London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 27th JANUARY 2015 AT 09.00 - 12.30
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.00 - 09.15	1.	**Welcome and apologies for absence** Apologies received from:			
	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	3.	**Minutes of and matters arising from the Part I meeting held on 16th December 2014** To approve the minutes of the meeting held on 16th December 2014 and to review any matters arising	Approval	RH	TAB 1
	4.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	ORAL
QUALITY GOVERNANCE AND PERFORMANCE REPORTING					
09.15 - 11.15	5.	**Quality and Safety** To receive reports and assurance on the quality and safety of the service 5.1 Quality Dashboard for October to December 2014 5.2 Clinical Quality and Patient Safety Report	Assurance	 ZP FM	 TAB 2 TAB 3
	6.	**Industrial Action** To receive a report on the arrangements to manage the service during the planned industrial action	Information	JK	TO FOLLOW
	7.	**Infection Prevention and Control Annual Report** To approve the annual report for 2013/14	Approval	ZP	TAB 4
	8.	**Integrated Board Performance Report** To receive the Integrated Board Performance report for Month 9, December 2014	Information	PW	TAB 5
	9.	**Plan to implement national pilot changes to clock start performance and determinant categorisation** To approve the plan	Approval	JK	TO FOLLOW
	10.	**Board Assurance Framework and Corporate Risk Register – Quarter 3 documents** 10.1 To receive the Board Assurance Framework and Corporate Risk Register for Quarter 3 10.2 To receive the report from the Audit Committee on 16th December 2014	Assurance Assurance	SA JJ	TAB 6 ORAL

	11.	**Quality Governance Assurance Report** To receive the Quality Governance Assurance report	Assurance	BMc	TAB 7
	12.	**Finance Report** To receive the finance report for month 9, December 2014 and to discuss the financial and business planning process for 2015/16 12.1 Finance Report Month 9, December 2014 12.2 Financial and Business planning process for 2015/16 12.3 Report from Finance and Investment Committee on 22nd January 2015	Information and Assurance	 AG AG/KB NM	 TAB 8 ORAL ORAL
STRATEGIC AND BUSINESS PLANNING					
11.15 - 12.00	13.	**Recruitment and Workforce Update** To receive an update on the recruitment programme and other workforce issues	Information	KB	PRESENT -ATION
	14.	**eAmbulance Strategic Outline Case** To approve the eAmbulance Strategic Outline Case (SOC) to move to the Outline Business Case (OBC) stage	Approval	AG	TAB 9
	15.	**Fleet Replacement Business Case** To approve the replacement of the fleet	Approval	AG	TAB 10
BUSINESS ITEMS					
12.00 - 12.30	16.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	FM	TAB 11
	17.	**Charitable Funds Annual Report and Accounts for 2013/14** To approve the 2013/14 annual report and account	Approval	AG	TAB 12
	18.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for January 2015	Approval	SA	TAB 13
	19.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Information	SA	TAB 14
	20.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 15
	21.	**Questions from members of the public**		RH	
	22.	**Any other business**		RH	
	23.	**Meeting Closed**			
	24.	**Date of next meeting** The date of the next Trust Board meeting is 24th March 2015			

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 16th December 2014 at 09:30 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Jessica Cecil (Chairing)	Non-Executive Director	
Ann Radmore	Chief Executive	
Fergus Cass	Non-Executive Director	
John Jones	Non-Executive Director	
Nick Martin	Non-Executive Director	
Theo de Pencier	Non-Executive Director	
Bob McFarland	Non-Executive Director	
Jason Killens	Director of Operations	
Fionna Moore	Medical Director	(by telephone)
Zoe Packman	Director of Nursing and Quality	

In Attendance:

Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation and Strategy
Brenda Thomas	Committee Secretary
Mark Whitbread	Director of Paramedic Education and Development
Paul Woodrow	Director of Performance

Members of the Public:

Karl Mercer	British Broadcasting Corporation
Malcolm Alexander	Patient Forum

Members of staff:

Anna McArthur	Communications Manager

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153. Welcome and Apologies

153.1 Apologies had been received from Richard Hunt (Chairman), Jessica Cecil chaired the meeting.

154. Declarations of Interest

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

155. Minutes of the Part I meeting held on 3rd June 2014

155.1 The minutes of the part I meeting held on 24th November 2014 were approved, subject to amendments in paragraphs 141.3 and 142.3.

Changes in 141.3, last sentence should read '*John Jones highlighted that the process of assurance for the risk register had been reviewed and the Audit Committee proposes a deep dive on high risk areas at future meetings*'

Changes in 142.3, last sentence should read '*John also noted that a new Audit Committee had been established from 1st April 2014 and the effectiveness of the Committee would be assessed in February 2015 with all members of the Board involved*'.

156. Matters Arising

156.1 The following action was discussed:

134.3 The outcome of the findings from the enhanced safety review would be discussed at the Quality and Governance Committee which next meet on 13th January 2015.

157. Safety

157.1 Mark Whitbread gave a presentation on the Safety Review for November 2014 and noted the following:

- The difference between Quality and Safety, with Quality being defined as care that is safe, clinically effective and provides a positive patient experience for all our patients, while Safety was care that allows us to prevent further injury or damage.
- Routine safety monitoring goes on throughout the year within the Ambulance service and the wider NHS, with feedback from patients, relatives, carers, Health Care Professionals, Commissioners and Staff (incident reports).
- Routine safety monitoring was carried out internally on a daily basis, 7 days per week and throughout the year. Complaints and potential serious incidents were reviewed, with the latter being considered by the Serious Incident Group which meets fortnightly. The incident reporting internally is referred to as LA52s, completed by staff 24hours, throughout the year, with completed forms sent to the Safety and Risk Department, where trends are monitored and the relevant department contacted.
- Other safety metrics in use include Survival from Out of Hospital (OOH) cardiac arrest, performance by call categorisation, Clinical Performance Indicators (CPI) completion and compliance, Ambulance Clinical Quality Indicators (ACQIs), National Clinical Performance Indicators, Learning from other Services (Preventing Future Deaths (PFDs) and Serious Incidents (SIs)). It was noted that in 2013/14 London had the highest ever survival rate of OOH cardiac arrest.
- Total complaints for 1st April to 6th November 2013 were 658 (297 delays), compared to 839 (458 delays) reported for the period 1st April 2014 to date, thereby resulting in a 21% overall increase in complaints and 35% in complaints regarding to delays, representing 0.06% of total incidents attended.
- The total serious incidents declared and not declared for 2013/14 were 35 and 91 respectively; and for 1st April 2014 to date the incidents declared and not declared were 27 (including 7 closed) and 57 respectively.
- In terms of mitigating risks, the measures put in place were also noted and it was concluded that there were a number of systems and layers to maintain safety on an on-going basis.
- A sampling exercise was undertaken by using an identical template to that of Yorkshire Ambulance Service. The results showed that of the clinical review of 336 Patient Report Forms, 15 were graded as 'High Risk', and on review one patient at risk was attended to in 33 minutes as opposed to 8 minutes.
- The lessons from other ambulance services were noted with the results indicating similar experiences between Yorkshire Ambulance Service and the London Ambulance Service (LAS).

157.2 The Board thought this helpful to note and to hear that the sample could be repeated more regularly but, as it was very time consuming as a process, this would need to be further defined and there would be a balance to strike between using frontline clinicians undertaking the review whilst carrying out their normal activities.

157.3 Jessica Cecil asked Fionna Moore whether she could provide an assurance to the Board that the LAS was running a clinically safe service. Fionna Moore responded that at the time the review was undertaken, a safe service was being provided and that the processes in place were robust in identifying patients that might be at risk.

157.4 Ann Radmore stated that work was planned to increase the amount of incident reporting by staff in order to capture more patient safety information.

157.5 Bob McFarland asked where the Trust was along the spectrum of a high quality service at one end and a safe service on the other end. Jason Killens responded that the surge plan was designed to maintain safety for the most critically ill patients at times of pressure on the service. He also noted that the surge levels escalated depending on the prevailing circumstances at the time, which could change on a daily or weekly basis and this made it more difficult to define where on the spectrum the Trust was currently sitting.

157.6 Paul Woodrow commented that in some respects, escalating through the surge levels meant offering some patients a better service because they were managed in a different way. Rather than allow those patients to remain in the queue of calls held and waiting for a vehicle response, they were proactively redirected to other parts of the system and potentially a quicker response.

157.7 Ann Radmore commented on the growth of the clinical hub, and the introduction of mental health and general nurses in the hub, with the development of a range of responses in 2015 which would also address the quality of response.

158. <u>Performance Reporting</u>

158.1 Paul Woodrow reported that as a result of the Board meeting being held prior to validating the data, the integrated report for month 8 was not yet available. A consolidated report for November & December 2014 would be presented at the next Board meeting.

158.2 Paul Woodrow gave the following oral update on current performance headlines for November 2014:

- Red 1 Performance - 64.25%
- Red 2 Performance - 54.84%
- Overall Category A Performance - 55.12% in 8 minutes
- The 75th percentile for the Red 1 and Red2 categories of patients were as follows:
    - 79.89%of Red 1 patients were reached within 10 minutes
    - 76.57% of Red 2 patients were reached within 12 minutes
- A19 Performance equalled 89.25%
- C1 Performance equalled 41.57%
- C2 Performance equalled 50.88%
- 95% of all Category A patients were reached within 24 minutes (12 minutes Cat A 75th percentile)

- The challenge of the second day of industrial action on 24th November 2014, followed by action short of strike for the rest of the week, with staff working reduced hours, resulted in a reduction in hours produced. The strike day was managed well and had incorporated lessons learned from the industrial action in October.

- In terms of activity, there had been a step change in activity since early November 2014. Category A activity was 4.6% above contracted level and 10% higher than November 2013 as winter and annual growth of 5.5% had already been accounted for in the figures and this clearly posed a challenge for the Service, particularly given the capacity issues.

- The top 5 chief presenting complaints were falls, breathing problems - reported as prevalent, NHS111 transfers, health care professional admissions, and non-traumatic chest pains.

- Hours produced continued to be below the levels to support the current rate of activity but remained in line with forecasted supply and trajectory. Strenuous efforts were being made to speed up recruitment of staff and optimise staffing from other areas such as temporary staff with PAS, Bank staff and overtime.

- The Clinical Hub (Hear and Treat) dealt with around 15,000 patients in November without the need for ambulance attendance. This was 200% above plan and reflected the delivery of the additional demand management actions within the Trust's performance improvement plan.

- In terms of the Performance Improvement Plan, all actions within the plan were currently on track.

- December continued to demonstrate unprecedented levels of Category A activity which was currently 12% above forecasted levels. Monday 15th December 2014 was recorded as one of the busiest day in the Trust's history with an increase in Category A activity of 17.5% on original forecast equal just under 1700 Category A incidents. The top 5 chief complaints remained consistent with the levels seen in November although there was significant variability in the geography of the increases on a daily basis which made it harder to predict and respond.

158.3 In addition to Paul Woodrow's update, Jason Killens reported that plans were in place for the next three weeks across the Christmas and New Year period, with each day individually risk assessed and a range of mitigating actions in place, ready to be deployed across the fifteen day period including overtime and incentives. It was noted that these varied by day and time with overtime and incentives targeted to specific days, and targeted deployment of private and voluntary ambulance providers, bank staff, and hub staff.

