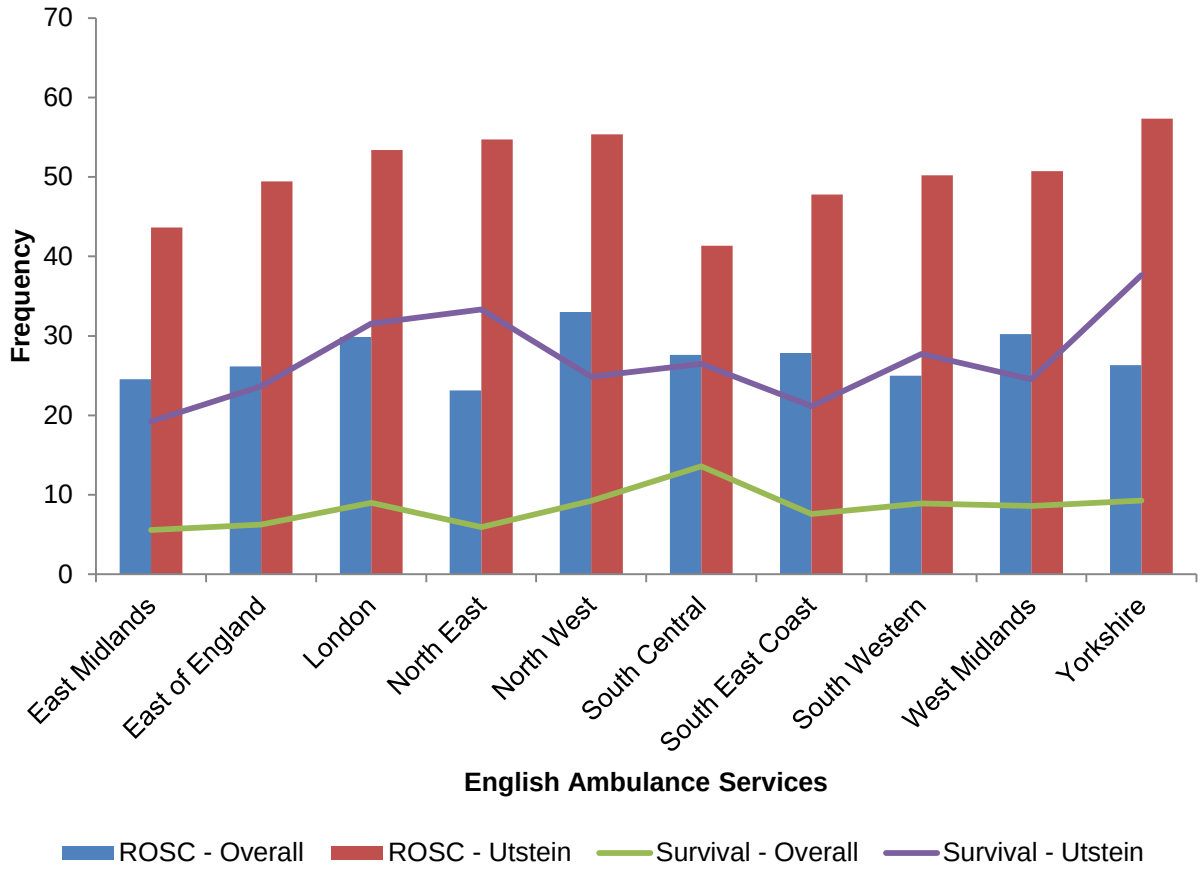


Figure 4 – ROSC sustained to hospital and survival comparisons to English Ambulance Services

4. Initial rhythm

An initial shockable rhythm of ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) was present in 849 of the 4,389 patients (19.3%). Of the non-shockable rhythms, asystole was present in 2,331 (53.1%) patients and pulseless electrical activity (PEA) in 1,151 (26.2%). The initial rhythm was not recorded for 58 (1.3%) patients. Table 4 below shows that patients with an initial rhythm of VF/VT have considerably higher rates of ROSC and survival (54.4% and 34.3% respectively).

Initial rhythm*	n	ROSC sustained to hospital	Survival to discharge
Asystole	2,331	19.9%; n=465/2,331	1.0%; n=24/2,308
PEA	1,151	30.5%; n=351/1,151	5.6%; n=63/1,132
VF/VT	849	54.4%; n=462/849	34.3%; n=282/822

** Initial rhythm not documented in 58 cases.*

+ Denominator excludes patients with unknown survival outcomes (n=72).

Table 4 – Initial rhythm compared with ROSC sustained to hospital and survival to hospital discharge rates

5. Aetiology

Presumed cardiac aetiology was the predominant cause of cardiac arrest (81.4%; n=3,571). There has been a marked rise in the number of patients recognised to have other medical causes for their arrest (such as respiratory conditions/failure, glycaemic or metabolic, neurological issues, sepsis/infection and internal haemorrhage). This year 299 patients were identified with this year compared to 159 previously. The remaining aetiologies include trauma from external causes (such as penetrating and blunt injuries), asphyxia (such as respiratory obstruction and asphyxiation from hangings or suffocation), drowning, electrocution and overdose. Table 5 shows the disparate ROSC and survival rates for the various aetiologies.

Aetiology	n	ROSC sustained to hospital	Survived to discharge[+]
Presumed cardiac	3,571	30.8%; n=1,101	9.8%; n=344/3,512
Other Medical[⊗]	299	20.1%; n=60	4.7%; n=14/296
Trauma[⊗]	222	14.0%; n=31	2.7%; n=6/219
Asphyxial[⊗]	178	41.6%; n=74	5.2%; n=9/174
Overdose	102	39.2%; n=40	11.1%; n=11/99
Drowning	16	31.3%; n=5	25.0%; n=4/16
Electrocution	1	0%; n=0	0%; n=0/1

+ Denominators exclude patients with unknown survival outcomes.

[⊗]*This data cannot be compared with previous years due to differences in classification of aetiology following updated Utstein definitions.*

Table 5 – ROSC sustained to hospital and survival to hospital discharge rates by aetiology.

6. EMS only witnessed arrests

LAS staff witnessed 745 patients enter into cardiac arrest. 37.4% (n=279) achieved a ROSC that was sustained to hospital and 18.4% (n=133/723) survived to be discharged. Both rates are an improvement on the previous year; ROSC increased by 0.9% (from 36.5% in 2014/15) and survival by 1.6% (from 16.8% in 2014/15). Table 6 below shows the outcomes of patients by the initial presenting arrest rhythm.

LAS witnessed arrest rhythms*	n	ROSC sustained to hospital		Survived to discharge[+]	
Asystole	187	31.0%; n=58	(↑ 2.1%)	4.9%; n=9/183	(↓ 0.6%)
PEA	380	27.1%; n=103	(↑ 0.9%)	7.6%; n=28/369	(↑ 1.8%)
VF/ VT	155	68.4%; n=106	(↑ 3.2%)	59.5%; n=88/148	(↑ 5.7%)
All patients	745	37.4%; n=279/745	(↑ 0.9%)	18.4%; n=133/723	(↑ 1.6%)

** Initial rhythm not recorded in 23 cases.*

+ Denominator excludes patients with unknown survival outcomes

Table 6 – Outcome of LAS witnessed arrests.

Table 6 shows that the levels of ROSC sustained to hospital have increased across all rhythms with the greatest improvement for patients with VF/ VT - up by 3.2% to 68.4% (from 65.2% in 2014/15). With the exception of asystolic rhythms, survival to discharge increased with the largest improvement being observed amongst those presenting in VF/ VT (up by 5.7% to 59.5% from 53.8% in 2014/15) and 1.8% increase for PEA to 7.6% (from 5.8% in 2014/15).

7. Advanced Paramedic Practitioners (APPs)

Advanced Paramedic Practitioners (APPs) manage resuscitation efforts and provide enhanced care to patients. They are dispatched to cardiac arrests either automatically or following a comprehensive triage by an APP based in the Emergency Operations Centre (EOC) which ensures that an APP attends those who are most likely to benefit from advanced skills. In 2015/16, an APP was present with primacy of care in 1,289 of cases – a figure that has more than doubled since 2014/15. An overview of some of the additional assessment and interventions provided by APPs is presented in Table 7 below.

For patients where an APP was present, ROSC sustained to hospital rates were 34.2% (n=441) and survival to discharge rates were 11.3% (n=144/1270). Of note, an initial presenting rhythm of VF/VT was present in 27.0% (n=348/1289) of cases which is almost 8% higher than the rate reported for all resuscitation attempted patients (see section 4).

APP skills and patient outcomes	
Mechanical CPR:	53.5%; n=690
Ultrasound	37.8%; n=487
Double Sequential Defibrillation	1.5%; n=19
ROSC sustained to hospital	34.2%; n=441
Survival to discharge[+]	11.3%; n=144/1,270

+ Denominator excludes patients with unknown survival outcomes (n=19)

Table 7 – APP skills and patient outcomes.

8. Public Access Defibrillator (PAD) use

A PAD was deployed by members of the public to 143 cardiac arrest incidents, which is an increase from 116 in the previous year. In 55 cases the defibrillator was not used as it was either not indicated or ambulance staff arrived on scene prior to its use. For the remaining 88 deployments the defibrillator was applied and at least one shock delivered to the patient. Further information for patients where the defibrillator was used is given in Table 8 overleaf:

PAD use	
Bystander witnessed	96.6%; n=85
Bystander CPR	100%; n=88
ROSC sustained to hospital	73.9%; n=65
Survival to discharge+	57.3%; n=47/82

+ Denominator excludes patients with unknown survival outcomes (n=6)

Table 8 – PAD use and patient outcomes.

This year there has been considerable improvement in rates of bystander witnessed arrests and bystander CPR for patients where a PAD was used. Bystander witnessed rates have increased by 29.5% to 96.6% (from 67.1%), with bystander CPR undertaken in 100% of cases (an increase of 28.8% from 71.2%). There was a reduction in ROSC sustained to hospital by 2.8% (from 76.7%) and survival to discharge rates were marginally lower by 1.3% (from 58.6%).

9. Resuscitated patients conveyed to Heart Attack Centres (HACs)

During 2015/16, 317 cardiac arrest patients who had a STEMI achieved a stable ROSC on-scene and were conveyed directly to a HAC. The vast majority of patients had an initial rhythm of VF/ VT (66.9%; n=212), with asystole presenting in 18.0% (n=57) of cases and PEA in 14.8% (n=47). Survival to discharge for patients within this specialist pathway remains higher than other groups at 48.9% (n=149/305), although this is a marginal decrease of 0.7% on the previous year's rate of 49.6%.

A breakdown of survival and initial rhythm for these patients by all London HACs can be found in Appendix 3.

10. Discussion

The survival rates reported demonstrate that we have continued to provide a high standard of cardiac care and are maintaining outcomes for patients who have had an out-of-hospital cardiac arrest in London. Survival to hospital discharge rates have remained constant at 9.0% for all patients where resuscitation was attempted and at 31.5% for the Utstein comparator group. These rates reflect the commitment of our staff in the pre-hospital care and management of cardiac arrest, and of our colleagues at hospital who provide the ongoing treatment required to enable patients to leave hospital alive.

A small reduction in ROSC sustained to hospital rates (1.5% overall and 1.7% for the Utstein comparator group) was observed. It is possible that these reduced ROSC rates are reflective of our on-scene cardiac arrest management. Our clinicians are continuing to ensure that patients are conveyed to hospital only when appropriate and are remaining on scene to manage cardiac arrests where no reversible causes have been identified. As such, there has been a greater proportion of patients who have been recognised as life extinct on scene by both LAS staff and other Healthcare Professionals (41.9% vs 36.9% in 2014/15).

A further contributing factor to the reduction in ROSC rates may be the decline in bystander CPR, seen for first time since the cardiac registry was established in 1998. Although the reduction in bystander CPR is minimal (by less than 1%) it is not reflective of the year on year increasing trend previously observed.

In 2015/16, the LAS collaborated with the developers of the GoodSam app, which alerts lay members of the public as well as off-duty professionals to the location of a nearby cardiac arrest and public access defibrillator sites to enable early resuscitation efforts. As a result, a greater number of public access defibrillators have been deployed and a shock delivered and in these instances the provision of bystander initiated CPR has been at 100%.

Of note, the rates of ROSC and survival to discharge for LAS witnessed arrests have improved, suggesting that the quality of care delivered by staff remains excellent. In addition, the Advanced Paramedic Practitioner (APP) programme has continued to develop with additional staff recruited in 2015/16 and the introduction of enhanced APP triage at EOC. Consequently, this year, a greater number of arrests have had an APP in attendance (1289 vs 853). APPs are able to assist frontline staff in managing complex resuscitations. The survival rate for arrests where an APP was present was 11.3%, which is 2.3% higher than the overall rate of 9.0%. The ROSC and survival rates are a testament to both the ongoing efforts of clinicians prior to the arrival of the APP and the contribution of the APPs. It is recognised that ROSC and survival rates are likely to be higher due to the types of patients that APP's attend as they are able to select calls at triage to ensure their attendance has the greatest benefit. Furthermore, patients attended by an APP were more likely to have an initial rhythm of VF/VT (27% vs 19%), which will also increase the chances of gaining and sustaining ROSC and survival.

We have continued to feedback survival outcomes to our staff and recognise their efforts in resuscitating patients successfully. In 2015/16, the LAS Clinical Audit and Research Unit sent out 1,500 letters to clinical staff that attended cardiac arrest patients and provided lifesaving interventions at the scene and en-route to hospital. Furthermore, we sent over 350 letters to our Emergency Medical Dispatchers to recognise their crucial role in early recognition of cardiac arrest and initiation of dispatcher assisted bystander CPR.

2015/16 was a challenging year for the LAS with an increased demand and operational response pressures. Despite this, we managed an overall response for cardiac arrest patients of 7 minutes and 47 seconds.

Although a presumed cardiac aetiology accounts for 81.4% of cardiac arrests, there were a greater number of patients where another medical causes were identified (299 vs 159 in 2105/16). This is likely to be a result of greater awareness amongst LAS staff of conditions such as sepsis, and the presence of APPs in a larger proportion of arrests who bring greater assessment skills allowing the recognition of other medical conditions.

The proportion of resuscitations attempted reduced this year from 47.5% to 43.4%. Co-ordinate My Care (CMC) provides greater information to clinicians prior to their arrival at the patient regarding DNA-CPR, other valid advanced directives, and palliative care. Together with an enhanced focus on end of life care within our training, CMC has enabled staff to increasingly react to instances where resuscitation is not appropriate or in line with patient wishes. The impact of this can be seen in the increased numbers of resuscitation attempts that were either not started or discontinued (1,040 vs 448 in 2014/15).

The LAS has continued its involvement in gold-standard, high-quality cardiac research. During 2015/16, we recruited 457 patients to the Paramedic 2 trial – a randomised control trial examining the effectiveness of adrenaline use in cardiac arrest and its impact on short and long term patient outcomes. We are also participating in a second phase pilot of the Immediate Coronary Angiography after Ventricular Fibrillation Out-of-Hospital Cardiac Arrest (ARREST) trial.

Going forward into 2016/17, the LAS aims to launch a 5 year strategy aimed at improving cardiac arrest survival by focussing on key initiatives. These initiatives will focus on: bystander intervention, continued development of co-responder schemes, ongoing staff education, promotion of tools such as the cardiac arrest checklist and increasing defibrillator data availability.

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Glossary for abbreviations and terms

999 call - The time at which the call is connected to the ambulance service.

Advanced Paramedic Practitioner – a Paramedic with a greater range of assessment and interventional skills.

Angiography – A procedure performed at a Heart Attack Centre to check the blood flow in the coronary arteries.

Automated External Defibrillator (AED) – A portable defibrillator that automatically diagnoses if the heart is in a rhythm that can be shocked and if so delivers a shock.

Basic Life Support – Includes skills such as CPR, manual airway positioning and AED use.

Bystander – A lay person or non-Emergency Medical Service personnel.

Cardiac tamponade – A collection of blood in the sac that surrounds the heart.

Chief Complaint – The primary medical reason that the caller has called 999 as defined by the call triage system.

Defibrillators – The LAS use portable defibrillators to help diagnose the heart's rhythm and deliver a pre-set charged shock of 360J. LAS staff use both AEDs and manual defibrillators, and are able to use an override to enable CPR to be continued whilst the AED is charging.

Double sequential defibrillation – uses two defibrillators to provide multiple high energy shocks in refractory VF to help terminate the rhythm.

Electrocardiogram (ECG) – The LAS use 12-lead ECGs to diagnose STEMIs.

Emergency Medical Technician (EMT) – A clinical grade below that of a paramedic with 4 different levels (1-4). EMT Level 4s are able to place the SGA advanced airway in cardiac arrest patients.

Emergency Operations Centre (EOC) – The control centre responsible for receiving and triaging incoming 999 calls and co-ordinating an appropriate response.

Endotracheal Tube (ETT) – Type of advanced airway that some paramedic staff are able to place.

End-Tidal Carbon Dioxide ($ETCO_2$) – Measurement of gas exchange in lungs which enables a clinician to accurately tell whether an airway device has been placed correctly, and allows other information such as effectiveness of compressions and ventilations to be ascertained. ETCO2 measurement is compulsory for patients where an advanced airway has been placed.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for angiography and primary Percutaneous Coronary Intervention (pPCI).

Initial rhythm – The rhythm that the heart is in on initial presentation to LAS staff.

Mechanical CPR – A mechanical device used to undertake compressions.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Paramedic – A majority of clinical staff are paramedics and are able to perform advanced airway management, cannulation and administration of drugs to cardiac arrest patients.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Primary Percutaneous Coronary Intervention (pPCI) – A surgical procedure performed at a Heart Attack Centre which seeks to unblock arteries by means of insertion of a catheter into the affected artery and inflating a small balloon to re-open it. The opened artery is then held in place with a small stent.

Recognition of Life Extinct (ROLE) – The LAS will recognise if life is extinct if there are signs unequivocal with life present or there is evidence of a prolonged period of cardiac arrest with no attempt at basic life support (BLS) prior to the arrival of the LAS. ROLE can be used upon arrival of a clearly deceased patient, or after resuscitation has been attempted.

Response Category: R1 – Red 1 is used for calls where the patient is not breathing and are classed as the most time critical.

Response Category: R2 – Red 2 is used for calls where the complaint is serious but slightly less immediately time critical.

Response Category: C1 to C4 – Calls where the complaint is not life-threatening are given a Category C response based on the information provided by the caller regarding the patient's condition.

Return of Spontaneous Circulation (ROSC) – Refers to a return of cardiac output by the heart after a period of cardiac arrest. ROSC sustained to hospital is the most widely used measure for out-of-hospital cardiac arrests and indicates the patient had ROSC at handover to hospital staff.

ST Elevation Myocardial Infarction (STEMI) – A type of heart attack.

Supraglottic Airway Device (SGA) – Type of advanced airway that all clinical staff from EMT4 upwards have the skill to place.

Survival to Discharge – The patient was successfully discharged from a hospital to a non-hospital environment (therefore excluding transfers from one hospital to another).

Ultrasound – A technique used to assess the internal organs, specifically in cardiac arrest used to assess if there is motion in the heart walls or if there is the presence of fluid around the heart.

Utstein – Refers to the internationally recognised criteria for outcomes. The patients in this group are all witnessed having a cardiac arrest by a bystander, all present with an initially shockable rhythm of VF or pulseless VT and have a presumed cardiac aetiology.

Witnessed – Either seen or heard by a bystander or seen by LAS staff.

Appendix 1: Patient characteristics, response times, and outcomes per Clinical Commissioning Group

Incident CCG*	Number of patients	Age (years)	Male %		Median response (mins)	Bystander CPR#		Presumed cardiac		Shockable initial rhythm		ROSC sustained to hospital		Survived to discharge+	
Barking & Dagenham	89	62	74.2%	(66)	07:37	58.1%	(43/74)	82.0%	(73)	16.9%	(15)	31.5%	(28)	9.2%	(8/87)
Barnet	176	67	63.6%	(112)	08:45	64.6%	(95/147)	79.5%	(140)	18.2%	(32)	22.7%	(40)	10.9%	(19/175)
Bexley	103	64	71.8%	(74)	07:55	72.2%	(57/79)	79.6%	(82)	21.4%	(22)	24.3%	(25)	9.7%	(10/103)
Brent	199	66	61.8%	(123)	08:19	57.9%	(92/159)	79.4%	(158)	15.6%	(31)	27.6%	(55)	5.6%	(11/198)
Bromley	167	72	62.9%	(105)	08:14	63.4%	(85/134)	79.6%	(133)	12.6%	(21)	28.7%	(48)	5.4%	(9/167)
Camden	117	61	76.9%	(90)	07:08	67.0%	(67/100)	71.8%	(84)	20.5%	(24)	35.0%	(41)	9.5%	(11/116)
Central London	136	62	77.9%	(106)	07:07	66.7%	(74/111)	86.8%	(118)	30.1%	(41)	36.0%	(49)	13.5%	(18/113)
City & Hackney	148	61	62.2%	(92)	08:01	66.7%	(82/123)	75.7%	(112)	20.3%	(30)	31.1%	(46)	8.9%	(13/146)
Croydon	213	65	54.9%	(117)	07:40	65.6%	(118/180)	88.3%	(188)	17.8%	(38)	32.9%	(70)	8.3%	(17/206)
Ealing	185	67	67.6%	(125)	08:07	63.7%	(100/157)	85.4%	(158)	22.7%	(42)	31.9%	(59)	11.0%	(20/182)
Enfield	191	64	60.2%	(115)	07:49	61.9%	(99/160)	78.0%	(149)	20.4%	(39)	28.8%	(55)	9.0%	(17/189)
Greenwich	134	66	59.7%	(80)	07:30	54.6%	(59/108)	77.6%	(104)	17.9%	(24)	35.8%	(48)	9.8%	(13/133)
Hammersmith & Fulham	68	60	63.2%	(43)	07:57	60.8%	(31/51)	76.5%	(52)	25.0%	(17)	36.8%	(25)	12.1%	(8/66)
Haringey	122	62	59.0%	(72)	07:42	63.1%	(65/103)	75.4%	(92)	22.1%	(27)	29.5%	(36)	5.8%	(7/120)
Harrow	125	69	70.4%	(88)	07:58	57.3%	(63/110)	88.0%	(110)	26.4%	(33)	24.0%	(30)	11.3%	(14/124)
Havering	153	70	62.1%	(95)	07:40	71.4%	(85/119)	86.3%	(132)	17.0%	(26)	32.0%	(49)	6.9%	(10/144)
Hillingdon	181	66	63.0%	(114)	08:27	68.2%	(107/157)	81.8%	(148)	19.3%	(35)	31.5%	(57)	9.4%	(17/180)
Hounslow	146	66	68.5%	(100)	07:38	62.0%	(75/121)	80.1%	(117)	13.0%	(19)	26.0%	(38)	4.9%	(7/142)
Islington	117	60	71.8%	(84)	07:29	64.8%	(68/105)	73.5%	(86)	17.9%	(21)	29.1%	(34)	8.7%	(10/115)
Kingston	89	65	64.0%	(57)	06:37	60.3%	(47/78)	80.9%	(72)	24.7%	(22)	33.7%	(30)	10.6%	(9/85)
Lambeth	142	60	60.6%	(86)	07:50	63.9%	(76/119)	75.4%	(107)	14.1%	(20)	23.2%	(33)	7.4%	(10/135)
Lewisham	132	63	65.9%	(87)	08:49	54.3%	(57/105)	78.8%	(104)	14.4%	(19)	28.8%	(38)	7.7%	(10/130)
Merton	98	64	63.3%	(62)	06:38	55.7%	(49/88)	86.7%	(85)	20.4%	(20)	28.6%	(28)	9.4%	(9/96)
Newham	138	59	65.9%	(91)	06:59	55.9%	(66/118)	81.2%	(112)	21.0%	(29)	33.3%	(46)	9.5%	(13/137)
Redbridge	174	69	60.3%	(105)	07:27	65.0%	(91/140)	85.1%	(148)	16.1%	(28)	28.7%	(50)	5.8%	(10/172)
Richmond	90	67	71.1%	(64)	07:37	67.6%	(46/68)	85.6%	(77)	27.8%	(25)	28.9%	(26)	14.6%	(13/89)
Southwark	129	63	65.1%	(84)	07:25	56.3%	(58/103)	85.3%	(110)	17.8%	(23)	22.5%	(29)	8.1%	(10/124)
Sutton	99	67	69.7%	(69)	07:03	60.5%	(49/81)	84.8%	(84)	23.2%	(23)	31.3%	(31)	10.1%	(10/99)
Tower Hamlets	125	63	64.8%	(81)	07:31	59.8%	(64/107)	82.4%	(103)	18.4%	(23)	32.8%	(41)	11.3%	(14/124)
Waltham Forest	134	64	64.9%	(87)	08:37	67.0%	(77/115)	84.3%	(113)	17.2%	(23)	27.6%	(37)	6.0%	(8/134)
Wandsworth	132	62	59.8%	(79)	08:00	58.2%	(64/110)	79.5%	(105)	18.9%	(25)	28.8%	(38)	8.5%	(11/129)
West London	131	64	67.2%	(88)	07:50	49.1%	(53/108)	84.0%	(110)	23.7%	(31)	37.4%	(49)	16.0%	(21/131)

** Patients conveyed to non- London CCG's are excluded from the table.*
 # Figures exclude arrests witnessed by LAS staff.
+ Denominators exclude patients with unknown survival outcomes.

Appendix 2: Survival per Hospital

Hospital	2013/14			2014/15			2015/16*		
	Number of patients	Survival with ROSC sustained to hospital+		Number of patients	Survival with ROSC sustained to hospital+		Number of patients	Survival with ROSC sustained to hospital+	
Barnet	58	24.2%	(8/33)	77	21.4%	(6/28)	42	25.0%	(3/12)
Barts Health^	-	-	-	-	-	-	124	53.5%	(54/101)
Charing Cross	43	47.1%	(8/17)	31	7.7%	(1/13)	40	18.2%	(4/22)
Chelsea & Westminster	40	25.0%	(4/16)	35	25.0%	(4/16)	33	35.7%	(5/14)
Croydon	104	6.1%	(2/33)	106	5.6%	(2/36)	123	10.4%	(5/48)
Darent Valley	15	16.7%	(1/6)	12	14.3%	(1/7)	10	50.0%	(2/4)
Ealing	76	18.5%	(5/27)	66	9.7%	(3/31)	54	12.5%	(3/24)
Hammersmith	119	49.4%	(40/81)	94	38.7%	(29/75)	76	53.8%	(35/65)
Harefield	36	40.0%	(12/30)	61	58.8%	(30/51)	30	56.0%	(14/25)
Hillingdon	82	29.7%	(11/37)	100	25.0%	(10/40)	83	25.6%	(10/39)
Homerton	35	10.0%	(1/10)	48	13.6%	(3/22)	43	4.8%	(1/21)
King's College	181	51.1%	(46/90)	192	40.7%	(44/108)	167	39.3%	(33/84)
King George	69	16.7%	(5/30)	75	16.2%	(6/37)	56	4.8%	(1/21)
Kingston	63	4.0%	(1/25)	58	16.7%	(3/18)	63	24.0%	(6/25)
London Chest^	107	47.3%	(43/91)	124	56.5%	(61/108)	7	71.4%	(5/7)
Newham	81	11.1%	(2/18)	114	16.7%	(6/36)	77	6.7%	(2/30)
North Middlesex	107	14.3%	(6/42)	149	9.8%	(6/61)	119	8.0%	(4/50)
Northwick Park	127	9.3%	(4/43)	120	9.8%	(5/51)	126	22.8%	(13/57)
Princess Royal	87	31.4%	(11/35)	87	9.8%	(4/41)	66	17.9%	(5/28)
Queen Elizabeth	133	29.6%	(16/54)	150	12.5%	(7/56)	110	18.6%	(8/43)
Queen's Romford	146	12.3%	(7/57)	150	6.0%	(3/50)	129	4.7%	(2/43)
Royal Free	129	38.8%	(31/80)	110	41.2%	(28/68)	133	44.4%	(40/90)
Royal London	100	20.0%	(8/40)	122	20.0%	(12/60)	91	24.1%	(13/54)
St George's	188	42.6%	(46/108)	200	38.7%	(46/119)	183	39.0%	(41/105)
St Helier	59	9.1%	(2/22)	78	17.2%	(5/29)	41	21.4%	(3/14)
St Mary's	73	32.0%	(8/25)	81	30.0%	(9/30)	87	12.2%	(5/41)
St Thomas'	97	42.0%	(21/50)	114	39.0%	(23/59)	116	47.5%	(28/59)
The Heart^	24	70.0%	(14/20)	17	66.7%	(10/15)	1	0.0%	(0/1)
University College Hospital	51	42.1%	(8/19)	44	27.3%	(6/22)	35	26.1%	(6/23)
Lewisham	79	20.8%	(5/24)	80	19.0%	(4/21)	70	24.1%	(7/29)
West Middlesex	85	29.0%	(9/31)	79	23.5%	(8/34)	88	13.3%	(4/30)
Whipps Cross	106	21.2%	(11/52)	112	13.2%	(5/38)	86	17.1%	(6/35)
Whittington	51	19.2%	(5/26)	45	24.0%	(6/25)	39	21.4%	(3/14)

^ *Following the closures of the London Chest and The Heart in April 2015, Barts Health opened its Heart Centre at their St. Bartholomew Hospital site.*
* *One patient was conveyed to hospital by another provider.*
\+ *Denominators exclude patients with unknown survival outcomes.*

Appendix 3: Rhythm and survival per Heart Attack Centre for resuscitated patients with a STEMI

Heart Attack Centre	Number of patients	Initial rhythm			Survival to discharge+
		Asystole	VF/VT	PEA	
Barts Health^□	80	13.8% (11)	68.8% (55)	17.5% (14)	50.0% (38/76)
Hammersmith*	53	26.9% (14)	59.6% (31)	13.5% (7)	42.0% (21/50)
Harefield	21	19.0% (4)	66.7% (14)	14.3% (3)	55.0% (11/20)
King's College□	38	23.7% (9)	63.2% (24)	13.2% (5)	38.9% (14/36)
London Chest^	6	-	100.0% (6)	-	66.7% (4/6)
Royal Free	46	15.2% (7)	67.4% (31)	17.4% (8)	56.5% (26/46)
St George's	47	23.4% (11)	63.8% (30)	12.8% (6)	45.7% (21/46)
St Thomas'	25	4.0% (1)	84.0% (21)	12.0% (3)	58.3% (14/24)
The Heart^	1	-	-	100.0% (1)	0.0% (0/1)

^ Barts Heart Centre opened in April 2015 following the closures of the London Chest and The Heart.

□ The total percentages do not equal 100% due to rounding.

** 1 patient had no initial rhythm documented.*

+ Denominators exclude patients with unknown survival outcomes.

Appendix 4: Cardiac arrest patients under 35 years old

	Under 1	1-8	9-18	19-35
Number of patients:	63	28	39	294
Gender:				
Male	49.2% (31)	50.0% (14)	71.8% (28)	75.9% (223)
Female	47.6% (30)	50.0% (14)	28.2% (11)	24.1% (71)
Unknown	3.2% (2)	-	-	-
Arrest location:				
Private	90.5% (57)	85.7% (24)	53.8% (21)	49.7% (146)
Public	9.5% (6)	14.3% (4)	46.2% (18)	50.3% (148)
Witnessed[◊]:				
Bystander	34.9% (22)	50.0% (14)	38.5% (15)	34.7% (102)
LAS staff	6.3% (4)	14.3% (4)	17.9% (7)	13.9% (41)
Unwitnessed	54.0% (34)	35.7% (10)	41.0% (16)	51.0% (150)
Not Documented	4.8% (3)	-	2.6% (1)	0.3% (1)
Bystander CPR[#]:				
Yes	57.6% (34/59)	50.0% (12/24)	71.9% (23/32)	71.5% (181/253)
No	42.4% (25/59)	50.0% (12/24)	28.1% (9/32)	28.5% (72/253)
Initial rhythm[◊]:				
Asystole	66.7% (42)	67.9% (19)	59.0% (23)	63.9%(188)
PEA	12.7% (8)	21.4% (6)	15.4% (6)	18.7% (55)
VF/ Pulseless VT	1.6% (1)	3.6% (1)	15.4% (6)	16.3% (48)
Not Documented	19.0% (12)	7.1% (2)	10.3% (4)	1.0% (3)
ROSC sustained to hospital:				
Yes	15.9% (10)	28.6% (8)	23.1% (9)	28.9% (85)
No	84.1% (53)	71.4% (20)	76.9% (30)	71.1% (209)
Survived to discharge[+]:				
Yes	10.2% (6/59)	16.7% (4/24)	8.1% (3/37)	11.9% (34/286)
No	89.8% (53/59)	83.3% (20/24)	91.9% (34/37)	88.1% (252/286)

◊ Totals for 9-18 year olds within the initial rhythm group and 19-35 year olds within witnessed and rhythm category do not equal 100% due to rounding.

[#] Figures exclude arrests witnessed by LAS staff.

+ Denominators exclude patients with unknown survival outcomes.

London Ambulance Service NHS Trust

Stroke Annual Report: 2015/16

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Produced by:

Gurkamal Virdi, Milda Rose, Scott Picton, Rachael Fothergill and Neil Thomson

✉ CARU.Enquiries@lond-amb.nhs.uk

Clinical Audit and Research Unit, Clinical and Quality Directorate, London Ambulance Service NHS Trust, 8-20 Pocock Street, London, SE1 0BW.

Contents

Key Findings

- In 2015-16, the LAS attended 12,251 patients who presented with symptoms of stroke as identified by the Face, Arm and Speech Test (FAST).
- Just over half of patients were women (52%).
- The average age was 71 years.
- The median response time for all stroke patients was 10 minutes.
- The median on-scene time was 32 minutes.
- Nearly all patients (97%) received a pre-hospital stroke care bundle consisting of a complete FAST, blood glucose measurement and blood pressure assessment.
- The majority of patients (91%) either had the stroke symptom onset time recorded or documentation that the time of onset could not be established.
- LAS staff demonstrated excellent compliance with the stroke pathway with 99% of stroke patients conveyed to the most appropriate destination for their condition.
- The median journey to hospital time was 15 minutes, which is well within the 30 minute target set by the stroke network in London.

1. Introduction

The London Ambulance Service NHS Trust (LAS) attended 12,251 patients between the 1st April 2015 and 31st March 2016 who presented with symptoms of stroke as identified by the Face, Arm and Speech Test (FAST). Stroke patients must receive a prompt response, and following a face-to-face assessment, rapid transportation to one of eight specialist hyper-acute stroke units (HASUs) in London.

As part of the on-scene assessment, LAS staff will provide the essential elements of pre-hospital care for suspected stroke patients consists of performing the FAST, and measuring the blood pressure and blood glucose. Together, they constitute a pre-hospital stroke 'care bundle'. In some instances there might be clinically justifiable reasons (such as patient refusal) why the full care bundle could not be provided and these will always be considered when the quality of patient care is assessed. The stroke care bundle is one of the NHS England mandated Ambulance Quality Indicators (AQIs) designed to measure and compare the quality of care provided by ambulance services across the country. In addition, staff must also establish the time of onset of stroke symptoms as this will help determining the continuing care delivered at hospital.

The exact treatment given at a HASU depends on the cause of the stroke and onset of symptom time. A stroke due to a blood clot can be treated with thrombolytic agents that dissolve the clot and restore blood flow to the brain. Thrombolysis is most effective when administered within 4.5 hours from the onset of stroke symptoms, with the benefits of therapy decreasing over time and the potential risk of harm increasing [1]. As such, a pre-alert call is placed for patients whose symptoms fall within this 4.5 hour 'window' to expedite their care on arrival at the HASU. Patients, whose symptoms are older than 4.5 hours, are transported under normal driving conditions. Even though these patients may no longer be eligible for some types of acute treatment, HASUs provide specialised stroke care and rehabilitation, including access to advanced radiology facilities, specialist stroke nursing, speech and occupational therapies. The evidence suggests that the London Stroke model reduces morbidity and mortality and is cost-effective [2].

This report presents information relating to the demographics of these patients, our clinical and operational performance and the use of specialist pathways available for those patients. Clinical data in this report is sourced from the LAS Patient Report Forms (PRFs), with data relating to response times taken from the Emergency Operations Centre (EOC) Call Log and the vehicle Mobile Data Terminals (MDTs).

A glossary of abbreviations and terms are included on page 10 for readers unfamiliar with the medical or operational terminology used in the ambulance service. Appendix 1 presents data for the three years previous to enable comparisons.

2. Findings

2.1. Patient demographics

Gender	n (%)
Male	5,878 (48.0%)
Female	6,373 (52.0%)

Age[2]	mean (range) in years
All patients	71 (16-110)
Male	69 (16-106)
Female	73 (16-110)

Race[1]	n (%)
White	7,559 (61.7%)
Mixed	58 (0.5%)
Asian/British Asian	864 (7.1%)
Black/Black British	958 (7.8%)
Other Race Groups	449 (3.7%)
Refused/Unable	1,500 (12.2%)
Not documented	863 (7.0%)

- Just over half of patients were female.
- The average age was 71, although male patients were on average 4 years younger than females.
- Nearly two-thirds of patients attended were of a white race origin.

2.2. Call and response information

Chief Complaint	n (%)
Stroke	5,874 (47.9%)
Unconscious / Fainting	1,261 (10.3%)
Health Care Professional admission	1,183 (9.7%)
111 transfer	1,094 (8.9%)
Falls	824 (6.7%)
Sick person	356 (2.9%)
Convulsions/fitting	385 (3.1%)
Breathing problems	339 (2.8%)
Chest pain	272 (2.2%)
Diabetic problems	80 (0.7%)
Other	583 (4.8%)

[1] Due to the condition of stroke patients, definite race information is not always possible to obtain and therefore this data should be regarded with some caution.
[2] The stroke network in London is designed for patients 16 years and over.

Response Category[3]	n (%)
R1	110 (1.0%)
R2	8,238 (74.4%)
C1	1,383 (12.5%)
C2	929 (8.4%)
C3	281 (2.5%)
C4	127 (1.1%)

999 Call to scene	median (range[4]) in mins
Call connect	10 (0-446)
ORCON	8 (0-443)

- Stroke was recognised as the chief complaint at the 999 call for just under half of patients.
- Patients who were allocated to the stroke chief complaint received a response time of 9 minutes. The response time was 2 minutes longer at 11 minutes for patients who were not identified as experiencing a stroke based on the information provided at the 999 call.
- Three-quarters of calls were categorised as a Red response, with the majority allocated a Red 2 category.
- The overall response time was 10 minutes for all patients when measured from the point at which the 999 call was connected, and 8 minutes when using ORCON definitions (which allows an initial period of time prior to the clock starting in an attempt to establish the chief complaint).

2.3. Patient Assessment

Care Bundle		n (%)
FAST	Assessed or a valid exception	11,974 (97.7%)
	Not assessed	277 (2.3%)
Blood Glucose	Assessed or a valid exception	12,195 (99.5%)
	Not assessed	56 (0.5%)
Blood Pressure	Assessed or a valid exception	12,224 (99.8%)
	Not assessed	27 (0.2%)
Overall	Complete or a valid exception	11,903 (97.2%)
	Not complete	348 (2.8%)

[3]Health Care Professional admissions are excluded from these figures because response timeframes for these patients are determined by the referring clinician.
[4] Zero minute times in the range are due to running calls where a patient/passerby has flagged an ambulance.

Onset of symptoms	n (%)
Symptom onset within 4.5 hours	7,534 (61.5%)
Symptom onset older than 4.5 hours	2,015 (16.4%)
Unknown	2,583 (21.1%)
Not documented	119 (1.0%)

- The majority of patients (97%) received a complete pre-hospital stroke care bundle consisting of FAST, blood glucose measurement and blood pressure assessment.
- The provision of blood glucose assessment, which historically has been the most challenging element of the stroke care bundle, has continued to improve from 96.7% (in 2012-13) to 99.5 % (see Appendix 1).
- The majority of stroke patients (99%) had the onset of symptoms time recorded or it was documented that the onset time could not be determined.

2.4. On-scene times

On scene time[5]	median (range) in mins
From arrival of first attending vehicle to leaving scene	32 (4-255)
From arrival of first ambulance to leaving scene	25 (4-255)

- The overall on-scene time from the arrival of the first vehicle to leaving scene was 32 minutes. However, when measured from arrival of the first ambulance vehicle the on-scene time was 25 minutes. The 7 minute difference can largely be attributed to the time when a first responder was on scene awaiting an ambulance capable of conveying a patient to hospital.

2.5. Conveyance assessment

Destination[6],[7]	n (%)
HASU	12,067 (98.5%)
ED appropriate	74 (0.6%)
ED inappropriate	63 (0.5%)

[5] Non-conveyed patients are excluded from on scene time figures.
[6] This table excludes 43 patients who refused to travel to hospital against the advice of staff.
[7] Four patients were conveyed to a HASU outside the defined stroke network in London and are therefore excluded from the table.

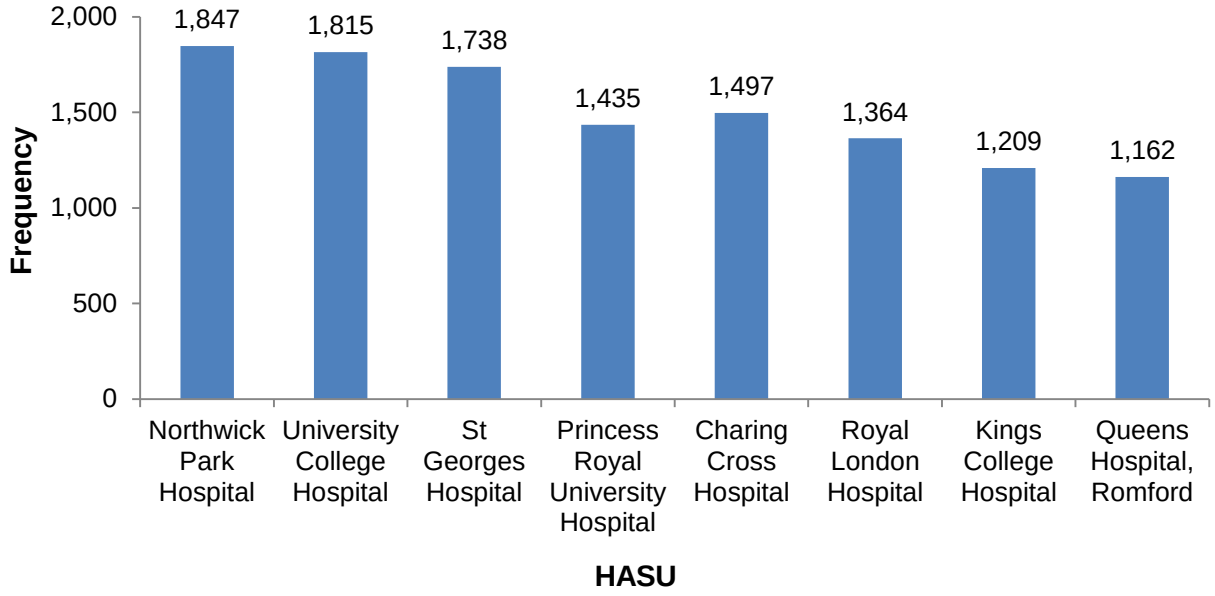

Figure 1: HASU Utilisation

- Almost all stroke patients (99.1%, n=12,141) were conveyed to the most appropriate destination for their condition, in compliance with the London stroke pathway.
- The majority of stroke patients conveyed to a HASU were transported to Northwick Park hospital, closely followed by University College London hospital.
- Of the patients conveyed appropriately to ED (n=74), 43 were clinically unstable or required assessment and intervention for other medical conditions/injuries. A further 8 were determined as suitable for ED conveyance by the Clinical Hub. The remaining 23 patients were conveyed to ED following instructions of a Health Care Professional, who arranged LAS attendance.
- 63 (0.5%) patients were conveyed to an ED when they should have been transported to a HASU as they were FAST positive and feedback was provided to staff regarding their decision.