158.4 Jason Killens further reported that the Alcohol Recovery Centres and a media campaign termed 'Party People' had gone live. The Alcohol Recovery Centres went live the previous week with operations in Croydon, Romford, Soho, Kingston and the City of London for the period leading up to Christmas, while the 'Party People' campaign had been set up as a preventative measure. Other mitigations include staff in the clinical hub and transfer of less acute calls to NHS111 as appropriate to the patient.

158.5 Paul Woodrow mentioned that a piece of work was being undertaken to re-model activity forecasts to the end of the financial year, in light of the sustained period of increased activity. This was being reflected nationally across the ambulance sector with all Trusts reporting significant rise in activity.

158.6 Andrew Grimshaw reported that due to the level of unprecedented calls, a decision was made to enact level Blue of the Surge Management Plan, to protect response to the most seriously ill and injured patients, in order to appropriately focus resources on where they were most needed, thereby redirecting patients with less acute illness and injuries to other more appropriate services.

158.7 Andrew explained that there were six levels within the surge management plan, blue being the fifth. Therefore the decision to enact surge blue was not taken lightly and all stakeholders were duly informed. On 15th December 2014, surge blue operated for five hours between the hours of 16.30 to 21.30, as calls in excess of three hundred per hour were received consistently from around 10.00am. The triggers to enact surge blue were met across the day. Ambulances were sent to all Category A patients, while Category C patients received clinical assessment over the phone. Surge

levels were reviewed at 17.30 and 19.30, the decision was reversed to move back to surge purple at 21.30.

158.8 Paul Woodrow responded to further questions raised and mentioned that overtime was enhanced in order to establish additional capacity, and in terms of targets set in the Performance Improvement Programme, those targets were met. For the Christmas period, a separate scheme had been put in place, as earlier described by Jason Killens. Outside of the normal overtime arrangements, there had been good take up of premium shifts. He further mentioned that Cat A activity on 15th December 2014 resulted in a 17.5% increase and between 1,000 to 1,200 x 999 calls had been received, which was a significant shift from current position.

158.9 Mark Whitbread supported the point about work increasing dramatically over the Christmas period, and in addition, mentioned that hospitals and A&E departments were putting in their winter plans, as the emergency departments across London were also experiencing increased demand. Therefore, it was essential that the whole of the NHS system work together.

158.10 Paul Woodrow further mentioned that the peak period came early this year, and noted that the question to bear in mind was whether the change was temporary or whether there was a step change, as the levels of pressure seen was unabated and unprecedented for six weeks, therefore the need for the activity forecast to be remodelled, as activity levels was pointing toward a step change. Bob McFarland reiterated this point and further mentioned that as patients would be diverted to other parts of the system, the pressure would be felt across the entire NHS system over the Christmas and New Year.

158.11 Karen Broughton commented that it was appropriate to look at how the system works and what happens before people get sick, which was dealt with at the primary care level. Paul Woodrow confirmed that LAS was working with partners within London's health economy in terms of supportive action. Jason Killens cited several examples of this partnership support, such as NHS England (London) asking NHS 111 providers to step up their clinical staff and change the way they manage the calls that they would normally send to the LAS.

158.12 Nicholas Martin questioned whether the less immediate availability of primary care was pushing demand to the A&E departments and emergency services, and Karen Broughton responded that she had asked for a local review to be undertaken with the primary care system, as it was vital to keep people healthy during winter.

158.13 Ann Radmore noted that one of the challenges for the Trust was the difficulty in getting hold of information or statistics from GPs, and whether crews could collect evidence to identify what primary care was offering, including why patients had not contacted their GP, for example. Ann further mentioned that on the surface, primary care seemed to be offering more with, for example, extended surgery hours. It was thought that urgent care centres had more flexibility; and that each part of the system could be used to obtain maximum benefit.

158.14 John Jones commented that, with the level of demand being sustained, it was even more important that the Trust should reduce the utilisation rate.

158.15 Jason Killens responded in the affirmative to Theo de Pencier's question of whether there was evidence that other ambulance services were experiencing the same step change in demand or increase in the level of activity as LAS. In addition, he mentioned that the increase in the level of activity was varying, broadly at the same time, broadly at the same level and broadly with the same types of patients, which confirmed that the problems highlighted were national, not just in London.

159. Questions from members of the public

159.1 There were no questions from members of the public.

160. Any other business

160.1 There were no items of other business.

160.2 The public meeting was closed.

161. Date of next meeting

161.1 The next meeting of the Trust Board is on Tuesday 27th January 2015 at 09.30am in the Conference Room, Waterloo.

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Signed by the Chair

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	27th January 2015
Document Title:	Quality Dashboards for October to December 2014
Report Author(s):	Briony Sloper, Deputy Director of Nursing Alison Blakely, Staff Officer
Presented by:	Zoe Packman, Director of Nursing and Quality
Contact Details:	Zoe.Packman@lond-amb.nhs.uk
History:	Quality Committee
Status:	For discussion

Background/Purpose

Since the introduction of the quality dashboard during 2014 the data has been prepared and presented two months in arrears. With the most recent data being tabled at the Quality Committee.

The recently appointed Director of Nursing and Quality has agreed to review this to ensure data is presented one month in arrears, shows a trend analysis and in the fullness of time is benchmarked externally. This new approach was welcomed at the Quality Committee in January 2014. It is hoped that the first version of the new dashboard will be available in February 2014. Work is currently in train to design and automate the process and to discuss the form and content with key stakeholders, for example the Commissioners.

Data completeness has also been an issue of concern, firstly in regards to data received from the operational areas when due to operational pressures audits and data collection have not been possible. Secondly in regards to a number of the metrics where data has not been populated in the dashboard since its instigation, work is on-going to either review the data set to allow collection or to identified to data source and ensure this is accessed in a timely fashion

In order to provide assurance to the Board in regards to Quality and safety the Director of Nursing and Quality asked the Deputy Director of Nursing and the Staff Officer to the Medical Director to ascertain data up until end December 2014. It was not possible to achieve this to the standard aspired too or until end December 2014. However the data available was presented at the Quality Committee and rigorously discussed.

October headlines

- The LAS provided an excellent level of care for patients in cardiac arrest in October, with Brent, Camden, City & Hackney, Edmonton, Fulham, Friern Barnet, Romford and Wimbledon Complexes, as well as HART, documenting patient outcome, whether the arrest was witnessed and whether pre-LAS CPR occurred for every patient in cardiac arrest.
- There has been a decrease in compliance to the transportation of FAST positive stroke patients to a HASU this month to 93% (usually above 95%). In particular, St. Helier

Complex reported less than 75% of FAST positive stroke patients transported to a HASU in October, and this should be investigated.

- Data suggests referral to social services for patients with mental health needs are being made via the safeguarding root when they should be referred to alternative care pathways. Or where the patient is conveyed to an Emergency Department a referral is not required as the Trust will undertake that..

- Documentation of peak flow for difficulty in breathing patients varies considerably across the LAS, although Chase Farm Complex achieved 100% for both initial and final peak flow assessment.

November Headlines

- Low CPI completion rates continue to have an impact on the proportion of complexes who have a large enough sample of PRFs to accurately represent the patient care provided; in November, over one quarter of all CPI data shown on the quality dashboard was based on data samples of less than 10 PRFs.

- The aspects of care highlighted in the quality dashboard for the Cardiac Arrest, ACS and Glycaemic Emergencies CPIs were provided to the usual high standard by the LAS in November. Documentation of symptom onset time for Stroke patients continued to require improvement across the LAS.

- Under the Non Conveyed CPI, a very high proportion of patients received appropriate advice but documentation of final observations and whether a copy of the PRF was left with the patient continued to require improvement across the LAS.

- The LAS used the capacity tool for a very high proportion of patients diagnosed with a psychiatric problem (where appropriate). However, only 70% of this patient group had their safeguarding concerns considered by crews in November.

Common themes

Cardiac arrest data good, Stroke – overall performance good however issues identified with transportation of FAST positive patients and documentation of onset of symptoms. MH is consistently the lowest CPI – improved regarding completion of capacity assessments, reduced safeguarding referrals. Overall data set is poor and therefore impacts reliability of data.

Action required

Review and redesign of Quality Dashboard and the data collection process

Assurance

Data samples are of a level to provide assurance to the Board, however in some areas there is room for improvement.

Key implications and risks arising from this paper	
Clinical and Quality	Data not complete for all areas this leaves a gap in assurance, however the daily assurance reviews and the Medical Directors Clinical review provide greater assurance of safety
Performance	
Financial	
Legal	
Equality and Diversity	
Reputation	Concern has been expressed by key stakeholders, commissioners and TDA in regard to the presentation of the quality dashboard
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

October

				Safey & Standards												
				Clinical Safety Standards												
				Cardiac Arrest		ACS		Stroke		See & Treat			Mental Health		DIB	
		Completion by →	DoN	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU
Sector	CCG	Complex/Main Station	Incidents	Patient Outcome Witnessed Arrest	Pre-LAS CPR	Blood Glucose	12 lead	Time	HASU	Observations	PRF left	Advice	Capacity	Safeguarding Referral	Peak flow (initial)	Peak flow (final)
North West	Hillingdon	Hillingdon	2916	94%	100%	100%	100%	93%	100%	83%	93%	89%	91%	55%	76%	69%
	Harrow	Pinner/Kenton	3333	100%	100%	100%	100%	100%	100%	87%	100%	93%	100%	100%	75%	100%
	Brent	Brent	3878	100%	100%	97%	100%	96%	100%	96%	96%	100%	100%	55%	85%	90%
West	Ealing	Hanwell	3364	100%	100%	100%	100%	80%	100%	79%	92%	96%	67%	67%	71%	71%
	Hounslow	Isleworth	2778	100%	97%	91%	100%	97%	100%	88%	84%	93%	100%	88%	95%	92%
	Central L,	Waterloo		100%	100%	None		100%	100%	100%	81%	100%	100%	100%	100%	100%
	Hammersmith & F	Fulham	3052	100%	100%	100%	95%	100%	100%	89%	95%	97%	100%	90%	78%	78%
	West London (K&C)															
N Central	Barnet	Friern Barnet	2900	100%	100%	90%	100%	100%	100%	92%	95%	100%	100%	77%	84%	95%
	Enfield	Chase Farm	1542	100%	100%	100%	88%	100%	100%	86%	100%	98%	100%	50%	100%	100%
	Haringey	Edmonton	4022	100%	100%	97%	95%	98%	100%	92%	94%	97%	91%	55%	81%	81%
	Camden	Camden	4999	100%	100%	100%	100%	94%	100%	95%	93%	95%	100%	67%	100%	100%
	Islington															
East Central	City & Hackney	Homerton	3487	100%	100%	95%	100%	97%	100%	98%	89%	98%	100%	100%	100%	100%
	Newham	Newham	2904	96%	100%	98%	96%	95%	67%	90%	85%	97%	91%	70%	69%	69%
	Tower Hamlets	Silvertown	2274	100%	100%	88%	100%	100%	100%	100%	90%	100%	33%	100%	100%	100%
North East	Waltham Forest	Whipps Cross	5038	100%	100%	95%	92%	89%	92%	93%	94%	98%	100%	85%	89%	93%
	Redbridge															
	Havering,	Romford	3845	100%	100%	100%	100%	85%	93%	98%	95%	100%	100%	75%	100%	100%
	Barking & Dagenham															
South East	Greenwich	Greenwich	3888	100%	100%	99%	99%	97%	98%	93%	94%	97%	100%	86%	94%	95%
	Bromley	Bromley	3357	100%	100%	100%	100%	100%	100%	86%	93%	98%	100%	30%	100%	86%
	Lewisham															
	Bexley	Barnehurst	3074	100%	100%	100%	100%	89%	88%	97%	90%	95%	100%	42%	94%	94%
	Southwark	Deptford	7145	100%	100%	100%	100%	None		79%	68%	79%	100%	67%	100%	100%
	Lambeth	Oval		100%	100%	100%	100%	100%	100%	95%	95%	95%	67%	67%	0%	50%
South West	Sutton	St Helier	4062	97%	97%	98%	98%	96%	68%	83%	94%	94%	100%	68%	88%	82%
	Richmond,															
	Kingston	New Malden	2920	96%	93%	94%	100%	90%	97%	89%	93%	99%	100%	63%	92%	92%
	Merton															
	Wandsworth	Wimbledon	2742	100%	100%	100%	100%	50%	100%	83%	90%	97%	None		100%	100%
	Croydon	Croydon	3095	100%	100%	100%	98%	90%	94%	85%	89%	95%	100%	30%	82%	79%
		HART		100%	100%	80%	100%	100%	100%	99%	96%	99%	60%	60%	100%	70%
		PTS														
		CONTROL														
		JRU														
		CHUB		None		100%	50%	100%	50%	81%	94%	81%	100%	50%	100%	100%
		Emergency Responders	No	100%	None	100%	None		None	None		None	None		67%	None
		other/unknown	5951													
		Private Ambulance		100%	100%	96%	96%	94%	79%	88%	95%	91%	92%	56%	88%	86%
		111														
		TRUSTWIDE	86566	99%	99%	97%	97%	94%	93%	91%	92%	97%	97%	67%	87%	87%