2.6. Journey times

Journey times	Median (range) in mins
All stroke patients	15 (1-123)
All patients conveyed to HASU	15 (1-123)
Patients with onset of symptoms <4.5 hours conveyed to a HASU	13 (1-111)
All patients conveyed to ED	13 (2-48)

- Overall, the average journey to hospital time for both patients conveyed to a HASU or an ED was 15 minutes.
- Stroke patients, who were potentially eligible for thrombolysis (i.e. the symptoms were less than 4.5 hours old) arrived at a HASU 13 minutes after leaving the scene. This was well within the 30 minute target set by the stroke network in London.

3. Discussion

This report demonstrates that the LAS has continued to provide high quality care to stroke patients, as evidenced by a timely response, comprehensive assessment and excellent compliance with the specialist HASU pathway in London.

This has been achieved against a background of an increase in the number of patients with a suspected stroke; growing by 25% over four years (see Appendix 1). Furthermore, the proportion of stroke patients allocated a Red response has increased from 63% in 2012/13 to 75% in 2015/16. These increases reflect the overall rise in demand for ambulance services. Although it is difficult to establish the reasons behind the increases in the numbers of stroke patients attended by the LAS each year, it is expected that this will be for a multitude of reasons and will in part include: larger volumes of calls to the LAS from 111 providers and referrals from Health Care Professionals (increasing by 8% from 2012/13 - see Appendix 1) as well as greater public awareness of stroke symptoms following Public Health England's 'Act-FAST' media campaign. The increase in Red response calls are also likely to be a result of changes in the categorisation of stroke calls whereby Emergency Medical Dispatchers establish the time of onset as part of the over the phone FAST assessment to ensure patients within the 3.5 hours of symptom onset receive a high priority response.

The percentage of stroke patients, who received a complete pre-hospital care bundle is at a record high of 97%, which reflects the success of initiatives aimed at improving the care bundle provision. In particular, all staff have been provided with personal-issue blood glucose monitoring kits, thus significantly reducing the instances where patients' were not tested due to the equipment not being available to less than 0.5%. As part of the continued education, staff were invited to attend a one- day stroke education event run by the LAS in conjunction with the stroke networks. The event provided a forum to discuss current and future stroke care in London with experts. The significance of the stroke care bundle and the importance of assessing and documenting all elements of the FAST were discussed, alongside a teaching session covering the wider mini-neurological assessment. Furthermore, a multimedia training tool has been made available to staff and educational material promoted, highlighting the need to appropriately assess speech deficits such as aphasia, which can often be overlooked.

Compliance with the stroke pathway by LAS staff is excellent: 99.1% of stroke patients were conveyed to the most appropriate destination for their condition, with the vast majority (98.5%, n=12,067) conveyed directly to a HASU. For patients conveyed to a HASU average journey times were well within the 30 minutes target set by the stroke network in London, with stroke patients reaching a HASU within 15 minutes on average from leaving the scene.

It is recognised that the data collected within the LAS stroke registry is dependent on clinicians identifying the patient as stroke and/or conveying the patient to a HASU and therefore it is not always possible to identify cases that were missed. However, a small proportion of stroke patients (0.5%) were transported to ED when they should have been conveyed to a HASU. The Clinical Audit and Research Unit flag these cases for review by the local Quality, Governance and Assurance Manager. This allows the clinicians involved to discuss the basis of their decision and, where indicated, receive feedback to inform future use of the stroke pathway. Feedback is also shared with voluntary and

private ambulance services contracted to assist the LAS. It is hoped that in the future outcome information from hospitals will better inform the development and use of the pathway, and enable further staff education.

Stroke patients often present with reduced mobility and an element of communication difficulty, which may complicate and prolong assessment and extraction from the scene to the ambulance. The data shows that when the on-scene time is measured from the arrival of the first vehicle (and therefore not including first responders awaiting a conveying vehicle), the median time spent on scene is 25 minutes. The proportion of time that can be attributed to first responders awaiting ambulances capable of conveying the patient to hospital is on average just 7 minutes. The LAS will continue its efforts to encourage staff to try and spend as little time as possible on-scene to enable stroke patients to reach definitive treatment and minimise neurological damage. A one minute video has been developed to reinforce the message that 'Time is Brain' and this will be released to staff via the LAS intranet and staff Facebook page.

The LAS remains committed to developing and improving stroke services in London. We are currently represented on Intercollegiate Guideline Development Groups for stroke in adults (Royal College of Physicians) and children (Royal College of Paediatrics and Child Health). In line with the evolving evidence on the role of interventional neuroradiology for thrombectomy (clot extraction), the LAS is in discussions with the London HASUs around how we will support network arrangements and potentially identify suitable patients early on.

In conclusion, this report demonstrates that the stroke pathway in London has been consolidated into clinical practice and that LAS staff should feel proud of the high quality care that they have continued to provide for stroke patients.

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Glossary for abbreviations and terms

Blood glucose (BM) – Blood glucose molarity is a measure of a patients' blood glucose level.

Blood pressure (BP) – Blood pressure measured in systolic and diastolic units.

Call to Hospital Time – The overall time taken from the initial 999 emergency call to the arrival of the patient at hospital.

Call to Scene Time – The overall time taken from the initial 999 emergency call to the arrival of a response to the patient.

Category C – Calls which are not deemed immediately life-threatening (based on the information given by the caller regarding the patient's condition) are classed as Category C. Some patients subsequently diagnosed with a stroke receive this response, primarily where the patient has not reported any FAST symptoms or where other medical conditions were reported instead (e.g. collapse/ not alert).

Computerised Tomography (CT) – A cross-sectional, three-dimensional picture of internal organs made by combining multiple x-ray images. HASUs to identify where in the brain the suspected stroke is occurring, how old it is, and how best it should be treated.

Emergency Operations Centre (EOC) – the co-ordinating centre where incoming 999 calls are taken, triaged and subsequent responses dispatched from.

Face, Arm and Speech Test (FAST)- A diagnostic test developed in the UK in 1998 used by ambulance clinicians to help assess and detect the symptoms of a stroke. The FAST assesses for Facial drooping, Arm weakness and Speech difficulties as signs of a stroke. The 'T' can also refer to Time to emphasise the importance of rapid assessment and treatment. If a patient presents with one or more of these features they are known as FAST positive (in this report these patients are referred to as stroke patients).

First responder – A solo resource dispatched to immediately life-threatening calls to ensure that the patient begins to receive care as quickly as possible prior to the arrival of an ambulance.

Hyper Acute Stroke Unit (HASU) – Specialist centres which patients suffering a stroke are taken directly to for rapid assessment and treatment.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

ORCON – a definition used to determine the clock start time. The ORCON start time allows for an initial period prior to the clock starting in an attempt to establish the chief complaint).

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Red category – Red calls (or category A) are those classed as immediately life-threatening, and should receive a response within 8 minutes of the initial 999 emergency call. The vast majority of patients diagnosed with a stroke receive a Red response.

Stroke network – the clinical network responsible for overseeing the stroke services delivered to patients.

Time of Onset – The potential time that the stroke occurred based on information available from patients and others. Where a time cannot be established the last time the patient was seen is used as an alternative to help assist ambulance staff with decisions regarding rapid conveyance to HASU.

Thrombolysis – A form of treatment in which a drug that breaks down blood clotsis used in an attempt to un-block the artery leading to the area of brain affected by the stroke. Also known as “clot busting” it carries a number of risks and is only used in a small number of patients where the benefit outweighs the risk..

Thrombectomy – Also known as mechanical thrombectomy or interventional neuroradiology. This is a procedure in which the clot causing the stroke is removed directly using a device inserted into the artery under x-ray guidance

Appendix 1: Comparisons to previous years (2012-2015)

Demographics		2012-13	2013-14	2014-15	2015-16
Number of patients		9,814	10,474	11,183	12,251
Gender* n (%)	Male	4,640 (47.3%)	5,132 (49.0%)	5,277 (47.2%)	5,878 (48.0%)
	Female	5,174 (52.7%)	5,340 (51.0%)	5,906 (52.8%)	6,373 (52.0%)
Mean Age (range)**	All patients	72 (18-107)	71 (18-105)	71 (16-104)	71 (16-110)
	Male	70 (18-103)	69 (18-103)	70 (16-104)	69 (16-106)
	Female	74 (18-107)	73 (18-105)	73 (16-103)	73 (16-110)

* Data excludes 2 cases from 2013-14 where gender was not documented.

** The HASU pathway in London for FAST positive patients was available for over 18's only until 2014-15 when the pathway became available for patients over 16 years of age.

Chief complaint	2012-13	2013-14˜	2014-15	2015-16
Stroke	5,451 (55.5%)	5,355 (51.1%)	5,665 (50.7%)	5,874 (47.9%)
Unconscious/fainting	805 (8.2%)	874 (8.3%)	1,010 (9.0%)	1,261 (10.3%)
Chest pain	210 (2.1%)	218 (2.1%)	234 (2.1%)	272 (2.2%)
Breathing problems	217 (2.2%)	266 (2.5%)	332 (3.0%)	339 (2.8%)
Convulsions/fitting	273 (2.8%)	323 (3.1%)	373 (3.3%)	385 (3.1%)
Sick person (specific diagnosis)	591 (6.0%)	473 (4.5%)	378 (3.4%)	356 (2.9%)
Falls	654 (6.7%)	715 (6.8%)	728 (6.5%)	824 (6.7%)
Diabetic problems	83 (0.8%)	103 (1.0%)	87 (0.8%)	80 (0.7%)
111 transfer	153 (1.6%)	770 (7.4%)	878 (7.8%)	1,094 (8.9%)
Health Care Professional admission	899 (9.2%)	883 (8.4%)	981 (8.8%)	1,183 (9.7%)
Other	478 (4.9%)	494 (4.7%)	517 (4.6%)	583 (4.8%)

˜ Percentages do not equal 100% due to rounding.

Response information		2012-13	2013-14	2014-15	2015-16
Category■# n (%)	Red calls	5,635 (63.2%)	6,479 (67.6%)	7,479 (73.3%)	8,348 (75.4%)
	Category C calls	3,279 (36.8%)	3,111 (32.4%)	2,723 (26.7%)	2,720 (24.6%)
Median 999 Call to scene^■ (range)	Overall	8 (0-246)	8 (0-282)	10 (0-570)	10 (0-446)
Median On- Scene£ (range)	From arrival of first attending vehicle	31 (4-139)	31 (7-175)	32 (3-261)	32 (4-255)
	From arrival of first ambulance	26 (0-139)	25 (2-175)	25 (2-261)	25 (4-255)

■ Health Care Professional Admissions are excluded from category and response time figures because the timeframe is specified by the clinician making the referral.

Data excludes cases where the category given to the call was unavailable (1 case in 2012-13 and 1 case in 2013-14).

^ Zero minute times in the range are due to running calls where a patient/passerby has flagged an ambulance.

£ Non-conveyed patients are excluded from on scene time figures.

Assessment		2012-13	2013-14	2014-15	2015-16
Complete FAST	Assessed or a valid exception documented	9,529 (97.1%)	10,905 (97.5%)	10,211 (97.5%)	11,974 (97.7%)
	Not assessed	285 (2.9%)	278 (2.5%)	263 (2.5%)	277 (2.3%)
Blood Glucose	Assessed or a valid exception documented	9,495 (96.7%)	11,111 (99.4%)	10,217 (97.5%)	12,195 (99.5%)
	Not assessed	319 (3.3%)	72 (0.6%)	257 (2.5%)	56 (0.5%)
Blood Pressure	Assessed or a valid exception documented	9,800 (99.9%)	11,163 (99.8%)	10,460 (99.9)	12,224 (99.8%)
	Not assessed	14 (0.1%)	20 (0.2%	14 (0.1%)	27 (0.2%)
Care Bundle	Complete or a valid exception documented	9,211 (93.9%)	10,816 (96.7%)	9,950 (95.0%)	11,903 (97.2%)
	Not complete	603 (6.1%)	367 (3.3%)	524 (5.0%)	348 (2.8%)

Conveyance		2012-13□	2013-14	2014-15~	2015-16
Patients conveyed to hospital$◊		9,765	10,427	11,149	12,204
HASU	Appropriate destination	9,442 (96.7%)	10,273 (98.5%)	10,991 (98.6%)	12,067 (98.5%)
ED	Appropriate destination	184 (1.9%)	106 (1.0%)	63 (0.6%)	74 (0.6%)
	Inappropriate destination	139 (1.4%)	48 (0.5%)	95 (0.9%)	63 (0.5%)

$ 120 cases patients refused transport to hospital (41 from 2012-13, 46 from 2013-14 and 33 from 2014-15) and are excluded from the table.

◊ 7 patients conveyed to a non-London site with ASU/HASU facilities are excluded from the table (5 in 2012-13, 1 from 2013-14 and 1 in 2014-15)

□ In 2012-13, 3 cases were excluded from the table as it was unclear as to whether the patient was conveyed to a HASU or ED.

~ Percentages do not equal 100% due to rounding.

HASU utilisation	2012-13	2013-14	2014-15	2015-16
Northwick Park Hospital	1,516 (16.1%)	1,518 (14.8%)	1,720 (15.7%)	1,847 (15.3%)
University College Hospital	1,502 (15.9%)	1,633 (15.9%)	1,677 (15.3%)	1,815 (15.0%)
St Georges Hospital	1,258 (13.3%)	1,412 (13.7%)	1,613 (14.7%)	1,738 (14.4%)
Princess Royal University Hospital	1,165 (12.3%)	1,280 (12.5%)	1,358 (12.4%)	1,435 (11.9%)
Charing Cross Hospital	1,114 (11.8%)	1,262 (12.3%)	1,270 (11.6%)	1,497 (12.4%)
Kings College Hospital	1,049 (11.1%)	1,101 (10.7%)	1,104 (10.0%)	1.364 (11.3%)
Royal London Hospital	974 (10.3%)	1,135 (11.0%)	1,188 (10.8%)	1,209 (10.0%)
Queens Hospital, Romford	864 (9.2%)	932 (9.1%)	1,060 (9.6%)	1,162 (9.6%)

Median journey times (range)		2012-13	2013-14	2014-15○	2015-16
All stroke patients		14 (1-100)	15 (1-98)	15 (0-134)	15 (1-123)
HASU	All patients conveyed to HASU	15 (1-100)	15 (1-98)	15 (0-134)	15 (1-123)
	Patients with onset of symptoms <4.5 hours	13 (11-78)	14 (1-80)	14 (1-134)	13 (1-111)
ED	All patients conveyed to ED	14 (1-61)	13 (2-45	14 (2-47)	13 (2-48)

○ Zero minute journey time as location of the incident was outside of the hospital.

London Ambulance Service NHS Trust

Clinical Audit Annual Report 2015-16

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Authors: Emily Cannon and Rachael Fothergill

Clinical Audit & Research Unit
Clinical & Quality Directorate,
London Ambulance Service NHS Trust,
18-20 Pocock Street,
London
SE1 0BW

CARU.enquiries@londonambulance.nhs.uk

2015-16 Clinical Audit Annual Report

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For Further Information

All documents referred to in this report are available on request from the Clinical Audit & Research Administrator on 0207 783 2504 or from CARU.enquiries@londonambulance.nhs.uk.

1.0 Preface

The London Ambulance Service NHS Trust (LAS) prides itself on delivering high quality care and it's Clinical Audit and Research Unit (CARU) plays a role in both evidencing high standards and driving forward quality improvement through a comprehensive programme of clinical audit.

CARU assesses patient care through individual clinical audit projects, which are often prompted by incidents, complaints or feedback and enable the Service to learn and improve. Assurance is also provided internally via our programme of Clinical Performance Indicators (CPIs) and continuous data quality monitoring, and nationally through contributions to the NHS England Ambulance Quality Indicators and the National CPIs. We ensure that learning is taken forward by forming recommendations where improvements are needed and sharing our findings with staff through training, posters and Clinical Update articles. Following the implementation of actions, clinical care is then re-assessed which, as demonstrated by this report, leads to improved patient care. CARU have also shared learning externally by publishing papers and presenting abstracts at a number of conferences throughout 2015-16 and informing national clinical practice guidelines.

In June 2015, the LAS were inspected by the Care Quality Commission who reported that significant improvements were needed across the Trust[1]. As a result, CARU have supported the organisation in working towards our quality improvement plan. The CQC inspection report found that particular improvement was needed in the way the Service manages medicine and the LAS should "set up a system of checks and audit to ensure medicines removed from Paramedic drug packs have been administered to patients". As a result, CARU have contributed to assurance by including an additional aspect of care in the Clinical Performance Indicators (CPIs) and focusing on medicines management in relevant clinical audits.

This report details all clinical audit activity undertaken within the LAS in 2015-16.

2.0 Clinical Audit Projects

All clinical audit findings and recommendations are approved by the Clinical Audit and Research Steering Group (CARSG) prior to dissemination through our publication process. This section outlines the key findings and recommendations from projects published in 2015-16.

2.1 Inter-hospital Transfers (May 2015)

A serious incident occurred within the LAS in 2013, whereby a transfer for a patient with aortic dissection was incorrectly triaged as an immediate rather than a critical transfer. This resulted in a delayed response and unfortunately the patient later died. Anecdotal concerns were also raised as to whether hospitals request faster transfers than necessary and for patients with non-urgent conditions suitable for transportation by the hospital's own patient transport service (PTS).

We found that the majority of conditions described by hospitals matched the criteria listed on the LAS hospital transfer flow chart, which is to be expected as hospital clinicians have been involved in the preparation of the list. LAS triage was in line with the hospital transfer flow chart for the majority of requests. However, the proportion of incorrect triages by call handlers was higher when the patient's condition was not on the flow chart, some transfers were assigned incorrect Medical Priority Dispatch System (MPDS) codes, and advice sought/given within the Control Group was not always recorded on Command Point. To address this, Control Services Bulletins were issued reminding call handlers of the correct procedures. This clinical audit also added to the evidence base for introducing an alternative MPDS triage card (card 37) specifically for inter-hospital transfers which was later adopted by the LAS.

2.2 IV Paracetamol (July 2015)

In December 2013, the London Ambulance Service NHS Trust (LAS) introduced intravenous (IV) paracetamol. This clinical audit aimed to determine the reasons that IV paracetamol is being administered, whether it has been used appropriately, and whether it's effective in reducing pain and/or temperature.

This clinical audit showed that, on the whole, IV paracetamol was used appropriately by LAS Paramedics in accordance with national guidelines and LAS training. However, there were some instances where its administration was not indicated and whilst this is not known to have caused harm to the patients, this means they were cannulated unnecessarily. In a small number of cases, IV paracetamol was administered to patients experiencing mild pain when oral tablets would have been more appropriate.

Inappropriate administrations may be due to the fact that guidance for oral and IV paracetamol are presented together in UK Ambulance Service Clinical Practice Guidelines[2] and the indications for each are not entirely clear. As a result, we have suggested to the Association of Ambulance Chief Executives that a clearer distinction is made in future clinical practice guidelines. In the meantime, we have

published a Clinical Update article reiterating the indications for IV paracetamol, in addition to issuing a poster to all ambulance stations and proposing that the pain tool is revised to include IV paracetamol.

2.3 Midazolam and Ketamine (September 2015)

In January 2014, the London Ambulance Service NHS Trust (LAS) introduced an Advanced Paramedic Practitioner (APP) role to provide selected practitioners with enhanced knowledge and clinical interventions beyond standard paramedic practice. Such clinical interventions include the administration of ketamine (KET) and midazolam (MDZ) given under LAS patient group directions (PGDs). This clinical audit aimed to determine whether these new drugs are being administered appropriately and safely.

Both drugs were indicated for all patients who received them. All patients were administered MDZ by an appropriate route. Nearly all patients were administered doses of MDZ as per the PGD and Medical Directorate permission was given to exceed the maximum dose of MDZ for four patients. However, a small number were administered doses of MDZ that exceeded the amount specified without Medical Directorate permission. Route and dosing regimen for all administrations of KET were in line with the PGD for all patients.

The PGD will be amended to reflect intraosseous and subcutaneous as appropriate routes of administration for MDZ and increase the permissible dose for MDZ and KET. Feedback was provided to the APPs whose documentation was not sufficient and those who exceeded the maximum incremental dose without consulting the Medical Directorate on call. The findings of the report were also shared at an APP development day to address areas of assessments and documentation which require improvement.

2.4 Paediatric Respiratory Assessment Re-audit (September 2015)

Respiratory distress in young children is a common scenario faced by the LAS clinicians. It can be caused by a range of conditions, some of which may prove fatal. Therefore, to prevent further deterioration, it is crucial to complete a thorough on-site assessment. A previous clinical audit in 2012 showed that not all patients had oxygen saturation levels measured or their chest auscultated during assessment. This re-audit served to evaluate whether the implemented actions, including the introduction of a paediatric oxygen saturation measuring device, have led to improvement.

The re-audit found an 11% increase in the number of patients who had two respiratory rates recorded when compared with the results of the 2012 clinical audit. The percentage of patients who had two oxygen saturation readings and their chest auscultated improved by 18% and 12% respectively. To aid further improvement, posters were sent to all ambulance stations congratulating clinicians on the improvements since the last audit and reiterating the areas which require further work. A Clinical Update article was published on the importance of an accurate

respiratory assessment and findings regarding missing oxygen saturation equipment were shared with the Clinical Equipment Working Group.

2.5 Section 136 (December 2015)

The early part of 2014 marked a national drive to improve the care of patients detained under Section 136 of the Mental Health Act. This clinical audit assessed Emergency Operations Centre (EOC) staff and crew compliance to LAS guidance, including: whether sufficient information was recorded by EOC, whether calls received a response within national timeframes, and whether patients were appropriately conveyed to a place of safety, or an Emergency Department (ED) if further medical attention was required.

This clinical audit found that when Section 136 transportation was requested by the police, the information provided lacked the detail required to ensure correct triage of calls. Of the calls cancelled by the police, a small number were not received in EOC and the LAS arrived on scene to find the patient had been transported by other means. Only one of the four patients who required a response within eight minutes were attended within this timeframe - there was no evidence of harm caused to the remaining three patients. Two-fifths of patients with no clinical risks received a response within 30 minutes.

Nearly all patients were appropriately conveyed to a Section 136 suite or an ED if they required medical attention. However, one patient was taken to a police station when they required medical assessment at an ED, and two patients were taken to an ED when their documentation indicated a Section 136 suite would have been more suitable.

This clinical audit produced 16 recommendations which included updating EOC guidance on the management of Section 136 requests and making it easily accessible for staff. We have communicated our findings to police forces in London and reminded them of the information the LAS needs to triage calls, which has also been included in draft NHS guidance on the Section 136 pathway in London. The Memorandum of Understanding between the LAS and Metropolitan Police Service will also be amended. To ensure that frontline staff are aware of the correct management of patients under Section 136, a Clinical Update article was published outlining the correct destination for patients, that patients should only travel in a police vehicle as a last resort if they display violent behaviour, and patients conveyed in a police vehicle must be accompanied by a qualified LAS clinician. The report has also been shared with external stakeholders.

2.6 Paediatric Sepsis (March 2016)

Following CARU's 2015 clinical audit assessing clinicians' ability to identify and manage sepsis in adults, this clinical audit applied a similar methodology to assess the identification and management of severe sepsis in paediatric patients (aged 16 and under). The audit focussed on the overall assessment of the child (including basic observations and a review of systems), whether crews recognised sepsis,

treatment provided on scene, and whether crews identified the urgency of the patient's condition (time spent on scene and pre-alert to hospital).

As a result of this clinical audit, the Medical Directorate will produce a web-tutorial on paediatric assessment to ensure clinicians are aware of the importance of undertaking core observations and the key indicators of severe sepsis. The LAS will also consider whether to introduce a paediatric sepsis Clinical Performance Indicator (CPI) or whether to re-audit in the future. Areas of good practice and areas for improvement were shared with clinicians in a Clinical Update article and a poster sent to stations. Clinicians who documented excellent paediatric assessment were also congratulated.

3.0 Continuous Clinical Audit Activity

3.1 Clinical Performance Indicators (CPIs)

During 2015-16 the LAS underwent an operational restructure, moving from three sectors to six. To coincide with this, protected office time for Team Leaders was introduced, providing them with more opportunity to undertake CPI audits. Following the restructure, completion of CPIs fluctuated, before peaking in March 2016. Similarly, the number of feedback sessions delivered to staff varied, with increased levels of feedback delivered during months when Team Leaders had more protected office time. Feedback sessions are pivotal in ensuring clinicians are made aware of areas for improvement, thus ensuring a high standard of patient care is delivered.

During the operational restructure, the role of Quality Governance and Assurance Manager (QGAM) was introduced, with one responsible for each of the newly formed sectors. This role is vital in monitoring completion and feedback levels.

Despite fluctuating levels of completion and feedback, compliance levels in every CPI were maintained. Figure 1 outlines a snapshot of the level of care provided for each patient group in April since 2006.

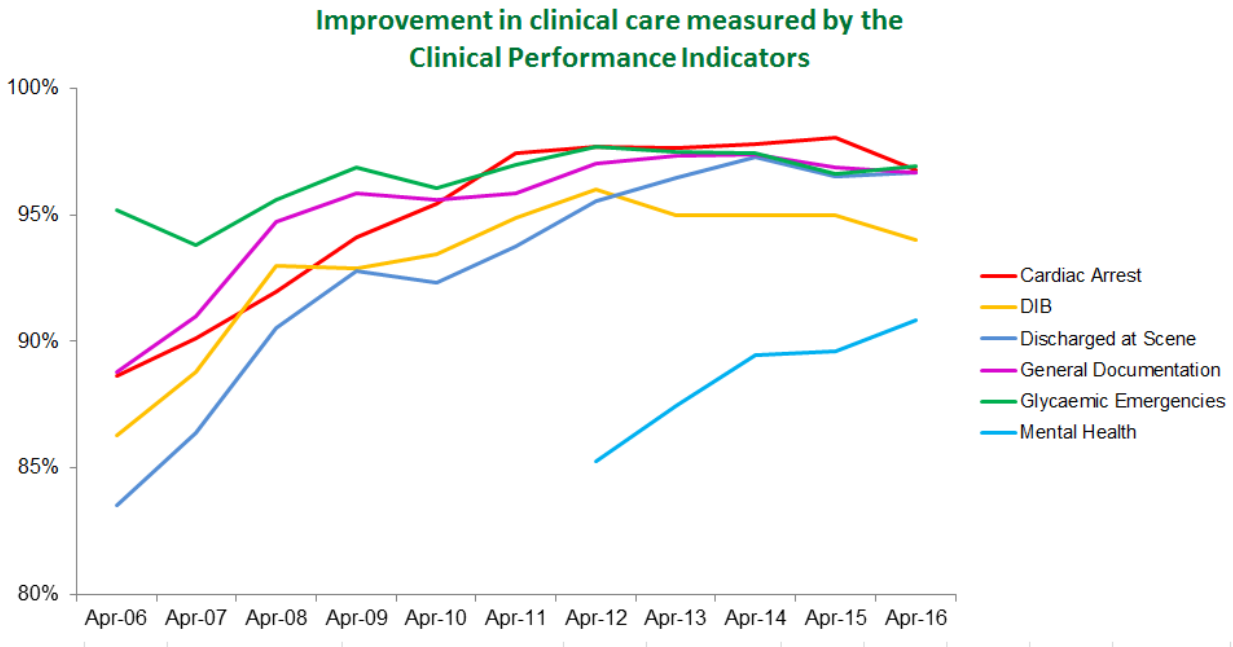

Figure 1: CPI compliance rates from April 2006 to April 2016

Significant developments in the CPIs were made in 2015-16. Following the Service's CQC inspection report, CARU added an aspect of care to the General Documentation CPI to determine whether crews are recording the drug pack code when administering a drug from the Paramedic drug pack.

Other developments included providing the Tactical Response Unit (TRU) with the facility to undertake CPI audits and feed back directly to their own staff.

Two new CPIs were also developed for introduction in 2016/17; Severe Sepsis and Elderly Falls.

3.2 Clinical Quality Monitoring

Throughout 2015-16 we continued to monitor and demonstrate high quality clinical care to our cardiac arrest, ST elevation myocardial infarction (STEMI - a type of heart attack), stroke and major trauma patients. However, the documentation of analgesia for our STEMI patients continues to require improvement and our ambulances are spending, on average, two minutes longer on scene than the 30 minute target. Return of spontaneous circulation (ROSC) and survival rates for 2015-16 remain consistent with figures reported in the previous year. Through monthly reports we inform clinical staff, Quality Governance and Assurance Managers, and operational management teams of the care provided in each sector enabling them to assess local improvement initiatives. Please see the cardiac arrest, STEMI and stroke annual reports for more detailed information.

In addition to assessing clinical care, staff in CARU also ensure the safety and wellbeing of patients. During 2015-16, we made 99 safeguarding referrals for patients whose PRFs suggested they may be vulnerable, but there was no

documentation by the attending clinician that a referral had been made. The majority of referrals were for patients aged under 18 involved in major trauma.

During routine data collection, CARU staff also forwarded a further 331 cases to QGAMs or specialty leads for review and where necessary, feedback was delivered to the clinician in order to improve their clinical practice. Examples of where we have been able to provide positive feedback to our clinicians is presented in Section 9.0.

3.3 Continuous Re-contact Clinical Audit

In 2012, the LAS took part in the National Audit of Non-Conveyance which revealed that one patient had unexpectedly died following their initial contact[3]. As a result we undertook a further clinical audit covering a seven day period. The audit found no unexpected deaths and recommended that re-contacts are continuously monitored in the Service. All re-contacts where the patient severely deteriorated (pre-alerted to hospital) or died unexpectedly in 2015-16 were reviewed to assess the appropriateness of the decisions made, with some escalated and reviewed by the Serious Incident Group. Monthly and quarterly reports detailing initial contacts have been shared with the LAS Clinical and Quality Directorate and an annual report will be published via CARU's normal dissemination process.

4.0 National clinical audit

4.1 National Clinical Performance Indicators (CPIs)

The National CPIs compare care across the country and evidence national clinical audit participation to the Department of Health (DH) in the Quality Accounts Mandatory Assurance Statements. Two reports were released during the 2015-16 period which demonstrated varying levels of LAS compliance to the different National CPIs[4,5], outlined below. As a result, CARU created an information booklet detailing the care bundles these patient groups should receive, which has been published on the Service's Listening in Action (LiA) Facebook page and phone app. Our performance has been presented at Team Leader Conferences and to CARSG, both of whom have discussed how to improve compliance to the national CPIs.

4.1.1 Asthma National CPI

We continued to see an upward trend for nearly all aspects of care necessary for asthmatic patients. Peak flow remains the lowest performing aspect of care; however, the importance of carrying out a peak flow was included in recent face-to-face Core Skills Refresher training delivered to all members of staff and it is expected this will lead to improvement.

4.1.2 Single Limb Fracture National CPI

The LAS saw an improvement in the care provided to patients with a single limb fracture between cycles 14 and 15. However, further improvement is still required.

4.1.3 Febrile Convulsion National CPI

The administration of an anticonvulsant and use of an appropriate discharge pathway remains high for patients who have had a febrile convulsion. However, a reduction in the number of patients who had their oxygen saturation measured and temperature managed led to a decrease in overall care bundle provision.

4.1.4 Elderly Falls National CPI

Following the pilot, Elderly Falls is now an established CPI. Carrying out a 12 lead ECG for non-mechanical falls and assessment of the patient's mobility are in need of particular improvement.

4.1.5 Mental Health CPI (pilot)

The Mental Health (Self Harm) pilot CPI was introduced during 2015-16. This national CPI assesses seven aspects of care, including the documentation of: the mental state of the patient, exact nature of the injury, a clinical assessment, and assessment of the patient's capacity. Nationally, the LAS has ranked top for recording the patient's social/family network, but bottom for documenting evidence of alcohol and/or drug ingestion.

4.2 Other National Clinical Audit

In 2015-16, the LAS continued to supply data to the Myocardial Ischaemia National Audit Project (MINAP) and validate the pre-hospital data entered by hospitals. Monthly submissions and six-monthly resubmissions were also made to NHS England for the AQI clinical outcome measures for cardiac arrest, STEMI and stroke.

5.0 Additional Data Requests

Clinical audit data played an important role during the Service's Care Quality Commission (CQC) inspection in June 2015. Our data provided evidence of the high standard of care given by our clinicians and that as an organisation we continuously learn from our audits and strive to deliver the best possible care to our patients.

6.0 Engaging Staff in Clinical Audit

In addition to clinical audit undertaken within CARU, we also encourage and facilitate clinician involvement in clinical audit through the following training and volunteering opportunities. This provides clinicians with the opportunity to demonstrate they are able to reflect on and review their practice for their Health and Care Professions Council (HCPC) registration.

6.1 Training

Throughout 2015-16, we continued to deliver a number of training sessions across the Service (as shown in Table 1) to ensure staff are aware of the role clinical audit and research plays in the LAS, both in terms of evidence based practice and the impact of our work.

Session	Audience	Participants in 2015-16
Emergency Operations Centre Induction: Clinical Audit & Research in the LAS	New Emergency Medical Dispatchers	127
LAS Internship	Internship Paramedics	122
Team Leader Conference: Clinical Audit & Research Update	Team Leaders	120
Clinical Performance Indicators (CPIs)	Team Leaders, Training Officers and Paramedics	101
LAS Stroke Education Event	All staff levels	60
Clinical Development Module: Evidence Based Practice	Paramedic Managers and Team Leaders	45
Severe Sepsis CPI Training	Team Leaders	30
Emergency Medical Dispatchers (EMD) Development Days	EMD Managers and Supervisors	13

Table 1: CARU training delivered in 2015-16

6.2 Volunteering

In 2015-16, eight members of front-line staff were supported to undertake clinical audit projects. In addition, seven medical students were provided with one-on-one support and guidance whilst on placement to conduct pre-hospital clinical audit projects with CARU.

Following an excellent response to an advert for volunteers in the LAS Routine Information Bulletin (RIB), 28 Paramedics and seven staff in EOC assisted with our continuous re-contact clinical audit in 2015-16.

7.0 Patient and Public Involvement

CARU continue to value patient and public involvement in clinical audit. Feedback from the LAS Patients' Forum and Sickle Cell Society was the key driver for adding a sickle cell re-audit to our 2016-17 workplan. We will also be sending out a patient questionnaire in order to understand patients' experiences of the care provided by the LAS when in sickle cell crisis.

In addition, the patient representative on CARSG continued to review our clinical audit working practices, as outlined in section 8.0.

8.0 Clinical Audit Assurance

For the third consecutive year, an annual review of the Service's clinical audit working practices was undertaken to ensure all work is carried out in line with our clinical audit strategy[6]. The review was undertaken by the patient representative on CARSG, who confirmed that all audits were carried out in line with the strategy.

Throughout 2015/16, CARU also continued to evaluate whether completed clinical audit projects met their aims and objectives in order to identify learning points for future projects. A cost analysis for every project was also conducted to demonstrate value for money.

Two members of the clinical audit team were also awarded their Advanced Clinical Audit accreditation by the Clinical Audit Support Centre, thus ensuring robust methodology in all clinical audits.

Quality improvement undertaken within CARU led to additions to the LA1 (dispatch summary/roadworthy form), including a checklist to ensure that at the end of a shift, PRFs have an incident and illness code, and that electrocardiogram (ECG) and End-Tidal Carbon Dioxide ($ETCO_2$) strips are submitted where necessary. This ensures all PRFs are included in clinical audit, CPIs, continuous data quality monitoring and we have the supporting print outs to assess clinical care.

9.0 Sharing and Learning

We often identify excellent areas of clinical practice in our clinical audits and share these with staff through posters, the Clinical Update and the RIB. In 2015/16 we also shared findings and reports on the Service's LiA Facebook page, of which a large proportion of staff are members. This platform is an excellent way of stimulating discussion amongst clinicians and is one we will be using throughout 2016-17.

CARU also ensures that clinicians are commended for excellent clinical practice where possible, for example 16 crews were given positive feedback on the care they provided as a result of the continuous re-contact audit. In 2015/16, we also sent out 1,500 letters to clinical staff that attended cardiac arrest patients and provided lifesaving interventions at the scene and en-route to hospital. Furthermore, we sent over 350 letters to our Emergency Medical Dispatchers to recognise their crucial role in early recognition of cardiac arrest and initiation of dispatcher assisted bystander CPR.

In addition to communicating our findings internally, CARU also promote the LAS and our clinical audit achievements to external audiences. In 2015-16, three papers were published using LAS clinical audit data (as shown in appendix two). In addition, ten LAS clinical audit abstracts were accepted at national conferences (appendix three).

10.0 Directions for 2016-17

In 2016-17, we will undertake a range of in-depth clinical audits (see appendix four for the complete work programme). We will support the Service in the lead up to, and during, the CQC's re-inspection and also assist the Service in meeting Commissioning for Quality and Innovation (CQUIN) targets, specifically sickle cell. We will also continue to participate in national clinical audit and promote LAS clinical audit through internal training and external publications.

11.0 References

[1]Care Quality Commission, 2015. London Ambulance Service NHS Trust Quality Report. London: Care Quality Commission.

[2]Joint Royal Colleges Ambulance Liaison Committee, 2013. UK Ambulance Services Clinical Practice Guidelines 2016. Bridgwater: Class Professional Publishing.

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[4]National Ambulance Service Clinical Quality Group, 2015a. *Report on National Ambulance Service Clinical Performance Indicators – Cycle 14.* Lincoln: East Midlands Ambulance Service NHS Trust.

[5]National Ambulance Service Clinical Quality Group, 2015b. *Report on National Ambulance Service Clinical Performance Indicators – Cycle 15.* Lincoln: East Midlands Ambulance Service NHS Trust.

[6]London Ambulance Service NHS Trust, 2016. *Strategy, Process and Application of Clinical Audit in the London Ambulance Service.* London: London Ambulance Service NHS Trust.

Appendix one: Glossary of abbreviations

APP	Advanced Paramedic Practitioner
AQI	Ambulance Quality Indicator
CARSG	Clinical Audit & Research Steering Group
CARU	Clinical Audit & Research Unit
CPI	Clinical Performance Indicator
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
ECG	Electrocardiogram
ED	Emergency Department
EOC	Emergency Operations Centre
HCPC	Health and Care Professions Council
IV	Intravenous
JRU	Joint Response Unit
KET	Ketamine
LA1	Dispatch summary/roadworthy form
LAS	London Ambulance Service NHS Trust
LiA	Listening in Action Facebook Page
MDZ	Midazolam
MINAP	Myocardial Ischaemia National Audit Project
MPDS	Medical Priority Dispatch System
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PGD	Patient Group Direction
PRF	Patient Report Form
PTS	Patient Transport Service
QGAM	Quality Governance and Assurance Manager
RIB	Routine Information Bulletin
ROSC	Return of Spontaneous Circulation
STEMI	ST elevation myocardial infarction
TRU	Tactical Response Unit

Appendix two: Papers accepted for journal publication

Title:	Ambulance clinician assessment and management of transient loss of consciousness: a retrospective clinical audit
Authors:	J Shaw, A Ulrich, R Fothergill, M Whitbread
Journal:	Journal of Paramedic Practice
Title:	Ensuring an appropriate pre-hospital response to patients in sickle cell crisis
Authors:	J Shaw, R Fothergill, G Virdi
Journal:	Emergency Medicine Journal
Title:	Improving pre-hospital paediatric pain management.
Authors:	J Shaw, R Fothergill, G Virdi
Journal:	Emergency Medicine Journal

Appendix three: Abstracts accepted for conference presentations

Title:	Clinical Performance Indicators evidencing good clinical practice
Authors:	Shaw J, Fothergill R, Salvidge H
Conference:	Evidence Live, April 2015
Title:	Improving outcomes for cardiovascular disease
Authors:	Murphy-Jones G, Shaw J, Fothergill R
Conference:	Evidence Live, April 2015
Title:	Clinical audit of the diagnosis, management, and treatment of sepsis in the London Ambulance Service
Authors:	Murphy-Jones B, Shaw J, Fothergill R
Conference:	Sepsis Unplugged, May 2015
Title:	A study to determine the EZ-IO® Intraosseous Infusion System success rate, including impact on return of spontaneous circulation
Authors:	B Woodhart, J Shaw, R Fothergill
Conference:	999 EMS Research Forum, March 2016
Title:	Elderly fallers: is increased ambulance response time associated with mortality?
Authors:	E Cannon, J Shaw, R Fothergill, J Lindridge
Conference:	999 EMS Research Forum, March 2016
Title:	Joint Response Unit: Improving collaborative working between the London Ambulance Service and the Metropolitan Police Service
Authors:	R Zipfel, S McIlwaine
Conference:	999 EMS Research Forum, March 2016

Title:	Level of sepsis knowledge in UK ambulance services
Authors:	B Murphy-Jones, J Shaw, R Fothergill
Conference:	999 EMS Research Forum, March 2016
Title:	Complications associated with supraglottic airway use in an urban ambulance service: A case series
Authors:	T Edwards
Conference:	999 EMS Research Forum, March 2016
Title:	Prehospital use of Ketamine and Midazolam in an urban Advanced Paramedic Practitioner service: A retrospective review
Authors:	T Edwards, J Shaw, D Gray, N Thomson, M Faulkner
Conference:	999 EMS Research Forum, March 2016
Title:	Data linkage across ambulance services and acute trusts: assessing the potential for improving patient care
Authors:	S Clark, A Porter, M Halter, M Damiani, H Dorning, M McTigue
Conference:	999 EMS Research Forum, March 2016

Appendix four: Clinical Audit Work Programme 2016-2017

In order to be responsive to the needs of the Service projects may change if the need arises.

CARU Clinical Audit Projects

- Paediatic Conveyance Review (carried over from 2015/16)
- Oramorph (carried over from 2015/16)
- Heart Failure (carried over from 2015/16)
- Exercise Unified Response
- Continuous Re-contact
- Sickle Cell Crisis Re-audit
- Hypovolaemic Shock
- Mental Capacity Act

Volunteer Clinical Audit Projects

- Paediatric pain management re-audit (carried over from 2015/16)
- Alcohol intoxication re-audit (carried over from 2015/16)
- Paediatric pyrexia management re-audit (carried over from 2015/16)
- Hydrocortisone re-audit (carried over from 2015/16)
- Adrenaline for anaphylaxis (carried over from 2015/16)
- Paediatric abdominal pain
- Head injuries
- Ondansetron
- Dexamethasone
- Analgesia use
- Undiagnosed psychiatric problems
- Burns management
- Pain assessment of cognitively impaired patients
- Cardiac arrest data downloads

Clinical Performance Indicator Audits

- Cardiac Arrest (all PRFs)
- Difficulty in Breathing (alternative months: 50% of all PRFs)
- Glycaemic Emergencies (alternative months: 50% of all PRFs)
- Mental Health (all PRFs)
- Severe Sepsis (all PRFs)
- Discharge at Scene (50% of all PRFs and 100% of police arranging removal)
- General Documentation (1/40: 2.5% of all PRFs)

Clinical Performance Indicator Audit Activity

- Continuous monitoring of audit completion
- Continuous monitoring of compliance to care guidelines
- Continuous monitoring of feedback provision
- Monthly training delivery
- Quarterly on track posters disseminated to all stations

Clinical Quality Monitoring

- Cardiac Arrest (all PRFs)
- Major Trauma (all PRFs)
- Acute Coronary Syndromes (ACS: all PRFs)
- Stroke (all PRFs)

Routine Reporting of Audit Activity

- Cardiac Care Pack (consisting of Cardiac Arrest and ST Elevation Myocardial Infarction Monthly Complex Reports)
- Stroke Care Pack (consisting of Stroke Monthly Complex Reports)
- Major Trauma Care Cack (consisting of Major Trauma Quarterly Complex Reports)
- Clinical Performance Indicator Monthly Report
- NHS England Ambulance Quality Indicators: Clinical measures
    - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
    - Outcome from cardiac arrest – Survival to discharge
    - Outcome from acute STEMI
    - Outcome from stroke

Annual Reporting of Audit Activity

- Clinical Audit Annual Report
- Cardiac Arrest Annual Report
- ST Elevation Myocardial Infarction Annual Report
- Stroke Annual Report
- Major Trauma Annual Report
- Strategy, Process and Application of Clinical Audit in the London Ambulance Service

National Clinical Audits

- Asthma National Clinical Performance Indicator (bi-annual data submission)
- Trauma National Clinical Performance Indicator (bi-annual data submission)
- Febrile Convulsions National Clinical Performance Indicator (bi-annual data submission)
- Elderly Falls National Clinical Performance Indicator (bi-annual data submission)
- Mental Health National Clinical Performance Indicator (bi-annual data submission)

Additional reporting for Meetings

- Clinical Development and Professional Standards Committee
- Safety Committee (specifically relevant NICE Quality Standards)
- Quality Governance Committee

Miscellaneous Activity

- Facilitation of clinical audit – all clinical audit projects undertaken by front line staff will be registered with and receive support and guidance from the Clinical Audit & Research Unit

- Clinical Audit Database – all clinical audit projects will continue to be registered on this database, and the implementation of recommendations will continue to be monitored
- Auditing Audit – clinical audit projects will be evaluated using the Health Services Management Centre's assessment tool and Best Practice in Clinical Audit evaluation tool
- Cost analysis – each clinical audit will be assessed for its expenditure.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Finance and Investment Committee assurance report**
Report Author(s):	**Nick Martin, Non-Executive Director** **Andrew Grimshaw, Director of Finance and Performance**
Presented by:	**Nick Martin**
Contact Details:	**andrew.grimshaw@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Assurance**

Background/Purpose

The Finance and Investment Committee (FIC) will meet on 24th November 2016 and an assurance report will be provided at the Board meeting. The agenda for the meeting is attached for information.