		Safey & Standards																		Development, Education & Enablers							Effectiveness, Experience & Evaluation							
		Time				Clinical Care										Safety	Resource			Education			Resourc	Feedback	Supervision		Clinical failure		Feedback		Right Place		Effectiveness	
		Answering		Response	Care	Cardiac Care				Stroke Care		Infection Control		Safeguarding		Contact	Staffing			CSR			Equipme	CPI	Supervision		Incidents		Complaints		Non Convey to A&		Recontact	
		DoN	DoN	DoN	DoN	CARU	CARU	CARU	CARU	C A R U	CARU	IPC	IPC	EBS	EBS	Ops	DoN	DoN	OPS	Ed	Ed	X	X	CARU	DoN	DoN	Govern ance	Governa nce	complai nts	DoN	DoN	DoN	DoN	DoN
CCG	Complex/Main Station	Time Taken to Answer 999 Calls (95th)	999 Calls Abandoned	Red 1 Time	Time to Treatment (95th Percentile)	Time: STEMI 999 call to arrival at Hospit	Cardiac care bundle	Defib Downloads	Print out for End Tidal C02	60 Minutes	Care Bundle	Hand Hygiene	Vehicle Cleaning	Number Referrals	Ratio of Referrals	Ring Backs	Clinical Staffing - All in post **(Sept)**	Clinical Staffing - All in post **(Latest)**	3rd Party Providers	% of CSR Allocated	% of CSR Attended	Evaluation of CSR 2	Spot Check on 10 vehicles	Feedback Sessions Undertaken	OWR	Actual PPED	Number of Serious Incidents	Number of Incidents as ratio	Number of Complaints **(October)**	Ratio of Complaints	Hear & Treat	See & Treat	Recontact Hear & Treat	Recontact See & Treat
Hillingdon	Hillingdon					82	70%	0%	100%		100%			69	2.4									0					6					
Harrow	Pinner/Kenton					73	71%	0%	100%		98%			127	3.8									3					4					
Brent	Brent					86	73%	0%	100%		94%			76	2.0									1					1					
Ealing	Hanwell					84	82%	0%	100%		98%			74	2.2									1					5					
Hounslow	Isleworth					70	80%	0%	100%		95%			50	1.8									3					5					
Central L,	Waterloo					50	80%	0%	93%		100%													0					4					
Hammersmith & F	Fulham					65	75%	0%	94%		100%			69	2.3									19					10					
West London (K&C)																																		
Barnet	Friern Barnet					68	80%	0%	80%		100%			68	2.3									0					7					
Enfield	Chase Farm					77	100%	0%	100%		100%			44	2.8									0					6					
Haringey	Edmonton					78	64%	0%	94%		97%			156	3.9									1					4					
Camden	Camden					51	100%	0%	70%		94%			100	2.0									19					5					
Islington											92%																							
City & Hackney	Homerton					55	75%	0%	87%		97%			54	1.5									17					4					
Newham	Newham					66	73%	0%	91%		100%			45	1.5									0					3					
Tower Hamlets	Silvertown					61	67%	0%	100%		100%			45	2.0									0					3					
Waltham Forest	Whipps Cross					68	92%	0%	96%		96%			118	2.3									18					7					
Redbridge																													4					
Havering,	Romford					83	100%	0%	100%		100%			82	2.1									28					4					
Barking & Dagenham																																		
Greenwich	Greenwich					68	67%	0%	94%		100%			152	3.9									97					6					
Bromley	Bromley					80	71%	0%	100%		93%			136	4.0									0					9					
Lewisham																																		
Bexley	Barnehurst					80	67%	0%	88%		100%			111	3.6									1					4					
Southwark	Deptford					63	56%	0%	100%		94%			211	2.9									0					0					
Lambeth	Oval					60	100%	0%	100%		100%													0					10					
Sutton	St Helier					61	45%	0%	92%		99%			247	6.1									1					8					
Richmond,																																		
Kingston	New Malden					78	88%	0%	93%		95%			109	3.7									1					5					
Merton																																		
Wandsworth	Wimbledon					80	60%	0%	100%		91%			117	4.3									0					3					
Croydon	Croydon					82	55%	0%	94%		100%			159	5.1									0					10					
	HART																							1										
	PTS																																	
	CONTROL																																	
	JRU																																	
	CHUB																							None										
	Emergency Responders																							None										
	other/unknown																												6					
	Private Ambulance										98%													None										
	111																												1					
	TRUSTWIDE																							211					144					

November

				Safey & Standards																																Development, Education & Enablers								Effectiveness, Experience & Evaluation									
				Clinical Safety Standards													Time				Clinical Care												Safety	Resource			Education			Resource	Feedback	Supervision		Clinical failure		Feedback		Right Place		Effectiveness	
				Cardiac Arrest		ACS		Stroke		See & Treat			Mental Health		Glycaemia		Answering		Response	Care	Cardiac Care				Stroke Care		Infection Control		Safeguarding		Contact	Staffing			CSR			Equipme	CPI	Supervision		Incidents		Complaints		Non Convey to A&E		Recontact	
	Completion by →		CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	DoN	DoN	DoN	DoN	CARU	CARU	CARU	CARU	CARU	CARU	IPC	IPC	EBS	EBS	Ops	DoN	DoN	OPS	Ed	Ed	X	X	CARU	DoN	DoN	Governance	Governance	complaints	DoN	DoN	DoN	DoN	DoN
Sector	CCG	Complex/Main Station	Incidents	Patient Outcome Witnessed Arrest	Pre-LAS CPR	Blood Glucose	12 lead	Time	HASU	Observations	PRF left	Advice	Capacity	Safeguarding Referral	BM (post)	Care	Time Taken to Answer 999 Calls (95	999 Calls Abandoned	Red 1 Time	Time to Treatment (95th Percentile)	Time: STEMI 999 call to arrival at HC	Cardiac care bundle	Defib Downloads	Print out for End Tidal C02	60 Minutes	Care Bundle	Hand Hygiene	Vehicle Cleaning	Number Referrals	Ratio of Referrals	Ring Backs	Clinical Staffing - All in post **(Sept)**	Clinical Staffing - All in post **(Latest**	3rd Party Providers	% of CSR Allocated	% of CSR Attended	Evaluation of CSR 2	Spot Check on 10 vehicles	Feedback Sessions Undertaken	OWR	Actual PPED	Number of Serious Incidents	Number of Incidents as ratio	Number of Complaints **(October)**	Ratio of Complaints	Hear & Treat	See & Treat	Recontact Hear & Treat	Recontact See & Treat
North West	Hillingdon	Hillingdon	2916	100%	100%	95%	100%	92%	95%	94%	94%	94%	100%	45%	100%	100%					77	73%	0%	100%	57%	96%	100%	85%	66	2.2									0					6					
	Harrow	Pinner/Kenton	3333	100%	95%	100%	100%	93%	94%	91%	96%	99%	100%	69%	91%	100%					60	75%	25%	100%	66%	100%	100%	95%	83	2.8									1					3					
	Brent	Brent	3878	100%	83%	100%	100%	92%	78%	78%	96%	100%	100%	75%	100%	100%					71	83%	0%	100%	41%	97%	100%	92%	77	2.1									2					6					
West	Ealing	Hanwell	3364	100%	100%	100%	100%	100%	100%	77%	92%	92%	100%	0%	100%	100%					72	75%	0%	100%	59%	95%	100%	85%	94	2.7									2					13					
	Hounslow	Isleworth	2778	92%	92%	100%	100%	100%	86%	86%	84%	86%	100%	89%	100%	91%					69	90%	0%	100%	50%	100%	100%	75%	45	1.7									1										
	Central L,	Waterloo		100%	100%	None		100%	100%	93%	71%	100%	None	None	100%	100%					48	78%	0%	100%	67%	943%		87%												0					7					
	Hammersmith & F	Fulham	3052	100%	100%	96%	96%	100%	100%	81%	95%	97%	100%	86%	97%	97%					63	57%	0%	100%	53%	97%	100%	81%	45	1.5									14					11					
	West London (K&C)																																										8					
N Central	Barnet	Friern Barnet	2900	100%	96%	100%	100%	92%	94%	95%	94%	98%	100%	79%	100%	100%					78	65%	0%	100%	52%	98%		96%	79	2.6									77					1					
	Enfield	Chase Farm	1542	100%	100%	None		100%	None	100%	100%	100%	None		None						82	75%	0%	100%	33%	100%		93%	24	1.7									0										
	Haringey	Edmonton	4022	100%	100%	100%	100%	100%	100%	100%	93%	98%	100%	100%	100%	100%					79	95%	0%	90%	37%	100%	98%	95%	162	4.4									0					11					
	Camden	Camden	4999	100%	100%	100%	100%	86%	90%	74%	91%	92%	100%	100%	97%	100%					71	88%	0%	93%	50%	100%	100%	95%	120	2.4									0					12					
	Islington																								57%	100%	100%	95%																2					
East Central	City & Hackney	Homerton	3487	100%	100%	100%	100%	100%	100%	97%	95%	99%	100%	47%	100%	90%					61	60%	0%	100%	87%	100%	100%	91%	46	1.4									0					2					
	Newham	Newham	2904	100%	96%	93%	100%	96%	95%	91%	87%	99%	91%	95%	98%	100%					70	56%	0%	100%	57%	100%	100%	85%	35	1.3									3					1					
	Tower Hamlets	Silvertown	2274	100%	100%	100%	86%	100%	50%	83%	94%	100%	100%	75%	100%	90%					58	75%	0%	88%	70%	100%	100%	94%											0					7					
North East	Waltham Forest	Whipps Cross	5038	98%	96%	97%	89%	93%	95%	94%	94%	96%	97%	80%	97%	97%					90	77%	10%	100%	53%	97%	100%	92%	127	2.5									18					6					
	Redbridge																																																
	Havering,	Romford	3845	100%	100%	96%	96%	100%	100%	99%	97%	99%	100%	100%	100%	100%					76	64%	0%	88%	69%	89%	100%	100%	78	2.0									32					7					
	Barking & Dagenham																																											6					
South East	Greenwich	Greenwich	3888	94%	97%	96%	96%	87%	96%	96%	90%	93%	94%	82%	98%	100%					69	100%	0%	100%	45%	100%	100%	99%	148	3.9									7										
	Bromley	Bromley	3357	100%	100%	97%	100%	95%	90%	89%	89%	97%	86%	71%	97%	100%					53	88%	0%	100%	59%	96%		97%	110	3.4									3					6					
	Lewisham																																											0					
	Bexley	Barnehurst	3074	96%	96%	100%	95%	96%	91%	90%	84%	93%	100%	88%	97%	97%					80	86%	0%	100%	50%	100%	100%	96%	96	3.1									60					6					
	Southwark	Deptford	7145	100%	100%	100%	100%	100%	100%	89%	84%	97%	None	None	100%	100%					81	88%	0%	100%	65%	97%		93%	204	2.8									0					6					
	Lambeth	Oval		100%	100%	100%	100%	75%	100%	100%	85%	85%	100%	0%	100%	100%					51	40%	0%	100%	78%	94%		92%												0										
South West	Sutton	St Helier	4062	98%	100%	98%	98%	92%	75%	87%	93%	99%	100%	77%	96%	98%					80	67%	0%	100%	53%	94%	100%	91%	221	5.3									0					5					
	Richmond,																																															
	Kingston	New Malden	2920	100%	100%	95%	95%	100%	89%	79%	94%	100%	97%	50%	98%	100%					70	50%	0%	100%	58%	100%		93%	94	3.2									2					1					
	Merton																																											8					
	Wandsworth	Wimbledon	2742	100%	100%	100%	100%	100%	100%	96%	95%	100%	100%	33%	100%	100%					66	78%	0%	90%	71%	97%	100%	90%	71	2.6									2										
	Croydon	Croydon	3095	95%	98%	100%	97%	92%	94%	88%	91%	95%	100%	60%	98%	100%					74	33%	0%	94%	65%	93%	99%	96%	126	4.3									20										
		HART		100%	100%	100%	100%	100%	100%	91%	91%	98%	None		100%	100%																							3					1					
		PTS																																										0					
		CONTROL																																										0					
		JRU																																										0					
		CHUB		None		100%	100%	100%	100%	83%	100%	100%	None		None																								4					3					
		Emergency Responders		75%	None	100%	None	None		None			None		100%	100%																							0					0					
		other/unknown	5951																																									3					
		Private Ambulance		92%	100%	100%	100%	89%	79%	89%	95%	93%	96%	46%	96%	96%									36%	98%													0					7					
		111																																															
		TRUSTWIDE	86566	98%	98%	98%	97%	94%	91%	90%	93%	97%	98%	70%	98%	98%																							251										