Action required

To note the agenda for the meeting and receive assurance at the Trust Board meeting.

Key implications

The FIC provides assurance to the Board on the oversight of finance and performance.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	**To be provided in the assurance report**
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	

London Ambulance Service NHS Trust

FINANCE & INVESTMENT COMMITTEE MEETING

TO BE HELD ON THURSDAY 24TH NOVEMBER 2016 AT 9.30am - 12pm

CONFERENCE ROOM, GROUND FLOOR HQ, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA

ITEM	SUBJECT	Time	Purpose	LEAD	TAB
1.	Welcome and Apologies for absence			NM / PB	
ACTIONS					
2.	2.1 Conflicts of Interest 2.2 Minutes of previous meeting (*26 May 2016*) 2.3 Actions from previous meetings 2.4 Matters Arising	**09.30**	 Agree	 NM NM NM	 Paper Paper
FINANCIAL PERFORMANCE					
3.	3.1 Finance Report Month 07 2016/17 3.2 Rolling 07 Months Cash Flow 3.3 Forecast 2016/17	**09.45** **10.15** **10.25**	Note Note Note	AB MJ AB	Paper Paper Paper
FINANCIAL PLANNING					
4.	4.1 Development 2017/18 Financial Plan	**10.35**	Approve	AG	Paper (To Follow)
FINANCIAL GOVERNANCE					
5.	5.1 Review of Assurance Framework Review 5.2 Self-Assessment of the Committee Performance and ToR 5.3 Financial Policies: - Financial Planning Policy - Cash Management Policy - Transaction Management Policy	**10.55** **11.10** **11.20**	Approve Note Approve Approve Approve	AG AG/SA MJ MJ MJ	Paper Paper Paper Paper Paper
OTHER FINANCIAL INFORMATION					
6.	6.1 Technical Releases and Publications	**11.35**	Note	MJ	Paper
REPORTS ASSOCIATED ACTIVITIES					
7.	7.1 Estates 7.2 IM&T 7.3 Performance Strategy	**11.40** **11.45** **11.50**	Note Note Note	AG/JW AG/VW JP	Presentation Presentation Paper
ANY OTHER BUSINESS					
8.	8.1 Agenda Planner 2016/17	**12.00**	Note	AG	Paper

Date of Next Meeting

The next meeting of the Finance & Investment Committee will take place on Thursday 19th January 2017, 2pm - 5pm, Conference Room, HQ.

London Ambulance Service NHS
NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Workforce and OD Committee: progress report to the Board by the Committee Chair**
Report Author(s):	**Fergus Cass, Non-Executive Director and Chair of the Workforce and OD Committee**
Presented by:	**Fergus Cass**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Assurance report from the meeting held on 26th October 2016**

Background/Purpose

The Workforce and Organisational Development (OD) Committee was established in 2016 and is a sub-committee of the Trust Board and therefore chaired by a Non-Executive Director.

The attached report from the Committee Chair summarises the progress made to date by the committee.

Action required

The Trust Board is asked to take assurance from the report of the Workforce and Organisational Development Committee meeting on 26th October 2016.

Key implications

The committee is a sub-committee of the Trust Board and has oversight of workforce and OD. Key to the role of the committee is the provision of assurance to the Board on these issues and to identify any emerging themes and risks to the achievement of the Trust's strategic objectives from these issues.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	
Taking Pride and Responsibility	**Yes**

Report to the Board on the meeting of the Workforce & Organisational Development Committee, 26 October 2016

The Committee held its third meeting on 26th October 2016. The main matters discussed are summarised below.

Workforce planning update

The Committee received a presentation on numbers and recruitment up to March 2019. This was based on a briefing given to the Board in September, with the addition of information on the EOC. A more comprehensive plan is dependent on finalisation of the clinical strategy and clarification of the skill mix required to implement it. Currently it is expected that recruitment of foreign paramedics will continue to be necessary: 145 in 2017/18 and an as yet unspecified number in 2018/19. EAC recruitment of approximately 260 per annum is envisaged, in addition to filling 115 vacancies from 2016/17. There is a projected requirement for 160 recruits to the EOC in 2017/18.

HR management expressed confidence that all of these recruitment needs can be met, while recognising risks associated with achieving the target numbers of Australian paramedics.

WRES progress

The Committee was briefed on the progress of the WRES Action Plan. It noted the focus on five indicators: % of BME and white staff in each AfC band and overall; relative likelihood of staff being appointed from shortlisting; relative likelihood of staff entering the formal disciplinary process; relative likelihood of staff accessing non-mandatory training and CPD; and Board representation. It also noted that regular information is not yet available to monitor these, including information relating to BME representation in current UK recruitment. It was briefed about: meetings, listening events and conferences aimed at advancing equality and diversity; reviews of recruitment, disciplinary processes and training that are currently being undertaken by the Interim Head of Equality and Inclusion; various other actions that are under consideration; and plans to develop the LAS BME Staff Forum and the WRES Working Group. It noted the progress in resourcing the Action Plan: the Interim Head of Equality and Inclusion will be a full time post until March 2017 and there will be an additional support post.

The Committee will receive regular updates and looks forward to seeing KPIs that monitor delivery.

People and Organisational Development

The Committee discussed the People and Organisational Development report. It was informed that the percentage of staff receiving appraisals is expected to reach 75% by the end of November despite shortfalls in earlier months and that, by March, appraisals will have been given to all those who should have received them. It was also informed that CSR is on track among clinical staff and that training of non-clinical staff was being closely monitored. Improvements in induction were noted.

The Committee noted that a People and Organisational Development Strategy has been drafted but is awaiting review by the incoming Head of HR and OD. It was given assurances that registration with the Core Skills Training Framework (CSTF) an outstanding action from the July meeting, will be quickly progressed. It was also informed that the Electronic Staff Record and Oracle Learning Management System project (ESR/OLM) is underway and is on track.

Leadership and management development activities were discussed; it was agreed that a consistent framework would be needed so that all management levels were exposed to a common approach.

Workforce indicators *(September figures are reported here, unless otherwise stated)*

There has been a reduction in the overall vacancy rate (5.6%) and the sickness percentage (4.9%). Although paramedic starters in September, at 39, were 9 below plan, paramedic and overall frontline recruitment were stated to be on track. Overall turnover increased slightly to 9.8% but remains below target. Bullying and Harassment training is ahead of target. Appraisals were behind target (52% versus a plan of 79%), but, as noted above, plans are in place to catch up.

The Board has already seen the results of the Q1 Staff Friends and Family Test (FFT), which showed further improvement in staff attitudes to the LAS as a place to work and to the care delivered by the trust; however, as discussed, the scores remain below those for ambulance services as a whole and for the NHS.

The Committee noted that all staff in roles with patient contact, including staff in EOC and numbering around 4,000, will now be required to undertake a new enhanced DBS check and to join and maintain subscription to the DBS update service. It was informed that the roll-out is now in progress.

Committee progress

Committee membership has now been clarified. Further discussion is needed to fully understand the various committees involved with people issues and define their relationship with the Workforce and OD Committee. A forward planner and programme of "deep dives" is being finalised.

The Committee plans to review: the HES Report (already circulated to the Board); the long term sickness / absence review; the People and Organisational Development Strategy; progress in implementing Internal Audit Reports related to HR, including the recent Amber/Red report on HR Governance; workforce risks; and the workforce strategy and workforce plan, when these become available.

Industrial relations matters will be among the areas on which the Committee will receive regular updates.

7 November 2016

London Ambulance Service NHS
NHS Trust

‘Healthcare engagement scale’

Summary of HES report for LAS and presentation to the Trust Board Workforce Committee from Professor Spurgeon, University of Warwick

Introduction

On 21 November the Workforce Committee heard a presentation about the Healthcare Engagement Scale for the London Ambulance Service, compiled by Professor Spurgeon from the University of Warwick. The HES report has been previously circulated to the Trust Board, discussed at Executive Leadership Team and with senior operational staff.

In April 2016 the Executive Leadership Team approved the London Ambulance Service using the University of Warwick’s healthcare engagement scale (HES) to measure the engagement of patient-facing staff in the different areas of the Service. NHSI have recommended HES in a number of NHS Trusts across England, over 100 have taken part. 653 LAS clinicians completed the HES survey in May 2016.

The University of Warwick’s research with NHS Trusts has consistently demonstrated, with national and international evidence, the direct link between the engagement of healthcare professionals and organisational performance and quality outcomes for patients. Professor Spurgeon’s work proves that real improvement in healthcare is cultural: it is about the day-today experience of our staff, and the quality of their interaction with their local managers.

The Service has a clear imperative to not only improve performance but also improve staff engagement; this has been re-enforced by a number of external and internal reviews e.g. CQC report, staff survey.

Our aim in using the HES was to:

- measure the engagement levels of our patient-facing staff in specific areas, so we could identify the different gaps in each area, and then support local managers to take the right local action.
- give managers the information and local intelligence they need to engage their workforce to improve delivery of the Quality Improvement Plan plan (now branded as Making the LAS Great).
- give the organisation a more accurate indication of the engagement levels of patient-facing staff and a bench-mark of an initial survey so we can measure progress into the future.

How did we do it at LAS?

The Healthcare Engagement Scale was in the form of a short survey. The results have shown us a hierarchy of engagement scores around organisational engagement and individual engagement. These are in three sections:

- **Collaboration - working in a collaborative culture**
- **Commitment - having purpose and direction**
- **Satisfaction - feeling valued and empowered**

The questions were around the everyday experience of staff at work and how they are engaged on a day-to-day basis. Below are some sample questions that clinical staff were asked to grade from *strongly agree*, to *strongly disagree*.

- I don't mind useful feedback about my about my performance at work
- There are few opportunities to properly share opinions or ideas
- I am able to personally initiate positive changes at work
- I feel my personal values are sometimes not supported at work
- I feel my personal contribution is appreciated and properly valued
- I find it difficult to be fully honest or open about my own concerns at work
- Establishing relationships based on mutual trust is essential to my effectiveness
- I am given sufficient information to keep my performance on track

The staff groups we surveyed

Our seven sectors

TEAC, EMT, paramedics, clinical team leaders

EOC

EMD1, EMD2, EMD3, allocator, area controller

NHS 111

CQI advisors, clinical advisors, operations supervisors, team managers, call handlers

Central Ops/HART

HART: clinical team leader / supervisor, paramedic, EMT

Central Operations: clinical team leader, senior paramedic, paramedic, EMT

PTS/NETS

PTS driver , NETS / PTS ambulance person, PTS meet & greet, NETS /PTS coordinators, PTS planners, NETS/ PTS work based trainers, PTS operations mangers, PTS customer relations managers

The outcome: overview summary

653 members of staff completed the HES survey. The results of this current baseline HES engagement survey indicates that engagement levels of clinical staff are generally low and the report details which staff groups are more engaged than others, and on which particular HES engagement scales.

The results show that staff engagement is more dependent on staff role rather than staff location. It is clear there are many current shortfalls in clinical staff engagement and these findings will help us to improve this position. The HES survey result quantifies the extent of these challenges and we have now established a reliable and valid baseline. We can now monitor levels of engagement over time, and we have the potential to improve understanding of the causes and consequences of productive staff engagement.

- ***Clinical Team Leader/Supervisors*** were more highly engaged than other staff groups but need more practical support. This group were still generally less engaged than the external reference norms.
- ***Paramedic/Senior Paramedics*** were generally less engaged than those in the external reference norms. Team work is a key driver for them.
- ***EMT*** staff were generally very disengaged compared to those in the external reference norms.
- ***EAC/TEAC*** staff generally approached the moderate engagement rank. Team wise happier and their job satisfaction better, but don't feel committed to the Trust.

Comments in response to the open question: *What single change would you make to improve your working life?* frequently included the following staff concerns: Condition of Vehicles & Equipment, Rota

Arrangements & Shift patterns, Time Targets, Work-Life Balance and Training & Development. These findings are consistent with ELT's focus on: staffing issues, vehicle prep and mobile technology.

Progress has been made since the survey was completed

It is important to add that the survey was undertaken in May earlier this year, and the Operations Directorate are keen to emphasise that engagement of clinical staff has improved since then with an increase in PDR appraisals, Operational Workforce Reviews, CISO reviews, and the launch of the Making the LAS Great campaign at local level, as well as the corporate engagement arranged around Job Cycle Time. More Clinical Team Leaders have been appointed who engage with front-line staff, and there have also been huge efforts around engagement by clinical managers using virtual engagement tools like complex and corporate Facebook pages. In addition, some of the practical issues to make working life better for clinical staff have also been addressed particularly around vehicle preparation for example our Vehicle Make-Ready Pilot for ambulances is now being rolled out across the Service.

What can we learn from Trusts with high levels of clinical engagement?

Professor Spurgeon was clear to emphasise that challenged trusts and those with poor CQC ratings have one factor in common, and that is poor clinical engagement at local level. He emphasised that the organisations with high levels of engagement had these characteristics which he believed London Ambulance could learn from:

- Leadership stable, relationship oriented, leading by example
- Setting expectations, enforcing professional behaviour and firm decision-making
- Clarity of roles and responsibilities and empowerment
- A future-focused and outward-looking culture
- Attention to selection and appointment of the right clinicians to leadership and management
- Providing support, development and leadership opportunities
- Effective communication
- Promotion of understanding, trust and respect between clinicians and managers

Recommendation

This report outcome is consistent with the outcome of the NHSI clinical review and the CQC review findings. It should inform and influence all our work on action plans going forward and how local managers plan their local engagement from now on. This report has already influenced how we approached the Job Cycle Time project. We invited 100 staff to participate in a week-long programme to discuss and examine the issues and co-design actions plans going forward.

Following a presentation and discussion at the Workforce Committee with members, and invited guests of senior operational staff, it was agreed that the Director of Communications would work with the Director of Operations to develop a plan and approach for improving clinical engagement across the Service. It was

agreed that this plan should include short term and long term actions. Short term actions considered included reviewing how we use protected core skills refresher (CSR) training time, and looking at how we support managers in prioritising how they spend their time. In the longer term, it was proposed that the Executive Leadership Team consider investing in clinical engagement by protecting time for staff to meet with local managers and providing training for managers. Depending on how this was organised it could have an impact on operational performance so would need careful consideration and planning. However, the longer term benefits based on the Professor's research, would indicate that high clinical engagement would lead to improved performance and patient care for the Service. A plan will be agreed by operations and ELT and will come back to the Workforce Committee and the Board in January.

Charlotte Gawne
Director of Communications

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Report from the Audit Committee on 7th November 2016**
Report Author(s):	**John Jones, Non-Executive Director and Chair of the Audit Committee**
Presented by:	**John Jones**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**Assurance report from the Audit Committee meeting held on 7th November 2016**
Status:	**Assurance report from the meeting held on 7th November 2016 and approval of a) the Charitable Fund Annual Accounts 2015/16 and b) the appointment of Ernst & Young for the Trust's External Audit Service.**

Background/Purpose

The purpose of this report is to update the Trust Board on the key items of discussion at the Audit Committee meeting on 7th November 2016. The Committee is also recommending the following to the Trust Board for approval:

- Charitable Funds Annual Accounts and Annual Report 2015/16.
- The appointment of Ernst & Young for the Trust's External Audit Service.

Action required

The Trust Board is asked to take assurance from the report of the Audit Committee meeting on 7th November 2016 and to approve the Charitable Funds Annual Accounts and Annual Report 2015/16 and the appointment of Ernst & Young for the Trust's External Audit Service.

Key implications

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 in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	**Assurance on financial systems and controls**
Workforce	
Governance and Well-led	**Assurance on risk systems and processes**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

Report from the Audit Committee on 7th November 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 2016/17 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. It is evident that progress has been made with managing and mitigating the high level risks and the Audit Committee has seen a reduction in the number of BAF risks this year.

The Committee received a report that one clinical risk had been added to the BAF since the last meeting at a rating of 15 and this reflected growing risk identified by incident reporting and serious incident review. Risk 33 on cyber security had been removed from the BAF and the Committee received an assurance report on this issue.

The Committee considered the risk appetite statement, particularly with regard to the longstanding BAF risks 4 and 7 regarding operational performance, however it was confirmed that the Director of Operations was running an operations risk workshop later in the week and it was anticipated that these two risks would be updated. It is hoped this will be reflected in the BAF to the November Board.

A report was given on the Trust Risk Register which included risks score >10 from local risk registers and that had been approved by the Risk Compliance and Assurance Group (RCAG), and those raised locally but that have not yet been reviewed by RCAG which meets monthly. There was discussion about the status report on local risk registers and assurance that there are registers in place across the Trust with support being given to managers through drop-in sessions and a designated contact from the Governance and Assurance team.

KPMG were undertaking an internal audit of local risk registers within Operations and the report is due for review at the next Audit Committee meeting in February 2017.

Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation
The Committee received the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation and heard that the financial sections of the Scheme had been re-worked and separated from the general Scheme of Delegation. The Committee approved the financial Scheme of Delegation subject to some final amendments, and approved the Standing Orders and Standing Financial Instructions for recommendation to the Trust Board.

Single Tender Waivers
The Committee received a report on single tender waivers received since August 2016.

Policy for External Auditor Non-Audit Work
The Committee approved this policy.

NHS Protect Standards for Security Management
A progress report was given on the latest compliance position with the standards and it was noted that the position had improved significantly. The Chair of the Audit Committee had reviewed the progress report with the Director of Corporate Governance and the Local Security Management Specialist and was content with the reported position. Further work was being undertaken and would inform the report to the November Board.

FINANCIAL REPORTING

Year End Timetable
The Committee noted the 2016/17 year-end timetable which would lead to the annual accounts being approved by the Trust Board on 25th May 2017.

Charitable Funds Annual Accounts 2015/16
The annual accounts and annual report for 2015/16 were considered and approved for recommendation to the November Board.

INTERNAL AUDIT AND LOCAL COUNTER FRAUD

Internal Audit Progress Report

The Audit Committee heard that the fieldwork for the review of core financial systems had been completed and the fieldwork for the risk management review was underway. The scope for the reviews of CIPs and CQC action plan had not been started however discussions were underway with the lead directors. The review on Medicines Management had been completed and the report presented to the Committee. The review had concluded with an assurance rating of partial assurance with improvements required. A number of areas of good practice had been identified along with a number of areas for development and there were 7 recommendations from the report. Two high priority recommendations related to insecure storage of medicines and medical gases, and there were 3 medium priority recommendations. The Committee expressed disappointment at this position taking into account the focus during the past 12 months on improving medicines management.

Review of progress against Internal Audit recommendations
The Committee received an update on progress against recommendations and actions. It was noted that of 40 outstanding recommendations on the tracker, 17 were not yet due for completion. 8 high priority recommendations were overdue however the Committee heard that since the report was written 2 had been completed. A number of requests were being made for revision to dates and the Committee agreed to those presented in the report but expressed concern that, having previously seen good progress being made to complete recommendations, the number overdue had started to increase again. Management were following these up throughout the months and this report had given renewed focus on bringing these up to date.

Local Counter Fraud Specialist Progress Report
The Committee noted the progress report since 5th September 2016 and received an update on cases.

EXTERNAL AUDIT

External Audit gave a verbal update to the Committee on progress with the NAO report on VFM and on the IT strategy work undertaken on behalf of the Trust.

REPORTS FROM COMMITTEES

The Audit Committee noted the agenda for the forthcoming meeting of the Quality Governance Committee on 15th November 2016.

ANNUAL REVIEW OF THE EFFECTIVENESS OF INTERNAL AUDIT AND LCFS

The format for the review had been scoped and the Committee agreed this would be facilitated internally by the Director of Corporate Governance/Trust Secretary.

Date of next meeting: The next meeting of the Audit Committee is on 15th February 2017.

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Report from Audit Panel – Award of Contract provision of External Audit Services**
Report Author(s):	**Michael John /John Jones**
Presented by:	**Chair of Audit Committee**
Contact Details:	**Michael John Michael.John@lond-amb.nhs.uk 02077832747**
History:	**N/A**
Status:	**For approval**

Background/Purpose

The Trust currently uses Ernst & Young LLP (E&Y) to carry out its external audit requirements. E&Y were appointed external auditors to the Trust for two years following a tender run by Public Sector Audit Appointments Ltd. This covers the audit of the accounts for 2015/16 and 2016/17.

The Local Accountability and Audit Act 2014 ("the Act") replaced existing centralised arrangements for appointing auditors to health service bodies and allows them to appoint their own external auditor. The Act makes provision for the local public bodies to have auditor panels who will advise them on the selection and appointment of their auditor and maintaining an independent relationship with their auditor.

Trusts are required to have an Auditor Panel in place by March 2016 and to have appointed their external auditors by 31 December 2016.

An Auditor Panel was created by the Board in March 2016 to lead the tender process and agreed that the members of the Audit Committee would provide the panel membership. Representatives from, the Finance Team and the Procurement Team, as well as the Trust Secretary have also attended the meetings. The Chair of the Audit Committee was appointed Chair of the Auditor Panel. Three meetings of the Auditor Panel have taken place.

The Panel recommends that Ernst & Young LLP are re-appointed as the external auditors for the Trust.

Action required
The Trust Board are asked to approve the appointment of Ernst & Young LLP for the Trust's External Audit Service provision on the contractual basis outlined in the attached paper.
Key implications
N/A

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	Yes
Workforce	
Governance and Well-led	Yes
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	Yes
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

London Ambulance Service NHS Trust

Trust Board 29 November 2016

Award of Contract provision of External Audit Services

Introduction

The Trust currently uses Ernst & Young LLP (E&Y) to carry out its external audit requirements. E&Y were appointed external auditors to the Trust for two years following a tender run by Public Sector Audit Appointments Ltd. This covers the audit of the accounts for 2015/16 and 2016/17.

The Local Accountability and Audit Act 2014 ("the Act") replaced existing centralised arrangements for appointing external auditors to health service bodies and allows them to appoint their own auditor. The Act makes provision for local public bodies to have auditor panels who will advise them on the selection and appointment of their auditor and maintaining an independent relationship with their auditor.

Trusts are required to have an Auditor Panel in place by March 2016 and to have appointed their external auditors by 31 December 2016.

An Auditor Panel was created by the Board in March 2016 to lead the tender process and agreed that the members of the Audit Committee would provide the panel membership. Representatives from, the Finance Team and the Procurement Team, as well as the Trust Secretary have also attended the meetings. The Chair of the Audit Committee was appointed Chair of the Auditor Panel. Three meetings of the Auditor Panel have taken place.

Procurement process and value for money

Prior to going to tender, specification and assessment criteria were drafted and agreed by the Auditor Panel to ensure all of the requirements of the exercise were appropriately captured and prioritised.

The Auditor Panel reviewed a number of procurement options including:

- completing a full tender;
- completing a mini tender on an approved framework; and
- making a direct award under an approved framework.

The Auditor Panel believes that the current arrangements are working well, the existing price is very competitive and going to a full or mini tender would be a lengthy and time consuming process and is unlikely to produce a better result.

The current External Auditor has recently successfully completed the audit of the 2015/16 accounts with a plan being developed for 2017/18.It was felt important to build on this experience of working with the Trust rather than lose this knowledge The Panel also took into account the potential change of internal auditors (tendering process due in 2017/18) and the wish to avoid changing both auditors at the same time.

The Auditor Panel elected to make a direct award to E&Y under NHS SBS Internal/External Audit, Counter Fraud & Well Led Governance Review Framework; a direct award is permissible through this framework. This award is subject to meeting the specification requirements, resourcing requirements, passing the assessment and obtaining a reasonable price.

Evaluation

The Trust used the Institute of Chartered Accountants in Scotland external auditor assessment check list to evaluate the external auditor as well as the views of the Audit Committee and Trust Finance.

The external auditor selected passed the assessment and this confirmed the views of the Audit Committee and the Finance Department.

As part of the qualitative evaluation E&Y were able to demonstrate:

- An awareness of the strategic factors which would influence the Audit plan.
- A good working relationship with the Audit Committee and Trust Finance.
- Strong qualifications and relevant experience.
- Innovative potential added value opportunities.

The Trust believes it has achieved a competitive price at a fixed rate for three years. Due to the on-going NHS tendering exercise for external audit services the price quoted is deemed to commercial sensitivity at this time and will be treated as confidential. The price quoted will be disclosed in part 2 of the Trust Board meeting.

Recommendation

Following the procurement process approved by the Auditor Panel it is recommended to the Trust Board that the contract for the provision of External Audit Services is awarded to **Ernst & Young LLP**.

The Contract will be for a period of three years with the option to extend for a further two years and will be effective from 1 April 2017.

The Trust Board are asked to approve the appointment of Ernst & Young LLP for the Trust's External Audit Service provision on the contractual basis outlined above.

John Jones
Chair of Audit Committee

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Charitable Funds Annual Report and Financial Statements for 2015/16**
Report Author(s):	**Michael John**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andrew.Grimshaw@lond-amb.nhs.uk**
History:	**The Annual Report and Annual Accounts for 2015/16 were reviewed by the Charitable Funds Committee on 3rd November 2016, Audit Committee on 7th November 2016 and now require approval from the Trust Board for approval.**
Status:	**The Trust Board is asked to approve the Charitable Funds Annual Report & Annual Report for 2015/16.**

Background/Purpose

To present the London Ambulance Service NHS Trust Charitable Funds Annual Report and Annual Accounts for 2015/16 for approval.

As the corporate trustees of the LAS Charity, we have a statutory requirement to publish the Annual Report and Accounts in the required format.

The Annual Report has been drawn up in accordance with the Charities SORP 2005. The financial statements are in accordance with the Charities Act 2011. The Trust is required to submit the Charities' Annual Report and Annual Accounts to the Charity Commission on or before 31st January 2017.

Independent examination of the Charity Accounts

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in any material respect the requirements:
   - to keep accounting records in accordance with section 130 of the 2011 Act; and
   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

The full statement can be found on page 8 of the annual report and annual accounts.

The Charitable Funds Committee and Audit Committee have both reviewed and endorsed the accounts for approval by the Trust Board.

Action required

Approve the accounts as presented

Assurance

An independent review has been undertaken of these accounts.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	**Yes**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

LONDON AMBULANCE SERVICE CHARITABLE FUND

UNAUDITED ANNUAL REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2016

LONDON AMBULANCE SERVICE CHARITABLE FUND

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2016

Foreword

The Charity's annual report and accounts for the year ended 31 March 2016 have been prepared by the Corporate Trustee in accordance with the Statement of Recommended Practice by Charities (SORP FRS 102) as it applies from 1 January 2015, applicable UK Accounting Standards and the Charities Act 2011.

The Charity has a Corporate Trustee, the London Ambulance Service NHS Trust. The members of the Trust Board who served during the financial year were as follows:

Board Member	Designation within the Trust
Richard Hunt	Chairman (resigned 31st March 2016)
Heather Lawrence	Chairman (appointed 1st April 2016)
Fionna Moore	Chief Executive (acting to 23rd July 2015)
Jessica Cecil	Non Executive Director
Nicholas Martin	Non Executive Director
John Jones	Non Executive Director
Robert McFarland	Non Executive Director
Fergus Cass	Non Executive Director
Theo De Pencier	Non Executive Director
Andrew Grimshaw	Director of Finance
Jason Killens	Director of Operations (resigned 25th September 2015)
Paul Woodrow	Director of Operations (acting Director of Operations from 28th September 2015)
Fenella Wrigley	Medical Director (acting to 29 February 2016)
Zoe Packman	Director of Nursing & Quality

REFERENCE AND ADMINISTRATIVE DETAILS

The London Ambulance Service Charitable Fund (No 1061191) was entered on the Central Register of Charities on 7 March 1997. It is an NHS Special Purpose Charity.

Charitable funds received by the Charity are accepted, held and administered as funds for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

Trustee

The London Ambulance Service NHS Trust is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and also the law applicable to Charities which is governed by the Charities Act 2011.

The Board has devolved responsibility for the on-going management of the funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

This committee was formed on 7 March 1997 and the names of the people who served during the year as agent for the Corporate Trustee as permitted under regulation 16 of the NHS Trust (Membership and Procedures) Regulations 1990 and reports to the Board Members were as follows:

Heather Lawrence (Chairman)

Andrew Grimshaw (Director of Finance)

Michael John (Head of Financial Services)
Eric Roberts (UNISON representative)
Eddie Brand (UNISON representative)
Mercy Kusotera (Committee Secretary)

The Charitable Funds Committee normally meets once a year and the minutes of the meeting are received by the Trust Board in the public agenda. In addition a sub group of the Charitable Funds Committee meets on a regular basis to review grant applications for the quarter and financial performance of the fund.

Principle Charitable Fund Adviser to the Board

Andrew Grimshaw, Director of Finance, is the budget holder, who under a scheme of delegated authority approved by the Corporate Trustee, has day-to-day responsibility for the management of the Charitable Fund, and must personally approve, on behalf of the Corporate Trustee, all expenditure over £1,000 with an upper limit of £5,000 using his delegated authority.

Michael John, Head of Financial Services, acts as the principal officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

Principal Office

The principal office, which is also the registered office, for the charity is:

Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London SE1 8SD

Principal Professional Advisers

Bankers

Lloyds Bank plc.
City Office
Bailey Drive
Gillingham Business Park
Gillingham
Kent
ME8 0LS

Independent Examiner

Janet Dawson
Ernst & Young LLP
1 More London Place
London
SE1 2AF

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2016

STRUCTURE, GOVERNANCE AND MANAGEMENT

The charity has two funds, the Voluntary Responders restricted fund and the General Fund. The General Fund was established using the model declaration of trust and all the funds held on trust as at the date of registration were part of this fund. The Voluntary Responders Fund was launched in March 2012. This fund supports the work of volunteer lifesavers in the capital.

Members of the Trust Board and the Charitable Funds Committee are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. Non Executive members of the Trust Board are appointed by the NHS Appointments Commission and Executive members of the Board are subject to recruitment by the NHS Trust Board. The NHS Trust as corporate trustee appoints the Charitable Funds Committee to manage the charitable funds under delegated authority.

Newly appointed members of the Trustees Board and the Charitable Funds Committee receive copies of the standing orders which include the terms of reference for the Charitable Funds Committee.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources;
- Manage and monitor the receipt of income and support/guide any fundraising activities;
- Ensure that best practice is followed in the conduct of its affairs fulfilling all of its legal responsibilities;
- Ensure that the Investment Policy approved by the NHS Trust Board as Corporate Trustee is adhered to and performance is continually reviewed whilst being aware of ethical considerations; and
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The financial record and day to day administration of the funds are dealt with by the Finance Department of the London Ambulance Service NHS Trust whose address is given above.

Trustees' Responsibilities in the Preparation of Financial Statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England & Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing those financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles in the Charities SORP;
- Make judgements and accounting estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2016

The trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the governing document. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Risk Management

The major risks to which the charity is exposed have been identified and considered. They have been reviewed and systems established to mitigate those risks.

ACHIEVEMENTS AND PERFORMANCE

Partnership Working and Networks

London Ambulance Service NHS Trust and its staff are the main beneficiaries of the charity and is a related party by virtue of it being the Corporate Trustee of the charity. By working in partnership with the Trust, the charitable funds are used to best effect and so when deciding on the most beneficial way to use charitable funds; the Corporate Trustee has regard to the main activities and plans of the Trust. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of the fund.

OBJECTIVES AND ACTIVITIES

The Charity has the following objective:

Voluntary Responders Group

To apply the income, and at its discretion, so far as may be permissible, the capital to advance health, save lives and to promote the efficiency of ambulance services, and in particular, but without limitation by the promotion of volunteering within London Ambulance Service's geographical area of responsibility and in relation to its services.

General Fund

To apply the income, at its discretion, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the London Ambulance Service NHS Trust.

The Charitable Funds Committee have agreed that the main purpose of the general fund is to fund projects for the benefit of all employees of the London Ambulance Service NHS Trust.

The London Ambulance Service Charitable Fund is defined as a Public Benefit Entity. The Trustees confirm that they have given due consideration to the Charity Commission's published guidance on the Public Benefit requirements under the Charities Act 2011.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2016

ANNUAL REVIEW

Donations received by the Voluntary Responders Fund are applied to advance health, save lives and to promote the efficiency of ambulance services, particularly, but not limited to, the promotion of volunteering within the geographical area served by the London Ambulance Service.

Donations received by the General Fund in the past and currently are specifically given to thank ambulance staff. Hence, the main charitable activities undertaken by the fund are those which will benefit staff by providing goods and services that the NHS is unable to provide. Typical examples are grants towards improved facilities for staff at ambulance stations.

The charity received £150,000 from the Metropolitan Masonic Charity and £20,000 grant from the cabinet office to support the purchase of five Community Responder Vehicles. The vehicles will be donated to the London Ambulance Service NHS Trust (LAS) to support community responder teams in London. Due to the vehicles arriving at the end of March 2016, they were not donated to the LAS in the current financial year and appear as Stock on the balance sheet as at 31 March 2016.

Grant Making Policy

Each year applications are invited from any member of the London Ambulance Service. Based on their knowledge of the service, the Charitable Funds Committee agrees funding priorities and reviews the applications for quality and value for money.

FINANCIAL REVIEW

Reserves are needed to provide funds, which can be designated to specific projects to enable those projects to be undertaken at short notice.

The level of reserves are monitored and reviewed by the Corporate Trustee, on an annual basis (free reserves at 31 March 2016 were £19,000).

The net assets of the charity as at 31 March 2016 were £213,000 (31 March 2015: £23,000). Overall net assets increased by £190,000 due to net income of £190,000.

The main source of income of the charity is donations. Total incoming resources for the year were £192,000 (2014/2015: £28,000).

Expenditure totalled £2,000 during the year.

The charity has no employees so relies on the London Ambulance Service NHS Trust staff to review the appropriateness of grant applications. Each year the Charitable Funds Committee sets a budget and reviews income and expenditure against this budget on a quarterly basis.

Reserves Policy

The Trustee recognises its obligation to ensure that funds received by the charity should be spent effectively in accordance with the funds objectives. The charity's reserves comprise those funds freely available for its

general purposes. The reserves are held at a level that will enable the charitable fund to operate for a year. The charities hold reserves of £3,000 for this purpose.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2016

OUR FUTURE PLANS

The future plans for the London Ambulance Service Charitable Fund is to expand the Volunteer Emergency and Community First Responders schemes in order that more patients can benefit and also to continue to fund projects for the benefit of staff education and welfare.

The Responders Fund has been set-up to support the groups of volunteers that operate under the management of the London Ambulance Services First Responder department. These include community first responders, emergency responders, staff at public access defibrillator sites and members of the public that have received

The Group plans to maintain and more actively use their Just Giving website and hold a number of funding raising events over the coming year to procure additional and replacement vehicles to support resuscitation training in the community.

Signed: ……

Heather Lawrence, Chairman of the Trust Board on behalf of the Corporate Trustee

Date: ……

STATEMENT OF TRUSTEES' RESPONSIBILITIES IN RESPECT OF THE TRUSTEES' ANNUAL REPORT AND ACCOUNTS

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the income and expenditure for that period.

In preparing these financial statements, generally accepted practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at the time, and to enable the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the trustees:

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF THE LONDON AMBULANCE SERVICE CHARITABLE FUND

I report on the accounts of the London Ambulance Service Charitable Fund for the year ended 31 March 2016**,** which are set out on pages 9 to 20.

This report is made solely to the Charity's trustee, as a body, in accordance with section 149 of the Charities Act 2011 and regulations made under section 149 of that Act. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustee, as a body, for this examination, for this report, or for the statements made.

Respective responsibilities of trustee and independent examiner

The charity's trustee is responsible for the preparation of the accounts. The trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in any material respect the requirements:
   - to keep accounting records in accordance with section 130 of the 2011 Act; and
   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act

   have not been met; or
2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Janet Dawson
For and on behalf of Ernst & Young LLP
Chartered Accountants

London

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2016

	Note	2015-16 Unrestricted Funds £000	2015-16 Restricted Funds £000	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Income from:					
Donations and Legacies	3	11	11	22	28
Charitable activities	4	-	170	170	-
Total income		**11**	**181**	**192**	**28**
Expenditure on:					
Charitable activities	5	2	-	**2**	25
Total expenditure		**2**	**-**	**2**	25
Net income/ (expenditure)		**9**	**181**	**190**	3
Net movement in funds		**9**	**181**	**190**	**3**
Reconciliation of Funds					
Total funds brought forward		10	13	23	20
Total funds carried forward		**19**	**194**	**213**	23

The net movement in funds for the year arises from the charity's continuing operation. No separate statement of total recognised gains and losses has been presented as all such gains and losses have been dealt with in the statement of financial activities.

The notes at pages 12 to 20 form part of these accounts.

BALANCE SHEET AS AT 31 MARCH 2016

	Note	2015-16 Unrestricted Funds £000	2015-16 Restricted Funds £000	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Current Assets					
Stock	6	-	159	159	-
Cash at bank and in hand	7	21	194	**215**	26
Total current assets		**21**	**353**	**374**	26
Creditors: Amounts falling due within one year	8	2	159	161	3
Net current assets/ (liabilities)		**19**	**194**	**213**	**23**
Total assets less current liabilities		**19**	**194**	**213**	**23**
Total net assets		**19**	**194**	**213**	**23**
Funds for the charity					
Income Funds:	11				
Restricted fund		-	194	194	13
Unrestricted fund		19	-	19	10
Total charity funds		**19**	**194**	**213**	**23**

The accounts set out on pages 9 to 20 were approved by the Corporate Trustee on ……2016, and signed on its behalf by

Signed: ……

Heather Lawrence, Chairman of the Trust Board on behalf of the Corporate Trustee

Date: ……

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2016

	Note	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Cash Flows from operating activities:			
Net Cash provided by (used in) operating activities	9	189	8
Change in cash and cash equivalents in the reporting period		**189**	**8**
Cash and cash equivalents at the beginning of the reporting period	7	26	18
Cash and cash equivalents at the end of the reporting period	7	215	26

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

1. Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared, in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The financial statements have been prepared to give a 'true and fair' and have departed from the charities Accounts and Reports Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The trustees consider that there are no material uncertainties about the London Ambulance Service Charitable fund ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the London Ambulance Service Charitable Fund is a fall in income from donations but the trustees have arrangements in place to mitigate those risks.

This is the first year in which the financial statements have been prepared under FRS 102.

1.2 Reconciliation with previous generally accepted accounting practise

In preparing these accounts, the trustees have considered whether any reinstatement of comparatives was required to comply with FRS 102 and the Charities SORP FRS 102. No reinstatements were required although there has been a change in the analysis of governance costs and donation and legacies.

Governance costs: Previously, these had been separately analysed on the face on the statement of financial activity. Governance costs are now classified as a support costs and have been apportioned to charitable activities. There is no overall effect on the total expenditure for 2014/15 or 2015/16.

Reconciliation of reported expenditure

	Expenditure on charitable activities	Governance costs	**Total expenditure**
	£000	£000	**£000**
2016 expenditure as previously reported	-	2	2
Adjustment for the reappointment of governance costs	2	(2)	-
2016 expenditure as restated	**2**	**-**	**2**

Donations and Legacies

Donations and Legacies have been grouped together on the Statement of financial activities.

1.3 Funds Structure

Where the donor has provided for the donation to be sent in furtherance of a specified charitable purpose and has therefore created a legal restriction on use of the funds the income is allocated to a restricted income fund.

The remaining funds held by the charity are classified as unrestricted income funds. The expenditure of these funds is wholly at the trustee's unfettered discretion.

The major funds held under these categories are disclosed at note 11.

1.4 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three conditions can be met:

- entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- probable – it is more likely than not that economic benefits associated with the transaction or gift will flow to the charity; and
- measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms and conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before income is recognised as the entitlement condition will not be satisfied until this point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1.5 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

Confirmation has been received from the representative of the estate that the payment of the legacy will be made or properly transferred and once all the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimated amount receivable.

1.6 Resource expended and irrecoverable VAT

Liabilities are recognised as resources are expended as soon as there is a legal constructive obligation committing the charity to the expenditure. A liability is recognised where the charity is under a

constructive obligation to make a transfer of value to a third party as a result of past transactions or events. All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category.

a. Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity.

b. Charitable activities

Costs of charitable activities comprise all costs identified as wholly or mainly incurred in the pursuit of the charitable objectives.

Grants payable which are payments, made to third parties (including NHS bodies) in the furtherance of the charity's charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. Provisions are made where approval has been given by the trustee due to the approval representing a firm intention which is communicated to the recipient.

c. Allocation of support costs

Support costs are those costs that do not relate directly to a single activity. The support costs have been allocated against charitable activities.

d. Irrecoverable VAT

Irrecoverable VAT is charged as a cost against the activity for which the expenditure was incurred.

1.7 Stock

Stock is stated at the lower of cost and net realisable value.

1.8 Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

1.9 Cash at bank and in hand

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

1.10 Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to pay to settle the debt.

2. Prior Year Comparatives by type of fund

2a. Restricted funds – Statement of Financial Activity for the year ended 31 March 2016

	2015-16 £000	2014-15 £000
Income from:		
Donations and Legacies	11	7
Charitable activities	170	-
Total income	**181**	**7**
Expenditure on:		
Charitable activities	**-**	-
Total expenditure	**-**	-
Net income/ (expenditure)	**181**	7
Net movement in funds	**181**	**7**
Reconciliation of Funds		
Total fund brought forward	13	6
Total fund carried forward	**194**	13

Restricted funds – Balance sheet for the year ended 31 March 2016

	2015-16 Total £000	2014-15 Total £000
Current Assets		
Stock	159	-
Cash at bank and in hand	194	13
Total current assets	**353**	13
Creditors: Amounts falling due within one year	159	-
Net current assets/(liabilities)	**194**	**13**
Total assets less current liabilities	**194**	13
Total net assets	**194**	13
Funds for the charity		
Restricted fund	194	13
Total charity funds	**194**	13

2b. Unrestricted funds – Statement of Financial Activity for the year ended 31 March 2016

	2015-16 £000	2014-15 £000
Income from:		
Donations and Legacies	11	21
Total income	**11**	**21**
Expenditure on:		
Charitable activities	**2**	25
Total expenditure	**2**	25
Net income/ (expenditure)	**9**	(4)
Net movement in funds	**9**	**(4)**
Reconciliation of Funds		
Total funds brought forward	10	14
Total funds carried forward	**19**	10

Unrestricted funds – Balance sheet for the year ended 31 March 2016

	2015-16 Total £000	2014-15 Total £000
Current Assets		
Cash at bank and in hand	21	13
Total current assets	**21**	13
Creditors: Amounts falling due within one year	2	3
Net current assets/(liabilities)	**19**	**10**
Total assets less current liabilities	**19**	10
Total net assets	**19**	10
Funds for the charity		
Unrestricted income fund	19	10
Total charity funds	**19**	10

3. Income from donations and legacies

	2015-16 Unrestricted Funds £000	2015-16 Restricted Funds £000	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Donations from individuals	5	-	5	9
Corporate donations	-	11	11	5
Legacies	6	-	6	14
	11	**11**	**22**	**28**

There was a legacy of £5,594 received during the year (2014/2015: £13,638).

4. Income from Charitable Activities

	2015-16 Unrestricted Funds £000	2015-16 Restricted Funds £000	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Donation and Legacies	-	150	150	-
Grants	-	20	20	-
	-	**170**	**170**	**-**

The charity received £150,000 from Metropolitan Grand Lodge for the purchase of 5 Community Response vehicles.

The charity received £20,000 grant from the Cabinet Office to assist in the purchase of Community Response Vehicles.

5. Analysis of charitable expenditure

	Support costs £000	**2015-16 Total Funds £000**	2014-15 Total Funds £000
Staff welfare	2	2	25
	2	**2**	**25**

All grant applications are considered and approved by a sub group of the Charity Funds Committee on behalf of the Corporate Trustee.

The independent examiners remuneration of £2,026 (2014/2015: £3,000) related solely to the independent examination with no other work undertaken (2014/2015: £nil).
The charity has no employees.

6. Stock

	2015-16 Total Funds £000	2014-15 Total Funds £000
Stock	**159**	-
Total Stock	**159**	-

Stock consists of vehicles purchased from donations held by the charity before distribution to the beneficiaries.

7. Analysis of cash and cash equivalents

	2015-16 Total Funds £000	2014-15 Total Funds £000
Cash in hand	**215**	26
Total cash and cash equivalents	**215**	**26**

8. Analysis of Liabilities

	2016 Total £000	2015 Total £000
Amounts falling due within one year:		
Trade Creditors	159	-
Accruals	2	3
Total creditors	**161**	**3**

9. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2015-16 Total Funds £000	2014-15 Total Funds £000
Net income/ (expenditure) for the reporting period as per the statement of financial activities	190	3
	190	**3**
Adjustment for:		
(Increase)/decrease in stock	(159)	-
(Increase) decrease in debtors	-	3
Increase/(decrease) in creditors	158	2
Net cash provided by (used in) operating activities	189	8

10. Allocation of Support Costs and Overhead

Governance costs are those costs which relate to the day to day management of the charity. The governance costs are wholly charged against charitable activities.

11. Analysis of Charitable income funds

a. Restricted funds

	Balance 1 April 2015 £000	Resources expended £000	Incoming resources £000	Balance 31March 2016 £000
Voluntary Responders Fund	13	-	181	194
	13	**-**	**181**	**194**

Name of Fund	**Description, nature and purpose of the fund**
Voluntary Responders Fund	The objects of the restricted fund are to advance health, save lives and to promote the efficiency of ambulance services.

b. Unrestricted income funds

	Balance 1 April 2015 £000	Resources expended £000	Incoming resources £000	Balance 31March 2016 £000
General Fund	10	(2)	11	19
	10	**(2)**	**11**	**19**

Name of Fund	Description, nature and purpose of the fund
London Ambulance Service General Fund	The objects of the unrestricted fund are that it is available for any charitable purposes relating to the NHS at the absolute discretion of the trustees.

The general fund includes all donations for which the donor has not expressed any preference as to how the funds shall be spent.

12. Related party transactions

The London Ambulance NHS Trust is the corporate trustee of the charity.

During the year, none of the members of the Trust Board, senior NHS Trust staff or parties related to them were beneficiaries of the charity. Neither the corporate trustee nor any member of the NHS Board has received honoraria, emoluments or expenses in the year and the Trustee has not purchased trustee indemnity insurance.

The London Ambulance Service NHS Trust waived the annual administration fee of £2,500 in both the current and previous year.

13. Trustees' remuneration, benefits and expenses

The charity's trustees give their time freely and receive no remuneration for the work that they undertake as trustees.

14. Role of Volunteers

Volunteer Emergency Responders and Community First Responders, are activated alongside LAS employees to provide an additional response to life-threatened or seriously ill or injured patients. If they arrive before the LAS response they are able to provide emergency life support to the patient. For incidents when the volunteer arrives after an LAS solo responder, they have a vital role in providing trained support to the LAS responders, adding significant benefit to patient outcomes.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

London Ambulance Service Charitable Fund
220 Waterloo Road
London
SE1 8SD

XX November 2016

Ernst & Young LLP
Attn: David Riglar
One Cambridge Business Park,
Cowley Road,
Cambridge CB4 0WZ,
United Kingdom

Dear Sirs

This representation letter is provided in connection with your examination of the financial statements of the London Ambulance Service Charitable Fund ("the Charity") for the year ended 31 March 2016. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention:

a. which gives you reasonable cause to believe that in any material respect the requirements:

   - to keep accounting records in accordance with section 130 of the 2011 Act;

   and

   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

b. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor

necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as Trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

    - Additional information that you have requested from us for the purpose of the examination and

    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: XX November 2016.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal advisers.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Grants and Donations

1. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions during the period in the application of such income.

G. Transactions with Trustees

1. The trustees during the period have received no emoluments, pensions, benefits, or compensation for loss of office.

H. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

Yours Faithfully

Signed on behalf of the Trustees

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Board Assurance Framework and Trust Risk Register**
Report Author(s):	**Frances Field, Risk and Assurance Manager**
Presented by:	**Sandra Adams, Director of Corporate Governance/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Trust Risk Register and Board Assurance Framework current as at 18th November 2016**

Background/Purpose

Board Assurance Framework (BAF)

Three new risks have been added to the BAF since the September Trust Board and they are included in the attached iteration of the BAF:

- **BAF risk 36** - There is a risk that clinical staff will withhold defibrillation in cases of fine VF where defibrillation is indicated. Net rating catastrophic x possible = 15.
- **BAF risk 37** - There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth. Net rating major x almost certain = 20.
- **BAF risk 38** - There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/008 Controlled Drugs. Net rating major x likely = 16.

Three risks have been removed from the BAF since the September Trust Board and are not included in the attached iteration of the BAF:

- **BAF risk 33**: There is a risk that Trust systems are vulnerable to cyber attacks that could defeat industry standard firewalls and virus detection systems, resulting in loss of sensitive personal data and access to critical operational systems.
- **BAF risk 4 -** There is a risk that Service Performance may be adversely affected by the inability to match resources to demand (this risk has been superseded by BAF risk 37).
- **BAF risk 35** - There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead.

Trust Risk Register

The following risks have been reviewed by the Risk Compliance and Assurance Group added to the Risk Register since September 2016:

- **Datix ID 495** - Children involved in youth violence may suffer greater harm as a result of a

safeguarding referral not being made and appropriate help and support may not be provided by the local authority or other agencies as a result. Net rating moderate x likely = 12.

- **Datix ID 13** - There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement.

  This risk had already been raised as a local risk by the Governance and Assurance team and has now been proposed for escalation due to the impact this may have on the CQC re-inspection under Well-Led, to a net rating of major x possible = 12.

- **Datix ID 28** - There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule.
  This risk has been raised by the Legal Department and has a proposed net rating of major x possible = 12.

There has been a significant amount of activity across the Trust since the risk module on Datix was introduced in June this year. As a result there are a large number of risks that have been added to the system which now need to be reviewed by their areas, to establish whether they need to be included on the Trust Risk Register. The Governance and Assurance team have circulated these risks to the responsible Directors, with a request that these risks are escalated through the system as appropriate.

General update on Risk Management

Risk management training has now been provided to over 90% of managers who were identified by their departments to attend. Sessions are being set up with the remainder of staff yet to attend, which mainly comprise of new staff, staff who are on rotas which has made it difficult for them to attend previously and staff returning to work after a period of absence.

Status of Local Risk Management Practices

The Governance and Assurance team have been working with areas and directorates across the organisation to embed the risk management process within their areas. Each area has a designated contact from the Team to support them and feedback has been provided to them on their risk registers and they have been invited either to attend a drop-in session or a meeting to facilitate their risk discussions. Drop in-sessions have been set up by the Team to assist risk co-ordinators and managers and these will continue for the foreseeable future.

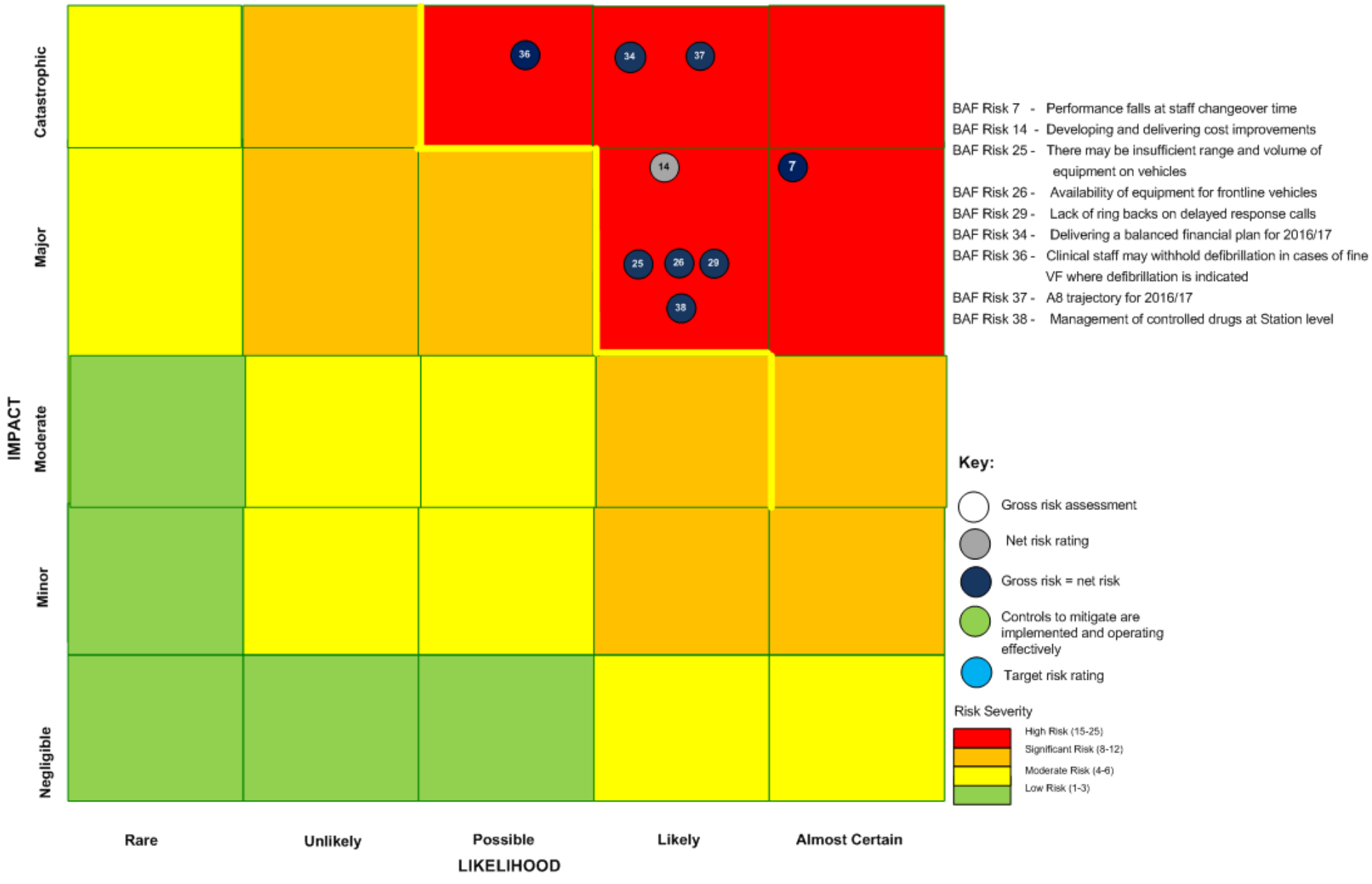
Risk Management - Internal Audit Review

KPMG have been reviewing specific areas as part of their review of local risk management procedures including sector services and operational review of risks on the Trust Risk Register and Board Assurance Framework. It is expected that there will be some recommendations coming out of this review, around ensuring the escalation process is clear both through Datix and communication required with the Governance and Assurance team to escalate risks to the Risk Compliance and Assurance Group. It is also expected that there will be a recommendation around dedication of more time to risk discussion at the Operations Division Quality Governance meetings to ensure there is sufficient time to review sector risks. Senior Operational Managers held a workshop to review their Trust level and strategic risks as well as to look at the risk management structure across sector services, and have put in place a revised governance framework to escalate risks through to the Operational Delivery Board. Therefore, although it is anticipated that this review will be given an amber/red rating, much of the work to address the recommendations has already taken place and is near completion.

Action required
To note the progress made with mitigating controls and actions for risks included in the Board Assurance Framework.
Key implications
The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives.

Key implications and risks arising from this paper	
Clinical and Quality	One new clinical risk added to the BAF and one risk relating to medicines management also added.
Performance	One new performance risk added to the BAF with one removed following review. The new risk better articulates the current position for the Trust.
Financial	Two high level risks relating to finance remain on the BAF.
Workforce	One BAF risk relating to potential industrial action has been reviewed and downgraded.
Governance and Well-led	The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives. One risk escalated to the Trust risk register regarding the BAG and risk.
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	Yes
Achieving Good Governance	The Trust Risk Register and Board Assurance Framework provide the Trust Board with information on how the organisation is currently managing its risk and provides an opportunity for scrutiny and escalation where required.
Improving Patient Experience	Yes
Improving Environment and Resources	Yes
Taking Pride and Responsibility	Yes

Board Assurance Framework – November 2016



BAF risks matched to Quality Improvement Plan 4: Improving Environment and Resources

Risk ID: 14	Description:	Risk opened:	20/06/2016
	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.	Expected risk closure:	N/A
Linked Risk(s): 217		Is this risk on track for closure?	N/A
	Risk Owner: Director of Finance	Please note Trust wide finance risks will not close as they are systemic and recur on an annual basis. However, actions will be reviewed and refreshed annually to reflect new pressures and situations	

Low Risk	Medium Risk				High Risk			
<=6	8	9	10	12	15	16	20	25
T							G N	
Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
20	20	20	20	20	20	20	20	20

Risk ID: 25	Description:	Risk opened:	21/05/2015
	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care	Expected risk closure:	31/08/2017
Linked Risk(s): 121		Is this risk on track for closure?	Yes
	Risk Owner: Director of Finance	It should be noted that whilst implementation of a Make Ready system within LAS will mitigate significantly against this risk, it is felt that this risk will always be an underlying or residual issue for any ambulance organisation.	

Low Risk	Medium Risk				High Risk			
<=6	8	9	10	12	15	16	20	25
T						G N		
Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
16	16	16	16	16	16	16	16	16

Risk ID: 26	Description:	Risk opened:	21/05/2015
	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care	Expected risk closure:	31/08/2017
Linked Risk(s): 120		Is this risk on track for closure?	Yes
	Risk Owner: Director of Finance	It should be noted that whilst implementation of a Make Ready system within LAS will mitigate significantly against this risk, it is felt that this risk will always be an underlying or residual issue for any ambulance organisation.	

Low Risk	Medium Risk				High Risk			
<=6	8	9	10	12	15	16	20	25
T						G N		
Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
16	16	16	16	16	16	16	16	16

Risk ID: 34	Description:	Risk opened:	17/11/2015
	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.	Expected risk closure:	31/12/2016
Linked Risk(s): 214		Is this risk on track for closure?	No
	Risk Owner: Director of Finance	Please note Trust wide finance risks will not close as they are systemic and recur on an annual basis. However, actions will be reviewed and refreshed annually to reflect new pressures and situations	

Low Risk	Medium Risk				High Risk			
<=6	8	9	10	12	15	16	20	25
			T				G N	
Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
20	20	20	20	20	20	20	20	20

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

BAF risks matched to Quality Improvement Plan Work stream 3: Improving Patient Experience

Risk ID: 7	Description:	Risk opened:	08/12/2006
	There is a risk that at staff changeover times, LAS performance falls	Expected risk closure:	N/A
Linked Risk(s): 430	Risk Owner: Director of Operations	Is this risk on track for closure?	N/A
		Risk currently under review by the Director of Operations.	

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

Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
20	20	20	20	20	20	20	20	20

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

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

Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
16	16	16	16	16	16	16	16	16

Risk ID: 36	Description:	Risk opened:	28/07/2016
	There is a risk that clinical staff will withhold defibrillation in cases of fine VF where defibrillation is indicated	Expected risk closure:	31/03/2017
Linked Risk(s): 445	Risk Owner: Medical Director	Is this risk on track for closure?	No
		Pending the planning of future training / supervisory support for clinical staff.	

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

Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
20	20	20	20	20	20	20	20	20

Risk ID: 37	Description:	Risk opened:	14/11/2016
	There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.	Expected risk closure:	N/A
Linked Risk(s): 531	Risk Owner: Director of Operations	Is this risk on track for closure?	N/A

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

Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

BAF risks matched to Quality Improvement Plan Work stream 2: Achieving good governance

Risk ID: 38	Description:	Risk opened:	21/10/2008
	There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/008 Controlled Drugs.	Expected risk closure:	01/04/2017
Linked Risk(s): 289	**Risk Owner:** Medical Director	Is this risk on track for closure?	Yes

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

Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

BAF Risk no. 7 There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.

Risk Classification:

Risk Owner: Woodrow, Paul

Scrutinising Committee: Operational Delivery

Underlying Cause/Source of Risk: Roster configuration
Rest break arrangements
Increased OOS
High demand
Response model

Gross Rating	Current/Net Rating	Target Rating
20	16	8

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Daily monitoring of and focus on 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) 5. Working group initiated to review the rest break process however due to competing pressures minimal progress has been made so far **Gaps in Controls** 1. There is no allocation process to ensure loss is spread evenly across the day to manage impact 2. No current process 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 3. The Incident Management Desk is not open consistently 24/7 due to sub-optimal staffing and relies mainly on overtime to ensure staff cover	1. New Rotas in place since Q2 14/15. Modernisation Programme Board minutes and weekly tracking report 2. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits 3. Rota changes to be implemented **Gaps in Assurance** 1. There appears to be a relationship between the number of rest breaks allocated per day and out of service (OOS)rates at shift end. The more rest breaks that are given the higher the end of shift OOS and this is being looked into	**2122**	757 - Out of Service (OOS) Hub implemented. Central Support Unit (CSU)on PD33 deals with all OOS requests	Complete
		2123	Recruit additional frontline staff	Complete
		2125	Rest breaks to be reviewed	31/03/2017
		2124	Update skill mix model	Complete
		757	Out of service HUB implemented	Complete
		753	Agree the process for the rest break arrangements to be implemented.	Complete
		754	Recruiting frontline staff to 3169 by March 2016	Complete
		755	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	Complete
		756	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).	31/03/2016

Signed: McKenna, Peter **Date Reviewed:** 11/11/2016

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

Risk Classification:	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Finance & Investment Committee

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

Gross Rating	Current/Net Rating	Target Rating
20	20	6

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments. **Gaps in Controls** See actions to be taken	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee **Gaps in Assurance** None identified	**1111**	Review support and engage additional support to drive the CIP Programme.	Complete
		1112	Ensure all schemes have clear project plans, including evidence to support, milestone plans and are owned by project leads.	Complete
		1113	Embed all CIPs in budgets.	Complete
		1114	Review current benchmarking information.	Complete
		1115	Establish Management of CIP as key Function of Resource Committee	Complete
		1116	Ensure all CIPs have QIA in place that have been agreed with the Medical Director	Complete

Signed: Bell, Andy **Date Reviewed:** 18/11/2016

BAF Risk no. 25 There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care

Risk Classification:	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Fleet and Logistics Risk Review Group
Underlying Cause/Source of Risk: This was risk 442 on the old risk register		

Gross Rating	Current/Net Rating	Target Rating
16	16	6

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
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 6, A “core” equipment list for DCA & FRU has been defined and agreed 7, funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed 8, An equipment amnesty and physically review all stations and complexes for “retained” equipment has been undertaken 9, an new paper based VP VDI form has been introduced 10, Pilot to assess benefits of VP proposal carried out **Gaps in Controls** To be determined	1, Progress made in agreement of core equipment and further equipment amnesty. 2, Decontamination of equipment commenced. 3, Analysis of asset tracking systems being undertaken. **Gaps in Assurance** None	**498** **499** **607**	Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG Email Justin Wand to see if thinks this risk should be merged with 120	20/07/2016 20/07/2016 Complete

Signed: Davidson, Geoffrey **Date Reviewed:** 21/10/2016

BAF Risk no. 26

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

Risk Classification:	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Fleet and Logistics Risk Review Group
Underlying Cause/Source of Risk: This risk was 443 on the old register		

Gross Rating	Current/Net Rating	Target Rating
16	16	6

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1, Serial numbers on all re-usable equipment that can be accurately tracked. 2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role 8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 9, Current VP contract reviewed and any immediate changes are agreed 10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed 11, Pilot project in NE area to provide and resupply equipment store implemented. 12, Business case for the roll out of VP pan London has been agreed 13, Project board and working groups established. 14, Review of delivery standards completed 15, New KPIs reported through to QIP 16, Deep dive by QIP panel completed 17, Preparation of tender documents and standard commencing DEC2016 18, Contract variations being developed to increase scope of works to include FRU and NETS vehicles 19, Proposal developed for the implementation of a depot based make Ready managers and 2 Make Ready Operations Managers to oversee the delivery of the contractor, coordinate more effectively with Fleet Workshop managers and local operational management teams on a daily basis. 20, Additional equipment is being sourced to facilitate the roll out where needed. 21, Vehicle equipment being recovered pan Trust. To date £350K (Nov2016) 22, Implementation of 'managed stock' project across the Trust in line with VP roll out. 23, Approval of BC for new vehicles for delivery during 2017 **Gaps in Controls** Review of processes and controls in Logistics team Review of medical device registers Need for the development of a planned replacement programme for Medical equipment. Development of a process that records missing equipment via CSU (PD33). Approval of Fleet Strategy with aligned 'unit' equipment.	1, Clinical Equipment Group; 2, Asset tracking report; 3, VP reports; 4, VP Contract; 5, Equipment Process; 6, Project completion 7, Board reports and meeting minutes. **Gaps in Assurance** None	**501**	Email Justin Wand to see if thinks this risk should be merged with 121	Complete
		1801	Roll out Vehicle Preparation to rest of service	31/08/2017
		1802	Ensure adequate stocks of consumables and equipment are available to VP staff	31/08/2017
		1803	Fully develop equipment database reports to indicate where any equipment is missing	31/08/2017

Signed: Wand, Justin **Date Reviewed:** 18/11/2016

BAF Risk no. 29 — There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.

Risk Classification:	**Risk Owner:** Millard, Katy	**Scrutinising Committee:** Control Services Quality Meeting

Underlying Cause/Source of Risk: Availability of frontline resources
Availability of EOC staff
Demand

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Clinical Hub scrutiny of held calls 2. Ring back status monitors. 3. Redistribution of staff to ringback functions as required 4. On-going recruitment and retention activities 5. Operational Procedures on ring backs (OP23) 6. Exit messaging – worsening advice **Gaps in Controls** 1. On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high. 2. ORH report received due to go to ELT, identifies minimum of 31 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level. 3. Additional front line resources are required.(covered by BAF risk 265 and 388)	Hub activity report weekly (1) Watch Manager live monitoring (2) IDM handover report and call taking manager's log (3) Serious Incident types reported through Control Services **Gaps in Assurance** 1. ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staff	**2119** **1062** **1381** **1382** **2120**	Evaluation of the ringback function Evaluation of the ringback function ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing Control Services to provide a report to the ELT on how they can create further capacity within the in order to determine the specific number of additional staff required for the base line staffing level Delivery of EOC improvement programme (ringback process and desk realignment)	Complete Complete 31/03/2017 31/03/2017 31/03/2017

Signed: Watkins, Susan **Date Reviewed:** 11/11/2016

BAF Risk no. 34 — 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.

Risk Classification:	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Finance & Investment Committee

Underlying Cause/Source of Risk: Failure to achieve this will mean the Trust is in deficit and will see deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.

Gross Rating	Current/Net Rating	Target Rating
20	20	10

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles 2. Clear view on operational capacity required to deliver ambulance performance targets 3. Clear view of achievable productivity targets which support performance targets 4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered 5. Funding from CCGs is consistent with capacity, productivity and demand assessments 6. Other factors such as investment for CQC are clearly understood, and associated funding identified 7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered. 8. Inflationary pressures are understood and managed within the overall financial position 9. Capital investment plans and their revenue consequences are understood. **Gaps in Controls** See actions to be taken	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee **Gaps in Assurance** None identified	**1139**	Productivity: Develop a clear understanding of productivity and how it can be influenced and managed.	Complete
		1140	Funding: Appropriately funded contract in place with commissioners	Complete
		1141	All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan.	Complete
		1142	Efficiency targets have scoped, stress tested and clear plans are in place to deliver.	Complete
		1143	Capital investment plans, funding and associated revenue implications are defined and agreed.	Complete

Signed: Bell, Andy **Date Reviewed:** 18/11/2016

BAF Risk no. 36 — There is a risk that clinical staff will withhold defibrillation in cases of fine VF where defibrillation is indicated

Risk Classification:

Risk Owner: Wrigley, Fenella

Scrutinising Committee: Clinical Safety and Standards

Underlying Cause/Source of Risk: There have been a number of cases identified by telephone during clinical on-call and during attendance at resuscitation attempts where staff have identified VF but failed to deliver shocks as they have judged that the ECG demonstrates fine VF and their interpretation of current LAS guidance is that Trust policy is not to shock fine VF and to continue resuscitation until such time as the VF coarsens.

Gross Rating	Current/Net Rating	Target Rating
15	15	10

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
Recent revision of Trust internal Adult Advanced Life Support guidance to provide further advice and clarification around the management of fine VF CSR updates specifically addressing the need to provide prompt defibrillation in cases of VF with apparent signs of life. **Gaps in Controls** Revisions to Trust guidance are publicised via The Pulse and the information is available electronically. The Trust does not provide a means through which operational staff can access these documents remotely when deployed on frontline clinical duties. All staff should attend Core Skills Refresher training but a period of time will elapse before a critical mass of staff have undertaken this training.	Increasing numbers of monitor-defibrillator downloads are being obtained by Advanced Paramedic Practitioners and Clinical Team Leaders which will enable treatment of VF to be monitored. Records are maintained of staff attending CSR training. **Gaps in Assurance** Overall, the number of monitor-defibrillator downloads obtained as a proportion of the total number of resuscitation attempts within the Service remains relatively low.	**2128**	To monitor the incidences of VF arrests where there has been a delayed time to shock	31/12/2017
		1201	Increase number of defibrillator downloads to monitor trends	31/10/2016
		1200	Medical Bulletin - Management of ventricular fibrillation	Complete
		1228	CSR updated with revised training notes for current training schedule of CSR2016.2	Complete

Signed: Whitbread, Mark **Date Reviewed:** 20/10/2016

BAF Risk no. 37 — There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.

Risk Classification:	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Risk Compliance & Assurance Group

Underlying Cause/Source of Risk: Demand, productivity, financial constraints

Gross Rating	Current/Net Rating	Target Rating
20	20	12

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1.CCGs have been directed to develop action plans to reduce activity by 5% by 1st January 2017 2.Surge Plan 3.REAP 4.OOS hub 5.Clinical Hub 6.Dispatch on Disposition 240 seconds implemented on 4th October 2016 7.Static defib performance recovery group 8.Non-clinical vacancy freeze and financial controls implemented in order to target additional spending at operational capacity 9.Sickness management on-going 10.Removed cat C determinants from FRU **Gaps in Controls** None identified	NHSE regional oversight group monthly review (1) NHSI Performance oversight group monthly review (1) Strategic commissioning management board monthly review (1) Service Delivery Group (2, 3, 4, 9, 10) A&E Resource Group (9) **Gaps in Assurance** None identified	**2029** **2030** **2031** **2032** **2033** **2027**	JCT Programme Increasing NETS journeys Development of performance improvement programme (over-arching programme of recovery actions) Co-responding schemes full rollout across London (MPS / LFB) Increase operational in-post from 95% to 100% Undertaking review of MPS	31/01/2017 31/01/2017 02/12/2016 01/04/2017 29/09/2017 12/12/2016

Signed: McKenna, Peter **Date Reviewed:** 11/11/2016

BAF Risk no. 38 — There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/008 Controlled Drugs.

Risk Classification:

Risk Owner: Wrigley, Fenella

Scrutinising Committee: Medicines Management Group

Underlying Cause/Source of Risk: TRR 305

Controlled Drugs Incidents arising from poor adherence to policy
Inadequate infrastructure / facilities for robust management on Stations
Lack of staff understanding / awareness of controlled drug management importance.

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls

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 ELT and Trust Board
12. Meds mgt events for Station Group management teams ongoing.
13. Seconded paramedic for audit / information collation and staff engagement.
14. findings from unannounced MPS visits shared with DDO's and ADO's.
15. Medicines management update for CSR2016.1 has been completed.

Gaps in Controls

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 MPS unannounced visits outcome to be implemented by DDO and ADO.
4. Appoint LAS pharmacist
5. Perfect Ward electronic auditing system in development.

Positive Assurance of Controls

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

Gaps in Assurance

N/A

Further Actions		Due Date
1709	Review process for managing controlled drugs	28/02/2017
1213	Funding request for LAS pharmacist and subsequent recruitment to post	Complete

Signed: Whitmore, David **Date Reviewed:** 20/10/2016

ID	Description	Opened	BAF Reference:	Risk Subtype	Principal objectives	CQC Domain	Gross Impact	Gross Likelihood	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Action ID	Description	Responsibility (To')	Due date	Done date	Assurance	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Approval status
214	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.	17/11/2015	34	Finance	Theme 4: Improving environment and resources		Catastrophic	Likely	20	High	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.	Grimshaw, Andrew	18/11/2016	Catastrophic	Likely	20	High	1139 1140 1141 1142 1143	Productivity: Develop a clear understanding of productivity and how it can be influenced and managed. Funding: Appropriately funded contract in place with commissioners All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan. Efficiency targets have scoped, stress tested and clear plans are in place to deliver. Capital investment plans, funding and associated revenue implications are defined and agreed.	Paul Woodrow Andrew Grimshaw Andrew Grimshaw Andrew Grimshaw Andrew Grimshaw	31/12/2016 31/05/2016 31/05/2016 31/07/2016 31/07/2016	18/11/2016 02/09/2016 02/09/2016 02/09/2016 02/09/2016	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	Catastrophic	Unlikely	10	Significant	Final approval
217	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.	20/06/2016	14	Finance	Theme 4: Improving environment and resources		Catastrophic	Likely	20	High	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.	Grimshaw, Andrew	18/11/2016	Catastrophic	Likely	20	High	1111 1112 1113 1114 1115 1116	Review support and engage additional support to drive the CIP Programme. Ensure all schemes have clear project plans, including evidence to support, milestone plans and are owned by project leads. Embed all CIPs in budgets. Review current benchmarking information. Establish Management of CIP as key Function of Resource Committee Ensure all CIPs have QIA in place that have been agreed with the Medical Director	Andrew Grimshaw Andrew Grimshaw Andy Bell Andrew Grimshaw Andrew Grimshaw Andrew Grimshaw	31/12/2016 30/09/2016 31/10/2016 30/09/2016 30/09/2016 30/09/2016	18/11/2016 18/11/2016 18/11/2016 05/10/2016 18/11/2016 18/11/2016	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	Moderate	Unlikely	6	Moderate	Final approval
531	There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.	14/11/2016	37	Operational	Theme 3: Improving patient experience		Major	Almost certain	20	High	1.CCGs have been directed to develop action plans to reduce activity by 5% by 1st January 2017 2.Surge Plan 3.REAP 4.OOS hub 5.Clinical Hub 6.Dispatch on Disposition 240 seconds implemented on 4th October 2016 7.Static defib performance recovery group 8.Non-clinical vacancy freeze and financial controls implemented in order to target additional spending at operational capacity 9.Sickness management on-going 10.Removed cat C determinants from FRU	Woodrow, Paul	11/11/2016	Major	Almost certain	20	High	2029 2030 2031 2032 2033 2027	JCT Programme Increasing NETS journeys Development of performance improvement programme (over-arching programme of recovery actions) Co-responding schemes full rollout across London (MPS / LFB) Increase operational in-post from 95% to 100% Undertaking review of MPS	Paul Woodrow Nicholas Daw Paul Woodrow Kevin Bate Mark Hirst Pauline Cranmer	31/01/2017 31/01/2017 02/12/2016 01/04/2017 29/09/2017 12/12/2016		NHSE regional oversight group monthly review (1) NHSI Performance oversight group monthly review (1) Strategic commissioning management board monthly review (1) Service Delivery Group (2, 3, 4, 9, 10) A&E Resource Group (9)	Moderate	Likely	12	Significant	Final approval
430	There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	08/12/2006	7	Operational	Theme 3: Improving patient experience		Major	Almost certain	20	High	1. Daily monitoring of and focus on 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) 5. Working group initiated to review the rest break process however due to competing pressures minimal progress has been made so far	Woodrow, Paul	11/11/2016	Major	Likely	16	High	2122 2123 2125 2124 757 753 754 755 756	implemented. Central Support Unit (CSU)on PD33 deals with all OOS requests Recruit additional frontline staff Rest breaks to be reviewed Update skill mix model Out of service HUB implemented Agree the process for the rest break arrangements to be implemented. Recruiting frontline staff to 3169 by March 2016 Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015 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).	Paul Woodrow Paul Woodrow Paul Woodrow Paul Woodrow Kevin Bate Paul Woodrow Karen Broughton Paul Woodrow Paul Woodrow	29/07/2016 31/07/2017 31/03/2017 15/07/2016 15/07/2016 30/09/2016 15/07/2016 15/07/2016 31/03/2016	29/07/2016 31/03/2016 15/07/2016 15/07/2016 15/07/2016 15/07/2016 15/07/2016 15/07/2016	1. New Rotas in place since Q2 14/15. Modernisation Programme Board minutes and weekly tracking report 2. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits 3. Rota changes to be implemented	Major	Unlikely	8	Significant	Final approval
120	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care	21/05/2015	26	Fleet and Logistics	Theme 4: Improving environment and resources		Major	Likely	16	High	1, Serial numbers on all re-usable equipment that can be accurately tracked. 2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to	Grimshaw, Andrew	18/11/2016	Major	Likely	16	High	501 1801 1802 1803	Email Justin Wand to see if thinks this risk should be merged with 121 Roll out Vehicle Preparation to rest of service Ensure adequate stocks of consumables and equipment are available to VP staff Fully develop equipment database reports to indicate where any equipment is missing	Geoffrey Davidson Christopher Vale Christopher Vale Christopher Vale	20/07/2016 31/08/2017 31/08/2017 31/08/2017	25/10/2016	1, Clinical Equipment Group; 2, Asset tracking report; 3, VP reports; 4, VP Contract; 5, Equipment Process; 6, Project completion 7, Board reports and meeting minutes.	Moderate	Unlikely	6	Moderate	Final approval

121	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care	21/05/2015	25	Fleet and Logistics	Theme 4: Improving environment and resources		Major	Likely	16	High	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 6, A "core" equipment list for DCA & FRU has been defined and agreed 7, funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed 8, An equipment amnesty and physically review all stations and complexes for "retained" equipment has been undertaken 9, an new paper based VP VDI form has been introduced 10, Pilot to assess benefits of VP proposal carried out	Grimshaw, Andrew	21/10/2016	Major	Likely	16	High	498 499 607	Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG Email Justin Wand to see if thinks this risk should be merged with 120	Justin Wand Justin Wand Geoffrey Davidson	20/07/2016 20/07/2016 20/07/2016	21/10/2016	1, Progress made in agreement of core equipment and further equipment amnesty. 2, Decontamination of equipment commenced. 3, Analysis of asset tracking systems being undertaken.	Moderate	Unlikely	6	Moderate	Final approval
289	There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/008 Controlled Drugs.	21/10/2008	38	Clinical	Theme 2: Achieving good governance		Major	Likely	16	High	1. Policy reminder to be reinforced by bulletins from Director of Operations/Medical Director. 2. Independent audits to be carried out throughout the Trust. 4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 5. Daily audit checks 6. The policy itself defines individual responsibility 7. Area governance reports to CQSEC 8. Mandatory LIN reports to CCG 9. Unannounced visits by MPS 10. Annual attendance by MMG to AO update days 11. MMG reports to ELT and Trust Board 12. Meds mgt events for Station Group management teams ongoing. 13. Seconded paramedic for audit / information collation and	Wrigley, Fenella	20/10/2016	Major	Likely	16	High	1709 1213	Review process for managing controlled drugs Funding request for LAS pharmacist and subsequent recruitment to post	David Whitmore Fenella Wrigley	28/02/2017 30/11/2016	30/08/2016	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	Significant	Final approval
339	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.	28/02/2015	29	Operational	Theme 3: Improving patient experience		Major	Likely	16	High	1. Clinical Hub scrutiny of held calls 2. Ring back status monitors. 3. Redistribution of staff to ringback functions as required 4. On-going recruitment and retention activities 5. Operational Procedures on ring backs (OP23) 6. Exit messaging – worsening advice	Millard, Katy	11/11/2016	Major	Likely	16	High	2119 1062 1381 1382 2120	Evaluation of the ringback function Evaluation of the ringback function ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffin Control Services to provide a report to the ELT on how they can create further capacity within the in order to determine the specific number of additional staff required for the base line staffing level Delivery of EOC improvement programme (ringback process and desk realignment)	Graham Seamons Simon Harding Katy Millard Katy Millard Simon Harding	31/08/2016 19/08/2016 31/03/2017 31/03/2017 31/03/2017	22/08/2016 18/08/2016	Hub activity report weekly (1) Watch Manager live monitoring (2) IDM handover report and call taking manager's log (3) Serious Incident types reported through Control Services	Major	Unlikely	8	Significant	Final approval
279	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	04/04/2006		Clinical			Moderate	Almost certain	15	High	1. Mark Whitbread is the Trust lead for the defibrillator download 2. Card reading and transmission is performed by team leaders. - obselete contol, no card readers. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from defib downloads. 5.LP1000 AED's have been rolled out and all complexes have been issued with new defib downloads for these units. 6. New Malden pilot has trialled the transmission of data from the LP15. 7. Defib downloads are conducted by TL's and APP's via cables. 8. APP use of defib data download as normal practice.	Wrigley, Fenella	20/10/2016	Moderate	Almost certain	15	High	1216 1215	Review of IG issues with patient data transmissionvia bluetooth on ambulances / FRU's Funding request for Bluetooth download technology for all LP15's	Andrew Watson Mark Whitbread	31/12/2016 31/12/2016		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 plug 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	Moderate	Unlikely	6	Moderate	Final approval
445	There is a risk that clinical staff will withhold defibrillation in cases of fine VF where defibrillation is indicated	28/07/2016	36	Clinical	Theme 3: Improving patient experience		Catastrophic	Possible	15	High	Recent revision of Trust internal Adult Advanced Life Support guidance to provide further advice and clarification around the management of fine VF CSR updates specifically addressing the need to provide prompt defibrillation in cases of VF with apparent signs of life.	Wrigley, Fenella	20/10/2016	Catastrophic	Possible	15	High	2128 1201 1200 1228	To monitor the incidences of VF arrests where there has been a delayed time to shock Increase number of defibrillator downloads to monitor trends Medical Bulletin - Management of ventricular fibrillation CSR updated with revised training notes for current training schedule of CSR2016.2	Mark Whitbread Mark Whitbread Timothy Edwards Timothy Edwards	31/12/2017 31/10/2016 30/08/2016 31/10/2016	26/08/2016 20/10/2016	Increasing numbers of monitor-defibrillator downloads are being obtained by Advanced Paramedic Practitioners and Clinical Team Leaders which will enable treatment of VF to be monitored. Records are maintained of staff attending CSR training.	Catastrophic	Unlikely	10	Significant	Final approval

218	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.	10/04/2014	396	Finance	Theme 4: Improving environment and resources		Catastrophic	Likely	20	High	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.	Grimshaw, Andrew	18/11/2016	Major	Possible	12	Significant	1146 1147 1148	Update LTFM (full revision by end of Q3) Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan. Develop future CIP planning.	Andy Bell Andy Bell Andy Bell	23/12/2016 23/12/2016 23/12/2016		Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	Moderate	Unlikely	6	Moderate	Final approval
286	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.	14/11/2002		Clinical			Major	Almost certain	20	High	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 LAS2'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	Wrigley, Fenella	20/10/2016	Major	Possible	12	Significant	1210 1211 1212	Present K2 Obstetric Emergency Training software as an alternative to current POET online training. Maternity simulations Maternity Screening Tool training	Amanda Mansfield Amanda Mansfield Amanda Mansfield	31/12/2016 31/10/2016 31/10/2016	28/10/2016	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 5. Obstetric emergency decision tool has been issued to all front line staff new entrant / CSR 2016.2. 6. Obstetrics emergencies clinical update article written and will appear in the next clinical update magazine 7. Birthing Sim-manikin ordered and training is planned for January with nominated clinical tutors from around London. 8.Maternity care update articles in the Clinical Update to be completed for March 2016. 9. CSR2016.2 maternity update training (2 hour session) is in progress (end Nov 2016) to all	Major	Possible	12	Significant	Final approval
288	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients.	14/11/2002		Clinical			Major	Almost certain	20	High	1.Monitor level of CSR training and delivery. 2. CPIs are used to monitor the standard of assessments provided. 3. LAS2 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	Wrigley, Fenella	20/10/2016	Moderate	Likely	12	Significant	1206 1207 1208 1209	Core Skill Fresher Training 2016/17 2. Design processes to audit and monitor the effectiveness of the pathfinder tool. 3. Development of the clinical career structure. New risk to be submitted to SMT/ELT to reflect current clinical risk for ongoing clinical supervision.	Tina Ivanov Jaqualine Lindridge Timothy Edwards Neil Thomson	31/03/2017 30/11/2016 31/01/2017 31/10/2016	03/11/2016	CPI reports OWRs CSDEC EMT/TB reports Learning from Experience	Moderate	Possible	9	Significant	Final approval
108	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 jeopardised continuous CQC registration.	08/10/2014		Health and Safety			Major	Likely	16	High	1, Education - embedded cleaning standard into LAS daily practice - induction, CSR Training content revised to raise awareness of need for equipment to be cleaned after each use by correct use of wipes and correct cleaning method 2, IPC arranged visit with Logistics to a third party decontamination service provider (Essentials) in March 2014 with a view to a one off clean of the Ambulance equipment and setting up a regular service. 3, Third party decontamination service for A&E equipment and soiled equipment by St Thomas' hospital 4There is now a proper process in place to collect and clean equipment left at hospitals. The management of Medical Devices policy now sits with the Clinical Equipment Working Group. Also the method of cleaning medical equipment should be in the	Grimshaw, Andrew	25/10/2016	Major	Possible	12	Significant	352 493 494	IPC Taskforce 19/08/15 KM/EH/FF to review and amalgamate risks 411 and 326 The management of Medical Devices Policy needs to include the Decontamination process, be finalised and communicated to front line staff on the arrangements both in and out of hospital IPC training for logistics drivers	Karen Merritt Karen Merritt Gordon Ballard	23/06/2016 20/07/2016 20/07/2016	23/06/2016 25/10/2016	1, Decontamination lead to oversee and report to IPCC quarterly 2, Policies: Management of Medical Devices Policy, Decontamination Policy 3, Third party decontamination service, Pam London framework 4, Quarterly monitoring at IPCC	Major	Unlikely	8	Significant	Final approval
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands	10/06/2016		Fleet and Logistics	Theme 4: Improving environment and resources		Major	Likely	16	High	1, Forward view of fleet requirement for next 5 years 2, Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that unplanned maintenance levels do not adversely affect fleet capacity and the provision of safe environment to operational staff 3, Ensure capital investment is committed to support fleet volume and replacement 4,External/stakeholder support in place as required 5, Maintain a capacity plan base 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 8, 140 new vehicles agreed 9, DCA and FRU specification	Grimshaw, Andrew	27/10/2016	Major	Possible	12	Significant	489 490 491 1800	Review case to retain ambulances following introduction of 140 new vehicles Retain 20 FRU cars to increase size of fleet to 180 Review additional ambulance capacity to support roll out of new Vehicle Preperation Scheme Delivery of 140 new vehicles throughout 2017	Justin Wand Christopher Vale Christopher Vale Justin Wand	20/07/2016 20/07/2016 20/07/2016 30/11/2017	25/10/2016 25/10/2016 25/10/2016	1, forward view of fleet requirements 2, Plan in place to move current fleet to under 7 years 3, Capital investment requirement understood and reflected in LTFM 4 vehicle specification in place 4, Vehicle specifications in place.	Moderate	Possible	9	Significant	Final approval