October

				Safey & Standards																														Development, Education & Enablers							Effectiveness, Experience & Evaluation									
				Clinical Safety Standards																Clinical Care											Safety	Resource																				
				Cardiac Arrest			ACS		Stroke		See & Treat			Mental Health		DIB		Time				Cardiac Care				Stroke Care	Infection Control		Safeguarding		Contact	Staffing			Education							CSR			Equipme	CPI			Incidents									
		Completion by →	DoN	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	CARU	DoN	DoN	DoN	DoN	CARU	CARU	CARU	CARU	CARU	IPC	IPC	EBS	EBS	Ops	DoN	DoN	OPS	Ed	Ed	X	X	CARU	DoN	DoN	Govern ance	Governa nce	complai nts	DoN	DoN	DoN	DoN	DoN	DoN
Sector	CCG	Complex/Main Station	Incidents	Patient Outcome	Witnessed Arrest	Pre-LAS CPR	Blood Glucose	12 lead	Time	HASU	Observations	PRF left	Advice	Capacity	Safeguarding Referral	Peak flow (initial)	Peak flow (final)	Time Taken to Answer 999 Calls (95th)	999 Calls Abandoned	Red 1 Time	Time to Treatment (95th Percentile)	Time: STEMI 999 call to arrival at Hospit	Cardiac care bundle	Defib Downloads	Print out for End Tidal CO2	Care Bundle	Hand Hygiene	Vehicle Cleaning	Number Referrals	Ratio of Referrals	Ring Backs	Clinical Staffing - All in post **(Sept)**	Clinical Staffing - All in post **(Latest)**	3rd Party Providers	% of CSR Allocated	% of CSR Attended	Evaluation of CSR 2	Spot Check on 10 vehicles	Feedback Sessions Undertaken	OWR	Actual PPED	Number of Serious Incidents	Number of Incidents as ratio	Number of Complaints **(October)**	Ratio of Complaints	Hear & Treat	See & Treat	Recontact Hear & Treat	Recontact See & Treat
North West	Hillingdon	Hillingdon	2916	100%	94%	100%	100%	100%	93%	100%	83%	93%	89%	91%	55%	76%	69%										95%	75%	65	2.1%						14			0			0	N/A	6						
	Harrow	Pinner/Kenton	3333																								100%	100%	76	2.4%						14			3					4						
	Brent	Brent	3878																								20%	100%	56	1.5%						29			1					1						
West	Ealing	Hanwell	3364																								no data	100%	82	2.6%						7			1			3	15.00	5						
	Hounslow	Isleworth	2778																								100%	100%	46	1.8%						13			3					5						
	Central L,	Waterloo																									no data	0%	n/a	n/a						0			0					4						
	Hammersmith & F	Fulham	3052																								100%	100%	62	2.0%						0			19					10						
	West London (K&C)																																																		
N Central	Barnet	Friern Barnet	2900																								100%	100%	57	1.9%						10			0			0	N/A	7						
	Enfield	Chase Farm	1542																								N/A	N/A	20	1.4%						no data			0					6						
	Haringey	Edmonton	4022																								100%	100%	110	3.0%						24			1					4						
	Camden	Camden	4999																								100%	100%	88	1.7%						11			19					5						
	Islington																										N/A	N/A																							
East Central	City & Hackney	Homerton	3487																								no data	100%	60	1.7%						7			17			0	N/A	4						
	Newham	Newham	2904																								no data	0%	46	1.8%						13			0					3						
	Tower Hamlets	Silvertown	2274																								100%	100%	32	1.5%						13			0					3						
North East	Waltham Forest	Whipps Cross	5038																								no data	0%	98	2.0%						17			18			1	5.00	7						
	Redbridge																																																		
	Havering,	Romford																									100%	0%	74	1.8%						13			28					4						
	Barking & Dagenham																																																	
South East	Greenwich	Greenwich																									100%	100%	126	3.1%						24			97			1	45.00	6						
	Bromley	Bromley																									no data	0%	110	3.5%						2			0					9						
	Lewisham																																																	
	Bexley	Barnehurst																									no data	0%	83	2.6%						9			1					4						
	Southwark	Deptford																									no data	0%	205	2.9%						0			0					0						
	Lambeth	Oval																									100%	100%								3			0					10						
South West	Sutton	St Helier																									100%	100%	165	3.9%						10			1			0	0.00	8						
	Richmond,																																																	
	Kingston	New Malden																									100%	0%	105	3.4%						6			1					5						
	Merton																																																	
	Wandsworth	Wimbledon																									no data	0%	63	2.3%						2			0					3						
	Croydon	Croydon																									no data	0%	113	3.7%						11			0					10						
		HART																																							1										
		PTS																																																	
		CONTROL																																																	
		JRU																																																	
		CHUB																																														None				
		Emergency Responders																																														None				
		other/unknown	5951																																																
		Private Ambulance																									98%																				None				
		111																																																	
		TRUSTWIDE	52438																																													211				

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Clinical Directors' Joint Report**
Report Author(s):	**Fionna Moore, Mark Whitbread, Zoe Packman**
Presented by:	**As Above**
Contact Details:	
History:	***Parts of this paper have previously been presented to the Executive Management Team***
Status:	***For information***

Background/Purpose

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

Action required

To note

Assurance

Although CPI completion has fallen significantly over the past months, CPI compliance remains high, demonstrating excellent patient care. However, the low completion levels make this assurance harder to make.

SI reporting is now a stronger process, and is reported to both EMT and Trust Board.

Key implications and risks arising from this paper	
Clinical and Quality	• **24/7 use of Surge Red, and rising use of Surge Purple as well as Surge Blue during December.** • **A rise in the number of Serious Incidents being declared.** • **Poor CPI completion rates** • **The number of PRFs being submitted without illness codes, meaning the PRFs aren't auditable.**
Performance	
Financial	
Legal	
Equality and Diversity	
Reputation	• **Rising number of Serious Incidents declared** • **High volume of complaints received by the patient experiences department** • **Long delays experienced by patients**
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**Yes**
Improve recruitment and retention	**No**
Implement the modernisation programme	**No**
Achieve sustainable performance	**No**
Develop our 111 service	**No**
Simplify our business processes	**No**
Increase organisational effectiveness and development	**No**

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Directors' Joint Report – 27th January 2015

This paper will outline a number of current risks to the Trust, as well as other factors which have an impact on the safety and quality of the service that the Trust provides.

In particular, the Clinical and Quality Directorate would like the Board to focus on the following areas:

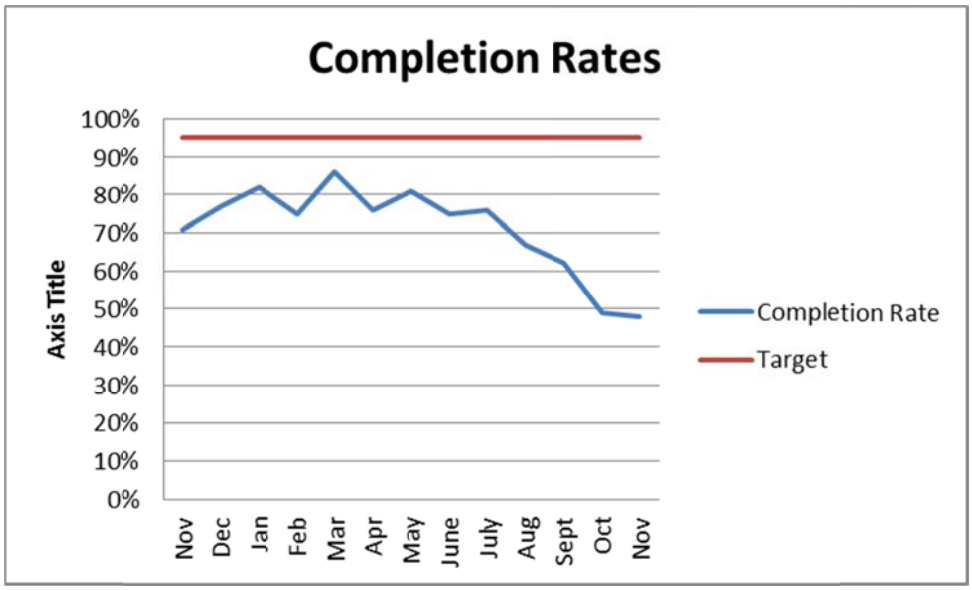
- **Increasing use of Surge, with 24/7 use of Surge Red since the beginning of October and the implementation of Surge Purple and Surge Blue for the first time during December 2014. A total of 275.75 hours were spent at Surge Purple or Surge Blue during the month of December**
- **Poor CPI completion rates, with the Trust's average currently sitting at 48% completion. This is the lowest completion rate since the database was started in April 2009.**
- **A concern surrounding the number of PRFs being submitted without illness code, meaning that the PRF isn't auditable via the CPI system. This in turn means that there is no audit of the care provided to these patients by the individuals involved; creating a clinical risk. The lowest compliance to submission of PRFs with illness codes were the volunteer responders group, followed by HART (42% and 76% respectively).**
- **The number of Serious Incidents being declared has risen during the financial year. The largest number of these relate to delays incurred, followed by a number of EOC mis-categorised calls and lastly clinical or equipment errors.**

Domain 1 - Safety

Clinical Performance Indicator completion and compliance

The CPI completion rate dropped significantly in June, remained low during July, and fell further during August. The completion rate for September was 62%, the lowest since the database was started, in April 2009. However, the completion rate for October has fallen further to 49%. The completion rate has again fallen during November (most recent available data), to 48%.
The East and West areas had a fall in their completion rates, but the South managed an improvement of 6% which they should be congratulated for, given the current pressures on all staff.