117	There is a risk that the equipment for front line vehicles may not be properly maintained. This may result in clinical failure due to faulty equipment	21/05/2015		Fleet and Logistics	Theme 4: Improving environment and resources		Major	Likely	16	High	1,Replacement equipment budgets in place, process agreed and adhered to. 2, Maintenance/Replacement of kit undertaken when required 3, Process for maintenance of equipment reviewed 4, asset database showing maintenance records	Grimshaw, Andrew	27/10/2016	Major	Possible	12	Significant	497 1774	Clarify the risk and totally review Roll out of vehicle preperation project	Christopher Vale Christopher Vale	20/07/2016 31/08/2017	25/10/2016	Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet Reports and OOS reports	Moderate	Unlikely	6	Moderate	Final approval
273	LAS will not be in a position to win new NHS Integrated Urgent Care (IUC), ie 111/OoH contracts as stated in the 5-year strategy.	20/06/2016		Corporate			Major	Likely	16	High	1.Interim Bid team required: current activities include gathering information on service requirements, understanding expected service models, i.e IUC implementation. 2.Contract meetings with SEL CCG maintain local relationship 3.BD monitoring market to review local opportunities, gather intelligence around commissioning requirement and competitors 4.Long list of Out of Hours (OoH) 'partners' drawn up and reviewed against capability and suitability to provide 5.Legal advice being sought around 'partnership arrangement' set up and management Update: 6.Regular updates on remaining	Broughton, Karen	21/10/2016	Major	Possible	12	Significant	2055 2056 2057 2053 2054	Bid for new 111 services as opportunities arise Local engagement IUC model would require LAS to partner with provider(s), a broad review of potential OoH providers has been undertaken to identify suitable partner(s) Understanding of opportunities and the timeframes for tendering opportunities established through market research structure / process – this monitors all 111 and Out of Hours procurement activity, i.e. IUC model Work with CCGs to influence 111 system development across London	Jo Nightingale Katy Millard Jo Nightingale Jo Nightingale Jo Nightingale	31/03/2018 31/03/2018 31/03/2018 31/03/2018 31/03/2018		1. Interim Bid team established: (a) Established monitoring of market place/ on-going intelligence gathering; (b)Indicative procurement time lines for bids across London monitored; (c) Interim Local delivery team engaged to prep/ plan bid submission; (d) Stakeholder feedback on LAS as a provider of 111 services 2. ELT updates on NHS111 bid process, opportunities and progress 3. Update reports to FIC and Trust Board where required	Moderate	Unlikely	6	Moderate	Final approval
291	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.	12/02/2014		Clinical			Major	Likely	16	High	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 regularly 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."	Sloper, Briony	25/10/2016	Major	Possible	12	Significant	1879 1880 1881	CHUB CTL's to process new CMC flags over weekends. CMC email to ooh.las@nhs.net unnecessary. Create new archives nhs.net email address. LAS and CMC to meet to discuss possibility of records being added directly to command point	Karen MacDonald Marie Fennell Karen MacDonald	17/11/2016 10/11/2016 10/11/2016	08/11/2016	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	Significant	Final approval
302	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system. NOTE: Risk ID 205	01/06/2005		Governance			Major	Likely	16	High	1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc. 2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system	Ivanov, Tina	18/11/2016	Major	Possible	12	Significant	2110 2111 2112	Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting	Jessica Cruz-Esteves Tina Ivanov John Hailstone	02/12/2016 23/12/2016 09/12/2016		Manager Governance responsible for: 1) Records are stored safely and securely, are identifiable and easily accessed, and meet all records management policies. 2) Records are archived in a timely manner as per Information Governance policy	Major	Unlikely	8	Significant	Final approval
380	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.	11/06/2014		Information Governance			Major	Likely	16	High	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies. 3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available.	Watson, Andrew	16/11/2016	Major	Possible	12	Significant	612 613 614 615	1. The current MDT software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 & 3. 2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above. 3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process. 5. Obtain 2nd hand SatNavs from other Trusts.	John Downard John Downard John Downard John Downard	30/11/2016 30/10/2015 30/12/2016 31/12/2015	12/10/2015 31/12/2015	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 outweigh the volume of units required. In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles.	Major	Rare	4	Moderate	Final approval
420	420/BAF33 There is a risk that Trust systems are vulnerable to cyber attacks that could defeat industry standard firewalls and virus detection systems, resulting in loss of sensitive personal data and access to critical operational systems.	01/07/2016	33	Information Governance	Theme 4: Improving environment and resources		Major	Likely	16	High	1.Enterprise antivirus monitoring all desktops 2.Enterprise grade firewall on external facing ports 3.Email system scanning for viruses and malware 4.File on access scanning for viruses and malware 5.Desktop ports disabled (i.e. USB, DVD) 6.Web filter scans for viruses and malware 7.No access to internet/ email for command and control desktops 8.Air-gapped DMZ for external facing services 9.Automated patch management, including for non MIcrosoft 10.Strength in depth, layered security architecture	Watson, Andrew	18/11/2016	Major	Possible	12	Significant	624 625 626 627	Implement Firewall between CAC and LAS corporate Networks Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed. RCAG approval of report and format Additional information, such as patches applied / outstanding to be included in subsequent reports	Robert Clifford Victor Wynn Victor Wynn Victor Wynn	31/12/2016 01/04/2016 31/10/2016 01/04/2016	01/04/2016 01/04/2016	1.IM&T daily monitoring 2.Firewall patched and malware detection software kept up to date. 3.Detected intrusion instances reported to IGIST and IGG 4.Detected and treated virus manifestations instances reported to IGIST and IGG 5.Anti-virus software updated at least daily. 6.Firewall and anti-virus software subject to formal change control 7.Firewall and anti-virus software on the daily IM&T assurance process	Major	Unlikely	8	Significant	Final approval

431	There is a risk that... the LARP2 project will not deliver its main objectives (of implementing the new ESN based radio system in the control room, all LAS operational vehicles and other key areas before Jan 2020 when the current LAS contract with Airwave Ltd. expires). This will result in the Trust not being able to deliver an adequate accident and emergency service.	05/07/2016		Operational	Theme 4: Improving environment and resources		Major	Likely	16	High	Project board set up and meeting monthly, pan Trust representation. Close working relationship with National programme for replacement of Airwave (ARP); represented on the LAS' project board. Project governance in place i.e. risk and issue logs etc. National programme risks are being managed by DH and HO project teams Increased level of Project Management - additional team members to be recruited to assist in the management of this programme.	Watson, Andrew	05/10/2016	Major	Possible	12	Significant	762	Sufficient resources being available to the Project to deliver the internal changes that will be required as/when the national programmes have delivered the new ESN and different frameworks	Andrew Watson	02/07/2018		Project board established, meeting regularly. Its terms of reference reviewed in December 2015 and amended to include requirement of 75% attendance by the project board members. Close working relationship with the national programme and attendance at Pan London ES monthly meetings to ensure that risks/issues relating to London are fully understood. Representation on the national ARP board (VW); representation from the national programme on the LAS' project board (RC & CL).	Major	Unlikely	8	Significant	Final approval
433	Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable.	15/07/2016		Finance	Theme 1: Making the LAS a great place to work, Theme 2: Achieving good governance, Theme 3: Improving patient experience, Theme 4: Improving environment and resources, Theme 5: Taking pride and responsibility		Major	Likely	16	High	•• Indicative costs have been identified by each of the project workstreams, and will form the basis of contract discussions with Commissioners which is currently underway. However these costs may be subject to change as projects progress delivery of activities, and the outcome following option appraisals may require funding that was not known at the outset	Grimshaw, Andrew	17/11/2016	Major	Possible	12	Significant	2129	take risk to Risk Compliance and Assurance Group for approval for archiving.	Frances Field	15/12/2016		ELT have considered all requests for funding, and prioritised these into a funding bid to Commissioners. • Exec discussions with lead Commissioner and SRG leads are ongoing. • Programme finances will be a regular agenda item to be reviewed by ELT and QIP Board	Moderate	Possible	9	Significant	Final approval
438	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection in particular with regard to returned equipment from EDs which does not have an identified process for decontamination	17/05/2010		Fleet and Logistics			Major	Likely	16	High	1, introduction of single use items 2, improved cleaning programme for equipment on vehicles 3, Detergent and disinfectant wipes for equipment being used	Grimshaw, Andrew	27/10/2016	Major	Possible	12	Significant	1804 1805	contract subject matter expert ot write draft policy consider , approve and issue policy	Karen Merritt Neil Thomson	13/07/2016 30/12/2016	27/10/2016	1, Policy approved and implemented 2, Area governance meetings 3, Incident reports	Minor	Unlikely	4	Moderate	Final approval
469	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.	11/02/2015	433	Corporate	Theme 1: Making the LAS a great place to work, Theme 5: Taking pride and responsibility		Major	Likely	16	High	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. Operational restructure will improve engagement with line managers. 3. Quality Improvement Programme Governance Structure in place.	Gawne, Charlotte	18/10/2016	Major	Possible	12	Significant	1697 1695 1696	Line managers to be set engagement objectives Communication audit to evaluate internal comms and engagement Hold regular managers' conferenes	Fionna Moore Alexander Bass Alexander Bass	30/04/2017 30/04/2017 30/04/2017		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	Significant	Final approval
470	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	11/02/2015		Corporate	Theme 1: Making the LAS a great place to work		Major	Likely	16	High	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.	Gawne, Charlotte	18/10/2016	Major	Possible	12	Significant	1690 1691 1692 1693 1694	Work with local stakeholder engagement managers Participate in weekly ADO call Introduce local stakeholder bulletin Support local leads Design process for local stakeholder feedback and reporting	Fiona Claridge Fiona Claridge Fiona Claridge Fiona Claridge Fiona Claridge	31/03/2017 31/03/2017 31/03/2017 31/03/2017 31/03/2017	18/10/2016 18/10/2016 18/10/2016 18/10/2016	To be confirmed	Major	Unlikely	8	Significant	Final approval
20	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. TRR 462	27/01/2016		Governance	Theme 2: Achieving good governance		Moderate	Almost certain	15	High	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 4.Call centre 8am-8pm in place from 28/6/16 for incident reporting 5. Deployment of Datixweb across the LAS now complete 6. Health Safety and Risk are being tasked with bringing down the backlog of incidents reported being added to Datix. BAcklog currently less than a week and Datixweb is live. _ consider this closed 7. Benchmark level of Serious Incident reporting against other ambulance services – results shared with EMT and Quality	Adams, Sandra	16/11/2016	Moderate	Likely	12	Significant	2133 438 439	Take risk to the Risk Compliance and Assurance Group on 15/12/16 with a proposal to close the risk. Launch of EBS call centre for Datix incdient reporting NRLS submission report to be shared with the Governance Department and Quality Governance Committee. Second 6 month submission for 2015/16 was made on time	Frances Field Peter Nicholson Andy Batters	15/12/2016 28/06/2016 29/07/2016	28/06/2016 08/08/2016	The Trust has submitted its NRLS data on time for the last two submission dates. Datixweb also puts harm level at the centre of incident reporting.	Moderate	Rare	3	Low	Final approval

112	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	07/05/2013		Fleet and Logistics			Moderate	Almost certain	15	High	1, Laundry contract in place for blankets 2, some local arrangements for use of sheets at hospitals 3, Additional capacity for reusable/disposable blankets in store 4, Single use couch rolls in place 5, Single use trolley cover has been sourced and the IPC taskforce and the QIP Blanket group approved it for the trial.	Grimshaw, Andrew	27/10/2016	Moderate	Likely	12	Significant	502 503 504 505 506 1799	Options paper to be prepared by K. Merritt to be taken forward to SMT and EMT for discussion and decision on plan of action Options paper has been considered by blanket group and it has been agreed that the best option is using hospital blankets, formalising what is already happening in many areas. This is the system used by other ambulance trusts. set up a Trial using hospital blankets at 2 sites (to be confirmed). Agreements to be put in place with hospitals Single use trolley cover has been sourced, this will be presented to IPC Taskforce in March and CEWG (next meeting) and VWG (April 16)by KM and CV Costs paper to be written Confirm future plan for blanket management	Karen Merritt Daniel Law Daniel Law Karen Merritt Karen Merritt Donia Harker	20/07/2016 20/07/2016 20/07/2016 20/07/2016 20/07/2016 25/11/2016	25/10/2016 31/05/2016	None in place	Minor	Unlikely	4	Moderate	Final approval
230	RISK 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 which may affect the care they receive.	22/07/2015		Corporate			Moderate	Almost certain	15	High	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. 3. A National section 136 Protocol was introduced in 2014 and adapted to LAS.	Sloper, Briony	21/10/2016	Moderate	Likely	12	Significant	1729 1731 1732 1733 1734	Review of current mental health protocols and alternative resources specifically guidance relating to control room management of people detained under section 136. Review for transport arrangements for detained people in collaboration with NHS England and Brent CCG. The LAS will amend the Memorandum of Understanding with the MPS to detail the information required from the police for Section 136 calls Updated section 136 protocol to be disseminated in a Control Services bulletin highlight the need to clarify the method of restraint and upgrade calls held for over 30 minutes Updated section 136 to be reflected in LAS Dispatch Policy OP/061 and Standard Operating Procedure for METDG.	Briony Sloper Paul Woodrow Clinton Beale Clinton Beale Clinton Beale	30/12/2016 30/12/2016 30/11/2016 30/11/2016 30/12/2016		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. 3.Quarterly Section 136 figures will be reported to and reviewed by the mental health committee which runs bimonthly prior to being shared with MHPB.	Moderate	Possible	9	Significant	Final approval
377	380 - The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls may 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 risk is further exacerbated by the intermittent inability to access and retrieve historical radio and telephony conversations currently held on obsolete hardware and software.	05/02/2013		Information Governance			Moderate	Almost certain	15	High	Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2015/16. Historical 999 call Data (over 2 yrs) will be converted to the format used by the newly selected system. Dat tapes will need to be converted to a current format and a gating template is in the development process. Engineers are running proactive weekly checks over the systems to ensure service continuity. Further investigations with the supplier are on-going to provide additional maintenance and operational plans to ensure the stability of the service	Watson, Andrew	18/11/2016	Moderate	Likely	12	Significant	2131	Deploy new recording service	Simon Alhadi	31/03/2017		Replacement will be complete with the latest supported version of software.	Moderate	Rare	3	Low	Final approval
432	The Quality Improvement Programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support	15/07/2016		Corporate	Theme 1: Making the LAS a great place to work, Theme 2: Achieving good governance, Theme 3: Improving patient experience, Theme 4: Improving environment and resources, Theme 5: Taking pride and responsibility		Moderate	Almost certain	15	High	•* In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17 •* A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders •* A PMO has been established that will central monitor and review programme progress	Broughton, Karen	17/11/2016	Moderate	Likely	12	Significant	2104 2105 2106	Monthly QIP ELT Meetings to review progress to date Establish Quality Improvement Board as sub committee of Trust Board To participate NHS Improvement Warning Notice Review	Fionna Moore Fionna Moore Karen Broughton	31/03/2016 31/03/2017 16/03/2016	18/03/2016	All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time	Moderate	Unlikely	6	Moderate	Final approval
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement	27/05/2016		Governance			Major	Possible	12	Significant	Risk management training sessions for managers was rolled out across the Trust from November 2015 and monthly sessions are still on-going. Risk registers are reviewed quarterly by the Governance and Assurance Team and areas of non compliance are reported to the Risk Compliance and Assurance Group. The Governance and Assurance Team provide support to areas and directorates through the attendance at meetings and 1:1 support where required.	Adams, Sandra	25/10/2016	Major	Possible	12	Significant	2026 2028	Governance Team to work with Departments and Areas to bring their risk registers in line with required standard. Audit of local risk registers to be presented to RCAG each month for escalation of non compliance.	Frances Field Frances Field	28/02/2017 28/02/2017		Compliance with the process is reviewed by the Risk Compliance and Assurance Group and areas of non compliance are escalated to the appropriate Directors.	Major	Rare	4	Moderate	Final approval

18	There is a risk that declared serious incidents are not investigated thoroughly and within a timely manner. TRR 405	09/07/2014		Governance	Theme 2: Achieving good governance		Moderate	Likely	12	Significant	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	Adams, Sandra	16/11/2016	Moderate	Likely	12	Significant	2059 522 523 524	SI training for lead investigators SI policy review SI session for SMT/ELT members SI training session for lead investigators	Peter Nicholson Peter Nicholson Peter Nicholson Peter Nicholson	31/01/2017 20/10/2016 31/01/2017 30/09/2016	21/10/2016 23/09/2016	A weekly outstanding investigations paper is presented at ELT detailing all SIs where a finalised report has not been submitted. This information is also presented Trust Board. % out of 7 reports were submitted in time in September-Early October	Moderate	Unlikely	6	Moderate	Final approval
28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investingating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule. The impact of this may be: * adverse publicity / reputation * court order for specific disclosure which has financial implications; * adverse finding by HM Coroner / trial judge; * financial implication of settling claim as a result of not having any evidence to rebut	10/02/2016		Support Services	Theme 2: Achieving good governance		Major	Possible	12	Significant	Whilst the call log provides a summary of information noted this is not deemed to be an adequate control. Work is being undertaken by IM&T to source parts to keep the system running as and when required	Adams, Sandra	14/11/2016	Major	Possible	12	Significant	2061 398 399	Have we heard from R Clifford? Procurement and installation of new equipment Investigate conversion of DAT tapes to a modern media	Laura O'Donoghue Robert Clifford Robert Clifford	23/11/2016 31/03/2017 31/03/2017		IM&T are working on two projects to convert existing tapes and to procure and install new equipment and to investigate conversion of DAT tapes into a modern media	Major	Unlikely	8	Significant	Final approval
63	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. Original Risk ID 426	10/09/2014		Support Services	Theme 3: Improving patient experience		Major	Possible	12	Significant	1. Local managers running own reports in absence of safeguarding officer. 2. Out of office message to manage expectations.	Sloper, Briony	08/11/2016	Major	Possible	12	Significant	1176 1177 2095	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). Obtain resources to employ full time administrator	Briony Sloper Briony Sloper Briony Sloper	29/07/2016 08/08/2016 31/03/2017	29/07/2016 08/08/2016	1. None. 2. Limited effectiveness. 3. None.	Major	Unlikely	8	Significant	Final approval
65	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. Original Risk ID 458	08/06/2016		Clinical	Theme 3: Improving patient experience		Major	Possible	12	Significant	None	Sloper, Briony	08/11/2016	Major	Possible	12	Significant	1185 1183	2. Develop escalation policy to manage multiple referrals 1. Introduce web based solution, confirm its ability to identify multiple calls.	Alan Hay Alan Hay	30/09/2016 30/09/2016		1. Due date for Datix web is 01/09/16. 2. To be developed once Datix web is imbedded.	Major	Rare	4	Moderate	Final approval
69	There is a risk that the Trust is unable to provide assurance that it is compliant with safeguarding training requirements for clinical and non-clinical staff. (Links to TRR - 446 and 439) Original Risk ID 2	08/06/2016		Clinical	Theme 2: Achieving good governance		Major	Possible	12	Significant	Figures obtained from various locations. Recorded on safeguarding balanced score care. Part of a larger risk on Trust risk register with capturing training figures across Trust.	Sloper, Briony	08/11/2016	Major	Possible	12	Significant	1178 1179 1180 1181 1182	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 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. Monitor compliance of training received and report to the Executive Management Team by the end of May.	Pauline Cranmer Paul Woodrow Paul Woodrow Jane Thomas Nikki Fountain	31/12/2017 31/12/2016 31/12/2016 31/12/2016 31/05/2016	30/08/2016	(Links to TRR - 446 and 439	Major	Rare	4	Moderate	Final approval
119	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	13/08/2014		Fleet and Logistics			Moderate	Likely	12	Significant	1, OP02 The procedure covering the issues and use of drugs by LAS staff 2, Local management on stations monitoring adherence to OP02 3,Need to comply with drugs policies reinforced through messages in the RIB 4,Message to just take one paramedic pack per vehicle reinforced through messages on the RIB 5, Medicines Management event held 6, Instigate 'Drug Pack Amnesty' to promote return of drug packs that may have been retained by staff and are therefore not in circulation	Grimshaw, Andrew	25/10/2016	Moderate	Likely	12	Significant	286 287 282 283 284 353	Instigate drug pack amnesty to promote return of drug packs Buy 350 Paramedic and 250 Technician drugs bags Review the maximum and minimum ordering checking on station. Tracking systems need to be looked at to monitor the location of drugs bags Identify stations where over ordering occours and identify the reasons for this Trial Drug Pouch Ststem in NE later in the year	Karen Merritt Karen Merritt Karen Merritt Karen Merritt Gordon Ballard Karen Merritt	30/11/2016 23/06/2016 23/06/2016 23/06/2016 23/06/2016 29/03/2017	18/07/2016 25/10/2016 25/10/2016 25/10/2016	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	Low	Final approval

372	282:There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.	03/07/2007		Information Governance			Major	Possible	12	Significant	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.	Watson, Andrew	18/11/2016	Major	Possible	12	Significant	547 2130	Implement new system Awareness campaign and future EDRMS strategy	Robert Clifford Robert Clifford	28/06/2016 18/11/2016	30/11/2015 18/11/2016	Risk discussed and monitored by IM&T SMT	Major	Unlikely	8	Significant	Final approval
410	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 unencrypted devices)	08/10/2014		Information Governance			Moderate	Likely	12	Significant	1. Local asset registers held by IM&T Infrastructure Teams. 2. local asset registers held of decommissioned IT equipment	Watson, Andrew	18/11/2016	Moderate	Likely	12	Significant	2132	Implementation of a system management Service	Robert Clifford	31/03/2017		Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	Low	Final approval
411	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.	08/10/2014		Information Governance			Moderate	Likely	12	Significant	None	Watson, Andrew	24/10/2016	Moderate	Likely	12	Significant	617 618	BEM's identify the IT information assets and owners Introduce a policy to assign an owner (individual/department) to every new and existing IT information asset	Gurjinder Rathore Gurjinder Rathore	30/12/2016 30/12/2016		Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	Low	Final approval
439	There is a risk that tail lift failures on operational ambulances will impact on patient care. Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07/10/2013		Fleet and Logistics			Major	Possible	12	Significant	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis (Updated 11/15 – S.Westrope amended maintenance schedule for A&E – every 12 weeks). 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with 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". 5, Ambulance design reviewed to include tail lift (from further actions) 6,Alternative tail lift has been fitted to a small percentage of vehicles (from further actions) 7, Training programme for workshops on fault finding organised (from further actions)	Grimshaw, Andrew	27/10/2016	Major	Possible	12	Significant	1806	140 new ambulances with new external tail lift subject od business case are awaitng TDA approval	Christopher Vale	30/03/2018		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	Significant	Final approval
442	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.	17/06/2015		Operational			Major	Possible	12	Significant	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. Director of Operatins agreed that the Clinical Team Leaders on the HUB will receive the additional £2500 awarded to Team Leaders. 6. New job description for Clinical Advisors on the HUB banded at 6.	Millard, Katy	19/10/2016	Major	Possible	12	Significant	1384 1385 1386 1387	Ensuring the 100 approximate staff out in operations book their 120 hours in a managed way 50:50 split, 27 operational Clinical Team Leaders being approached to do the majority of their operational shifts in the clinical hub Band 6 for Clinical Advisors Review of balance of Advisors to Team Leaders	Tracy Pidgeon Michael Ward Tracy Pidgeon Katy Millard	31/03/2017 01/06/2016 31/03/2017 31/03/2017	27/09/2016 01/06/2016 01/06/2016 27/09/2016	None	Major	Unlikely	8	Significant	In holding area, awaiting review
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made and appropriate help and support may not be provided by the local authority or other agencies as a result.	18/10/2016		Clinical	Theme 3: Improving patient experience		Moderate	Likely	12	Significant	1. EBS to check for gang involvement on safeguarding concerns raised. 2. Article written for clinical update (to be included in October 2016 edition).	Sloper, Briony	08/11/2016	Moderate	Likely	12	Significant	1964 1968 1969 1970 1971	1. RIB article reminding crews of need to report and undertake staff survey post CSR to check learning. 2. CSR 2016.3 session on children and gangs. 3. Scope possible gang work with Red Thread. 4. Undertake a re Audit of code 65 PRF's 5. Raise awareness in EOC to identify potential gang involvement and notify EBS.	Ginika Nwafor-Iwundu Alan Taylor Alan Taylor Ginika Nwafor-Iwundu Ginika Nwafor-Iwundu	10/11/2016 18/11/2016 31/03/2017 31/03/2017 31/12/2016	10/11/2016 16/11/2016	1. EBS to continually review referrals data.	Moderate	Unlikely	6	Moderate	Final approval
341	There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	01/10/2014	16	Operational	Theme 3: Improving patient experience		Catastrophic	Likely	20	High	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	Millard, Katy	17/11/2016	Catastrophic	Unlikely	10	Significant	1390 1391 1392 1393 1388	Deliver efficiencies in full from Capacity Review and complete Roster Implementation. Recruit to establishment in the clinical hub. Band 6 is now agreed for all HUB posts. 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 Allocate EMDs to clinical hub to assist with ring backs (when capacity allows) Recruit to front line Establishment minus agreed vacancy factor of 5%. Details included in advert to action in improvement programme.	Paul Woodrow Katy Millard Katy Millard Katy Millard Karen Broughton	31/03/2017 01/06/2016 30/04/2016 01/04/2016 31/03/2017	01/06/2016 30/04/2016 01/04/2016	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 6. Medical Directorate clinical safety review carried out.	Catastrophic	Unlikely	10	Significant	Final approval

246	Failure of the 999 and EBS lines recording system to record all calls into and out of the Control Suites will compromise the Trust's ability to maintain a full Patient Record, to manage quality or respond or learn from queries, complaints and investigations.	15/03/2012		Operational			Catastrophic	Possible	15	High	1. Review by IM&T of all lines to be recorded and provision of extended service to EBS 2. Testing of recording at Bow to ensure consistency of service	Millard, Katy	19/10/2016	Catastrophic	Unlikely	10	Significant	1243 1244	Ongoing monitoring of the system, particularly at Bow, where problems have been experienced. IM&T to work to ensure all critical lines recorded at both sites.	Kevin Canavan John Downard	31/03/2017 31/03/2017		1. On-going monitoring of the system, particularly at Bow, where problems have been experienced. 2. IM&T to work to ensure all critical lines recorded at both sites	Catastrophic	Rare	5	Moderate	Final approval

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Fit and Proper Person Policy**
Report Author(s):	**Sandra Adams, Director of Corporate Governance/Trust Secretary**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**ELT**
Status:	**Approval**

Background/Purpose

The Fit and Proper Person policy outlines the commitment of the London Ambulance Service NHS Trust ('the Trust') to ensuring that all persons appointed as directors satisfy the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activity Regulations'). The Trust has responsibility to ensure these requirements are met and the Care Quality Commission (CQC) role is to monitor and assess how well this responsibility is discharged.
There is an expectation that senior leaders will set the tone and culture of the organisation, which leads to staff adopting a caring and compassionate attitude and adds weight to the importance of the Fit and Proper Person requirements.

Attached is a summary of the policy for ease of reference together with the draft policy itself. This will replace the current process which was implemented in November 2013 and has been applied to all directors since that date. The CQC reviewed the FPP arrangements in June 2015 however a more formal policy arrangement will provide more robust assurance and is consistent with practice elsewhere in the NHS.

The highlighted areas are being checked with HR to confirm whether these are currently or can be applied going forward. The Trust Board is also asked to consider whether it accepts 6.1, 3rd point: regular health checks including mental health (where these are deemed to be appropriate).

Action required

To consider and approve the policy for implementation with effect from 1st December 2016.

Key implications

The Trust is required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activity Regulations') to ensure it meets and discharges its responsibility for

the Fit and Proper Person Requirements. http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	**Requirement under the Regulated Activity Regulations.**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

Fit and Proper Person Policy – Summary

The Fit and Proper Person policy outlines the commitment of the London Ambulance Service NHS Trust ('the Trust') to ensuring that all persons appointed as directors satisfy the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activity Regulations'). The Trust has responsibility to ensure these requirements are met and the Care Quality Commission (CQC) role is to monitor and assess how well this responsibility is discharged.

There is an expectation that senior leaders will set the tone and culture of the organisation, which leads to staff adopting a caring and compassionate attitude and adds weight to the importance of the Fit and Proper Person requirements.

Scope

It is proposed that the following roles fall within the scope of the Regulations:

- Trust Chair
- All Non-Executive and Associate Non-Executive Directors
- Chief Executive
- Director of Finance and Performance
- Medical Director
- Chief Quality Officer
- Director of Operations
- Director of Corporate Governance/Trust Secretary
- Director of Transformation and Strategy
- Director of Workforce and Organisational Development
- Director of Strategic Communications
- Director of Performance
- Any other board member (regardless of voting rights) not listed above
- Any other person who performs the functions of, or functions equivalent or similar to, those of a director.

Objectives

Under the Requirements, the Trust must not appoint to a post under the scope of the Regulated Activity Regulations without first satisfying itself that the individual:

- Is of good character
- Has the necessary qualifications, competence, skills and experience
- Has the appropriate level of physical and mental fitness
- Has not been party to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity
- Is not deemed unfit under the Regulated Activity Regulations' provisions
- Can provide the personal information as set out in the Regulations which must be available to be supplied to the CQC when required.

These requirements must be held at the point of commencing the role and on an ongoing basis.

Implementation of the policy

It is proposed to implement the policy with effect from 1st December 2016 which will require all existing directors to self-declare using the form at Appendix B of the policy.

At the point of recruitment the following system will be applied:

- Confirming the status of specific qualifications as outlined within the relevant job description/person specification
- Identity checks

- Qualification and registration checks
- Right to work checks
- Disclosure and Barring Service (DBS) checks
- References (covering at least three years of employment, one of which must be from the current/most recent employer)
- Search of insolvency and bankruptcy register
- Review of full employment history seeking any explanation for gaps in employment
- Health questionnaire and occupational health clearance
- *Values-based recruitment* – values tested through the interview process
- *A search of the individual through internet search engines to note any information in the public domain which the Trust should be made aware of*
- A self-declaration from the individual (Appendix B)
- *An explicit clause within the contract of employment/service level agreement to ensure the individual accepts the requirements of the Regulated Activity Regulations at the point they commence with the Trust.*

In terms of continued compliance it is intended this requirement will be fulfilled through a number of processes including:

- The completion of an annual self-declaration by all directors
- Introduction of annual checks for credit, bankruptcy and registration
- Requirement for regular health checks including mental health (where these are deemed to be appropriate
- Formal appraisal processes
- Maintenance of the register of declared interests.

Checklist of Directors to whom the FPP arrangements have applied since November 2013

Name	Position	Date FPP applied
Richard Hunt	Chair	December 2013
Roy Griffins	Non-Executive director	December 2013
John Jones	Non-Executive director	December 2013
Caroline Silver	Non-Executive director	December 2013
Jessica Cecil	Non-Executive director	November 2013
Robert McFarland	Non-Executive director	December 2013
Nicholas Martin	Non-Executive director	December 2013
Theo de Pencier	Non-Executive director	February 2014
Fergus Cass	Non-Executive director	February 2014
Ann Radmore	CEO	December 2013
Fionna Moore	Medical Director – now CEO	December 2013
Steve Lennox	Director of Nursing & Quality	December 2013
Andrew Grimshaw	Director of Finance and Performance	February 2014
Jason Killens	Director of Operations	January 2014
Sandra Adams	Director of Corporate Affairs/Trust Secretary	December 2013
Tony Crabtree	Acting Director of Workforce	December 2013
Vic Wynn	Acting Director of IM&T	December 2013
Mike Evans	Director of Business Development	*Done but check date*
Jane Chalmers	Director of Modernisation	December 13 ROI
Paul Woodrow	Director of Performance – now Operations	January 2014

Karen Broughton	Director of Transformation & Strategy	December 2013
Charlotte Gawne	Director of Strategic Communications	November 2013
David Prince	Director of Support Services	*Done but check date*
Mark Whitbread	Director of Paramedic Education & Development	January 2014
Fenella Wrigley	Medical Director	May 15
Zoe Packman	Director of Nursing & Quality	TBC – given to AR before appointment
Jill Patterson	Interim Director of Performance	February 2016 ROI
Briony Sloper	Interim Chief Quality Officer	TBC
Heather Lawrence	Chair	April 2016
Andrew Watson	Chief Information Officer	May 16
Mark Hirst	Interim Director of Workforce	July 2016 ROI

London Ambulance Service NHS Trust

Fit and Proper Person Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document:
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Sponsor Department: Corporate Governance

Author/Reviewer: Director of Corporate Governance/Trust Secretary
To be reviewed by: December 2017

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
14/11/2016	0.1	Sandra Adams	Formal policy to replace the current process

***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.

For Approval By:	**Date Approved**	**Version**
PMAG	XX/XX/XX	1.0
Ratified by (If appropriate):		
ELT Trust Board	16/11/2016 29/11/2016	1.0 1.0

Published on:	**Date**	**By**	**Dept**
The Pulse	XX/XX/XX		G&A
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The RIB			G&A

Equality Analysis completed on	**By**
18/11/2016	Sandra Adams
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**

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 not controlled nor substantive.

1. Introduction

1.1 The Fit and Proper Person policy outlines the commitment of the London Ambulance Service NHS Trust ('the Trust') to ensuring that all persons appointed as directors satisfy the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activity Regulations'). The Trust has responsibility to ensure these requirements are met and the Care Quality Commission (CQC) role is to monitor and assess how well this responsibility is discharged.

1.2 There is an expectation that senior leaders will set the tone and culture of the organisation, which leads to staff adopting a caring and compassionate attitude and adds weight to the importance of the Fit and Proper Person requirements.

2. Scope

2.1 The Trust confirms that the following roles fall within the scope of the relevant provisions of the Regulated Activity Regulations:

- Trust Chair
- All Non-Executive and Associate Non-Executive Directors
- Chief Executive
- Director of Finance and Performance
- Medical Director
- Chief Quality Officer
- Director of Operations
- Director of Corporate Governance/Trust Secretary
- Director of Transformation and Strategy
- Director of Workforce and Organisational Development
- Director of Strategic Communications
- Director of Performance
- Any other board member (regardless of voting rights) not listed above
- Any other person who performs the functions of, or functions equivalent or similar to, those of a director.

2.2 The individual falls under the requirements of the Regulated Activity Regulations regardless of whether they undertake the above role via a temporary, secondment or interim basis. The individual does not have to be an employee of the Trust to fall within the scope of this policy.

3. Objectives

3.1 Under the Requirements, the Trust must not appoint to a post under the scope of the Regulated Activity Regulations without first satisfying itself that the individual:

- Is of good character
- Has the necessary qualifications, competence, skills and experience
- Has the appropriate level of physical and mental fitness
- Has not been party to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity
- Is not deemed unfit under the Regulated Activity Regulations' provisions

- Can provide the personal information as set out in the Regulations which must be available to be supplied to the CQC when required.

3.2 These requirements must be held at the point of commencing the role and on an ongoing basis.

3.3 The CQC's definition of 'good character' is not the objective test of having no criminal convictions but rather a judgement to be made as to whether a person's character is such that they can be relied upon to do the right thing under all circumstances. The Trust will use its discretion in reaching a decision regarding character.

3.4 The Trust has no discretion in relation to the requirement that the individual is not deemed unfit under the Regulated Activity Regulations and such individual is automatically prevented from holding any of the positions listed under paragraph 2 above.

3.5 In the event that an individual ceases to be a fit and proper person, the individual may be summarily dismissed and the Trust will notify the individual and the Trust's regulator.

3.6 **Appendix A** provides information on what constitutes a fit and proper person under the Regulated Activity Regulations.

3.7 **Appendix B** contains the self-declaration form which all directors and director-equivalents will be required to fill out.

4. Responsibilities

4.1 Trust Chair

- To take overall responsibility and accountability for ensuring all those required to confirm that they meet the requirements of the Regulated Activity Regulations do so at appointment and as an ongoing requirement.

4.2 Those within the scope of the Fit and Proper Person requirement

- To hold and maintain suitability for the role they are undertaking
- To respond to any requests of evidence of their ongoing suitability
- To disclose any issues which may call into question their suitability for the role they are undertaking.

4.3 Trust Secretary

- In conjunction with the Workforce and Organisational Development directorate to ensure all appointment checks (as outlined in Appendix B) are undertaken for Directors and ensure the results are recorded and evidenced within the individual's file
- To liaise with the appointments team of NHS Improvement on appointment of the Chair and Non-Executive Directors to the Trust
- In conjunction with the Workforce and Organisational Development directorate to undertake an annual refresh of suitability (as outlined in Appendix B) for all Directors.

4.4 Procurement

- To ensure all agencies/candidate providers understand their responsibilities and comply with the requirements of this policy. This should be evidenced through suitable contract documentation to ensure the policy is clear.

4.6 Agency Providers

- To ensure the necessary checks have been outlined in this policy and make those checks available as and when required.

5. Compliance at the point of recruitment

5.1 The Trust has robust policies in place with regard to the appointment of directors, including:

- Confirming the status of specific qualifications as outlined within the relevant job description/person specification
- Identity checks
- Qualification and registration checks
- Right to work checks
- Disclosure and Barring Service (DBS) checks
- References (covering at least three years of employment, one of which must be from the current/most recent employer)
- Search of insolvency and bankruptcy register
- Review of full employment history seeking any explanation for gaps in employment
- Health questionnaire and occupational health clearance
- *Values-based recruitment* – values tested through the interview process
- *A search of the individual through internet search engines to note any information in the public domain which the Trust should be made aware of*
- A self-declaration from the individual (Appendix B)
- *An explicit clause within the contract of employment/service level agreement to ensure the individual accepts the requirements of the Regulated Activity Regulations at the point they commence with the Trust.*

5.2 All of the above will be recorded and held on the individual's personal file.

6. Assessment of continued compliance

6.1 The Trust is responsible for ensuring the continued compliance of those persons to whom the Regulated Activities Regulations apply. It is intended this requirement will be fulfilled through a number of processes including:

- The completion of an annual self-declaration by all directors
- Introduction of annual checks for credit, bankruptcy and registration
- *Requirement for regular health checks including mental health (where these are deemed to be appropriate*
- Formal appraisal processes
- Maintenance of the register of declared interests.

7. Policy review

7.1 This policy will be reviewed on a three-yearly basis or more frequently if changes are made to the Fit and Proper Person requirement.

8. Implementation Plan

IMPLEMENTATION PLAN TEMPLATE				
Intended Audience	All directors			
Dissemination	Available on The Pulse and on the website under 'About Us' http://www.londonambulance.nhs.uk/about_us/how_we_are_run.aspx			
Communications	To be sent to all Directors; Workforce and OD; Procurement			
Training	N/A			
Monitoring:				
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**
List aspects/ Key elements of the policy/ procedure that will be monitored, Employment checks Annual self-declaration Appraisal Register of Interests for Board members/ Directors	***How often will this take place and What tool will be used,*** Annual self-declaration Review of declaration of interests at each Board meeting Annual update of Declared Interests	***Who is responsible for carrying this out? Title of individual/team that will do this, and Name of Group/committee where the results will be reported,*** Director of Corporate Governance/Trust Secretary and Director of Workforce and OD – Workforce and OD committee and Trust Board	***Who monitors outcomes/ recommendations? Name of Higher level group/committee that will monitor outcomes/ recommendations,*** Trust Board	***Describe how learning will take place for relevant areas,*** ELT and Trust Board

APPENDIX A

FIT AND PROPER PERSON DECLARATION

1. Fitness to carry out the role of Director (or Director-equivalent post) in the London Ambulance Service NHS Trust (the Trust) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 ('the Regulated Activities Regulations').
2. By signing the declaration in Appendix B, you are confirming that you do not fall within the definition of an 'unfit person' or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.
3. It is a condition of employment that those holding Director (or equivalent) posts in the Trust provide confirmation in writing on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post.
4. The Chair and Non-Executive Directors are also required to meet the Fit and Proper Persons test for Directors.
5. The Trust shall not appoint, or permit to continue as a director, any person who is an unfit person.
6. The Trust will ensure that its contracts of employment with its Directors contain a provision permitting summary termination in the event of a Director being, or becoming, an unfit person. The Trust will enforce the provision promptly upon discovering any Director to be an unfit person.

Regulated Activities Regulations

7. 'Regulated Activities' covers the provision of:
    - Personal care
    - Accommodation for person who require nursing or personal care
    - Accommodation for persons who require treatment for substance misuse
    - Treatment of disease, disorder or injury*
    - Assessment or medical treatment for persons detained under the Mental Health 1983 Act
    - Surgical procedures
    - Diagnostic and screening procedures*
    - Management of blood and blood derived products
    - Transport services, triage and medical advice provided remotely*
    - Maternity and midwifery services
    - Termination of pregnancy services
    - Services in slimming clinics
    - Nursing care
    - Family planning services.

    *denotes the Activities the Trust is regulated to provide.

8. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The CQC document 'Regulations 5: Fit and Proper Persons: directors – Information for NHS Bodies,

March 2015' as amended from time to time provides further guidance on the requirement.

9. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:
   a) The individual is of good character
   b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position for the work for which they are employed
   c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
   d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
   e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

'Serious misconduct' includes assault, fraud and theft.
'Mismanagement' includes mismanaging funds and/or not adhering to recognised practice, guidance or processes regarding care quality.
'Privy to' means evidence that could lead the Trust to conclude that the individual was aware of some serious misconduct or mismanagement but did not take appropriate action to address it.

10. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:
    a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
    b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order made to like effect in Scotland or Northern Ireland
    c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (Debt relief orders) of the Insolvency Act 1986
    d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
    e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
    f) The person is prohibited from holding the relevant office or position, or in the case of an individuals for carrying on the regulated activity, by or under any enactment.

11. In assessing good character, the matters to be considered must include those listed in Part 2 of Schedule 4 to the Regulated Activities Regulations which are:
    a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence

b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator or health care or social work professionals.

APPENDIX B

PRE-EMPLOYMENT & ANNUAL DECLARATION – FIT AND PROPER PERSON

1. Fitness to carry out the role of Director (or Director-equivalent post) in the London Ambulance Service NHS Trust (the Trust) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activities Regulations').

2. By signing the declaration below, you are confirming that you do not fall within the definition of an 'unfit person' or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into questions.

3. It is a condition of employment that those holding Director posts provided confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post.

4. The Chair and Non-Executive Directors are also required to meet the fit and proper persons test for Directors.

5. The Trust shall not appoint, or permit to continue as a Director, any person who is an unfit person.

6. The Trust will ensure that its contracts of employment with its Directors contain a provision permitting summary termination in the event of a Director being, or becoming, an unfit person. The Trust will enforce that provision promptly upon discovering any Director to be an unfit person.

Regulated Activities Regulations

7. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The CQC document 'Regulations 5: Fit and Proper Persons: directors – Information for NHS Bodies, March 2015' as amended from time to time provides further guidance on the requirement.

8. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:
   a) The individual is of good character

   b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position for the work for which they are employed

   c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

9. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

    a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
    b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order made to like effect in Scotland or Northern Ireland
    c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (Debt relief orders) of the Insolvency Act 1986
    d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
    e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
    f) The person is prohibited from holding the relevant office or position, or in the case of an individuals for carrying on the regulated activity, by or under any enactment.

10. In assessing good character, the matters to be considered must include those listed in Part 2 of Schedule 4 to the Regulated Activities Regulations which are:
    a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence
    b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator or health care or social work professionals.

I acknowledge the extracts from the Regulated Activities Regulations above.

I confirm that I comply with the requirements as set out in Section 8 above, having regard also to matters in section 10 above.

I confirm that I do not fit within the definition of an 'unfit person' as listed in Section 9 above.

I confirm that there are no other grounds under which I would be ineligible to continue in post.

I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a 'fit and proper person' or any grounds under which I would ineligible to continue in post come to my attention.

Name:

Signed:

Position:

Date:

Pre-employment: Yes/No

Annual declaration: Yes/No

APPENDIX C

Due Diligence

Professional Registration	
Bankruptcy and Insolvency Registers	The Trust has searched the England and Wales Bankruptcy and Insolvency Register on (X Date) and can confirm that (Name) does not appear on the register. www.gov.uk/search-bankruptcy-insolvency-register The Trust searched the Insolvency Service of Ireland register on (X Date) and can confirm that (Name) does not appear on the register. www.isi.gov.ie/en/ISI/Pages/Registers
Disqualified Directors Register	The Trust searched the disqualified directors register via the Companies House register on (X Date) and can confirm that (Name) does not appear on the register. https://beta.companieshouse.gov.uk/
Internet based web search	The Trust conducted an internet based web search on (Name). the following search engines and websites were used: www.google.com and www.bing.com Word searches that were used were:
Social Profiles	The following websites were used: www.linkedin.com www.facebook.com www.twitter.com (for example)
Proof of Identity	Passport checked and verified on (Date)
Referees	

London Ambulance Service NHS Trust

Report to:	**Trust Board Part 1**
Date of meeting:	**29th November 2016**
Document Title:	**Financial and performance**
Report Author(s):	**Director of Finance**
Presented by:	**Director of Finance**
Contact Details:	
History:	**Executive Leadership Team** **Finance and Investment Committee**
Status:	

Background/Purpose

- LAS faces a material range of challenges in developing a two year plan for 2017-19.
    - Continued growth in activity levels, circa 5%.
    - The need to improve productivity.
    - The need to invest to improve services and infrastructure.
    - The potential need to grow to address these issues.
    - The challenge of securing more funding from CCGs given overall system pressures and previous funding.
    - Working with CCGs to identify opportunities to manage demand to avoid the need for additional funding and growth.
- By 23rd November the Trust is required to submit an initial plan for the next two years, with the final plan and signed contract with CCGs completed by 23rd December.
- A paper outlining some of the key issues and options for the 23rd November submission will be presented to Part 2 of the Trust Board.
- This is being discussed in part 2 as the plan is in draft at this stage as further work is required internally and with CCGs to confirm final positions.

Action required

The Board is asked to Note this papersandr

Key implications

Key implications and risks arising from this paper	
Clinical and Quality	*Yes*
Performance	**Yes**
Financial	**Yes**
Workforce	**Yes**
Governance and Well-led	**Yes**
Reputation	**Yes**
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	**Yes**

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Standing Financial Instructions/Standing Orders/Scheme of Delegation (SFIs/SOs/SoD)**
Report Author(s):	**Various**
Presented by:	**Sandra Adams, Director of Corporate Governance/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**The revisions to the Standing Financial Instructions, Standing Orders and Scheme of Delegation have been reviewed by the Finance & Investment Committee (FIC) and the Audit Committee (AC)**
Status:	**Presented for approval**

Background/Purpose

NHS Trusts are required to have Standing Orders and Standing Financial Instructions, and to ensure they are regularly reviewed to ensure they are up to date and robust. The SFIs/SOs/SoD were last updated in November 2014 however there have been minor updates to these, approved by the Audit Committee and Trust Board since then and the Audit Committee agreed to extend until the more thorough review could take place. The attached updated draft documents have been reviewed by the Finance and Investment Committee and the Audit Committee over the last two months and any comments/recommendations from those committees have been incorporated. The Audit Committee has approved the changes and recommend these to the Trust Board for approval. The full revised documents will be circulated to each director and to senior management team with a request for signature as assurance that they have received these.

Action required

Finance/Corporate Governance will publish the amended documents on the Pulse, and inform all staff via the RIB. All directors and the senior management team will be required to sign a declaration confirming that they have read and understood the SFIs/SOs/SoD. They will also be expected to ensure that all staff within their Directorates understand the importance of adhering at all times to the requirements of the SFIs/SOs/SoD.

Key implications

Good governance practice plus enhancing this through requirement for all Directors and the senior management team to sign a declaration.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	Implementation of revised Scheme of Delegation, Standing Financial Instructions and Standing Orders should improve ease of understanding of financial responsibilities and limits, and improve financial control.
Workforce	
Governance and Well-led	Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of Sections 99(3), 97(A)(4) and (7) of the National Health Service Act 1977; National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts for the Trust in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders of the Trust.
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

TRUST BOARD MEETING

29th November 2016

Approval of Standing Financial Instructions/Standing Orders/Scheme of Delegation (SFIs/SOs/SoD)

Background

The Standing Financial Instructions, Standing Orders and Scheme of Delegation were last fully reviewed in November 2014 and are thus due for review.

A review has been conducted with the aim of clarifying delegation of authority, clarifying responsibilities, ensuring changes to processes have been properly represented and ensuring identified gaps in coverage of the previous versions were addressed.

The following summarises the suggested significant and minor changes which have been reviewed and approved by the Audit Committee at recent meetings, with comments/recommendations from those committees being incorporated.

Principal Changes

There are some significant changes to the SFIs, SOs and Scheme of Delegation since the last review in November 2014 which are summarised below. Other minor changes (for example, updated job titles, regulatory references, policy names etc) have also been made, but are not detailed below.

Document	New Section	Issue	Amendment
SFIs	2	Previously indicated Finance Director responsible for management of internal audit arrangements	Amended to Director of Corporate Governance/Trust Secretary
SFIs	2	Previously indicated Head of Internal Audit accountable to Finance Director	Amended to indicate they are accountable to the Trust Board through the Audit Committee
SFIs	5.3	No reference to disciplinary processes where SFIs or Delegated limits breached	Paragraph added to indicate that Finance Director is responsible for devising and maintaining a disciplinary process to address breaches of the Trust's financial control framework
SFIs	11	No specific reference as to who could determine and approve overtime and incentives structures, and who had responsibility for the system for approving these payments	Paragraph added to give overarching responsibility for this to the Chief Executive and set out that it must allow pre-approval (except in the case of shift over-run); must provide confirmation that the work was completed; must provide for approval by the budget holder responsible; and must allow the purpose and location to be determined and show whether the overtime has been paid or remains unpaid
SFIs	11	Previously no reference was made to who had authority to physically sign contracts for employment on behalf of the Trust, or how and where they were kept.	Adjustment made to give responsibility for determining who may sign these contracts to the Director of Workforce and requiring electronic copies of employment contracts to be kept in an accessible manner
SFIs	12	Previously made reference to a authorised signatories policy (which was not in existence) and did not refer specifically to budget holder responsibilities or changes to non-pay budgets	Amendments have been made to remove the reference to an authorised signatories policy; state that budget holders are expected to manage within their non-pay budget; state that changes must be approved by the Chief Executive; and state that changes over £500k must be approved by the Trust Board
SFIs	14	Previously referred to a Financial Framework that we understand is no longer being updated	This section has been amended to state more generally that the Finance Director should ensure that members of the Board are aware of all relevant guidance issued by

			the Trust's regulating authority (NHSI), and should ensure that the directions and guidance issued by the Trust's regulating authority are followed by the Trust
SFIs	15	Previously referred to assets only, no mention was made of non-capitalised equipment	A section has been added giving overall responsibility for the control of non-capitalised assets and equipment to the Chief Executive, and a requirement for Directors and budget holders to maintain registers of assets and equipment has been added
SFIs	15	Previously unclear as to the approval requirements for business cases for their use	The section has been adjusted to clarify that within delegated limits, the Trust Board may approve the business case for a PFI, and over these limits the Trust Board may approve once authorisation has been granted by the regulatory authority
SFIs	15	The stores section in SFI 15 was previously unclear as to what was covered by the section, Directors referred to were out of date, and not all areas stores are held were covered	The section has been adjusted to clarify that both central and local stores of equipment and consumables are covered; identify Directors responsible for those stores and update the types of stores included; and clarify that those Directors are responsible for ensuring that the procedures laid out by the Director of Finance for stores management are followed
SFIs	17	Previously failed to address the circumstances under which gifts and donations were able to be made, and who had the authority to approve them	A new section has been added which defines gifts as per DH definitions and sets out that gifts may only be made where no net value can be realised by the Trust; that they may only be made to non-profit making organisations and not to individuals; that neither Gifts nor Donations may be made to political parties; and that Chief Executive approval is required for gifts up to £5,000, Trust Board approval is required for gifts up to £300,000, and Treasury approval is needed for all gifts valued at more than £300,000
SFIs	20	Previously provided that the responsibility for ensuring the Trust's liability in relation to taxation and excise duty was maintained appropriately was the responsibility of the Finance Director only	This section has been adjusted to reflect that the Director of Workforce is responsible for ensuring the Trust's liability to PAYE, NI and Pensions is managed appropriately
SFIs	23	Previously provided three exceptions where commercial insurance arrangements could be entered into, however there are other approved instances where commercial insurance arrangements are in place to cover specific risks	A fourth exception has been added to state that commercial insurance arrangements may be entered into where the Trust cannot obtain appropriate cover from the NHSLA and any required regulatory authority approval is sought and provided
SOs	44	In defining the criteria for approving overseas travel, the Standing Orders (section 44) did not previously refer to whether budget was available to fund the travel, and noted that irrespective of the reason for travel, the Trust would pay all travel and subsistence costs unless the Board approved other arrangements	This section has now been amended to indicate that the process for approval should ensure that no trips are undertaken without budget being identified to fund the trip and that only where overseas travel is approved will the Trust pay travel and subsistence costs
SoD	General	Left gaps between levels of delegated authority, contained inconsistencies between levels of delegated authority for similar items and were silent on delegated authority for other items	These items have been addressed in a new structure of table for the Scheme of Delegation, and financial delegations have been clarified and broken down to improve understanding

It is also proposed that the Scheme of Delegation be split out as a separate document instead of being included as an appendix to the Scheme of Delegation as it is at present, and that the following delegation levels for general non-pay expenditure and non-appointment related pay expenditure be incorporated.

Budget Holder Level 1	Up to £2,500
Budget Holder Level 2	Up to £5,000
Budget Holder Level 3	Up to £25,000
Budget Holder Level 4	Up to £50,000
Budget Holder Level 5	Up to £100,000
Finance Director	Up to £500,000
Chief Executive	Up to £1,000,000
Chief Executive or Finance Director with ELT approval	Up to £2,000,000
Chief Executive or Finance Director with FIC approval (after ELT review)	Up to £5,000,000
Chief Executive or Finance Director with Trust Board approval (after FIC review)	Over £5,000,000

Recommendation

The Trust Board is requested to approve the attached SFIs/SOs/SoD.

Actions

1. Corporate Governance will publish the amended documents on the Pulse, and inform all staff via the RIB.

2. All Directors and senior leadership team members will be required to sign a declaration confirming that they have read and understood the SFIs/SOs/SoD, and that all staff within their Directorates understand the importance of adhering at all times to the requirements of the SFIs/SOs/SoD.

London Ambulance Service
NHS Trust

London Ambulance Service NHS Trust

Standing Financial Instructions

August 2016

Approved
Trust Board
XX.XX.2016

PREAMBLE

1. The “Directions on Financial Management in England” issued under HC (91)25 in 1991 state that each Board must adopt Standing Financial instructions (SFIs) setting out the responsibilities of individuals.

2. Each Board operates within the statutory framework within which it is also required to adopt Standing Orders. In addition to the Standing Orders, there is a Scheme of Delegation, Financial Procedural Notes and locally generated rules and instructions. Collectively these must comprehensively cover all aspects of financial management and control. They set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

Andrew Grimshaw
Finance Director
August 2016

CONTENTS

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of Sections 99(3), 97(A)(4) and (7) of the National Health Service Act 1977; National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts for the regulation of the conduct of London Ambulance Service NHS Trust (the Trust) in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders of the Trust.

1.1.2 The Bribery Act 2010, which repeals existing corruption legislation, has introduced the offences of offering and receiving a bribe. It also places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. Under the Act, Bribery is defined as "Inducement for an action which is illegal unethical or a breach of trust. Inducements can take the form of gifts loans, fees rewards or other privileges". Corruption is broadly defined as the offering or the acceptance of inducements, gifts or favours payments or benefit in kind which may influence the improper action of any person; corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. To demonstrate the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency, all staff are required to comply with the requirements of Standing Financial Instructions.

1.1.3 The Fraud Act 2006 (the Act) came into force on 15 January 2007 and applies in England, Wales and Northern Ireland.

The Act repealed the following offences:

(i) Theft Act 1968

- Section15 (obtaining property by deception);
- Section15A (obtaining a money transfer by deception);
- Section 16 (obtaining a pecuniary advantage by deception);
- Section 20(2) (procuring the execution of a valuable security by deception);
- Reference to "cheat" in Section 25 (going equipped).

(ii) Theft Act 1978

- Section 1 (obtaining services by deception);
- Section 2 (evasion of liability by deception).

(iii) These offences continue to apply for any offences committed before 15 January 2007.

(iv) Section 1 of the Fraud Act 2006 creates a general offence of fraud and introduces three ways of committing it set out in Sections 2, 3 and 4.

- Fraud by false representation (Section 2);
- Fraud by failure to disclose information when there is a legal duty to do so (Section 3); and
- Fraud by abuse of position (Section 4).

(v) In each case:

- the defendant's conduct must be dishonest;
- his/her intention must be to make a gain; or cause a loss or the risk of a loss to another.

- No gain or loss needs actually to have been made.
- The maximum sentence is 10 years' imprisonment.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders and Scheme of Delegation adopted by the Trust.

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental financial procedure notes. All financial procedures must be approved by the Finance Director.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, the advice of the Finance Director must be sought before action is taken. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.7 Failure to comply with SFIs and Standing Orders is a disciplinary matter that could result in dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible.

1.1.9 For a more detailed explanation see the Trust's Anti-Fraud Policy and Anti-Bribery Policy. Should members of staff wish to report any concerns or allegations, they should contact their Local Counter Fraud Specialist.

1.1.10 Standing Financial Instructions shall be reviewed every year as required by the Board, and not less frequently than every two years.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Trust" means the London Ambulance Service NHS Trust;

(b) "Board" means the Board of the Trust;

(c) "Budget" means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

(d) "Chief Executive" means the chief officer of the Trust;

(e) "Finance Director" means the chief financial officer of the Trust;

(f) "Budget Holder" means the director or employee with delegated authority to manage finances and resources for a specific area of the organisation; and

(g) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

(h) A Service Level Agreement (SLA) is a part of a service contract where the level of service is formally defined. In practice, the SLA is used to refer to the contracted service and performance when referring to the third party or host.

(i) Key Performance Indicator is a specific indicator embedded into the SLA as a measurement to monitor the performance.

(j) "Shared Service" is the host/third party who will provide the outsourced Services Contract and overarching SLA with the Trust.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them, subject to the Scheme of Delegation.

1.2.3 Wherever the term "employee" is used, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSBILITIES AND DELEGATION

1.3.1 **The Board** exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation Document (EL(94)40 refers)

(e) defining specific contractual responsibilities placed on Shared Services as indicated in the Scheme of Delegation Document (EL(94)40 refers)

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust.

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and, as its Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions

within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.4 The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and put in a position to understand their responsibilities within these instructions.

1.3.6 **The Finance Director** is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

(d) the provision of financial advice to the Trust, its directors and employees;

(e) the design, implementation and supervision of systems of financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties;

(g) ensuring that where management and processing of transactions is delegated to a Shared Financial Service, there are proper arrangements for procedures, records and reports as the Trust may require for the purpose of carrying out its statutory duties including appropriate internal audit arrangements; and

(i) overseeing Anti-Fraud arrangements.

1.3.7 **All board members and employees,** severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 **Any contractor or employee of a contractor** who is empowered by the Trust, in writing, to commit the Trust to expenditure or who is authorised to obtain income

shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

1.3.9 For any and all board members and employees who carry out financial functions, the form in which financial records are kept and the manner in which board members and employees discharge their duties must be to the satisfaction of the Finance Director.

2. AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2011), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial judgements;

(c) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Finance Director in the first instance.

2.1.3 It is the responsibility of the Director of Corporate Governance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 DIRECTOR OF CORPORATE GOVERNANCE

2.2.1 The Director of Corporate Governance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the Police, following consultation with the Local Security Management Specialist (LSMS), in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for consideration by the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control measures in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) progress against the annual work plan for the Audit Committee;
(iii) major internal financial control weaknesses discovered;
(iv) progress in the implementation of internal audit recommendations;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Director of Corporate Governance, Finance Director, Local Anti Fraud Specialist (LAFS) or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration; and

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

2.3.2 The plan of work for Internal Audit should be reviewed and approved by the Audit Committee at the beginning of each financial year. This plan should be drawn up with full consideration of all risks as detailed within the risk register.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director and Director of Corporate Governance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

2.3.5 The Head of Internal Audit shall be accountable to the Trust Board through the Audit Committee. The reporting system for internal audit shall be agreed between the Director of Corporate Governance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.3.6 In obtaining third party assurance from other Auditors, in relation to Shared Financial Services' Auditors, the Head of Internal Audit should follow the assurance guidance of the Internal Audit Practitioners Group (IAPG).

2.4 FRAUD AND CORRUPTION

2.4.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance with the NHS Standard Contract (National Commissioning Contract) directions on fraud and corruption. This document should be read in conjunction with the Anti-Fraud, Bribery and Corruption Policy which is available on the Trust intranet site.

Anti-Fraud Arrangements - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

Anti-Bribery Policy - On 1st July 2011 the Bribery Act 2010 came into force. The Act creates four distinct offences:

- Organisations negligently failing to prevent a bribe.
- Bribery which occurs abroad by an organisation which is 'ordinarily resident' in the UK.

- Offering/agreeing to accept a bribe is an offence even if no money/goods have been exchanged.
- A key part of the legislation is the offence of 'bribing a foreign official.'

The ability to prosecute those who commit bribery abroad should help to eradicate bribery from the UK.
The potential penalties are: debarment from public procurement contracts, an unlimited fine and reputational damage.

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist (LAFS) as specified by the NHS Counter Fraud and Corruption Manual and guidance.

2.4.3 The Local Anti-Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.4.4 Shared Financial Services should also be party to this report and as per the contractual agreement between the Shared Financial Services and the Trust be maintaining an Anti-Fraud and Corruption procedures internally, that on request should be visible to auditors.

2.4.5 Shared Financial Service providers under their contractual terms and conditions also require the Local Anti-Fraud Specialist to report to the Trust's Finance Director in accordance with the NHS Counter Fraud and Corruption Manual.

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.

2.5.2 The Audit Committee is responsible for ensuring a cost efficient external audit service.

3. SECURITY MANAGEMENT

3.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions set out in the NHS Standard Contract (National Commissioning Contract) on NHS Protect

3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as set out in the NHS Standard Contract (National Commissioning Contract) guidance on NHS Protect.

3.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS Protect. The above should also be synergized by Shared Financial Services as part of their internal procedures and policies

3.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

4. RESOURCE LIMIT CONTROL

4.1 Not applicable to NHS Trusts.

5. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

5.1 Preparation and approval of service plans and budgets

5.1.1 The Board must ensure that there is an approved annual business plan before the commencement of each financial year.

5.1.2 The Chief Executive will compile and submit to the Board an Annual Business Plan which takes into account financial targets and forecast limits of available resources. The Annual Business Plan will contain:

(a) aims and objectives;

(b) a statement of the significant assumptions on which the plan is based;

(c) details of major changes in workload, delivery of services or resources required to achieve the plan;

(d) the individual and collective responsibilities of directors.

5.1.3 Prior to the start of the financial year the Finance Director will, on behalf of the Chief Executive, prepare and submit the Integrated Financial Plan (comprising revenue income & expense and capital expenditure & disposals) for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Business Plan;

(b) accord with workload and staffing plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income; and

(e) identify potential risks.

5.1.4 The Finance Director shall monitor financial performance against budget and service plans, periodically review them, and report to the Board.

5.1.5 Budget holders are responsible for providing sufficient information, as required by the Finance Director, to enable budgets to be compiled.

5.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

5.1.7 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

5.2 BUDGETARY DELEGATION

5.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing, in the Scheme of Delegation, and be accompanied by clear definitions of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

5.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virements limits set by the Board.

5.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Finance Director.

5.3 BUDGETARY CONTROL AND REPORTING

5.3.1 The Finance Director will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) data correlating financial, establishment and activity trends;

(iii) movements in working capital;

(iv) movements in cash and capital;

(v) capital project spend, including commitments, and projected outturn against plan;

(vi) explanation of any material variances from plan; and

(vii) details of any corrective action where necessary and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) a disciplinary process to address breaches of the Trust's financial control framework (the Standing Financial Instructions and Standing Orders, Reservation and Delegation of Powers of the Trust Board Directors); and

(f) arrangements for the authorisation of budget transfers.

5.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) any potential underspend is highlighted to the Finance Director (for virement if necessary);

(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(d) no permanent employees are appointed other than those provided for within the available resources and in the budgeted establishment as approved by the Board. Permanent employees must be appointed against recurrent income.

5.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

5.4 CAPITAL EXPENDITURE

5.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure~~.~~

5.5 MONITORING RETURNS

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the relevant monitoring organisation.

6 ANNUAL ACCOUNTS AND REPORTS

6.1 The Finance Director, on behalf of the Trust, will:

(a) prepare financial returns for the Trust, in accordance with the accounting policies and guidance given by the Department of Health and the

Treasury, the Trust's accounting policies, and generally accepted accounting principles;

(b) prepare, certify and submit annual financial reports to the Department of Health for each financial year in accordance with current guidelines; and

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

6.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's Audited Annual Accounts must be presented to a public meeting and made available to the public.

6.3 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's NHS Manual for Accounts. The document will include inter alia:

(a) the Annual Accounts of the Trust;

(b) details of relevant directorships and other significant interests held by Board members, as defined in Standing Orders;

(c) composition of the Remuneration and Nominations Committee;

(d) remuneration of the chairman, highest paid Director, and other Directors and highly paid employees, in accordance with guidance relating to the NHS.

7. COMMERCIAL BANK ACCOUNTS AND GOVERNMENT BANKING SERVICE ACCOUNTS

7.1 GENERAL

7.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the NHS and the Department of Health. In line with 'Cash management in the NHS' Trusts should minimise the use of commercial banks accounts and maximise the use of the Government Banking Service.

7.1.2 The Board shall approve the banking arrangements.

7.2 BANK ACCOUNTS

7.2.1 The Finance Director is accountable for:

(a) Commercial bank accounts and Government Banking Service Accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the Trust's bankers for overdraft facilities;

(e) monitoring compliance with DH guidance on the level of cleared funds.

(f) Where an agreement is entered into with the Shared Financial Services for payment to be made on behalf of the Trust from bank accounts maintained on behalf of the Trust , or by Electronic Funds Transfer (BACS), the Finance Director shall ensure that satisfactory security regulations of Shared Financial Services relating to bank accounts exist and are observed. This is specified in a Contractual Agreement between the Shared Financial Services and the Trust.

7.3 BANKING PROCEDURES

7.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

7.3.2 The Director or Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Finance Director may delegate these written instructions to a Shared Financial Services provider under contractual agreement with the Trust.

7.4 TENDERING AND REVIEW

7.4.1 The Finance Director will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary with Government Banking Service accounts.

8 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.1 INCOME SYSTEMS

8.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

8.1.2 The Finance Director is also responsible for the prompt banking of all monies received.

8.1.3 The Finance Director may delegate the above activities as part of a Shared Financial Service under contractual agreement with the Trust.

8.2 FEES AND CHARGES

8.2.1 The Trust shall follow Department of Health's advice in the 'costing' manual in setting prices for NHS service agreements.

8.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

8.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's Commercial Sponsorship – Ethical standards for the NHS (2000) shall be followed.

8.2.4 All employees must inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. Employees must ensure approval is obtained on sales and goods from the Finance Director

8.3 DEBT RECOVERY

8.3.1 The Finance Director is responsible for the appropriate recovery action on all outstanding debts.

8.3.2 Income not received should be dealt with in accordance with losses procedures. The Finance Director may delegate responsibility for ensuring that the Shared Financial Services take appropriate recovery action on all outstanding debts. This would be specified in the contractual agreement between both parties.

8.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated. Overpayments will be reviewed in order that procedures are introduced to prevent recurrence.

8.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.4.1 The Finance Director is responsible for ensuring delegated arrangements via contractual Shared Financial Services for:

(a) approving the form of all receipt books, agreements forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery; Banking stationery shall be handed over to the Shared Financial Services who will, on behalf of the Trust, become the custodian of all visible audit of this and will be monitored in accordance with the contractual agreement between the Trust and the Shared Financial Services and physical signatures required.

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

8.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

8.4.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

8.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless, exceptionally, such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. The Finance Director may delegate the above activities as part of a Shared Financial Service under contractual agreement with the Trust.

9 TENDERING AND CONTRACT PROCEDURE

9.1 DUTY TO COMPLY WITH STANDING ORDERS

9.1.1 The Trust shall ensure that the appropriate procurement route is selected for:

(a) the supply of goods, materials and manufactured articles;

(b) The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens);

(d) Disposals.

9.1.2 Every contract, whether made by the Trust, or by a committee of the Trust or by a nominated officer to whom the power of making contracts shall have been delegated, shall comply with these Standing Orders and, unless the Board has resolved to do otherwise in advance and on a per project/procurement basis, with any extant Departmental guidance. Where the Board makes such a resolution then it shall take precedence over any provisions to the contrary in these Standing Orders. Copies of such guidance documents can be obtained for reference purposes from the Finance Director. No exception from any of the following provisions of these Standing Orders shall be made other than by direction of the Board.

9.1.3 All companies entering into contracts with the Trust must provide a minimum of Full name; Company Registration number; and Company Registered Address and any separate principal trading addresses.

9.1.4 Additionally, for unquoted companies, the Trust may require some or all of the following information:

(i) Names of all directors; beneficial owners, or those with significant influence over the business and its assets, with particular attention paid to any significant shareholders.

(ii) For group companies, the structure of the group and any beneficial owners of the ultimate parent.

(iii) Verification of the existence of the company via:
- confirmation of the company's listing on a regulated market;
- a search of the relevant company registry; or
- by obtaining a copy of the company's certificate of incorporation.

(iv) Confirmation that the company is not currently, and has not been in the process of being dissolved, struck off, wound up or otherwise terminated.

(v) documented evidence that the business is well known, reputable and of long standing.

(vi) The reason for any changes to the company's structure or ownership, or the nature of the business transacted.

9.1.4 The Trust shall comply as far as is practical with the requirements of the Department of Health and NHSI guidance in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance.

9.2 EU DIRECTIVES

9.2.1 Directives by the Council of the European Union (EU) as incorporated by the UK Public Sector Contract Regulations prescribing procedures for awarding contracts for services, building and engineering works and for the supply of goods, materials and manufactured articles (hereafter referred to as goods and services) shall have effect as if incorporated in these Standing Orders and shall apply throughout.

9.2.2 The EU public procurement thresholds represent contractual value levels above which public authorities must follow EU procedural rules with regard to the issuing of contracts.

9.2.3 Value is defined as the total consideration excluding VAT that is to be paid over the lifetime of the contract or, if the lifetime is not defined, it is taken to be the equivalent of 48 months' spend. Reference must be made to extant EU procurement thresholds.

9.2.4 Where the contract includes options, the value of these options must be taken into account in determining whether the threshold has been reached. In the case of contracts for lease, rental or hire purchase, the relevant figure is the aggregate of the consideration that will be paid throughout the duration of the contract. Where the term exceeds 12 months the estimated residual value must also be included. Where the duration is indefinite or uncertain, the relevant figure is the monthly contract value multiplied by 48. In the case of regular or renewable contracts the

relevant figure is either the aggregate of the consideration to be paid during the anticipated duration of the contract (or over the first 12 months if the duration is indefinite) or the consideration paid by the buyer under similar contracts for goods of the same type during the preceding 12 months (adjusted for any expected changes), whichever is the more appropriate. A single contract providing for a regular supply over a period of time and a series of separate contracts concluded over a period of time for the same type of goods are both regarded as 'regular' contracts for these purposes.

9.3 PROCUREMENT FRAMEWORK

9.3.1 Standard Procurement Method

9.3.1.1 The Trust's standard method of procurement shall be through competition in the open marketplace. However, as detailed below, the Trust's standard method of procurement shall be affected by the monetary value of the goods and services being procured.

9.3.2 Purchases below £3,000

9.3.2.1 Wherever possible the goods and services being purchased shall be joined together so that the value shall exceed £3,000.

9.3.2.2 Purchases shall be made from the Trust's online catalogues or by obtaining a written or verbal quotation from a supplier.

9.3.3 Non-Estates Purchases between £3,000 and £25,000

9.3.3.1 Competing quotations shall be sought, unless the purchase is made through an existing Trust contract. Refer to paragraph 9.4.

9.3.3.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.3.4 Non-Estates Purchases above £25,000

9.3.4.1 Competitive tendering shall be conducted by the Trust's Procurement Department. Refer to paragraph 9.5.

9.3.4.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.3.5 Non-Estates Purchases above the EU Tender Threshold

9.3.5.1 Competitive tendering in compliance with the EU Procurement Regulations shall be conducted by the Trust's Procurement Department. Refer to paragraph 9.5.

9.3.5.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.3.6 Estates Purchases between £3,000 and £100,000

9.3.6.1 Competing quotations shall be sought unless the purchase is made through an existing Trust contract. Refer to paragraph 9.4.

9.3.6.2 Estates purchases relate to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.3.7 Estates Purchases above £100,000

9.3.7.1 Competitive tendering shall be conducted by the Trust's Estates Department in conjunction with the Trust's Procurement Department requirements. Refer to paragraph 9.5.

9.3.7.2 Estates purchases relate to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.3.8 Estates Purchases above the EU Tender Threshold

9.3.8.1 Competitive tendering in compliance with the EU Procurement Regulations shall be conducted by the Trust's Estates Department. Refer to paragraph 9.5.

9.3.8.2 Estates purchases relate to building and engineering works as defined within the EU Public Procurement Regulations Works contracts.

9.4 COMPETING QUOTATIONS

9.4.1 For non-Estates purchases between £3,000 and £25,000 and Estates purchases below £100,000 which are not purchased through an existing Trust contract, three competing quotations shall be obtained in writing.

9.4.2 The value of contracts allocated without formal competitive tendering shall not exceed £25,000 in the case of non-Estates goods or services or £100,000 in the case of Estates purchases (as detailed in paragraph 9.5.1).

9.4.3 Where three competing quotations are not able to be obtained, the Finance Director shall be informed, in writing, of the reasons for and the outcome of the limited quotations. A copy of the written record shall also be retained by the Finance Director along with the associated project working papers.

9.5 COMPETITIVE TENDERING

9.5.1 The Board shall ensure that competitive tenders are invited for:

(a) the supply of goods with a monetary value in excess of £25,000;

(b) the supply of materials and manufactured articles with a monetary value in excess of £25,000;

(c) the rendering of services, including consultancy costs, with a monetary value in excess of £25,000;

(d) building and engineering works as defined within the EU Public Procurement Regulations Works contracts, with a monetary value in excess of £100,000;

(e) for fee bids which take price into consideration for disposals and for all other projects.

9.5.3 Competitive tendering is not required:

a) where the goods or services can be obtained through an existing Trust contract.

b) The goods or services can be obtained through a pre-tested competitive framework or catalogue arrangement to which the Trust has legitimate access and meets the requirements of EU Public Procurement Regulations.

9.5.4 The Trust shall ensure that invitations to tender are advertised in a manner that allows any interested suppliers to apply to tender in order to provide fair and adequate competition.

9.5.5 When shortlisting suppliers to be invited to tender, the Trust shall consider amongst other factors:

a) their financial stability;

b) their experience to date;

c) references; and

d) the capacity of the suppliers to supply the goods or materials or to undertake the services or works required.

9.5.6 The Trust may, from time to time, use framework agreements as an alternative procurement route to a full invitation to tender process. Any frameworks used

(a) must have been advertised in the Official Journal of the European Union

(b) have provision for the Trust to utilise them and

(c) the resulting framework agreement must have been awarded in full compliance with EU Procurement Regulations.

9.5.7 When a framework agreement is used, the Trust will either:

(a) conduct a further competition to select the preferred bidder; or

(b) use the direct award process (where pricing is disclosed upfront and the preferred bidder is selected on lowest price).

9.5.8 The use of a framework agreement is considered to be competitive tendering. Any references throughout this document to ‘invitations to tender’, ‘tenders’, ‘tendering’ etc. shall be interpreted to include and apply to further competitions conducted under framework agreements and direct contract awards made under framework agreements.

9.6 EXCEPTIONS TO TENDERING (SINGLE SOURCING WAIVER)

9.6.1 Competitive tendering may be waived under the following circumstances:

(a) as provided for under paragraphs 9.6.3 and 9.6.6 and 9.13 (Disposals).

(b) where so provided in DH and NHSI guidance.

(c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender.

(d) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(f) where in the opinion of the Chief Executive and the Finance Director, the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances.

(g) the supply of proprietary or other goods and the rendering of services where such goods or services are of a special or unique character, for which, in the opinion of the Chief Executive and the Finance Director it is neither possible nor desirable to purchase through competitive tendering.

(h) the supply of goods or manufactured articles of any kind which, in the opinion of the Chief Executive and the Finance Director are required quickly for the continuance of the provision of the service provided by the Trust and are not obtainable under existing contracts.

9.6.2 In the event of any of the above referenced circumstances where competitive tendering is waived, the reasons shall be set down in a permanent and signed record. The signed record shall be retained with the associated project working papers and the original signed record shall be retained by the Director of Corporate Governance/Trust Secretary.

9.6.3 The provisions of this paragraph apply where EU procurement regulations have been satisfied.

9.6.4 Where it is proposed that competitive tendering shall be waived and single tender action is being proposed, the relevant Director shall provide detailed information in writing regarding:

(a) the justification for single tender action (as per 9.6.1 above);

(b) compliance with public procurement regulations (EU Directives);

(c) the possible effects of not seeking competitive tenders; and

(d) the effect on and level of value for money achieved.

9.6.5 Where it is proposed that competitive tendering shall be waived, the information (as detailed in paragraph 9.6.4) shall be presented to the Finance Director. The Finance Director shall seek further authorisation from the Chief Executive for waiving of tenders over £500,000. Where the Finance Director and/or the Chief Executive approve the waiving of competitive tendering, the relevant record (as detailed in paragraph 9.6.4) shall be authorised. Where the approval to waive competitive tendering is authorised, such decisions shall be reported by the Finance Director to the Trust's Audit Committee.

9.7 INVITATIONS TO TENDER

9.7.1 All invitations to tender shall be in compliance with these Standing Orders and be submitted in either:

(a) hard copy; or
(b) electronically using the Trust's e-tendering portal.

9.7.2 For hard copy tender returns it will be stated that no tender shall be accepted unless it is submitted in either the special envelope/package provided by the Trust or a plain, sealed envelope/package bearing the word "Tender" followed by the subject to which it relates and the latest date and time for receipt of such tender.

9.7.3 For electronic returns the 'Sealed' option for viewing responses shall be used.

9.7.4 Every tender for goods, materials, services or disposals shall embody the NHS Standard Contract Conditions that the tender shall be awarded under, unless a framework agreement is used, in which case the framework agreement terms and conditions shall prevail.

9.7.5 Every tender for building and engineering work, except any tender for maintenance work only (where DH and NHSI guidance shall be followed), shall be in the terms of the current editions of the Appropriate Standard Forms of Contract. Where appropriate, these base documents shall be modified and amplified to accord with extant DH and NHSI guidance and other instructions and, in minor respects, to cover special features of individual projects.

9.7.6 All invitations to tender shall state in the invitation to tender that no tender shall be accepted unless it includes details of at least three recent referees who can be contacted to provide information on the technical and organisational competence of the tenderer, and the latest set of published financial statements of the tenderer.

9.7.7 All invitations to tender shall require tenderers to submit prices exclusive of VAT where applicable

9.7.8 All persons involved in a tender evaluation are required to provide a written declaration that their involvement in the tender evaluation poses no conflict of interest.

9.8 RECEIPT AND SAFE CUSTODY OF TENDERS

9.8.1 The Director of Corporate Governance/Trust Secretary shall be responsible for the receipt, endorsement and recording of competitive tenders in the competitive tendering register and, for hard copy tender returns, for the safe custody of tenders received until the time appointed for their opening.

9.8.2 The competitive tendering register shall be in the form of a bound book with pre-numbered pages. For reference purposes, an example of the type of information held within the competitive tendering register has been included as Appendix A.

9.8.3 The date and time of receipt of each tender shall be endorsed by the Director of Corporate Governance/Trust Secretary on the unopened tender envelope/package and recorded in the appropriate register (as detailed in paragraph 9.8.2).

9.8.4 For electronic tender returns, tenders may not be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

9.9 OPENING TENDERS

9.9.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, tender returns shall be opened by or in the presence of two senior officers/managers designated by the Chief Executive, one of whom shall by an Executive Director.

9.9.2 For any tenders with a value greater than £1 million, the tenders must be opened in the presence of an additional Executive Director

9.9.3 All Executive Directors and members of the Trust Board will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

9.9.4 All eligible tenders received shall be opened on one and the same occasion.

9.9.5 Every hard copy tender received shall be endorsed with the date of opening and initialled by two persons present at the opening

9.9.6 A record of the opening of the tenders shall be maintained in the appropriate register (as detailed in paragraph 9.8.2). The record is to be signed by the two persons present at the opening of the tenders, in accordance with paragraph 9.9.3 as appropriate. The record shall show for each set of competitive tenders:

(a) the name of all firms invited to tender;

(b) the names of firms from which tenders have been received;

(c) the date the tenders were opened;

(d) the price tendered (excluding VAT).

9.9.7 Except as in paragraph 9.9.8 below, a record shall be retained within the appropriate register (as detailed in paragraph 9.8.2) of apparent price alterations within the tender. The record shall take the form of an addendum to the appropriate register and shall be initialled by at least two of those present at the

opening, signed in accordance with paragraph 9.9.6 as appropriate. The addendum shall detail:

(a) all price alterations on the tender;

(b) the final price shown on the tender;

(c) any letter, document or material enclosed with or accompanying the tender.

9.9.8 A record shall be made in the addendum to the appropriate register (as detailed in paragraph 9.8.2), if the price alterations are so numerous on any one tender as to render the procedure outlined in paragraph 9.9.6 unreasonable in the opinion of the Chief Executive or the Director of Corporate Governance/Trust Secretary.

9.9.9 All records required to be maintained shall be held in the custody of the Director of Corporate Governance/Trust Secretary.

9.10 ADMISSIBILITY OF TENDERS

9.10.1 Late tenders shall not be considered, except in exceptional circumstances, and in any event shall only be accepted in compliance with EU and UK legislation, and where appropriate, after seeking legal counsel.

9.11.2 Where such tenders are accepted, a permanent signed record shall be kept of the reasons for their admission, and the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.10.3 Amended or re-submitted tenders shall not be considered after the due time for receipt.

9.10.4 Incomplete tenders are those from which information necessary for the adjudication of the tender is missing. These shall be dealt with in accordance with paragraph 9.10.5 to 9.10.7 below.

9.10.5 If it is considered necessary by the Chief Executive or his/her nominated officer to discuss with a tenderer the contents of his/her tender in order to elucidate technical points before the award of a contract, the tender need not be excluded from the adjudication. A record of the nature of the discussion and its outcome shall be kept. For hard copy tenders, the record shall be signed and retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.10.6 Where the examination of tenders reveals errors which, in the opinion of the Chief Executive or his/her nominated officer, would affect the tender figures, the tenderer is to be given details of such errors and given the opportunity of confirming or withdrawing their offer. In such circumstances, the tender need not be excluded from the adjudication and a record of the nature of the discussions and their outcomes shall be kept. In these circumstances, for hard copy tenders, the record shall be signed and retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.10.7 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration and while negotiations are in progress or re-tenders are being sought, the tender documents shall be kept strictly confidential and held in safe

custody by the Chief Executive or the Director of Corporate Governance/Trust Secretary.

9.11 ACCEPTANCE OF TENDERS

9.11.1 Non-Competitive Tenders

9.11.1.1 Where only one tender is sought and/or received the Chief Executive or his/her nominated officers shall, as far as is practicable, determine that the price to be paid is fair and reasonable and keep a signed record of the reasons for this decision. In such circumstances, the signed record is to be retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.11.1.2 In circumstances where no tender is received by the Trust

(a) For tenders below the EU Tender Threshold the Chief Executive shall empower the Finance Director or his/her nominated officer to approach suppliers which can provide the relevant goods or services to the Trust. The Finance Director or his/her nominated officer shall retain a report detailing , in writing:

(i) the content and outcome of their discussions with the approached firms;

(ii) the agreed prices for the provision of the specified goods or services;

(iii) the recommendations as to which firms shall provide the goods or services to the Trust.

(b) For tenders above the EU Tender Threshold, the Finance Director or his/her nominated officer shall undertake a further procedure in accordance with EU and UK legislation The Finance Director or his/her nominated officer produce a written report detailing:

(i) the content and outcome of their discussions with the approached firms;

(ii) the agreed prices for the provision of the specified goods or services;

(iii) the recommendations as to which company shall provide the goods or services to the Trust.

9.11.1.3 The Finance Director shall forward the record (as detailed in paragraph 9.11.1.2) to the Chief Executive or the Trust Board for approval of their recommendations as per the financial limits detailed in the Scheme of Delegation.

9.11.1.4 Where this procedure is adopted, the Finance Director shall maintain the duly authorised record, and report the decisions made to the Trust's Audit Committee.

9.11.1.5 In circumstances where the Chief Executive or his/her nominated officer determine that the price to be paid is not fair and reasonable, no contract award will be made. If the Trust determines that the goods/services are still required, the process outlined in 9.11.1 to 9.11.1.4 shall be followed.

9.11.2 Basis for Acceptance of a Tender

9.11.2.1 The basis for the acceptance of a tender shall be that which is the Most Economically Advantageous Tender (MEAT) to the Trust and this may be, but is not necessarily, that with the lowest price where payment is made by the Trust.

9.11.2.2 The possible criteria for acceptance of the tender shall be:-

(i) price
(ii) quality
(iii) delivery date
(iv) cost effectiveness
(v) aesthetic characteristics
(vi) functional characteristics
(vii) technical merit
(viii) after sales merit
(ix) technical assistance
(x) any other relevant criteria.

9.11.2.3 The basis for the acceptance of a hard copy tender shall be kept in a signed record, signed in accordance with paragraph 9.9.5. The signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.11.3 Tender Other than the Lowest

9.11.3.1 Any tender accepted shall be the most economically advantageous to the Trust, where payment is made by the Trust or have the highest income where payment is received by the Trust.