The decrease in audits undertaken is mainly due to the performance pressures, as team leaders are spending the majority of their time operationally and not in the office. A large number of the audits being undertaken are being completed by restricted duties staff, and complexes who have these staff available are encouraged to assist complexes without this available assistance.



CPI Completion November 2013 to November 2014

Area	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
East	62%	64%	85%	81%	91%	71%	71%	62%	72%	65%	70%	60%	52%
South	65%	89%	94%	77%	81%	79%	91%	79%	73%	62%	62%	49%	37%
West	82%	77%	68%	69%	88%	76%	77%	79%	80%	71%	54%	38%	55%
LAS	**71%**	**77%**	**82%**	**75%**	**86%**	**76%**	**81%**	**75%**	**76%**	**67%**	**62%**	**49%**	**48%**

CPI Compliance November 2014

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	99%	96%	95%	97%	91%	98%	97%
South	98%	96%	95%	96%	91%	96%	97%
West	98%	97%	97%	97%	91%	96%	97%
LAS Total	**98%**	**96%**	**96%**	**96%**	**91%**	**97%**	**97%**

CPI Compliance October 2014

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	99%	96%	96%	97%	92%	97%	97%
South	98%	95%	96%	96%	89%	96%	97%
West	98%	95%	96%	98%	93%	97%	98%
LAS Total	**98%**	**95%**	**96%**	**97%**	**91%**	**97%**	**97%**

CPI compliance remains >95% against all clinical care standards, except mental health.

Care for stroke patients has been consistently high at 97% throughout the financial year, with all complexes aside from St Helier and the Clinical Hub achieving the 95% target.

The compliance to the non-convey audit has remained at 97% in November, with City and Hackney, Whipps Cross, Friern Barnet, Hillingdon, Greenwich and St Helier complexes providing the highest level of care to this group of patients.

Friern Barnet, Barnehurst and Bromley complexes should be congratulated for their compliance of >95% to all audits.

No complexes in the Trust achieved the 67% cumulative CPI feedback target as part of the AOM objectives. Romford complex was the complex to achieve nearest to this level, providing just over 50%.

PRF submission is continues to be an issue for the Trust. All East, West and South complexes are now reaching an acceptable level of PRF submission, all in excess of 97% with most reaching 99%. However, of concern are the levels of PRFs being submitted by other areas, which remain low. The clinical hub's submission has increased to 98% which they should be congratulated for. However, HART and Volunteer responders continue to have low submission rates of 81% and 74% respectively. HART's submission rates have fallen since the last report. This has been brought to the attention of the relevant managers supervising these teams, and as this has been ongoing for a number of months, an action plan has been requested from each.

There is also some ongoing concern surrounding the numbers of PRFs being submitted to management information without illness codes. This continues to be a problem, and presents a risk because without an illness code, the PRF isn't auditable through the clinical risk CPI groups (although is auditable via the 1:40 CPI). The Trust wide achievement for PRFs submitted with illness codes remains low and has fallen since last month's report and is now at 85%. No complex has achieved above 90%. The highest achievement was 88% which was seen in Barnehurst and New Malden complexes. The lowest compliance to this was seen by the volunteer responders, who submitted only 42% of their PRFs with illness codes (an improvement of 2%), followed by HART who submitted 76% with illness codes. The managers for HART and volunteer responders have been contacted and have been asked to devise an action plan to attempt to rectify this. Area Assistant Director of Operations will also be asked to flag this issue with their complexes and asked to submit a report back per area with a plan for how this will be improved. This creates a clinical risk and therefore needs to be addressed.

Both PRF submission and PRF submission without illness code will continue to be reported to EMT in the coming months.

Full CPI reports can be accessed at:
X:\Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2014-15\Monthly Reports 2014-15\November 2014

Serious Incidents

An update on serious incidents which have been declared will now be included within the clinical report to Trust Board. This will briefly detail incidents which have been declared during the previous month.

Serious Incidents declared during December:

STEIS 2014-42633. Incident date: 11/07/2014. Date of declaration: 03/12/2014.

STEIS 2014-40027. Incident date: 07/11/2014. Date of declaration: 03/12/2014.

STEIS 2014-41370. Incident date: 10/11/2014. Date of declaration: 17/12/2014.

STEIS 2014-39699. Incident date: 19/11/2014. Date of declaration: 03/12/2014.

STEIS 2014-39713. Incident date: 24/11/2014. Date of declaration: 03/12/2014.

STEIS 2014-41361. Incident date: 08/12/2014. Date of declaration: 17/12/2014.

DATIX 68924. Incident date: 14/12/2014. Date of declaration: 17/12/2014.

DATIX 69181. Incident date: 22/12/2014. Date of declaration: 31/12/2014.

NHS Central Alerting System (CAS)

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

In total during September there were 17 CAS alerts. Of these 17, only one was of relevance to the Trust but all were noted. The one notice of relevance to the Trust was regarding the ingestion of button batteries. An article will be written to appear in the next issue of the Clinical Update.

NHS Signals

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

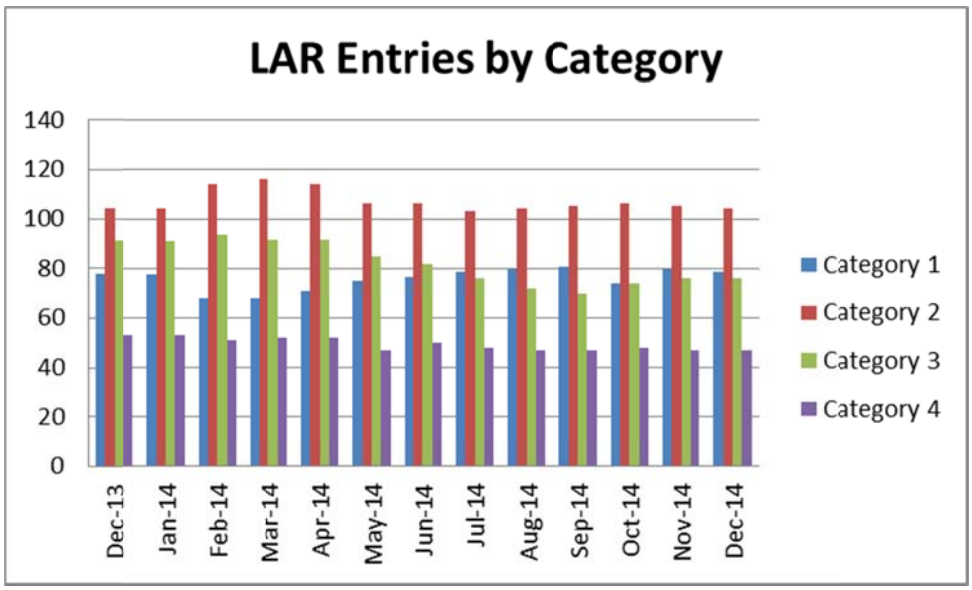
NICE Guidance

The NICE guidance updates for December have been released. None of the updates have a direct impact upon the Trust, but all have been noted.

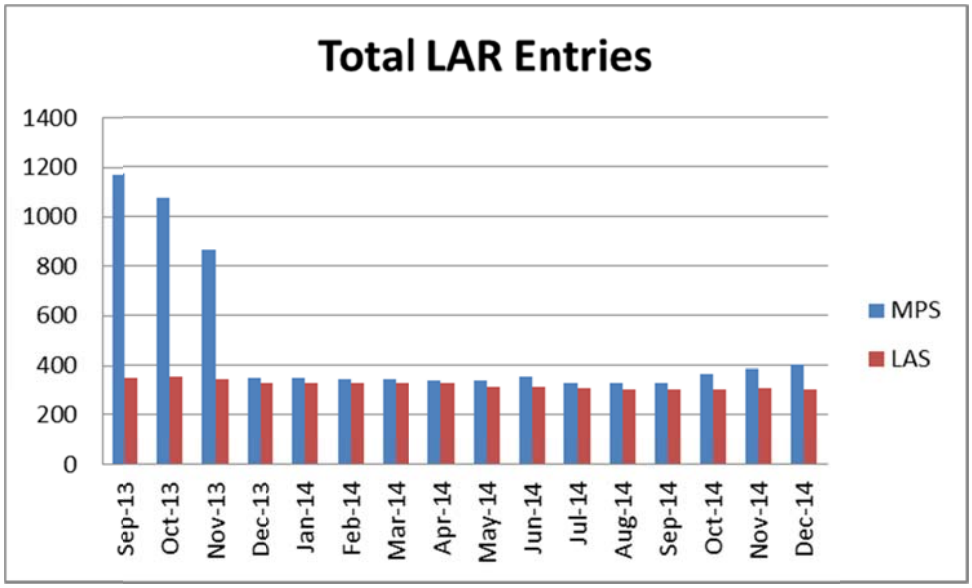
The full guidance is available upon request.

Locality Alert Register

There are currently 305 addresses on the Locality Alert Register (LAR). These are broken down as follows:
CATEGORY 1: 79
CATEGORY 2: 103
CATEGORY 3: 76
CATEGORY 4: 47



The Trust has notification of 401 high risk addresses from the Metropolitan Police.



Surge Plan

The last month for which we have complete Surge data is December 2014.

Surge Red has been in place within the Trust 24/7 since early October 2014 due to the performance pressures and the high levels of calls being held continually in London. Despite Surge Red being in place 24 hours a day, Surge Purple has also been in place on a number of occasions. Surge Blue has also now been used within the Trust.

The implementation of Surge Red has enabled the Trust to respond to the highest priority calls within the required timeframe. However, there is significant risk associated with increasing Surge level, and the Trust has seen some extended delays for lower priority calls.

A revision of Surge is now complete, following the feedback from the use of Surge Purple and the extensive use of Surge Red. The new version has now been implemented.