9.11.3.2 A tender, other than the lowest where payment is to be made by the Trust or the highest where payment is to be received by the Trust, shall only be accepted for good and demonstrable reasons if the Chief Executive or his/her nominated officer so decide and keep a signed record of that decision. This decision shall then be reported to the Trust Board. The original signed record shall be retained with the Trust Board's relevant working documents and a copy shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.8.2).

9.11.4 Financial Competence

9.11.4.1 Any tender or quotation shall only be accepted by the Trust where the Finance Director is satisfied with the financial competence of the firms involved. Such assurance shall be sought by the use of financial criteria, to be determined as appropriate by the Finance Director or his/her nominated officer, to analyse the financial information received with the tender documentation, and any other documentation the Finance Director or his/her nominated officer consider appropriate.

9.11.4.2 In circumstances where the Finance Director is not satisfied with the financial competence of the firms, the position shall be discussed by the Finance Director or his/her nominated officer with the firms in an attempt to be satisfied with the tenderer's financial competence on behalf of the Trust.

9.11.4.3 Only where the Finance Director is satisfied with the financial competence of the firms shall the tender or quotation be assigned to those firms. A permanent, signed record of the discussions and outcomes shall be retained with the appropriate working papers used to analyse financial competence and retained

within the Finance department - where the records can be viewed by appropriate officers of the Trust as appropriate.

9.11.5 Technical & Organisational Competence

9.11.5.1 Any tender or quotation shall only be accepted by the Trust where the Director responsible for the originating department or his/her nominated officer is satisfied with the technical and organisational competence of the firms involved.

9.11.5.2 At least one recent reference shall be taken up from the selection of three provided with the tender documentation of the chosen tenderer. Any tender shall only be accepted where the references taken up are satisfactory, in the opinion of the relevant Director or his/her nominated officer (as detailed in paragraph 9.11.5.1).

9.12 POST-TENDER NEGOTIATIONS

9.12.1 Post tender negotiations with the successful tenderer shall only be performed with the prior agreement of the Chief Executive or the Finance Director and a signed record shall be kept of the reasons for the negotiations and the outcome of the discussions, with the signed record being retained with the associated tender working papers.

9.13 DISPOSALS

9.13.1 Paragraph 9.5 (Competitive Tendering) shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer.

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procedures of the Trust related to disposals and condemnations;

(c) items arising from works of construction, demolition or site clearance, which shall be dealt with in accordance with the relevant contract;

(d) land or building concerning which Department of Health guidance has been issued, but subject to compliance with such guidance;

(e) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

9.14 IN HOUSE SERVICES

9.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

9.15 FORMS OF CONTRACT

9.15.1 Every contract for building and engineering works (except contracts for maintenance work only where DH and NHSI guidance shall be followed) shall be covered by a suitable form of contract, for example the Joint Contracts Tribunal (JCT) Minor Building Works contract or the National Engineering Council (NEC) contract. In the case of contracts for building and engineering works costing more than £100,000 (or such other amount as the Department of Health may from time to time determine), the contract shall be embodied in a formal document executed under seal.

9.15.2 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS and in accordance with Standing Orders, there shall, where possible, be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010, Trust's Anti-Fraud Policy and other appropriate legislation.

9.15.3 **Determination of Contracts for Failure to Deliver Goods or Material** – Where possible, there shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.15.4 **Contracts involving Funds Held on Trust** – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act 2006.

9.15.5 Anyone tasked with entering into contract negotiations shall seek assistance from the Trust's Legal Department, and where advised appropriate, seek external legal advice from Trust Solicitors and other professional groups such as NHS Protect.

9.16 ADVANCE AND PHASED PAYMENTS

9.16.1 Advance payments, except those made for capital building projects or software licences as laid down in the conditions of contract, are only to be made in exceptional circumstances and shall only be made following the agreement of the Chief Executive and/or the Finance Director or his/her nominated officer.

9.16.2 Phased payments, except those made for capital building projects, as laid down in the conditions of contract, are only to be made if authorised by the Chief Executive and/or Finance Director or his/her nominated officer.

9.16.3 A signed record shall be kept of the reasons for this method of payment, with the signed record being retained with the associated tender working papers.

9.17 APPLICATION OF LIQUIDATED AND ASCERTAINED DAMAGES ON CONSTRUCTION CONTRACTS

9.17.1 The Chief Executive or his/her nominated officer shall normally enforce the application of liquidated and ascertained damages on construction contracts, except where the Chief Executive or his/her nominated officer determine that they should be waived. In circumstances where such damages are waived the Chief Executive shall note the reasons in a signed record, which will be passed to the Finance Director and presented to the Audit Committee as appropriate.

9.18 REPORTING OF TENDER ACTIVITY

9.18.1 The Director of Corporate Governance/Trust Secretary shall report to the Board any tenders received and the names of those organisations tendering.

9.18.2 After the analysis of tenders by the senior manager responsible has completed, the Director of Corporate Governance/Trust Secretary shall report to the Board for noting in the Part 2 meeting:

(a) what was being tendered,
(b) the names of those tendering and
(c) the amounts of each tender.

9.18.3 This report is to be presented as soon as practicable after tenders have been opened.

9.18.4 The senior manager responsible for the procurement shall provide the Director of Corporate Governance/Trust Secretary with sufficient information to enable the reporting required at paragraph 9.18.2.

9.19 PRIVATE FINANCE INITIATIVE (PFI)

9.19.1 Where appropriate the Trust will test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits set by the Department of Health (DoH), a business case must be referred to the organisation designated by the DoH for approval.

(c) The proposal must be specifically agreed by the Board.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

10. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

10.1 Contractual Arrangements and Service Level Agreements (SLAs)

10.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable contractual arrangements with service commissioners for the provision of NHS services.

10.1.2 All SLAs should specify the agreed priorities within the service specification, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service and quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on activity and associated cost;

(d) the latest NHS planning guidance;

(e) that contracts build where appropriate on existing Joint Investment Plans; and

(f) that contracts are based on integrated care pathways.

10.1.3 No Officer of the Trust may provide Trust services to another organisation or entity, unless those services are specified in contractual agreements agreed to and signed by the Chief Executive Officer or their delegate as defined in the scheme of delegation.

10.1.4 The Trust board is responsible for approving arrangements for the submission of tenders to provide services by the Trust.

10.2 Involving partners and jointly managing risk

10.2.1 A good contractual arrangement will result from a collaborative dialogue between Commissioners of the service and the Trust (for example clinicians, users, carers, public health professionals and managers). It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contractual arrangements will apportion responsibility for handling a particular risk to the party or parties in the best position(s) to influence the event and financial arrangements should reflect this. In this way that Trust can jointly manage risk with all interested parties.

10.3 Reports to Board on Contractual Arrangements and SLAs

10.3.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract.

10.4 SHARED AND HOSTED SERVICE ARRANGEMENTS

10.4.1 Where the Trust uses a shared or hosted service provided by another NHS organisation or private company to undertake part of its functions, these functions shall remain the ultimate responsibility of the Trust.

10.4.2 Where an external organisation is responsible for the provision of a Financial Shared Service on behalf of the Trust, the Shared Financial Service provider must be contractually bound to deliver the financial services to the Trust, and the Finance Director shall oversee and retain overall accountability in relation to the delivery of the financial services provided to the Trust.

10.4.3 The contractual agreement with an overarching SLA agreed between the Trust and the Shared Financial Services provider must set out the arrangements for the delivery of a Shared Financial Service with a clearly defined mechanism in order to monitor and report the performance in full.

10.4.4 All arrangements detailing accountability, responsibilities and authority of the respective parties must be clearly set out in the KPIs. The KPIs must also set out the framework by which the Trust and its auditors can gain assurance and the timescales by which this will be provided.

10.4.5 In the case of Shared Financial Services, the Finance Director shall ensure an adequate Internal Audit Service is specified in any contractual agreement between the Trust and the Shared Financial Service provider, and shall specify the assurance arrangements between the Internal and External Auditors for the Trust and the Shared Financial Services' Auditors.

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EMPLOYEES

11.1 REMUNERATION

11.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

11.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust as determined by the committee but normally to include the first layer of management below Board of Director level including:

i. all aspects of salary (including any performance related elements or bonuses);

ii. provisions for other benefits, including pensions and cars;

iii. arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of office members of the Board as per 11.2.1 (a) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members and other senior employees as per SFI 11.1.2 (a);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.1.3 The Committee Chairman shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities. The minutes of the relevant Board meetings are formally to record decisions taken.

11.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for senior management, the definition of which shall be determined by the Committee.

11.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

11.2 FUNDED ESTABLISHMENT

11.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may not be varied without the approval of the Workforce Control Panel, both the Director of Workforce and the Finance Director, the Executive Leadership Team or the Chief Executive except as detailed in 11.3 and 11.4 below.

11.2.3 Changes resulting in variation from the annual budget exceeding £500k must be approved by the Trust Board.

11.3 STAFF ESTABLISHMENT AND APPOINTMENTS

11.3.1 No officer or member of the Trust Board may:

(a) establish a new post;
(b) engage, re-engage, or re-grade employees, either on a permanent or temporary nature;
(c) hire agency staff; or
(d) agree to changes in any aspect of remuneration (including the issuing of schemes of incentives and incentivised overtime);

unless the authorisation of the Chief Executive Officer has been provided in writing and communicated to the Finance Director and Director of Workforce.

11.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

11.4 OVERTIME AND OTHER VARIABLE REMUNERATION CLAIM APPROVAL

11.4.1 The Chief Executive Officer is responsible for approving a system/process for submitting and authorising Overtime and other variable remuneration claims.

11.4.2 The approved system/process must provide any information required by the Finance Director in order to maintain appropriate financial control, and must provide any information required by the Director of Workforce in order to process claims for payment, in a timely manner.

11.4.3 The system/process must:

(a) ensure that overtime has been pre-approved before it is worked (except in the case of shift over run overtime at end of shift) and that budget is available for that overtime;

(b) ensure confirmation is received that the work the payment is due for was completed satisfactorily;

(c) ensure claims are approved by the budget holder responsible for the area the work is completed in;

(d) allow the purpose and location for which the overtime or other remuneration was applied to be identified and reported on;

(e) detail where overtime and other variable remuneration is due, and whether claims in relation to it have been paid or remain unpaid, and provide for this to be reported.

11.6 PROCESSING OF PAYROLL

11.6.1 The Director of Workforce is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notification;

(b) the final determination of pay remitted and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

11.6.2 The Director of Workforce will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment; and

(f) authority to release payroll data under the provisions of the Data Protection Act.

11.6.3 The Finance Director will issue instructions to the Shared Financial Services provider in respect of:

(a) methods of payment available to various categories of employee;

(b) procedures for payment by cheque, bank credit to employees;

(c) procedure for the recall of cheques and bank credits;

(d) maintenance of regular and independent reconciliation of pay control accounts;

(e) separation of duties of preparing records and handling cash; and

(f) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

11.6.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the instructions of the Director of Workforce and in the form prescribed by the Director of Workforce; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce must be informed immediately.

11.6.5 Regardless of the arrangements for providing service, the Director of Workforce shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.7 CONTRACTS OF EMPLOYMENT

11.7.1 The Board shall delegate responsibility to the Director of Workforce for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment;

(c) signing employment contracts, variations and other related documents on behalf of the Trust; and

(d) ensuring electronic copies of all employment contracts, and related variations are maintained in an accessible manner.

12. NON-PAY EXPENDITURE

12.1 DELEGATION OF AUTHORITY

12.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level; and

(c) the list of managers who are authorised to sign official documents on behalf of the Trust; a list of authorised signatories will be held by the Finance Department.

12.1.3 The list of authorised signatories held by the Finance Department with such thresholds will be advised to the Shared Financial Services on a regular basis to ensure on-going compliance. This is specified in the contractual agreement between the Trust and the Shared Financial Services.

12.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.1.4 Budget holders are expected to manage within their delegated non-pay budgets.

12.1.6 Changes to delegated non-pay budgets must be approved by the Chief Executive Officer in writing and communicated to the Finance Director.

12.1.7 Changes resulting in variation from the annual budget exceeding £500k must be approved by the Trust Board.

12.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

12.2.1 The Budget Holder, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Finance Director or his/her nominated officer shall be sought.

12.2.2 Requisitions are not to be split or otherwise raised in a manner devised so as to avoid the financial thresholds. No requisition is to be raised which would cause a budget overspend, unless expressly agreed in advance in writing by the Finance Director, and a budget virement agreed. Breaches of this requirement may result in the enactment of the disciplinary process determined by the Finance Director (as noted in 5.3.1 (e)).

12.2.3 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Shared Financial Services are contracted to carry out the above procedure on behalf of the Trust, this is part of the contractual agreement between the Shared Financial Services and the Trust.

12.2.4 The Finance Director will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) a list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and that charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined.
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

12.2.5 The Shared Financial Services will provide the Trust with the appropriate monitoring on the Better Payment Practice Code as required. Pre-payments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%, or where in the nature of the business, prepayment is a normal term and condition eg telephone line rental).

(b) the appropriate officer must provide, in the form of a written report to the Finance Director, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to make his commitments;

(c) the Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a pre-payment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

12.2.6 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Finance Director;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

12.2.7 Budget Holders must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

(a) all contracts (except as provided in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;

(b) all leases for property over £3 million in value over the life of the lease must be referred to the NHSI for approval prior to commitment.

(c) contracts above specified thresholds are advertised and awarded in accordance with EU on public procurement.

(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health

(e) no requisition/order may be approved for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases on purchasing cards within the limits of the instructions issued by the Finance Director and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future un-competitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Finance Director;

(k) purchases from petty cash are restricted in value and by type or purchase in accordance with instructions issued by the Finance Director;

(l) petty cash records are maintained in a form as determined by the Finance Director.

(m) purchases using purchasing cards are restricted in value and by type of purchase in accordance with instructions issued by the Finance Director.

(n) Purchasing card records are maintained in a form as determined by the Finance Director.

12.2.8 The Chief Executive must ensure that the Trust's Standing Orders are compatible with the requirements issued by the NHS in respect of building and engineering contracts and land and property transactions (The Efficient Management of Healthcare Estates and Facilities (HBN 00-08)). The technical audit of these contracts shall be the responsibility of the Director managing those areas. The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

13 EXTERNAL BORROWING AND INVESTMENTS

13.1 EXTERNAL BORROWING

13.1.1 The Finance Director will advise the Board concerning the Trust's ability to pay interest on, and repay, both the Trust's Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the NHS. The Finance Director is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

13.1.2 The Board will agree the list of employees (including specimen of their signatures) who are authorised to make short term borrowing on behalf of the Trust. This must contain the Chief Executive and the Finance Director.

13.1.3 Any application for a loan or overdraft will only be made by the Finance Director or by an employee so delegated by him and the Board will be informed of this at the following meeting.

13.1.4 The Finance Director must prepare detailed procedural instructions concerning applications for loans and overdrafts.

13.1.5 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money and comply with the latest guidance from the Department of Health.

13.1.6 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Finance Director. The Board must be made aware of all short-term borrowings at the next Board meeting.

13.1.7 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

13.2 INVESTMENTS

13.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board via the Treasury policy.

13.2.2 The Finance Director is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

13.2.3 The Finance Director will maintain the Cash Management Policy and prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13.2.4 The Finance Director will agree the list of employees (including specimen of their signatures) who are authorised to make short term investments on behalf of the Trust. This must contain the Chief Executive and the Finance Director.

14 FINANCIAL FRAMEWORK

14.1 The Finance Director should ensure that members of the Board are aware of all relevant guidance issued by the Trust's regulating authority (NHSI). The Finance Director should also ensure that the direction and guidance issued by the Trust's regulating authority is followed by the Trust.

15 CAPITAL INVESTMENT, PRIVATE FINANCING, ASSET AND EQUIPMENT REGISTERS AND SECURITY OF ASSETS AND EQUIPMENT

15.1.1 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for ensuring that there is a system in place to ensure the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchasers support and the availability of resources to finance all revenue consequences, including depreciation and PDC.

15.1.2 For every capital expenditure proposal above the limits set in the Scheme of Delegation the Chief Executive shall ensure:

(a) that a business case (in line with the guidance issued by the regulating authority) is produced setting out:

(i) an option appraisal comparing potential benefits compared with known costs to determine the option with the highest possible ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangement; and

(b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

15.1.3 The Finance Director shall assess on an annual basis the requirements for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Efficient Management of Healthcare Estates and Facilities (HBN 00-08) guidance.

15.1.5 The Finance Director shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.6 The Finance Director shall issue procedures for the regular reporting of expenditure and commitments against authorised capital expenditure.

15.1.7 The approval of a capital programme shall not constitute approval for expenditure on any individual scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Efficient Management of Healthcare Estates and Facilities (HBN 00-08) guidance and the Trust's Standing Orders.

15.1.8 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall take fully into account the delegated limits for capital schemes included in DH and NHSI guidance.

15.2 PRIVATE FINANCE

15.2.1 When the Trust proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

(a) The Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum involved does not exceed delegated limits, the business case may be approved by the Trust Board.

(c) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health (or other organisation in line with current regulatory authority guidelines), and only following receipt of authorisation from that organisation may the proposal be approved by the Trust Board.

15.3 ASSET REGISTERS

15.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director and Directors responsible for Trust assets, concerning the form of the register and the method for updating it. The Chief Executive is responsible for arranging for a physical check of assets against the asset register to be conducted at least once a year.

15.3.2 The Trust shall maintain an asset register for recording capitalised assets. The minimum data set to be held within these registers shall be designed so as to generate the standard accounting figures to enable the annual accounts to be produced, and will comply with any guidance issued by the Department of Health or the NHSI.

15.3.3 Additions to the capital asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

15.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

15.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.3.6 The value of each asset shall be indexed to current values in accordance with guidance issued by the Department of Health or the NHSI.

15.3.7 The value of each asset shall be depreciated using methods and rates as specified in guidance issued by the Department of Health or NHSI.

15.3.8 The Finance Director shall calculate and pay PDC as specified in guidance issued by the Department of Health or NHSI.

15.4 SECURITY OF ASSETS

15.4.1 The overall control of capital assets is the responsibility of the Chief Executive.

15.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Finance Director. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) physical security of assets;

(d) periodic verification of the existence of assets recorded;

(e) identification and reporting of all costs associated with the retention of an asset; and

(f) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.4.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Finance Director.

15.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees to the Finance Director in accordance with the procedure for reporting losses. The Finance Director will escalate the report to the Chief Executive and will refer any suspicions of fraud or other criminal activity to the appropriate authority.

15.4.6 Where practical, assets should be marked as Trust property.

15.5 NON-CAPITALISED ASSETS AND EQUIPMENT

15.5.1 The Chief Executive retains overall responsibility for the control and management of non-capitalised assets and equipment.

15.5.2 Directors and Budget Holders must maintain a register of the non-capitalised assets and equipment they are responsible for, in a form defined by the Finance Director. At a minimum, the register must contain:

(a) A description of the item;

(b) The location of the item;

(c) The date of purchase (or the approximate date if not available);

(d) The cost of the item;

(e) The approximate date the item would need to be replaced; and

(f) Who the item is issued to (if applicable).

15.5.3 These registers must be kept up to date, be available to finance on request and will be subject to audit.

16 STORES AND RECEIPT OF GOODS

16.1 Stores of equipment and consumables (either controlled central stores or local departmental stores for immediate use) should be:

(a) kept to a minimum;

(b) subjected to regular stock-take (at least once per year);

(c) valued at the lower of cost or net realisable value.

16.2 Subject to the responsibility of the Finance Director for the system of control, overall responsibility for the control of:

(a) central consumable stores and pharmaceutical stocks shall be delegated to the Director responsible for Logistics;

(b) stocks of vehicle parts, oil and lubricants shall be the responsibility of the Director responsible for Fleet;

(c) stocks of IM&T equipment shall be the responsibility of the Chief Information Officer; and

(d) station consumable, equipment and specialised equipment stores and fuel stocks shall be the responsibility of the Director of Operations.

16.3 The day-to-day responsibility may be delegated by the above Directors to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director.

16.4 The responsibility for security arrangements and the custody of keys for all stores at ambulance stations shall be clearly defined in writing by the Director of Operations. Wherever practical, stocks should be marked as health service property.

16.5 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses. Directors noted in 16.2 above must ensure these procedures are followed and that records detailing the above transactions and stock levels are available upon request.

16.6 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year. Directors noted in 16.2 above must ensure these checks are completed and that records detailing the check and stock levels are available upon request.

16.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

16.8 There will be a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The Directors noted in 16.2 above shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also section 17, Disposals and Condemnations, Losses and Special Payments, Gifts and Donations). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS, GIFTS AND DONATIONS

17.1 DISPOSALS AND CONDEMNATIONS

17.1.1 The Finance Director must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset, the Director or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

(b) recorded by the Condemning Officer in a form approved by the Finance Director which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

17.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

17.2 LOSSES AND SPECIAL PAYMENTS

17.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for losses and special payments, which are in line with HM Treasury Managing Public Money Guidance and the Department of Health Manual for Accounts. These will be authorised by the Audit Committee.

17.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department. The Head of Department must in turn immediately inform the Chief Executive and the Finance Director, or inform an officer charged with the responsibility for responding to concerns involving loss. If an officer other than the Chief Executive or Finance Director is informed, they must then inform the Finance Director and/or Chief Executive as appropriate. Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved. Disciplinary and recovery action should be undertaken wherever appropriate.

17.2.3 In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Finance Director must inform the relevant Area Counter Fraud Specialist in accordance with guidance set out in the NHS Standard Contract (National Commissioning Contract)

17.2.4 The Finance Director must notify the NHS Protect and the External Auditor of all frauds.

17.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board;

(b) the LAFS; and

(c) the External Auditor.

17.2.6 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

17.2.7 The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 For any loss, the Finance Director should consider whether any insurance claim can be made against insurers.

17.2.9 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded.

17.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

17.2.11 A losses and special payments report must be provided to the Audit Committee quarterly.

17.2.12 Any significant losses must be reported to the Audit Committee immediately.

17.3 GIFTS AND DONATIONS OF TRUST PROPERTY

17.3.1 A gift is something voluntarily donated, with no preconditions and without the expectation of any benefit in return.

17.3.2 Items of Trust property may only be gifted or donated to another organisation where it can be demonstrated that the value that could be realised by selling the item is lower than the costs associated with its sale.

17.3.3 Items may only be gifted or donated to non-profit making organisations, and may not be donated to individuals.

17.3.4 The Chief Executive must approve all gifts with a value of less than £5,000, the Trust Board will approve all gifts of £5,000 and below £300,000. Treasury approval is needed for all gifts valued at more than £300,000.

17.3.5 Donations or gifts may not be made to political parties.

18 INFORMATION TECHNOLOGY

18.1 The Finance Director and the Chief Information Officer are responsible for the accuracy and security of the computerised financial data of the Trust, and shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that adequate management (audit) trails exists through the computerised system and that such computer audit reviews as are considered necessary are being carried out.

18.2 The Trust's main finance system is managed on its behalf by an external shared financial services provider. The detailed requirements are specified in the Service Level Agreement with the contractual agreements between the Trust and the shared financial services provider., and should align with the above requirements.

18.3 The Finance Director shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by

another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.4 The Director of Corporate Governance/Trust Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

18.5 The Finance Director shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.6 Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.

18.7 Where computer systems used within the Trust have an impact on, feed information into, or receive information out of corporate financial systems, the Director of Finance and the Chief Information Officer shall be satisfied that:

(a) systems acquisitions, development and maintenance are in line with corporate policies and strategies;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Finance staff have access to such data in a timely manner; and

(d) such computer audit reviews as are considered necessary are being carried out.

18.8 In the case of computer systems which are proposed general applications (i.e. those applications which the majority of Trusts in an NHS environment normally wish to sponsor jointly), all responsible directors and employees will send to the Chief Information Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.10 A person must not knowingly or recklessly, without the consent of the data controller:

- Obtain or disclose personal data or the information contained in personal data; or

- Procure the disclosure to another person.

Unless they can show:

- This was necessary for the purpose of preventing or detecting crime, or was required or authorised by or under any enactment, by any rule of law or by the order of a court;
- That he acted in the reasonable belief that he had in law the right to obtain or disclose the data;
- That he acted in the reasonable belief that he would have had the consent of the data controller; or
- That in the particular circumstances the action was justified as being in the public interest.

Any person found breaching the above could be liable to criminal offences in accordance with Section 55 of the Data Protection Act.

18.11 The Finance Director and the Chief Information Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

19 PATIENTS' PROPERTY

19.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients or found in the possession of deceased patients.

19.2 The Director of Operations must provide detailed written instructions on the collection, custody, and safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

19.3 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.4 The Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20 CHARITABLE FUNDS

20.1 INTRODUCTION

20.1.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities

cover both charitable and non-charitable purposes. The Finance Director shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

20.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

20.1.3 The Finance Director will have primary responsibility to the Board for ensuring that these SFIs are applied to charitable funds.

20.2 **EXISTING FUNDS**

20.2.1 The Finance Director shall arrange for the administration of all existing charitable funds, in conjunction with the Legal Advisor. They shall ensure that a governing instrument exists for every trust fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identity the restricted nature of certain funds.

20.2.2 The Finance Director shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

20.2.3 The Finance Director may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific stations or departments.

20.2.4 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

20.2.5 The Scheme of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion rearing the disposal and use of the funds are to be taken by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

20.2.6 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20.3 **NEW FUNDS**

20.3.1 The Finance Director shall, in conjunction with the Legal Advisor, arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

20.3.2 The Finance Director shall present the governing document to the Board for adoption as required in Standing Orders for each new trust. Such document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Trust to delegate powers to manage and the power to assign the residue of the trust to another fund contingent upon certain conditions, e.g. Discharge of original objects.

20.4 **SOURCES OF NEW FUNDS**

20.4.1 In respect of Donations, the Finance Director shall:

(a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's charitable funds and that the donor's intentions have been noted and accepted.

20.4.2 In respect of **Legacies and Bequests,** the Finance Director shall, with appropriate legal advice:

(a) provide guidelines to officers of the Trust covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary;

(c) be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the, for the appropriate treatment of all legacies and bequests.

20.4.3 In respect of **Fund-raising,** the Finance Director shall:

(a) after consultation with the Legal Advisor, deal with all arrangements for fund-raising by and/or on behalf of the Trust and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Finance Director shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible, along with the Legal Advisor, for alerting the Board to any irregularities regarding the use of the Trust's name or its registration numbers; and

(d) be responsible, after due consultation with the Legal Advisor, for the appropriate treatment of all funds received from this source.

20.4.4 In respect of **Trading Income,** the Finance Director shall:

(a) be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by the Trust as corporate trustee; and

(b) be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

20.5 **INVESTMENT MANAGEMENT**

20.5.1 The Finance Director shall be responsible for all aspects of the management of the investment of income and funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) in conjunction with the Legal Advisor, the formulation of investment policy within the powers of this Body under Statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and where appropriate, fund managers and:

(i) the Finance Director shall agree, in conjunction with the Legal Advisor, the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of NHS Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

20.6 **DISPOSITION MANAGEMENT**

20.6.1 The exercise of the Trust's dispositive discretion shall be managed by the Finance Director in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each charitable fund;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and

(f) the definitions of "charitable purposes" as agreed by the NHS and the Charity Commission.

20.7 BANKING SERVICES

20.7.1 The Finance Director shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

20.8 ASSET MANAGEMENT

20.8.1 Charitable fund assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets. The Finance Director shall ensure:

(a) in conjunction with the Legal Adviser, that appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the charitable funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Trust.

20.9 REPORTING

20.9.1 The Finance Director shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

20.9.2 The Finance Director shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

20.9.3 The Finance Director, in conjunction with the Legal Advisor, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the NHS and to the Charity Commission for adoption by the Board.

20.10 ACCOUNTING AND AUDIT

20.10.1 The Finance Director shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

20.10.2 The Finance Director shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

20.10.3 The Board shall be advised by the Finance Director on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

20.11 ADMINISTRATION COSTS

20.11.1 The Finance Director shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

20.12 TAXATION AND EXCISE DUTY

20.12.1 The Finance Director shall ensure that the Trust's liability to taxation and excise duty (excluding PAYE, NI and Pensions) is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

20.12.2 The Director Workforce is responsible for ensuring the Trust's liability to PAYE, NI and Pensions are managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

21 ACCEPTANCE OF GIFTS BY STAFF

21.1 The Director of Corporate Governance/Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

22 RETENTION OF RECORDS

22.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines, currently the Records Management: NHS Code of Practice.

22.2 The records held in archives shall be capable of retrieval by authorised persons

22.3 Records held in accordance with the Records Management: NHS Code of Practice shall only be destroyed at the express instigation of the Information Governance Manager within the authority delegated by the Chief Executive. Records shall be maintained of documents so destroyed.

23 RISK MANAGEMENT

23.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

23.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured; and

(g) arrangements to regularly review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

23.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme, this decision shall be reviewed annually.

23.4 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, four exceptions when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

1) Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
2) Where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;
3) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority; and
4) Where the Trust cannot obtain appropriate cover from the NHSLA and any required regulatory authority approval is sought and provided.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Finance Director should consult the Department of Health.

23.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, the Director of Corporate Governance/Trust Secretary shall ensure that the arrangements entered into are appropriate and

complementary to the risk management programme. The Finance Director shall ensure that documented procedures cover these arrangements.

23.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Finance Director shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

23.7 All the risk-pooling schemes require members to make some contributions to the settlement of claims (the 'deductible'). The Finance Director should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix A

London Ambulance Service NHS Trust
Competitive Tendering Register
Record of Invitations to Tender

Tender:	
Reg. No:	
Date & Time:	
Estimated Value:	
Date Reported to Trust Board:	
Present At Opening:	
Closing Date:	
Name	**Amount**

APPENDIX IX:

SCHEME OF DELEGATION AND FINANCIAL LIMITS

Please Note: Where a particular officer or director mentioned in this scheme of delegation has a formally appointed deputy, that deputy is able to exercise the authority given to that officer when the officer is absent from the Trust's premises for longer than one day or as otherwise agreed in writing between the deputy and the officer and notified to the Finance Director.

Unless otherwise noted, all references to financial limits apply to the value of the transaction excluding any applicable VAT.

Ref Number	Delegated Responsibilities	Delegated Officer	SFI Reference
1	**Standing Orders & Standing Financial Instructions**		
1.1	Approving Standing Orders and Standing Financial Instructions	Trust Board	
1.2	Approving suspensions of Standing Orders	Trust Board with review by Audit Committee	
1.3	Monitoring compliance with Standing Orders and Standing Financial Instructions.	Audit Committee	
1.4	Final Authority on Interpretation of Standing Orders	Chairman	
1.5	Exercising the powers the board has retained for itself in an emergency	Chairman and Chief Executive having consulted at least two NEDs	
1.6	Creation and Submission of Standing Orders for Authorisation	Chief Executive	
1.7	Creation and Submission of Standing Financial Instructions for Authorisation	Finance Director	
2	**Audit Arrangements**		
2.1	Approving Internal and External Audit Arrangements	Trust Board following advice from Audit Committee	
2.2	Deciding on action in response to the external auditors' management letter	Trust Board	
2.3	Receiving the minutes of the Audit Committee	Trust Board	
2.4	Submitting External Auditor's management letter to the Trust Board	Chief Executive	
2.5	Following though the implementation of all recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office.	Chief Executive	
2.6	Managing arrangements for the provision of external audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Finance Director	
2.7	Managing arrangements for the provision of internal audit, and involving the Audit Committee in selection processes when/if a service plan is changed	Director of Corporate Governance	

2.8	Monitoring and ensuring compliance with directions set out in the NHS Standard Contract (National Commissioning Contract) on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Finance Director	
2.9	Monitoring reliance placed upon the internal audit function of the Trust's Shared Financial Services function by either internal or external audit.	Finance Director	
2.10	Approving the appointment of external auditors to provide non-external audit services in line with Trust Policy	Audit Committee	
3	**Banking**		
3.1	Approving Banking Arrangements	Trust Board	
3.2	Managing banking arrangements and advising on the provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.	Finance Director or Deputy	
3.3	Reviewing banking arrangements at regular intervals	Finance Director	
4	**Financial Strategy and Performance**		
4.1	Setting overall policy and strategy for the financial performance of the Trust within the requirements of the Secretary of State or Regulatory Authority	Trust Board	
4.2	Responsible for the performance of the Trust subject to accountability to the Trust Board	Chief Executive	
4.3	Delegation of responsibility for budgets to Directors and agreement to virement	Chief Executive	
4.4	Overall Financial Control and implementation of Trust Financial Policies	Finance Director	
4.5	Advising the Chief Executive and Directors on budgets allocated and spending against budgets	Finance Director	
5	**Financial Plan, Operating Plan, Annual Report and Accounts**		
5.1	Receiving and deciding on reports submitted by the Chief Executive and/or Finance Director	Trust Board	
5.2	Approving the financial plan submitted by the Director of Finance	Trust Board following review by Finance and Investment Committee	
5.3	Approving the operating plan submitted by the Director of Transformation and Strategy	Trust Board	
5.4	Approving Annual Report and Accounts	Trust Board	
5.5	Reviewing the Annual Financial Statements prior to submission to the Trust Board	Audit Committee	
5.6	Compiling and submitting annual financial and operating plan to the Trust Board	Chief Executive	
5.7	Approving financial reports for submission to the Trust Board	Chief Executive	
5.8	Compiling and submitting Annual Report for the Trust to the Trust Board	Chief Executive	

5.9	Approving budget for submission	Chief Executive	
5.10	Preparing and submitting financial plan and reports to the Chief Exec for approval prior to submission to the Trust Board	Finance Director	
5.11	Devising and maintaining systems of budgetary controls	Finance Director	
5.12	Monitoring financial performance and reporting to the Trust Board	Finance Director	
5.13	Submitting Financial Statements and Accounts to the Trust Board	Finance Director	
5.14	Preparing and submitting operating plan to the Trust Board	Director of Transformation and Strategy	
6	**Delegation of the management of budgets and approval to spend funds (revenue & capital)**		5
6.1	Budgetary control		
6.1.1	Delegation of the management of individual budgets if included within the Trust approved Plan and agreed at the commencement of the financial year	Director	
6.1.2	Movements from reserves:		
	Up to £500,000	Finance Director	
	Over £500,000	Chief Executive Officer (if previously approved by the Finance Director)	
6.1.3	Virements:		
	Up to £50,000 and not between pay and non-pay	Director	
	Above £50,000 or below £50,000 and between pay and non-pay	Finance Director or Chief Executive	
6.2	**Staff and Agency Staff Appointments and Regrading**		11
6.2.1	Approval of, and signing contracts for new staff appointments and regrading if within budgeted establishment:		
	Up to £90,000 basic salary (excluding on-costs)	Director	
	Above £90,000 (excluding on-costs)	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)	
6.2.2	Approval of Material Staff Restructures	Executive Leadership Team (ELT) approval	
6.2.3	Approval of appointments and amendments of charges in relation to agency staff if within budget (and in accordance with regulatory authority requirements):		
	Within regulatory authority price limits (non-VSM)	Director	
	Above regulatory authority price limits (non-VSM)	Finance Director within Trust Board approved process on exceptional patient safety grounds only	

	VSM Posts	Chief Executive (all Director/VSM posts must be submitted to regulatory authority for approval)	
6.2.4	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director	
6.3	**Other Pay Expenditure**		11
6.3.1	Approval of schemes of incentives or incentivised overtime or other pay expenditure within budget	Finance Director and Director of Operations	
6.3.2	Approval of other pay expenditure and claims within budget (e.g. approving overtime worked, incentives due and approving staff or agency staff timesheets)		
	Up to £2,500	Budget Holder Level 1	
	Up to £5,000	Budget Holder Level 2	
	Up to £25,000	Budget Holder Level 3	
	Up to £50,000	Budget Holder Level 4	
	Up to £100,000	Budget Holder Level 5	
	Up to £500,000	Finance Director	
	Up to £1,000,000	Chief Executive	
	Up to £2,000,000	Chief Executive or Finance Director with ELT approval	
	Up to £5,000,000	Chief Executive or Finance Director with FIC approval (after ELT review)	
	Over £5,000,000	Chief Executive or Finance Director with Trust Board approval (after FIC review)	
6.3.3	Introduction of further control processes and restrictions in addition to the above.	Trust Board with recommendation from Finance Director	
6.4	Approval of pay expenditure £250,000 or more in excess of budget:		11
	Up to £500,000 cumulative in financial year	Chief Executive and Finance Director and reported to Audit Committee	
	Over £500,000	Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with SFI 11	
6.5	**Credit notes**		8
6.5.1	Reimbursing income previously invoiced (correcting an error):		
	Up to £25,000	Head of Financial Services	
	Up to £100,000	Deputy Finance Director	
	Up to £250,000	Finance Director	
	Over £250,000	Audit Committee	

6.5.2	Where cancelling and re-raising invoice (e.g. incorrect organisation, additional information requested on invoice): Up to £100,000 Up to £250,000 Up to £500,000 Over £500,000	 Head of Financial Services or Deputy Head of Financial Services Deputy Finance Director Finance Director Audit Committee	
6.5.3	All credit notes must be reported to the Audit Committee on a quarterly basis	Head of Financial Services	
6.6	**Non-Pay Expenditure**		12
6.6.1	Authorisation of non-pay expenditure (revenue and capital, including leases and service contracts valued over the term of the agreement but excluding business rates and NHS Litigation Authority expenditure) within budget or for capital, within the capital plan: Up to £2,500 Up to £5,000 Up to £25,000 Up to £50,000 Up to £100,000 Up to £500,000 Up to £1,000,000 Up to £2,000,000 Up to £5,000,000 Over £5,000,000	 Budget Holder Level 1 Budget Holder Level 2 Budget Holder Level 3 Budget Holder Level 4 Budget Holder Level 5 Finance Director Chief Executive Chief Executive or Finance Director with ELT approval Chief Executive or Finance Director with FIC approval (after ELT review) Chief Executive or Finance Director with Trust Board approval (after FIC review)	
6.6.2	Authorisation of business rates and NHS Litigation Authority expenditure within budget Up to £5,000,000	 Chief Executive or Finance Director	
6.7	Authorisation of non-pay expenditure in excess of budget: Up to £500,000 Over £500,000	 Chief Executive or Finance Director Trust Board following recommendation by Executive Leadership Team and reported to Audit Committee in accordance with the process set out in SFI 12	12
6.8	Approval of routine expenses claims Up to £5,000 Over £5,000	 Budget Holder following Line Manager confirmation Deputy Finance Director	12

7	**Approval of business cases, gating templates and other requests for budget**		11 and 12
7.1	Revenue funding in excess of allocated budget.	Executive Leadership Team (ELT) or Committee of ELT if formerly delegated by the ELT	
7.2	Capital:		
	Up to £1,000,000	ELT	
	Up to £2,000,000	Finance and Investment Committee (FIC)	
	Up to £5,000,000	Trust Board approval following review by FIC	
	Over £5,000,000	Regulatory Authority following Trust Board Review	
8	**Operation of all detailed financial matters**		
	Establishment and management of bank accounts	Finance Director or Deputy	8
	Payroll	Director of Workforce	11
	Purchase ledger/creditor payments	Finance Director or Deputy	8
	Petty cash	Finance Director or Deputy	7, 12
	Debtors	Finance Director or Deputy	8
	Treasury Management	Finance Director or Deputy	7
	Asset Register	Finance Director or Deputy	15
	Inventory Management	Directors and Direct Reports to Directors	16
9	**Income systems**		8
	System design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash	Finance Director or Deputy Finance Director	
10	**Funding contracts, Contracts for the Provision of Services and Service Level Agreements:**		10
	Below £100,000	Relevant Director and Deputy Finance Director	
	Up to £500,000	Finance Director	
	Up to £2,000,000	Finance Director and Chief Executive	
	Up to £5,000,000	FIC following ELT review	
	More than £5 000 000	Trust Board following FIC review	
	Routine mid term variations to any of the above if contract baseline value not changed by more than 5%	Finance Director	
11	**Annual capital programme and capital expenditure proposals**		5
11.1	Approval of Annual Capital Plan as part of the Integrated Financial Plan before the start of the financial year.	Trust Board following review by Finance and Investment Committee	

11.2	Capital Project Budget Variation Total budget spend of each capital scheme may be varied by 10% or £100,000, whichever is the smaller, subject to capital programme remaining within budget. Total budget spend of each capital scheme may be varied by 20% or £500,000, whichever is the smaller, subject to capital programme remaining within budget. **If any individual variation in project value results in a breach of approval limits as set out in 2 above, re-approval in line with section 2 is required**	Finance Director Executive Leadership Team or as delegated through Finance and Investment Committee	
12	**Arrangements for the management of land, buildings and other assets and equipment belonging to or leased by the Trust**		15
	Physical management and maintenance of assets	Directors responsible for assets	
	Land and buildings	Director responsible for Estates	
	Vehicles	Director responsible for Fleet	
	Equipment	Directors and Direct Reports to Directors responsible for equipment assets	
	Asset register, depreciation and PDC	Finance Director	
13	**Management and control of stock and equipment**		16
	Central Consumables Stores and Pharmaceuticals Stocks	Director responsible for Logistics	
	Vehicle Parts, Oil and Lubricants	Director responsible for Fleet	
	IM&T Equipment	Chief Information Officer	
	Station Consumables, equipment and specialised equipment stores and fuel stocks	Director of Operations and Director responsible for Logistics	
	Other stocks	Directors and Direct Reports	
14	**Recording, monitoring and approval of payments under the losses and special payments regulations including theft and fraud**		17
	All losses and special payments reported through to Audit Committee on a quarterly basis	Finance Director	
	Monitoring and approval of losses and special payments	Finance Director	
	Accounting for losses and special payments	Finance Director, Deputy Director and Head of Financial Services	
	General administration	Directors and Direct Reports	
	Cash losses and bad debts		

	Note: These write-offs, once agreed, will impact on individual budgets - there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the Trust, whether or not invoiced - it does not include adjustments relating to invoices raised in error. Up to £10,000 Over £10,000 **Losses of equipment and property** Up to £50,000 Up to £250,000 Over £250,000 **Claims net of recovery from NHSLA** Up to £100,000 Up to £500,000 Over £500,000 **Staff grievance settlements other than in response to a formal process** **Complaints**	 Finance Director or Deputy **Chief Executive and Finance Director or Deputy** Finance Director Chief Executive Audit Committee or Trust Board Finance Director or Chief Executive Executive Leadership Team Audit Committee or Trust Board As for losses of equipment and property As for losses of equipment and property	
15	**Disposal of deceased patients' property** **Property of value up to £5,000** Cash up to £100 and all valuables may be relatives who sign an indemnity form Cash over £100 may be released by cheque together with all valuables to relatives who sign indemnity form **Property of value over £5,000** Cash over £100 may be released by cheque together with all valuables on production of probate or letters of administration	 Deputy Finance Director Deputy Finance Director Finance Director	19
16	**Management of Patients' monies**	Finance Director	19
17	**Insurance arrangements** Approval of Insurance Arrangements	 Finance Director with approval of Trust Board (Finance Director to obtain quotes for insurance cover, and to present an annual report to the Audit Committee, Chief Executive to report to Trust Board on potentialinsurable risks and associated costs)	23
18	**Appointment of Consultancy Firms**		9, 12