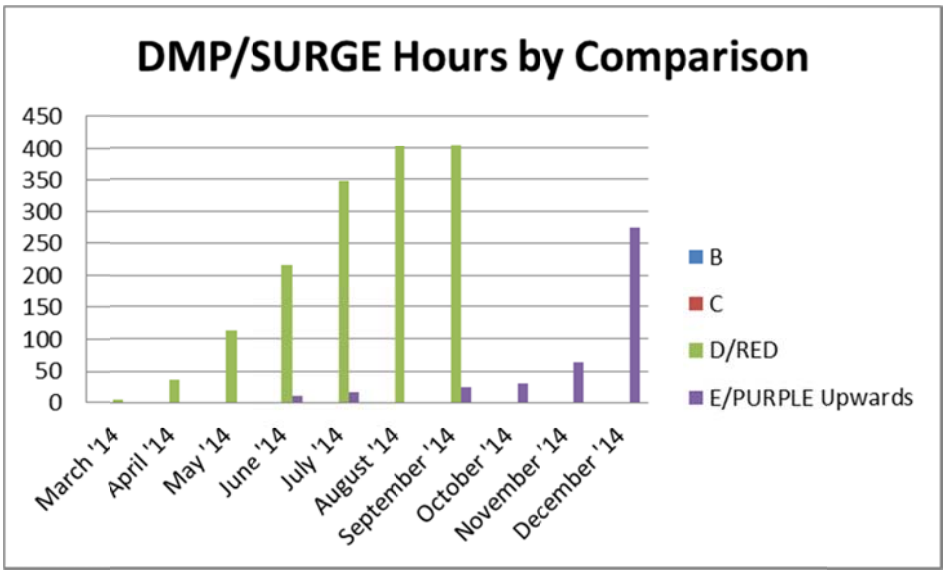
Following this revision, the decision was made that there were a number of elements of Surge Purple which didn't appropriately address the number of calls being held, and the continual incoming call volume. With this in mind, Surge Purple (Enhanced) was written and implemented.

DMP and Surge use March – December 2014

Month	Number of occasions DMP/Surge increased above normal working	Stage B (hours)	Stage C (hours)	Stage D / Surge RED (hours)	Stage E / Surge PURPLE Upwards (hours)	Ambulances reprioritised
March	2	Winter Working		4.25	0	6591
April	10	Winter Working / Surge Amber		36.25	0	7163
May	18	Surge Amber		112.25	0	7881
June	26	Surge Amber		217.25	11.5	8687
July	26	Surge Amber		347.5	16.25	7498
August	28	Surge Amber		401.75	0	7600
September	26	Surge Amber		404.5	24.75	8636
October	5*	Surge Amber		Surge Red	30.0	8725
November	10*	Surge Amber		Surge Red	64.75	9367
December	26*	Surge Amber		Surge Red	275.75	12,271

The increase seen in 'Ambulances Reprioritised' during December 2014 can be attributed in part to a 'Clinical Safety Cell' being opened within the Incident Control Room (ICR) during the periods of Surge Blue.

*Although the number of occasions that Surge was invoked was only 5 in October, 10 in November and 26 in December, this is not a true representation of this information, as the Trust was continually operating at Surge Red from the beginning of October.



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

The Trust has not received any prevention of future deaths reports since the last report to Trust Board.

Infection Prevention & Control

There is no update on this subject.

Domain 2 – Development and Practice

Medicines Management

Controlled Drugs (CD) / General Drugs

1. There has been one reportable CD incident since the last report. This occurred at Romford Ambulance Station on 14th December 2015. It involved the discovery of one ampoule of morphine sulphate that had gone out of date in November 2013. The physical count of the morphine ampoules in the safe tallied with the CD Register, and there was no discrepancy going back in the CD Register. There have been no recorded discrepancies from this specific CD Safe since records were started in 2005. Despite several theories being mooted, it is not known how this has occurred. At the moment the only credible theory is that the ampoule date was overlooked in November 2013 when the LAS knew that there were some ampoules of that date

still in circulation and had asked stations to check their stock. (The LAS does not destroy big quantities of out of date morphine sulphate ampoules as we limit what a station can hold, thus the stock will be used before it can go out of date. (I.E a form of "just in time ordering"). The incident has also been reported to the NHSE (London Region) Accountable Officer as is required. At the moment there is no indication to change LAS Policy or Procedure – just remind Station Management Teams of its application in practice.

2. There have been no incidents involving general drugs.

Drug Errors / MHRA Alerts

3. There has been one reported drug error since the last report. This occurred on 10th December on the Greenwich Complex and involved the accidental nebulisation of a dose of dexamethasone, rather than it being given orally with the use of a filtered filling straw and oral syringe. The member of staff concerned realised her error as the patient was being handed over at hospital. The case was discussed with the Team Leader and Clinical Tutor. The Medical Directorate were informed and the matter was investigated by the Assistant Medical Director and the facts of the incident established. This was a genuine error made by the member of staff and full reflection and education has taken place. It has been deemed that there is no need for any disciplinary action to be taken. A bulletin has also been issued via the Clinical RIB on 6th January 2015, reminding staff that dexamethasone is not to be nebulised.

4. There have been no MHRA Drug Alerts since the last report.

5. There has been one Drug Action Team Alert since the last report. This was dated 3rd January 2015 and concerned a batch of "bad" ecstasy that had been implicated in four deaths. It is believed that the drug involved is derivative of "ecstasy" and is weaker than "normal" ecstasy. Thus people were taking tablets and when they had little to no effect in the usual time, they took more tablets resulting in a sometimes fatal overdose. A Bulletin was issued alerting staff via the Clinical RIB on 6th January 2015.

Medicines Management Group (MMG)

6. MMG met on 17th December 2014. The next meeting is on 11th March 2015 at LAS HQ. Agenda items included: New Chair of MMG will be required from April 2015, New combined drugs policy, drugs supply issues and new drug bags, and that we had started the process of making IV paracetamol a station based drug. .

   New Chair and Vice Chair of MMG – Both the Chairman and Vice Chairman of the MMG retire from their substantive LAS posts on 31st March 2015. The MMG meeting were adamant that the future Chair must be a member of the LAS and preferably a senior paramedic, or a doctor.

   Drug Bags - A full project initiation document is now being prepared with the assistance of the Head of Change Management and Programmes. .

7. There are currently two medicines supply issues still affecting the LAS. One is for the supply of hydrocortisone, the other for the supply of rectal diazepam (Stesolid). These two drugs are not high use drugs by LAS staff, but are of course important to continuing patient care by LAS staff. Unfortunately there are no other manufacturers that hold UK licences for these two drugs – thus we cannot easily substitute like-for-like. .

Hydrocortisone

This issue affects the manufacture of the 100mg ampoules, which are currently in short supply from the manufacturer with a date of March 2015 before supplies are stabilised. In the interim the LAS is reducing the number of ampoules carried in the Paramedic Drug Bag to one ampoule, (normally two) and leaving one ampoule in the Technician Drug Bag. There is a temporary replacement product being used which is a 100mg in a dry powder format which is reconstituted with a diluent (supplied as a kit). The substitute product also means that here is a minimal increase in the drug budget, (*circa £110).*

Diazepam

There is a current shortage of the 2.5mg rectal diazepam tubes. There is currently no indication of when stocks will become available. Our supplying pharmacy is unable to obtain stocks either from their normal supply line or other avenues. As an interim measure we are reducing the number of 2.5mg rectal tubes to one in the Paramedic Drug Bags.

Medicines Optimisation

8. There is nothing to report since the last report on this topic. However the actions taken regarding the drug error reported above do provide evidence of how the Trust deals with drug errors.

Domain 3 - Effectiveness and Experience

Clinical Audit and Research

Cardiac

The Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports (Cardiac Care Pack) for November 2014 have been published.

The full report can be accessed at:
Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '14 - March '15\Cardiac Care Pack (November'14).pdf

Key Findings:

- 31% of cardiac arrest patients that had resuscitation commenced, gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital. This percentage includes all arrest rhythms. This is on a par with the previous month.
- 97% of the advanced airways placed during a cardiac arrest had end-tidal CO2 measured and recorded. 10 patients had no ETC02 noted and no printout of the waveform included with the PRF.

- 99% of STEMI patients attended by the LAS were transported to the most appropriate destination.
- Overall call to arrival at hospital time for STEMI remained at 72 minutes during November. The length of time on scene remains high at 42 minutes. Both of these figures are higher than expected and continue to require monitoring.
- The number of patients receiving the full STEMI care bundle decreased to 74%.

Stroke

The monthly Stroke report for November 2014 has been published.

The full report can be found at:
X:\Clinical Audit & Research Unit\Stroke Reports\Monthly Reports\April '14-Mar '15\Stroke Care Pack (November '14).pdf

Key findings:

- 97% of suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded. This is a fall of 1%.
- 98% of FAST positive patients had the onset time documented.
- 99% of FAST positive patients were conveyed to the most appropriate destination
- Average on scene times remain higher than the recommended 30 minutes, with 53% of crews spending more than 30 minutes on scene with patients who were eligible for thrombolysis.
- The percentage of patients eligible for thrombolysis who arrived at a HASU within 60 minutes has decreased to 56% in October.

Patient Experiences

Patient Experiences Department
December 2014

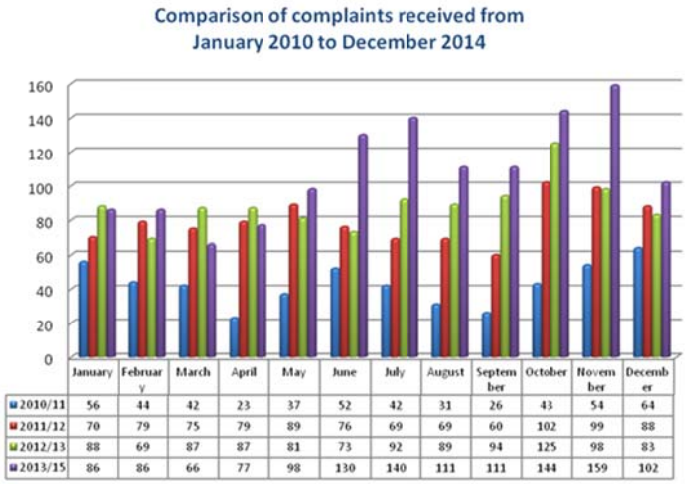
COMPLAINTS

Complaint Volumes

Complaints recorded this month have greatly been affected by the IT issues. The usual weekly average number of complaints has been 25-30; however, over the Christmas week only 8 complaints were recorded due to the inability to access the departmental in-box. Total complaints added for December were 102.

Complaints about delays and ambulances not being sent were once again the predominant subjects.

Graph 1. The following graph demonstrates the increase in complaints managed in 2013/15 (purple)



11 complaints involved other Trusts/agencies including 5 x Acute Trusts, 2 x CCG's, 1 x NHS 111 providers, 1 x local authority; and 1 case has been flagged as a potential SI - (C9828).