	Up to £50,000 excluding VAT over the period of the contract Up to £250,000 excluding VAT over the period of the contract Over £250,000 excluding VAT over the period of the contract All appointments of consultancy firms must be in line with regulatory authority approval requirements at the point of appointment, and relevant procurement requirements as per SFI 9 and 12	Directors Chief Executive or Finance Director with report to Trust Board over £100k Chief Executive with report to, and approval of Trust Board	
19	**Legal Obligations** Payment of compensation payments etc under legal obligation: Up to £100,000 Over £100,000 Quarterly Report on payments to the Trust Board	 Chief Executive Trust Board Director of Corporate Governance and/or Director of Workforce	12
20	**Signing Tenders Submitted By The Trust** Approving arrangements for the submission of tenders Signing general tenders submitted by the Trust: Up to £500,000 per annum Over £500,000 per annum	 Trust Board Finance Director Chief Executive and Finance Director	10
21 **21.1** **21.2** **21.3** **21.4** **21.5**	**Charitable Funds** Approving the composition and terms of reference for the Charitable Funds Committee and approving the Annual Report and Accounts for funds held on trust to be submitted to the Charity Commission Setting overall policy on investment and presenting annual progress reports on the update of the Trust's charitable funds. Monitoring the effective administration of charitable funds, including management and accounting arrangements Approving the appointment of the Financial Adviser to the Charitable Funds Committee Approval of Transactions: Up to £5,000 Up to £25,000 Over £25,000	 Trust Board Charitable Funds Committee Finance Director Finance Director Head of Financial Services Finance Director Finance Director with approval of the Charitable Funds Committee	20
22 **22.1**	**Ex-gratia Payments** Making Ex-Gratia Payments in respect of liability claims where legal advice has indicated a case can be made for LAS liability which would need to be contested in court or tribunal.		17

	Up to £500,000	Approval by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000	
	Over £500,000	Approval by Trust Board following recommendation by Chief Executive and Finance Director with report to Chairman following Legal advice from instructed solicitor / counsel. Report / recommendation from the Director of Workforce to settle tribunal claims. Formal reporting and approval to DH in line with Manual for Accounts for all cases above £1,000	
22.2	Making other ex-gratia payments, including where legal advice has not been obtained		
	Up to £500	Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report)	
	Up to £3,000	Finance Director upon recommendation from Directors (Finance Director must be informed, must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority for all cases over £1,000)	
	Over £3,000	Chief Executive or Director of Finance (Finance Director must be informed and must be reported to Audit Committee via losses and special payments report, and formal reporting to regulatory authority)	
23	**Tribunal Payments**		17
	Making payments resulting from a tribunal not under legal obligation:		
	Up to £50,000	Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel for Tribunal claims over £10,000. Formal reporting and approval for all payments.	
	Over £50,000	Trust Board to approve following recommendation by Chief Executive and Finance Director with report to Audit Committee following advice from Director of Workforce, Legal advice from the instructed solicitor / counsel. Formal reporting and approval for	

		all payments.	
24	**Payment of Claims arising under Property Expenses Scheme** Up to £20,000 Over £20,000	 Finance Director with Chief Executive review following report from Head of Estates Chief Executive and Finance Director following report from Head of Estates (Trust Board to be informed)	17
25	**Payment of Personal injury and other liability claims outside the NHSLA indemnity schemes and commercial insurance** Up to £50,000 which are not under legal obligation and are not novel, contentious, or repercussive Over £50,000 which are not under legal obligation and are not novel, contentious, or repercussive Claims which are under legal obligation and are novel, contentious, or repercussive	 Chief Executive and Finance Director following recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services. Chairman following review by Chief Executive and Finance Director based on recommendation from the Directors of Finance, Corporate Governance and Workforce, legal advice from the instructed solicitor / counsel and report from the Head of Legal Services. Chief Executive and Finance Director following Regulatory Authority approval	17
26	**Disposals of Trust Property** Approval of disposals by sale of Trust property with an value of: Up to £25,000 Up to £100,000 Up to £250,000 Up to £1,000,000 Over £1,000,000 Approval of Gifts of Trust property with a value of: Up to £5,000 Up to £300,000	 Deputy Director of Finance following consideration of formal proposal Finance Director following consideration of formal proposal Finance Director and another Executive Director following consideration of formal proposal Chief Executive, Finance Director and another Executive Director following consideration of Combined Business Case Trust Board following consideration of Full Business Case Chief Executive Trust Board	17

	Over £300,000	Trust Board following Regulatory Authority Approval	
27	**Dismissals**		
27.1	Approving arrangements for the discipline and dismissal of staff	Trust Board	
27.2	Nomination of a panel to hear appeals against dismissal brought by the Chief Executive or Executive Trust Board Directors	Trust Board	
27.3	Authority to dismiss the Chief Executive and Executive Directors	Chairman	
27.4	Nomination of a panel to hear appeals against dismissal brought by Directors who are not members of the Board.	Chairman	
27.5	Dismissal of staff below Director level	Chief Executive, Director or Director's Deputy	
27.6	Nomination of a panel of Directors to hear appeals against dismissal by staff below Director level	Chief Executive	
27.7	Ensuring that appropriate processes are completed to ensure salary and other payments cease as appropriate following dismissal.	Directors	
27.8	Advising panels dealing with dismissals and appeals	Director of Workforce	
28	**Remuneration and Terms of Service for the Chief Executive, Directors and Other Senior Officers**		
28.1	Decides the Directors' remuneration and terms of service	Trust Board on recommendation from Nominations and Remuneration Committee	
28.2	Decides performance related payments to the Chief Executive	Trust Board	
28.3	Reporting in writing to the Trust Board the basis of its recommendations in relatioon to remuneration, terms of service and performance related payments	Nominations and Remuneration Committee with advice from the Director of Workforce	
28.4	Recommending performance related payments for the Chief Executive.	Chairman	
28.5	Deciding performance related pay awards for Directors and all staff on performance related pay.	Chief Executive	
28.6	Recommending performance related payments to their staff to the Chief Executive.	Directors	
28.7	Advising on remuneration and terms of service	Director of Workforce	
29	**Human Resources Policy and Disputes**		
29.1	Approving all human resources policies	Trust Board (Chief Exec to determine submissions to Trust Board following advice from Director of Workforce)	
29.2	Approving premature retirement for the Chief Executive and all Directors	Trust Board	
29.3	Approving premature retirement for staff up to Director level	Chief Executive	
29.4	Settling disputes in line with the agreed disputes procedure	Chief Executive	
29.5	Preparing options and draft policy in conjunction with Directors	Director of Workforce	

29.6	Advising on human resources policy matters	Director of Workforce	
30	**Human Resources Arbitration**		
30.1	Approving arbitration submissions	Trust Board	
30.2	Determining and approving submissions to the Trust Board when appropriate	Chief Executive	
30.3	Advising on arbitration matters	Director of Workforce	
31	**Human Resources Disciplinary Matters**		
31.1	Receiving reports and hearing appeals on disciplinary action relating to the Chief Executive and/or Directors	Nominations and Remuneration Committee	
31.2	Initiating action on disciplinary matters relating to the Chief Executive and/or Directors.	Chairman	
31.3	Determining and approving submissions to the Trust Board when appropriate	Chief Executive	
31.4	Advising on disciplinary matters	Director of Workforce	
32	**Management and Control of Computer Systems and Facilities**		
32.1	Approving the overall corporate IT Policy on procurement and control of systems and facilities on the recommendation of the Chief Information Officer	Trust Board	
32.2	Co-ordinating IT Policy on behalf of the Trust and being the responsible officer for control and security of hardware, software and data	Chief Information Officer	
32.3	Compliance with the Data Protection Act, Use of Computers Act and other legislation in their Directorates	Directors	
32.4	Operation and compliance with legislation for all telecommunications and radio systems	Chief Information Officer	
32.5	Ensuring that risks to the Trust from IT are identified and considered, and that disaster recovery plans are in place	Chief Information Officer	
32.6	Ensuring that where computer systems have an impact on corporate financial systems: • System acquisition, development and maintenance are in line with corporate polices; • Data assembled for processing by finance system is adequate, accurate, complete and timely and that a management trail exists; • That the Finance Director and staff have access to such data; and • That such computer reviews are being carried out as are considered necessary.	Finance Director	
33	**Contracts for Computer Services with Other Health Bodies or Outside Agencies**		

33.1	Ensuring that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and that the contract ensures rights of access for audit purposes	Chief Information Officer	
33.2	Periodically seeking assurances that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications	Finance Director	
34	**Data Protection**		
34.1	Approving policy on Data Protection	Trust Board	
34.2	Notification under the Data Protection Act and the implementation of the Board's Data Protection Policy	Director of Corporate Governance	
34.3	Advising the Board on Data notification	Director of Corporate Governance	
34.4	Ensuring compliance with the Data Protection Act and the Board's Data Protection Policy in Directorates	Directors	
35	**Health and Safety Arrangements**		
35.1	Approving overall policy on Health and Safety at work.	Trust Board	
35.2	Ensuring an effective overall Health and Safety system within the Trust and compliance with legislative requirements	Chief Executive	
35.3	Ensuring the effective implementation of the Human Resources aspects of Trust Health & Safety policy and advising the Chief Executive of requirements	Director of Workforce	
35.4	Ensuring the effective implementation of clinical aspects of Trust Health and Safety policy and advising the Chief Executive of requirements	Director of Operations	
35.5	Ensuring the effective implementation of the Health and Safety Policy in individual Directorates	Directors	
36	**Complaints Against the Trust**		
36.1	Approves the Trust's Complaints Procedure	Trust Board	
36.2	Receiving reports regarding complaints about any aspect of service.	Trust Board	
36.3	Management of complaints within the Trust and ensuring complaints receive written responses in line with regulations	Chief Executive	
36.4	Supporting the Chief Executive in the management of complaints within the Trust and signing written responses to complaints	Directors	
37	**Executive and Non-Executive Directors Issues (Visits, Hospitality etc)**		
37.1	Approving overall policy on hospitality and visits.	Trust Board	
37.2	Advising the relevant Regulatory Authority on the performance of Non-Executive board members	Chairman	
37.3	Ensuring Directors are aware of guidelines	Chief Executive	

37.4	Ensuring compliance with Guidelines	Directors	
37.5	Developing policies and guidelines on behalf of the Chief Executive	Director of Corporate Governance	
38	**Freedom of Information**		
38.1	Approving Freedom of Information Policy	Trust Board	
38.2	Receiving an annual report on the implementation of the Freedom of Information policy	Trust Board	
38.3	Ensuring the Trust is compliant with current Freedom of Information legislation	Director of Corporate Governance	
38.4	Publishing and maintaining a Freedom of Information scheme	Director of Corporate Governance	
39	**Risk Management**		
39.1	Approving and Monitoring the risk management programme	Trust Board	
39.2	Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activity both clinical and non-clinical that support the achievement of the organisation's objectives	Audit Committee	
39.3	Deciding whether the Trust will use the risk pooling scheme administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed), and reviewing decisions to self-insure annually	Trust Board	
39.4	Ensuring that where NHSLA risk pooling schemes are used, the arrangements entered into are appropriate and complementary to the risk management programme, and that documented procedures cover these arrangements	Director of Corporate Governance	
39.5	Ensuring that where the Board decides not to use NHSLA risk pooling schemes, they are informed of the nature and extent of the risks that are self-insured as a result of this decision, and that formal documented procedures are drawn up for the management of any claims arising from 3rd parties and payments in respect of losses that will not be reimbursed	Finance Director	
40	**Signing and Sealing of Documents**		
40.1	Receiving a report of all sealings	Trust Board	
40.2	Affixing the seal	Chairman and the Chief Executive or another Executive Director in accordance with standing orders	
40.3	Approving and signing all documents which will be used in legal procedures	Chairman, Chief Executive and an Executive Director	
40.4	Keeping the common seal of the Trust in a secure place in accordance with arrangements approved by the Trust	Trust Secretary	
40.5	Keeping a register of sealings	Trust Secretary	
41	**Tendering Procedures - General**		
41.1	Approving standing orders regarding tendering	Trust Board	

41.2	Approves exceptions to Standing Orders regarding Competitive Tendering	Trust Board	
41.3	Receiving reports regarding all waiving of competitive tendering	Audit Committee	
41.4	Ensuring compliance with Standing Orders	Chief Executive	
41.5	Authorising exceptions to Standing Orders in an urgent situation	Chief Executive following consultation with the Chairman or Deputy Chairman under Standing Order 41	
41.6	Where EU procurement regulations have been satisfied, waiving the requirement for competitive tendering for goods and services up to £200,000	Chief Executive in conjunction with Finance Director	
41.7	Where insufficient tenders are received, authorising the originating Directors to approach known firms with a view to procuring the goods or services required	Chief Executive	
41.8	Ensuring that at least 3 competing quotations from comparable firms are received for appropriate contracts (unless NHS Supplies is used)	Directors	
41.9	Authorising all tenders and waivers and ensuring satisfaction with the financial competence of all tendering organisations	Finance Director	
42	**Tendering Procedures - Limits**		
42.1	Ensuring that proper tendering arrangements are in place	Audit Committee	
42.2	Ensuring that competitive tenders are received for non-estate purchases above £25,000 and estate purchases over £100,000	Chief Executive	
	Ensuring that competing quotations are received for non-estates purchases between £3,000 and £25,000 and for Estates purchases between £3,000 and £100,000 except where ordered through NHS Supplies	Directors	
43	**Tendering Procedures - Receipt and Opening Tender Submissions**		
43.1	Nominating officers, including the Trust Secretary to open tenders	Chief Executive	
43.2	Accepting late tenders, despatched in good time but delayed through no fault of the tenderers	Chief Executive	
43.3	Accepting late tenders other than those that are despatched in good time but delayed through no fault of the tenderers	Chief Executive in conjunction with Finance Director	
43.4	Being present at the opening of tenders of value:		
	Up to £1m	Senior Manager responsible for the procurement and the Trust Secretary	
	Over £1m	Senior Manager responsible for the procurement, Executive Director responsible for the originating department, and the Trust Secretary	
43.5	Advising the Board by way of a report on both tenders invited and received and, in due course, tender amounts after their analysis is complete	Trust Secretary	

44	**Tendering Procedures - Post Tendering**		
44.1	Authorising post tender negotiations	Chief Executive or Finance Director	
44.2	Requesting in writing that post tender negotiations take place	Directors	
44.3	Keeping a record of the reasons for post tender negotiations and their outcome	Directors	
45	**Tendering Procedures - Approvals**		
45.1	Deciding where a tender other than the lowest (if payment is to be made by the Trust), or other than the highest (where payment is to be received by the Trust), shall be accepted	Chief Executive (with report to the Trust Board)	
45.2	Approving non-competitive tenders	Chief Executive (subject to report to the Trust Board)	
46	**Education and Training**		
46.1	Approving Trust policy on education and training	Trust Board	
46.2	Submitting policy on education and training to the Trust Board	Chief Executive	
46.3	Developing and updating the Trust policy on education and training	Medical Director	
46.4	Development of vocational/technical training	Medical Director in conjunction with Directors	

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Terms of Reference for Board committees**
Report Author(s):	**Sandra Adams, Director of Corporate Governance/Trust Secretary**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**Each of the existing committees will have reviewed and signed off the terms of reference during 2016**
Status:	**For approval**

Background/Purpose

The Trust Board receives its assurance through a governance structure of sub-committees known as Board committees. Each Board Committee has a set of terms of reference that define the scope and governance of the business discussed and these are incorporated in the Standing Orders that define the governance processes for the Board of Directors.

Terms of reference are reviewed annually and each of the existing committees has established and/or reviewed its terms of reference in 2016. A new committee is proposed that will have oversight and take assurance on logistics and infra structure matters, and specifically fleet & logistics, IM&T and estates. These terms of reference are attached for Board approval and will have been discussed at the Finance and Investment Committee (FIC) prior to the Board meeting. The scope of the FIC is being revised to become the Finance, Investment and Performance Committee and the revised terms of reference are attached for approval following FIC discussion on 24th November.

Action required

To approve the revised governance structure providing assurance to the Trust Board and to approve the terms of reference.

Key implications

Good governance practice to review the reporting and assurance structure supporting the Trust Board.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	**Reviewed by the Quality Governance Committee**
Performance	**To be reviewed by the Finance, Investment and Performance Committee**
Financial	**As above**
Workforce	**Reviewed by the Workforce and Organisational Development Committee**
Governance and Well-led	**The Audit Committee has oversight of the risk management systems and processes and signs off the Annual Governance Statement for recommendation to the Trust Board**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	**Yes**

London Ambulance Service NHS Trust
Terms of Reference
November 2016
Audit Committee

1. Authority

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

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

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

2. Purpose

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

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

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

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

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

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

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

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

3. Internal Audit

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

3.1.1 approval of the appointment of internal auditors and any question of resignation and dismissal.

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

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

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

3.1.5 an annual review of the effectiveness of Internal Audit.

4. External Audit

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

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

4.3 The auditor panel's functions are to:

4.3.1 Advise the 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:

4.4.1 consideration of the performance of the External Auditor;

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

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

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

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

5. Risk and Assurance Functions

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

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

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

5.1.3 review of the Executive Management Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Senior Management Team;

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

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

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

6. Counter Fraud

6.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. [1]

7. Management

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

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

8. Financial Reporting

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

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

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

8.3 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.[2]

[1] From the NHS Audit Committee Handbook
[2] As above

9. Whistleblowing

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

10. Membership

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

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

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

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

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

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

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

11. Accountability

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

12. Responsibility

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

13. Reporting

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

Board.

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

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.[3]

14. Administration

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

14.2 The Agenda and papers will be distributed 5 working days before each meeting.

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

14.4 Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting.

14.5 Papers tabled will be at the discretion of the Chair of the Audit Committee.

15. Quorum

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

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

16. Frequency

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

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

17. Review of Terms of Reference

17.1 The Audit Committee will review these Terms of Reference at least annually

[3] The NHS Audit Committee handbook

from the date of agreement.

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

Document Profile and Control

Audit Committee Terms of Reference		
Version:	**Approved by:**	**Date:**
November 2016	Trust Board – minor update to job titles	29th November 2016
March 2016	Trust Board – agreed revision to section 4 External Audit	29th March 2016
November 15	Audit Committee	9th November 2015

Sandra Adams
Director of Corporate Governance /Trust Secretary

Terms of Reference
November 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; operating framework quality standards.

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
Chief Quality Officer
Medical Director
Director of Corporate Governance/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
November 2016

Document Profile and Control

Quality Governance Committee Terms of Reference		
Version:	**Approved by:**	**Date:**
November 2016	Quality Governance Committee	(15th March 2016)

Terms of Reference

Finance, Investment and Performance Committee

1. Authority

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

1.2 The Committee is authorised by the Board of Directors 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.

2. Purpose

2.1 The Finance and Investment Committee shall conduct independent and objective review(s) of financial and investment policy and performance.

3. Duties

3.1 **Financial Policy, Management and Reporting**

3.1.1 To consider the Trust's medium term financial strategy, in relation to both revenue and capital prior to its submission to the Board.

3.1.2 To consider the Trust's annual financial targets and performance against them.

3.1.3 To review the annual budget before submission to the Board.

3.1.4 To review performance against the Cost Improvement Programme focussing on specific issues raised by the Board.

3.1.5 To review proposals and make recommendations to the Board for major business cases and their respective funding sources.

3.1.6 To monitor progress with the capital programme making any recommendations for changes or re-allocation of capital.

3.1.7 To commission and receive the results of in-depth reviews of key commercial issues affecting the Trust on behalf of the Board.

3.1.8 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and related contractual risk.

3.1.9 To consider the Trust's tax policy and compliance.

3.1.10 To annually review the financial policies of the Trust and make appropriate recommendations to the Board.

4. Investment Policy, Management and Reporting

4.1 To approve and keep under review, on behalf of the Board, the Trust's investment strategy and policy.

4.2 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHS Improvement's requirements.

5. Performance oversight

The proposed remit of the Finance, Investment and Performance Committee in respect of this is:

5.1 To review the form and content of the Integrated Performance Report to ensure it is adequately focused and acts to highlight variation from intended performance, the reason for this and action to address it.

5.2 To receive assurance regarding the timeliness, relevance and accuracy of the data included within the Integrated Performance Report together with recommendations for improvement.

6. Other

6.1 To examine any other matter referred to the Committee by the Board.

7. Membership

7.1 The Board will confirm the membership of the committee which as a minimum shall be:

Core members
Trust Chair
Audit Committee Chair (Chair)
Director of Finance and Performance (Executive director lead)
Director of Corporate Governance / Trust Secretary
Deputy Director of Finance
Chairman of the Logistics and Infrastructure Committee (covering Estates, Fleet and Information and Technology).

7.2 The committee will invite the following directors to attend for specific items of discussion as scheduled in the forward planner:

Chief Quality Officer
Director of Transformation and Strategy
Director of Operations
Director of Performance
Director of Human Resources and Organisational Development.

7.3 Other officers may be invited to attend to discuss matters on the forward planner as directed by the committee.

8. Attendance

8.1 The Committee may invite other Trust staff to attend its meetings as appropriate.

8.2 The PA to the Director of Finance and Performance shall be Secretary to the Committee.

9. Accountability

9.1 The Committee will report to the Trust Board of Directors.

9.2 The Executive Management Team will report on finance and investment issues to the Committee.

10. Reporting

10.1 The PA to the Director of Finance and Performance will be responsible for taking the minutes of each meeting of the Committee and for monitoring any action arising from discussion.

10.2 The PA to the Director of Finance and Performance shall maintain the forward planner for the Committee ensuring that key reporting requirements are scheduled in a timely fashion.

10.3 The Committee will report after every meeting to the next meeting of the Trust Board of Directors, co-ordinated by the Secretary and Chair of the Committee.

11. Administration

11.1 The Secretary of the Committee will take responsibility for agreeing of the Agenda of each committee with the Chair and attendees, collate papers, take minutes and keep formal records of matters arising and issues carried forward.

11.2 The agenda and papers will be distributed four working days before the Committee meets.

Draft action points will be available to Committee members seven working days after the meeting.

Draft minutes will be available to the Committee Chair and the Director of Finance and Performance 21 days after the meeting.

Agenda items, papers and updates be submitted to the Secretary seven working days prior to each committee meeting.

The Chair and Secretary will decide which papers are tabled at the committee.

12 Quorum

12.1 The meeting will be quorate with a two non-executive and one executive director plus the Deputy Director of Finance present. The Chairman can delegate the chair to another non-executive. The executive directors can delegate to a nominated deputy as required.

13 Frequency

A minimum of 3 meetings will be held per year, with additional meetings as deemed necessary.

14 Review of Terms of Reference

14.1 The terms of reference will be reviewed annually and any changes agreed with the Trust Board of Directors.

14.2 The Chair of the Committee may trigger a review of the Terms of Reference at any time and the Deputy Director of Finance will ensure the initial review and then annual review are scheduled in the Committee's forward planner.

London Ambulance Service NHS
NHS Trust

Draft
Workforce and Organisational Development Committee
Terms of Reference

1. Authority

1.1 The Workforce and Organisational Development 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 outside 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 Workforce and Organisational Development (OD) Committee will be to assure the Board on all aspects of workforce management and organisational development, including the identification, mitigation and escalation of workforce-related risks.

3. Responsibility

3.1 The Workforce and OD committee will:

- Seek assurance that strategies are in place to recruit, train, develop, retain, organise, engage, and promote the health, safety and wellbeing of a high quality workforce that will enable the Trust to meet its responsibilities to patients and other stakeholders
- Assure the Board that relevant and timely workforce planning takes place to give effect to these strategies and enable delivery of the Trust's operating plan
- Receive regular assurance reports on Trust performance against key performance indicators related to the workforce strategies and plans
- Receive assurance on the appropriateness of workforce training and education plans, and on the effective implementation of those plans
- Receive assurance on the design and implementation of the performance appraisal system
- Assure itself that the Trust has an effective strategy for dealing with industrial and employee relations

- Receive assurance that the Trust meets best practice as well as statutory and regulatory obligations in equality, diversity and human rights , including compliance with the Equality Act 2010 and the NHS workforce race equality standard, and agree actions required to address issues that arise
- Assure the Trust Board that requirements set by external bodies such as the CQC that relate to workforce are met and that the Trust is compliant with all legislation relating to the employment of staff
- Receive and review reports on the safety, morale and wellbeing of the Trust's employees, including employee surveys, and gain assurance that appropriate action is taken to address issues and concerns
- Review the annual Staff Engagement Plan and the Trust's progress in implementing it
- Oversee the identification, tracking and reporting of HR and workforce risks, ensuring that actions are in place to mitigate and manage such risks

4. Membership

The committee shall be appointed by the Board and shall comprise the following:

4.1 Core membership

- Three Non-Executive Directors, including a non-executive chair
- Director of Transformation Strategy and Workforce
- Director of Operations;
- Director of Finance;
- Medical Director
- Director of Quality;

Executive membership to be confirmed

The following should normally attend all meetings of the Committee:

- Director of Workforce
- Assistant Director of Human Resources;
- Deputy Director Clinical Education and Standards;
- Assistant Director of People and Organisational Excellence

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

Other participants, including members of staff, should be invited as appropriate, dependent upon the topics under discussion.

5. Accountability and reporting

5.1 The Workforce and OD Committee is a formal subcommittee of the Board of Directors and have no executive powers other than those specifically delegated in these Terms of Reference.

5.2 The committee will be accountable to the Board of Directors.

6. Administration

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

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

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

6.3 Papers will be tabled at the discretion of the Chair of the Workforce and OD Committee.

7. Quorum

For a meeting to be quorate, at least three Directors, including the Director of Transformation Strategy and Workforce, and two non-executive Directors, shall be present.

8. Attendance

8.1 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.

8.2 Deputies or representatives may attend in the absence of the committee member but this must be agreed with the Chair or nominated deputy in advance.

10. Frequency and arrangements

9.1 Meetings shall be held bi-monthly.

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

11. Review of Terms of Reference

The Workforce & OD Committee will review these terms of reference annually.

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
May 2016

Workforce and OD Committee Terms of Reference		
Version:	**Approved by:**	**Date:**
	TBC	

London Ambulance Service NHS Trust

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 review and assess progress and assure the Board on delivery against the Quality Improvement Plan, with the objective that the Trust exit special measures at its re-inspection.

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.
- Approve and agree actions proposed by the Executive Leadership Team on behalf of the Trust Board in line with the scheme of delegation.

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 Corporate Governance / Trust Secretary
- Director of Human Resources and Organisational Development
- Director of Operations
- Director of Finance and Performance
- Director of Strategic Communications
- Chief Quality Officer
- Medical Director

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

In regular attendance

- Chief Information Officer
- NHSI Improvement Director
- Programme Management Office (PMO) Lead

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 Plan work stream leads on 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 and external 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 (to 80 days past re-inspection date i.e. to allow for post inspection document requests, receipt of the inspection report, and response to the inspection report) 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 as SRO for the QIP, and Executive Directors as responsible leads for 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 two executive director members (one to be a voting Board member).

10. Frequency

10.1 Meetings shall be held monthly with the proviso that toward re-inspection the Chair may wish to increase the frequency of the meeting.

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 (recognising the statement in section 6.1).

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.

London Ambulance Service NHS Trust

Terms of Reference
October 2015
Charitable Funds Committee

1. Authority

The terms of reference of the Charitable Funds Committee shall be set out below and subject to amendment when directed and agreed by the Trust Board.

The Committee is authorised by the Trust 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.

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

2. Purpose

To oversee, on behalf of the trustees of the London Ambulance Service Charitable Funds[1], the management, investment and disbursement of charitable funds within the regulations provided by the Charities Commission and to ensure compliance with the laws governing charitable funds.

3. Responsibility

3.1 To act on behalf of the Trust in satisfying the duties and responsibilities of trustees in managing the funds;

3.2 To ensure that policies and procedures are in place to meet the requirements of the Charities Commission and the laws governing charitable funds;

3.3 To establish an investment strategy in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf;

3.4 To monitor the performance of investments and of appointed Investment Managers;

3.5 To review the charity's reserves policy;

3.6 To review the income and expenditure transactions for all funds;

3.7 To review legacies received and ensure that the Trust complies with the terms of the legacy;

[1] The Trust Board members shall act as the Trustees of the London Ambulance Services' Charitable Funds. The Trustees shall hold the Trust Funds upon trust to apply for any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by the LAS NHS Trust.

3.8 To examine the financial statements of the charity and approve the annual return and the annual accounts in line with the requirements of the Charities Commission and the laws governing charitable funds;

3.9 To approve the charitable funds annual budget;

3.10 To authorise the establishment of new funds and new charities.

4. Membership

4.1 The membership of the Committee shall comprise one non-executive director, the Director of Finance and Performance, the Financial Controller, a nominated staff-side representative, and representation from LAS Communications and the Voluntary Responders Group.

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

4.3 Other managers/staff may be invited to attend meetings depending upon issues under discussion.

5. Accountability

5.1 The Charitable Funds Committee shall be accountable to the Trust Board of Directors.

6. Reporting

6.1 The minutes of Charitable Funds Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board;

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

7. Administration

7.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the agenda with the Chair of the Committee on the advice of the Committee members, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;

7.2 The agenda and papers will be distributed 5 days before each meeting;

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

7.4 Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting;

7.5 Papers tabled will be at the discretion of the Chair of the Charitable Funds Committee.

8. Quorum

8.1 The quorum shall be one non-executive director, the Director of Finance and Performance, and a staff-side representative present.

9. Frequency

9.1 The Charitable Funds Committee shall normally twice a year, in October and March, for 1 ½ hours per meeting.

9.2 The Chair may request additional meetings if they consider it necessary.

10. Review of Terms of Reference

10.1 The Charitable Funds Committee shall review these terms of reference at least annually from the date of agreement.

London Ambulance Service NHS
NHS Trust

Terms of Reference

November 2016

Nominations and Remuneration Committee

1. Authority

1.1 The Nominations and Remuneration 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 Trust 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 at the Trust's expense:

I. 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; and/or

II. Within any budgetary restraints imposed by the Board of Directors, to appoint remuneration consultants, and to commission or purchase any relevant reports, surveys or information which it deems necessary to help fulfil its duties.

2. Purpose

The primary purpose of the Nominations and Remuneration Committee is to appoint and, if necessary, dismiss the executive directors, establish and monitor the level and structure of total reward for executive directors, ensuring transparency, fairness and consistency.

3. Duties

The Committee shall:

3.1 Appoint and, if necessary dismiss the Chief Executive of the Trust.

3.2 Make such recommendations to the Board on the remuneration and terms of service of the Chief Executive.

3.3 Appoint and, if necessary dismiss the executive directors, taking into account the advice of the Chief Executive. The Committee shall not make an appointment to an executive director position which the Chief Executive does not support, rather a further recruitment process shall commence for the role in question.

3.4 In consultation with the Chairman of the Board of Directors and the Chief Executive, determine the total individual remuneration package of each executive director, other than the Chief Executive. In doing so the Committee shall:

I. Ensure that the levels of remuneration are sufficient to attract, retain and motivate executive directors of the quality required to run the Trust successfully. They shall, however, avoid paying more than is necessary for the purpose;

II. Judge where to position the Trust relative to other NHS Trusts, NHS foundation trusts and comparable organisations. Such comparisons, however, shall be used in caution in view of the risk of an upward ratchet of remuneration levels with no corresponding improvement in performance;

III. Be sensitive to pay and employment conditions elsewhere in the Trust, especially when determining annual salary increases;

IV. Ensure that neither the Chief Executive nor any other executive director is involved in deciding his or her own employment arrangements, including their own remuneration; and

V. Ensure that where executive directors or senior management are involved in advising or supporting the Committee, care is taken to recognise and avoid conflicts of interest.

3.5 In consultation with the Chief Executive, agree and monitor the level and structure of remuneration for senior management, the definition of which shall be determined by the Committee but shall normally include the first layer of management below Board of Director level.

3.6 Agree the policy for authorising claims for expenses from the Chairman of the Board of Directors and executive directors.

3.7 Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

3.8 Be exclusively responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any independent remuneration consultants who advise the Committee. Where remuneration consultants are appointed, a statement shall be made available of whether they have any other connection with the Trust.

3.9 Obtain reliable, up-to-date information about remuneration in other Trusts and comparable organisations.

4. Responsibility

4.1 In developing recommendations for remuneration packages, the Committee will wish to ensure that they have:

i. A clear statement of the responsibilities of the individual posts and their accountabilities for meeting objectives of the organisation;

ii. Means of assessing the comparative size of the job by job evaluation;

iii. Comparative salary information from the NHS, other public sector organisations including Trusts, and other industrial and service organisations;

iv. The Board should decide in advance its general policy on Directors' remuneration and terms of service and look to the Committee to ensure that its policy is applied consistently.

5. Membership and attendance

5.1 The Committee will comprise the Chairman of the Board of Directors, independent non-executive Directors and in attendance the Director of Human Resources and Organisational Development.

5.2 The Chairman of the Committee shall be the Chairman of the Board of Directors.

5.3 The Chief Executive will normally be in attendance at meetings but will not be present for discussions about their own remuneration and terms of service.

6. Accountability

6.1 The Nominations and Remuneration Committee shall be accountable to the Trust Board.

7. Reporting responsibilities

7.1 The Committee Chairman shall report formally to the Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities.

7.2 The minutes of the relevant Board meetings are formally to record decisions taken.

7.3 The Committee shall produce an annual report of the Trust's remuneration policy and practices which shall form part of the Trust's annual report.

8. Administration

8.1 The Committee will meet as directed by the Board. Its proceedings will be formally minuted and it will be supported by the Director of Human Resources and Organisational Development.

9. Quorum

9.1 The quorate number of members shall be 3 non-executive directors plus the Chair or Deputy Chair.

9.2 In the absence of the Committee Chairman and/or an appointed Deputy, the remaining non-executive members present shall elect one of themselves to chair the meeting.

10. Frequency

10.1 Meetings shall be held at least twice a year and at such other times as the Chairman of the Committee shall require.

10.2 Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chairman and/or Chief Executive.

10.3 Minutes of the Committee shall be circulated to all members and to all members of the Board of Directors save where the minutes concern decisions relating to individual executive directors.

11. Review of Terms of Reference

11.1 The Trust Board shall review these terms of reference annually.

Document Profile and Control

Nominations and Remuneration Committee Terms of Reference		
Version:	**Approved by:**	**Date:**
2.0		

Terms of Reference
November 2016
Logistics and Infrastructure Committee

1. Authority

The Logistics and Infrastructure Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

The Committee is authorised by the Trust Board of Directors 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.

2. Purpose

The Logistics and Infrastructure Committee shall oversee the strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate.

3. Duties

3.1 To take assurance on the executive oversight of the Fleet, Estates and IM&T functions of the Trust.
3.2 To seek assurance that effective strategies are in place that enable the achievement of the overall Trust strategy.
3.3 To have oversight of the regulatory and compliance framework for each function ensuring that all requirements and reporting requirements are being met.
3.4 To consider and review key risks to delivery of strategic objectives within each function and to confirm the risk appetite accordingly, escalating key risks to the Trust Board.
3.5 To consider the capital and investment plans for each function within the overall Trust financial plan and to inform/advise the Trust Board as appropriate.
3.6 To review and approve for recommendation to the Trust Board outline and full business cases for development and investment within each of the functions.
3.7 To receive assurance that all policies relating to each function are up to date and remain relevant and complied with.
3.8 To receive performance/compliance/other reports from the Environment and Resources Group at each meeting.
3.9 To receive reports on key performance indicators for each function at each meeting, escalating any concerns to the Trust Board as appropriate.
3.10 To receive any external and internal assurance reports on the functions, and to take assurance from these or escalate concerns to the Trust Board.
3.11 To approve the annual work plan for the Environment and Resources Group.

4. Other

4.1 To examine any other matter referred to the Committee by the Trust Board of Directors.

5. Membership

5.1 The Trust Board will confirm the membership of the committee which as a minimum shall be:

Three non-executive directors one of whom shall be the Chair of the Committee, and one of whom will be a member of the Audit Committee and one a member of the Finance and Investment Committee;
Director of Finance and Performance (Executive director lead)
Deputy Director of Finance
Deputy Director – Fleet and Logistics
Chief Information Officer or Acting Director of IM&T
Head of Estates
Director of Corporate Governance/Trust Secretary

5.2 The committee will invite the following directors to attend for specific items of discussion as scheduled in the forward planner:
Director of Strategy & Transformation
Director of Operations
Director of Performance
Chief Quality Officer
Director of HR&OD

5.3 Other officers may be invited to attend to discuss matters on the forward planner as directed by the committee.

6. Attendance

6.1 The Committee may invite other Trust staff to attend its meetings as appropriate.

6.2 The *XXX* shall be Secretary to the Committee.

7. Accountability

7.1 The Committee will report to the Trust Board of Directors.

7.2 The Executive-led Environment and Resources Group will report on Fleet & Logistics, Estate, and IM&T issues to the Committee.

8. Reporting

8.1 The *XXX* will be responsible for taking the minutes of each meeting of the Committee and for monitoring any action arising from discussion.
8.2 The *XXX* shall maintain the forward planner for the Committee ensuring that key reporting requirements are scheduled in a timely fashion.
8.3 The Committee will report after every meeting to the next meeting of the Trust Board of Directors, co-ordinated by the Secretary and Chair of the Committee.

9. Administration

9.1 The Secretary of the Committee will take responsibility for agreeing of the Agenda of each committee with the Chair and attendees, collate papers, take minutes and keep formal records of matters arising and issues carried forward.

9.2 The agenda and papers will be distributed 4 working days before the Committee meets.

9.3 Draft action points will be available to Committee members 7 working days after the meeting.

9.4 Draft minutes will be available to the Committee Chair and the Director of Finance and Performance 21 days after the meeting.

9.5 Agenda items, papers and updates be submitted to the Secretary 7 working days prior to each committee meeting.

9.6 The Chair and Secretary will decide which papers are tabled at the committee.

10. Quorum

The meeting will be quorate with a two non-executive and one executive director plus the Deputy Director of Finance present. The Chair can delegate the chair to another non-executive. The executive directors can delegate to a nominated deputy as required.

11. Frequency

A *minimum of 3 meetings will be held per year*, with additional meetings as deemed necessary.

12. Review of Terms of Reference

12.1 The terms of reference will be reviewed annually and any changes agreed with the Trust Board of Directors.

12.2 The Chair of the Committee may trigger a review of the Terms of Reference at any time and the Deputy Director of Finance will ensure the initial review and then annual review are scheduled in the Committee's forward planner.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**29th November 2016**
Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams, Director of Corporate Governance/Trust Secretary**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	
Status:	**For information and assurance**

Background/Purpose

Since the Trust Board meeting on 4th October 2016, there has been one tender received and opened and entered into the register; and there has been 1 entry 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 26th July 2016 and to be assured of compliance with Standing Orders and Standing Financial Instructions.

Key implications

None identified.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	**Compliance with Standing Orders and Standing Financial Instructions**

Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

Trust Secretary Report – November 2016

Tender received

Refurbishment of NETS site at Orpington

Tenders received from:

- Coniston Ltd
- Bowmite Ltd
- Ensignia Construction Ltd
- Arena Maintenance Contractors
- Abbeywood Grange Solutions.

Use of the Trust Seal and entries into the Register

- The Ambulance Station situate at 104/142 Lee High Road, Lewisham SE13 5PR

TRUST BOARD FORWARD PLANNER 2017

31st January 2017 9am

Standing Items	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Assurance Reports from sub-committees** **Finance Report M9** **BAF and Corporate Risk Register** **EPRR update**	2017-19 Business and financial planning process	Report from Trust Secretary Trust Board Forward Planner Outcome of the Well-led governance review Preparation for the CQC Inspection Quality Improvement Plan report	Quality and Governance Committee – 10th January 2017 Finance and Investment Committee –19th January 2017 Workforce and Organisational Development – 23rd January 2017 Quality Improvement Programme Board -	

28th March 2017 9am

Standing Items	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M11**	2017 – 19 Business and Financial Plan	Report from Trust Secretary Trust Board Forward Planner Outcome of the CQC Inspection	Audit Committee – 15th February 2017 Board Strategy - 28th February 2017 Quality Improvement Programme Board – Quality Governance Committee – 14th March 2017 Finance and Investment Committee – 23rd March 2017 Workforce and Organisational Development – 20th March 2017	

25th May 2017 – 2pm

Standing Items	Annual Reporting	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Annual Report and Accounts 2016/17 including Annual Governance Statement** **Quality Account 2016/17 for approval** **Audit Committee Assurance Report** **Annual Report of the Audit Committee 2016/17** **BAF and Corporate Risk Register** **Infection Prevention and Control Annual Report 2016/17** **Annual Safeguarding Report 2016/17**	Integrated Board Performance Report Assurance Reports from sub-committees Finance Report Report from Finance and Investment Committee Risk Management Policy Review EPRR update	2017 – 19 Business and Financial Plan	Report from Trust Secretary Trust Board Forward Planner	Audit Committee – 18th April, 18th & 25th May 2017 Board Strategy - 25th April 2017	

1st August 2017 – 9am

Standing Items	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M3** **EPRR update**	Patient Engagement Strategy	Report from Trust Secretary Trust Board Forward Planner and 2018 dates Quality Improvement Programme Assurance Report Security Management Annual Reports: - Patient Experience - Patient and Public Involvement and Public Education	Board seminar - 27th June 2017 Quality Governance Committee – 11th July 2017 Finance and Investment Committee – 20th July 2017 Workforce and Organisational Development – 24th July 2017	

3rd October 2017 – 9am

Standing Items	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chair Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M5**	2017-19 Business and Financial planning Review of 2017/18 Business Plan	Report from Trust Secretary Trust Board Forward Planner Quality Improvement Programme	Audit Committee – 4th September 2017 Quality Governance Committee – 19th September 2017 Finance and Investment Committee – 21st September 2017 Annual General Meeting – 26th September 2017 Workforce and Organisational Development – 18th September 2017	

28th November 2017 – 9am

Standing Items	Assurance Performance/Quality /Workforce /Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chair Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M7** **EPRR update**	6 month review of business plan	Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement Quality Improvement Programme HES report	Board seminar - 31st October 2017 Audit Committee – 6th November 2017 Quality Governance Committee – 14th November 2017 Finance and Investment Committee – 23th November 2017 Workforce and Organisational Development – 18th November 2017	

Board Seminar	Topic
28th February 2017	**Strategy Review**
25th April 2017	**Strategy review**
27th June 2017	**Strategy review**
31st October 2017	**Strategy review**
12th December 2017	**Strategy review**

2017 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	31		28		25pm			1		3	28		9.00 - 14.00
Private Trust Board (Strategy Review and Planning)	Trust Chair		28		25		27				31		12	9.00 - 16.00
Annual General Meeting	Trust Chair									26				14.00 - 15.30
Charitable Funds Committee	Trust Chair						22				5			15.00 - 16.30
Nominations and Remuneration Committee	Trust Chair													
Audit Committee	John Jones		15		18	18 pm/ 25am				4		6		14.00 - 17.00
Finance and Investment Committee	Nick Martin	19		23		22		20		21		23		
Quality Governance Committee	Bob McFarland	10		14		16		11		19		14		13.00 - 16.00
Workforce and Organisational Committee	Fergus Cass	23		20		15		24		18		18		
Quality Improvement Programme Board	Heather Lawrence													
Risk, Compliance and Assurance Committee	Chief Executive Officer			9			6			5			5	
Improving Patient Experience Committee	Director of Nursing and Quality		14		20		20		15		17		7	14.00 - 16.00
Clinical Safety and Standards Committee	Medical Director	17		7		9		4		12		7		14.00 - 16.00
Executive Leadership Team (ELT)	Chief Executive Officer	Every Wednesday 9.00 - 12.00												9.00 - 12.00
Environment and Resources	Director of Finance													
Operations Board	Director of Operations	3rd Thursday of every month												
Workforce	Director of Human Resources													


Denotes formal sub-committee of the TB
Awaydays
Annual Reports

Trust Board Register of Interest - September 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
Heather Lawrence	05/04/2016		✓	Chairman Apos Medical Ltd healthcare					
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	✓							
Jill Patterson	18/02/2016		✓	Tall Poppies Management Ltd	Tall Poppies Management Ltd	Tall Poppies Management Ltd			
Andrew Watson	04/05/2016	✓							
Mark Hirst	12/07/2016		✓	Managing director of Point Clear Consulting Ltd	Managing director of Point Clear Consulting Ltd			Undertaking current interim role through Rethink Recruitment	
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