Table 1: Comparison of complaints received against calls attended by month

Month	Calls attended	Complaints received
Nov-13	89860	98
Dec-13	92144	83
Jan-14	91980	86
Feb-14	85871	86
Mar-14	96344	66
Apr-14	88361	77
May-14	88348	98
Jun-14	88454	130
Jul-14	85287	140
Aug-14	82840	111
Sep-14	78857	111
Oct-14	86566	144
Nov-14	84101	159
Dec-14	87053	102
Totals		**1491**

Average per annum =0.12

Complaints by complex

Table 2:

The following data indicates complaints by individual complex during December:

ID	Sector	Speciality
67 cases for control services	Control Services (EOC, UOC, CTA etc)	Emergency Operations Centre
9853	111 Beckenham	111 Beckenham Call Centre
9840	Contracted Services	Mediforce PB20
9842	Contracted Services	PA30 - PA39
9857	LAS Headquarters	Patient Advice and Liaison Service
9881	LAS Headquarters	Emergency Preparedness Unit
9901	North Central	Tottenham
9852	North Central	G1 - Islington
9863	North Central	Barnet
9868	North Central	Islington
9890	North Central	E3 - Camden
9896	North Central	Barnet
9899	North Central	Friern Barnet
9828	North East	West Ham
9876	North East	K3 - Ilford
9838	North West	Hayes
9894	North West	Hayes
9902	North West	Pinner
9924	North West	Pinner
9928	North West	Pinner
9832	Not our service	Not our service
9871	Not our service	Not our service
9844	South East	Greenwich
9858	South East	Barnehurst
9891	South East	Bromley
9892	South East	Beckenham
9903	South East	Barnehurst
9914	South East	Barnehurst
9920	South East	Deptford

9862	South West	South Croydon
9875	South West	Wimbledon
9883	South West	South Croydon
9889	South West	Coulsdon
9895	South West	Wimbledon
9839	Unknown or No Trace	Unknown or no trace
9887	West	North Kensington

Table 3: Complaints by Area by percentage of total:

Area	Number of complaints December	Ratio of total (% rounded)
Control Services	67	66%
South East	7	7%
North Central	7	7%
Other	7	7%
South West	5	5%
North West	5	5%
North East	2	1%
West	1	1%
Unknown	1	1%
PTS	0	0%
East Central	0	0%
Not Our Service	0	0%
Total	**102**	**100%**

Complaint Themes

REAP remained at Level 5 for the entire month, following a persistent period of high demand. Surge Purple has also been fairly regularly implemented as call rates continued to be above average.

Complaints relating to delay (71) and staff conduct (19) continue to be the main themes. These are increasingly inter-related. The intermittent unavailability of the Medical Directorate due to operational pressures, whilst understandable, is also slowing down the organisational response to complaints.

Table 4: The following table shows complaint subjects: December 2013 to November 2014

Complaints by subject 2013 - 2015	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Delay	22	29	24	33	50	72	62	45	65	87	95	71
Conduct	29	16	22	20	22	16	27	18	23	33	37	19
Road handling	8	12	7	8	9	9	14	9	7	7	10	4
Non-conveyance	10	11	7	5	5	16	19	16	8	6	5	3
Not our service	3	0	1	0	0	2	0	1	0	3	1	0
Treatment	12	13	4	8	7	12	12	17	4	1	5	1
Patient Injury or Damage to Property	2	0	0	1	0	1	0	1	2	3	1	0
Location Alert referral	0	0	0	0	1	1	1	1	0	2	1	1
Conveyance	0	3	2	1	1	1	1	2	1	1	2	3
Clinical Incident/Equipment	0	0	0	0	0	0	1	1	0	0	0	0
Assisting with external agency	0	0	0	0	0	0	0	0	0	0	1	0
Disputes safeguarding referral	0	2	0	1	2	0	2	0	0	1	1	0
Challenging paramedic qualification	0	0	0	0	1	0	0	0	0	0	0	0
Aggravating factors	0	0	0	0	0	0	1	0	1	0	0	0
Totals	**86**	**86**	**67**	**77**	**98**	**130**	**140**	**111**	**111**	**144**	**159**	**102**

Case examples - cases closed in November/December 2014

Service provision

Concerns were raised by a patient that his records had been released to a third party. He was advised that Section 35(2)(a) of the Data Protection Act (1998) enables release of the records in these circumstances without the express permission of the patient.

Performance/Quality

Overtime and a concerted team effort resulted in the department closing an impressive 149 during December. QA officers continue to work overtime within the department and new staff coming to post are also becoming more familiar with work arrangements etc.

New cases continue to be monitored by a manager who actions urgent or high risk complaints with the remainder being actioned by additional administrative input to obtain QA reports etc, Overtime remains available to staff where we are focusing on the oldest 'open' cases (within existing budget). This is proving successful with only a small number of complaints remaining incomplete up to 30 September 2014. The IT issues have impacted on throughput and we are currently reviewing the high numbers of emails that have been represented to the departmental inbox.

Table 5: Closed complaints April 2013 to December 2014

2013/15	Number of closed complaints
April	94
May	92
June	80
July	95
August	54
September	102
October	85
November	74
December	114
January	75
February	95
March	127
April	71
May	91
June	88
July	113
August	98
September	67
October	118
November	96
December	149
Totals:	**1978**

Concerted efforts by staff resulted in a higher than normal number of complaints being closed during December as we continue to concentrate resources on the backlog of older complaint responses.

As at 08 January 324 complaints remain open including 279 awaiting input from another depts., QA etc (compared to 379 in December, 331 in November, 301 in October, 235 in early September, 227 in August, 198 in 8 July, 170 in June and 136 in May).

Table 6: The following table shows the current stage of individual complaints by month to 8 January 2015

Current stage of complaints	Cases open up to 30 Sept	October	November	December	To 08 January
Allocated	0	0	0	0	0
Awaiting Allocation	0	0	4	7	16
Awaiting Clinical Hub review	0	0	0	0	0
Awaiting Clinical Opinion	3	8	7	1	0
Awaiting information from Watch	0	0	0	1	0
Awaiting input from complainant	0	0	0	0	0
Awaiting input from other agency	0	2	0	0	0
Awaiting input from other LAS department	1	3	3	0	0
Awaiting Operational Input	1	2	14	11	0
Awaiting QA Report	0	24	95	70	4
Case under enquiry with PED Officer	1	11	3	1	0
Comeback received	0	0	0	0	0
Comeback Response with Executive Office	0	0	0	0	0
Draft Reponse with Executive Office	5	7	3	2	0
Draft Response with involved parties	4	1	0	0	0
Draft Response with PED Management	0	5	0	0	0
Draft response with PED Officer	1	1	0	1	0
SI Considerative	0	0	0	0	0
SI Declared	0	0	0	0	0
Totals:	**16**	**64**	**129**	**94**	**20**

Closure rates for 2013/15 are set out in the table below.

Total complaints

Table 7: The following table extracts data from the above and demonstrates the number of complaints closed each month within the 35 day target:

	0-25	0-35	Totals closed within 35 working days	Total complaints	Percentage of complaints closed within 35 working days
2013 12	23	7	30	83	36%
2014 01	16	22	38	86	44%
2014 02	24	15	39	86	45%
2014 03	24	14	38	66	57%
2014 04	15	20	35	77	45%
2014 05	27	18	45	98	45%
2014 06	34	6	40	130	30%
2014 07	30	11	41	140	29%
2014 08	15	9	24	111	21%
2014 09	18	8	26	111	23%
2014 10	20	10	30	144	21%
2014 11	24	4	28	159	18%
2014 12	7	1	8	102	7%
Totals:	**277**	**145**	**422**	**1393**	**Average 33% closed in time frame**

It should however be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = minimum of 26 January 2015.

'Comeback' Activity

Table 8: This table evidences the numbers of comeback enquiries.

Year	Numbers of comeback responses recorded
2009/10	9
2010/11	4
2011/12	12
2012/13	35
2013/14	57
2014/15 (to date)	54
Totals:	**171**

This month there were 2 cases where a 'comeback' was received.

Health Service Ombudsman

Table 9 The following table presents cases referred by the Ombudsman 2013 – 15 which remain 'open'

Datix reference	Current status	Outcome
C8535	File requested by HSO 17 Oct 2014	File sent to HSO 17 October 2014
C8707	File requested by HSO 16 October 2014	File sent to HSO 17 October 2014
C8772	File requested 30 October 2014	File sent 30/10/14
C8787	Further details requested by Ombudsman	Request for 999 recording 27 Oct 2014
C8882	File requested 20 August 2014	Local Resolution undertaken further correspondence with HSC and complainant
C8885	Enquiry from HSO who may investigate	Outcome awaited
C9023	File requested 28 August 2014	File sent 05 September 2014/CD sent 06/01/15
C9030	File requested 29 December 2014	File sent 29 December 2014
C9313	File requested 15 August 2014	File sent 15 August 2014
C9321	File requested 22 December 2014	File sent 22 Dec 2014

PALS

PALS specific enquiries = 269 for December against 263 for November, 316 in October, 355 in September and 283 in August. The duty function was affected by IT issues during December and a statement was placed on the website to explain this.
Average monthly PALS for 2013/14 = 287. Current average for 2014/15 = 296.

Currently there are 76 PALS cases remaining open, this includes medical record requests awaiting consent from the patient, cases awaiting QA reports and further supporting information.

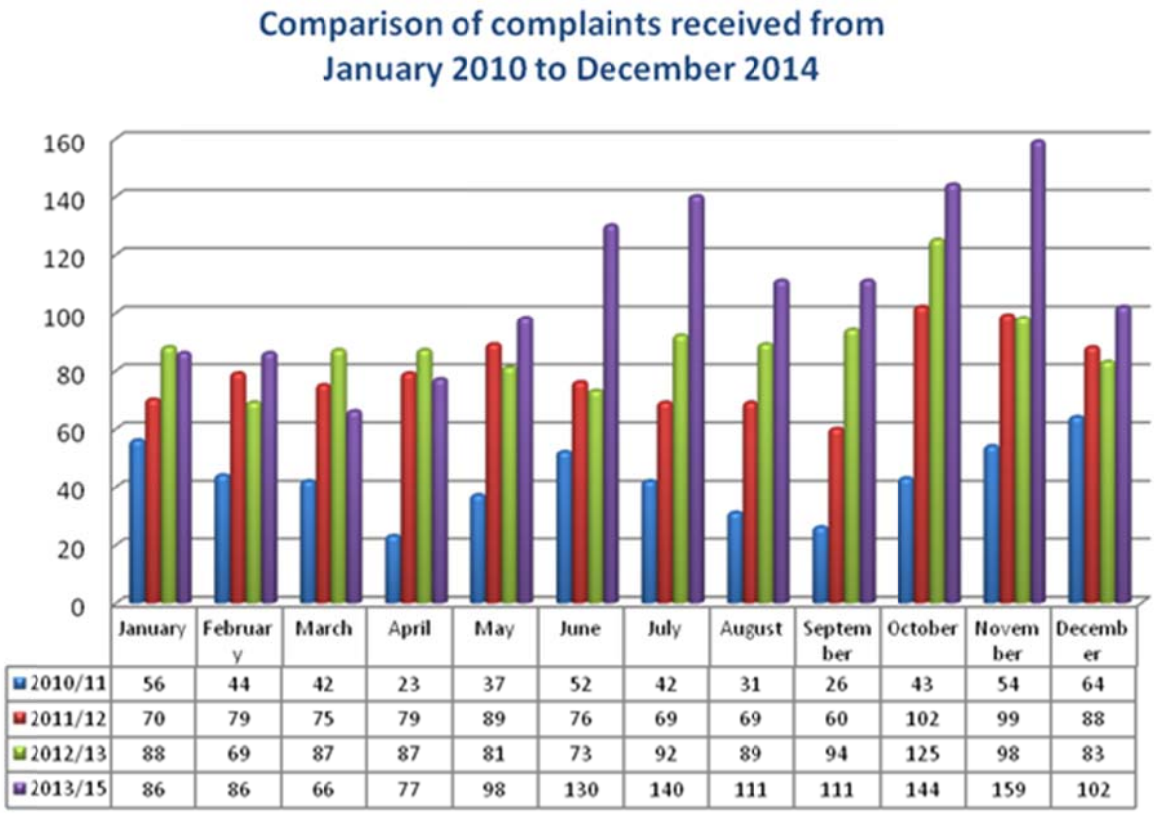
There has also been a slight decrease in Solicitor requests this year which reflects seasonal expectations.

Table 10: Solicitor requests for medical records

Solicitors request for medical records					
	2010	**2011**	**2012**	**2013**	**2014**
January		84	94	125	104
February		89	104	120	128
March	105	91	109	116	96
April	82	69	118	122	110

May	75	78	121	100	103
June	84	98	96	109	100
July	87	94	107	123	114
August	72	79	135	94	90
September	87	117	100	108	124
October	80	80	138	149	119
November	116	109	124	141	96
December	69	66	87	83	88
Totals	**857**	**1054**	**1333**	**1390**	**1272**

Graph 2 The following graph highlights the numbers of PALS SPECIFIC enquiries by month December 2013 to December 2014



	January	February	March	April	May	June	July	August	September	October	November	December
2010/11	56	44	42	23	37	52	42	31	26	43	54	64
2011/12	70	79	75	79	89	76	69	69	60	102	99	88
2012/13	88	69	87	87	81	73	92	89	94	125	98	83
2013/15	86	86	66	77	98	130	140	111	111	144	159	102

Table 11: Total PALS enquiries received in the past 7 years is as follows:

Financial Year	**Total PALS**
2008/09	5606
2009/10	5674
2010/11	6031
2011/12	6264
2012/13	5714
2013/14	6790
2014/15 (to November 2014)	5042
Totals:	**41121**

PALS Themes

Consistent themes as ever; patient destination, signposting to other departments, policy and procedure requests and families seeking clarification of events.

Some PALS cases remain immensely time consuming but the work does not attain a high profile given the Trust's focus on other mechanisms, on occasion PALS enquiries have escalated to complaint. Lost property inquiries remain at a consistent level.

Table 12: The following table breaks down the PALS specific enquiries in December 2014

Subject - December 2014	Number of enquiries
Information/Enquiries	190
Lost Property	41
Medical Records (patient request)	19
Other general	15
Appreciation	4
Totals:	**269**

Other

Industrial Action

The Trust was involved in a period of Industrial Action on 13th October 2014, and on 24th November 2014. These periods saw a large number of frontline staff, and some EOC staff take full strike action between 0700 and 1100. This impacted on the care that was provided to the patients within London.

A Clinical Safety Cell was arranged and worked from the Incident Control Room (ICR) at Waterloo HQ, supplementing the actions of the Clinical Hub. The Safety Cell was staffed with a number of HCPs from Acute Trusts, GPs and LAS clinicians. The cell was able to review a number of held calls, and also reviewed in conjunction with the referring HCP, all HCP admissions.

A further period of Industrial Action is now planned for 29th January 2015. The clinical planning for this is underway.

Fionna Moore
Medical Director

Zoe Packman
Acting Director of Nursing and Quality

Mark Whitbread
Director of Paramedic Education and Development

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	27th January 2015
Document Title:	Infection Prevention and Control Annual Report 2013/14
Report Author(s):	Eng-Choo Hitchcock, Infection Control Nurse
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History:	Quality Committee Clinical Safety, Development and Effectiveness Committee
Status:	*For information and assurance and to note the k*ey areas to be incorporated into the 2015/2016 action plan which will be agreed at the inaugural infection control taskforce

Background/Purpose

Background/Purpose

There is a requirement from all NHS organisations to present an annual report from the Director of Infection Prevention and Control (DIPC). Due to operational pressures the annual report for 2013/14 had slow progress through the feeder committees to the board. When the new DIPC commenced in November 2014 they recommended that due to the time that had lapsed between the year end and the presentation of the report that an addendum to the report should be provided to reassure the Trust Board of progress made. It is within that context that this report is presented today.

There is a recommended format for the DIPC report which has not been adopted. The current DIPC has therefore recommended that for the annual report 2014/2015 the recommended format is followed and that the report is presented to the Trust Board at the earliest opportunity in the new fiscal year 2015. In addition to support the Trust in achieving the required standards of practice the DIPC is establishing a monthly Infection Control Taskforce who will operationalize and manage an infection control action plan to assure the Infection Control Committee and the Board.

Areas of note from the report are:

- **Infection control committee**

From Quarter 1 in 2014, the IPCC format changed to focus on the performance of each Area in rotation to provide a deeper understanding of local issues, ensure local ownership and drive continuous improvements. It is hoped that with the taskforce in place the operational teams will be able to share this information and identify any barriers to change

- **Vehicle prep, Environment and storage**

Challenging structures and layouts and clear ownership led to some areas of poor practice and some concerns in regards to water quality management. During 2014 progress has been made in

addressing these and further work will continue in 2015 via the taskforce. Decontamination and vehicle preparation need to be areas of focus for fleet and logistics in 2015 who are the leads in these areas.

- **Hand Hygiene**

There has been inevitable variability in hand hygiene scores which have been addressed at a local level and for which on-going monitoring is continuing. Though, reassuringly, there have been no cross infection issues identified this will continue to be an area of focus in 2015

- **Training**

Infection control education forms part of the Trust's mandatory education programme and also for corporate induction of new starters. In addition there are a number of on-going training courses for all staff with a variety of IPC updates; these have been delivered face to face on Clinical Skills Refresher (CSR) courses for clinical staff, bulletins via The Pulse and Routine Information Bulletin, communication briefings and reinforced with the rollout of a new Training Workbook.

- **Audit**

The audit schedule is operated on a monthly basis, with each complex reporting compliance within a strict timeframe and populating the data on the infection control balance scorecard

- **Incidents and outbreaks**

The Trust participated in a multi-agency Post Infection Review of a case transferred in March 2014. It formed part of the Acute Hospital investigation into the subsequent acquisition MRSA bacteraemia by this patient.

Communicable disease exposure best practice has been followed in 2013/2014. Further strengthening of relations with Occupational Health Services is required in 2015. Lessons learned have resulted in changes in practice.

- **Flu**

Overall uptake improved steadily, and achieved 48% at end of the programme; the innovative use of minibuses from the EPRR fleet, to provide mobile clinics/ moving vaccine between complexes/stations, was recognised nationally as good practice.

- **Risk register**

A number of risks have been closed and as new risks are identified the risk register is amended accordingly. The mitigations will be managed via the infection control taskforce

Summary of Achievements in 2013-2014

The report identified a number of achievements in improving infection prevention and control within the Trust, as well as development areas.

- Gap analysis undertaken to develop 2013 -2015 Delivery Plan
- Care Quality Commission Inspection August 2013
- QGARD/NASIPCG External Review of the IPC standards November 2013
- 30 IPC inspections of stations undertaken
- Flu uptake increased to 48%; good practice by Flu Team nationally recognised.
- Hand hygiene (self-audited) 99-100%
- Premises cleaning consistently exceeds 85%

- CSR training uptake increased to 88%, highest in 3 years
- 35% reduction of razor injuries from previous year

Action required
• Accept and adopt the report for 2013/2014 • Note the contents of the Addendum which reflect the remedial action taken • Acknowledge the recommendations from the annual report • Be cognisant of the risks and mitigations
Assurance

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

London Ambulance Service NHS
NHS Trust

Infection Prevention & Control

Annual Report 2013 / 2014

Contents

1 Introduction

1.1. This annual report from the Director of Infection Prevention Control (DIPC), is to inform the Board of the progress made against the Care Quality Commission Essential Standards, and the Health and Social Care Act 2008 (revised 2010): Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department of Health), commonly known as the 'Hygiene Code', for the period April 2013 to March 2014.

1.2. The report provides information of the on-going commitment of the Trust to entrench IPC principles and practices throughout the service and shows the significant improvements, identifies the outstanding gaps and risks to the organisation

2 Background

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

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

2.3. The 'Hygiene' Code and its 10 Criteria contains statutory guidance for compliance with the Care Quality Commission's (CQC) Essential Quality standards to ensure continuous registration for Outcome 8, Cleanliness and Infection Control, in addition to other related CQC Outcomes (Table 1).

3 Board Assurance

3.1. The NHS Operating Framework recognises that there is still scope to drive Healthcare Associated Infections (HCAIs) down further to safeguard patients through a zero tolerance approach to all avoidable HCAIs. Healthcare providers have to have a delivery plan to reduce *MRSA* bloodstream and *Clostridium difficile* infections in line with the national objectives, and by proxy, other related HCAIs. This organisation continues to drive performance towards harm free care through its assurance structure.

3.2. Director of Infection Prevention and Control (DIPC) has lead responsibility for the Trust for IPC and was designated to the Director of Nursing and Quality. The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national standards and ensure continuous CQC registration as healthcare provider. For Accountability Organogram - See Appendix 1

The DIPC:

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

3.2. Head of Infection Prevention and Control (HIPC)

The HIPC was recruited in August 2013 to replace the Ambulance Operations Manager for IPC who left the organisation in May 2013. The HIPC has delegated responsibility from the DIPC to provide strategic leadership, challenge and improve poor practice and provide infection control expert advice to all disciplines within the Ambulance Trust on a day to day basis.

- To produce the IPC delivery plan
- To advise line managers within the Trust on the implementation of agreed policies in their areas.
- To have oversight of IPC performance within the Trust
- To produce written reports on compliance status with the Health & Social Care Act 2008 Hygiene Code, and the Care Quality Commission Essential Quality Standards to ensure continuous registration and ensure that accurate records are kept.
- To report to the Trust IPCC and other appropriate committees within the Trust's Governance structure as necessary.
- To use evidence based practice and to ensure clinical effectiveness when transforming and planning future services, addressing any training needs.
- To horizon scan for emerging issues and provide a mitigation plan, undertake research to contribute to and enhance clinical practice in the ambulance service.

3.2.1. This senior role is currently not supported by administrative or data analytical support, and is operational during office hours, with no-call responsibility. Currently there are some gaps in service provision, and in resources e.g. capacity, service and system support, as identified in an external review in November 2013.

3.3. The Quarterly Infection Prevention and Control Committee (IPCC), chaired by the DIPC, provides assurance to the Trust Board that all services are provided in a clean and safe environment through the effective performance monitoring of key performance indicators.

3.3.1. The IPCC provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust. It monitors IPC compliance with the Hygiene Code through the monthly updates from complexes relating to the IPC audits for vehicles, premises and observed practice, deep clean status of vehicles, training attendance and reported infectious and sharps incidents, which continues to capture Razor Injuries and Used Sharps Incidents data separately, as well as annual flu uptakes. Lessons are shared through its membership.

3.3.2. The IPCC receives recommendations from other key groups including the Clinical Equipment Group, Vehicle Working Group, and Corporate Health and Safety, and plays a key role in scrutinizing, challenging and poor practice, risk mitigation, performance monitoring and managing, oversight of appropriate policy implementation and escalation. The Clinical Decontamination Group is not represented as the group currently does not exist, and likewise the Decontamination Lead role.

3.3.3. From Quarter 1 in 2014, the IPCC format will change to focus on the performance of each Area in rotation to provide a deeper understanding of local issues, ensure local ownership and drive continuous improvements.

3.4. Ambulance Operations Managers (AOMs) supports the HIPC to deliver the IPS service locally and is responsible for IPC standards in their complexes, with support from the Duty Station Officers.

3.5. Practice Learning Manager (West)

The Practice Learning Manager (PLM) for the West is delegated as the Training Lead for IPC within the Clinical Education Team. Working with HIPC, the PLM's role supports the development of training packages, input into the content of policies regarding training and IPC, ensure IPC knowledge, skills and competencies are embedded into training and practice of all staff and represents the training department in the various sub groups. The PLM provides the monthly compliance data for IPC training for clinical staff. (Compliance data for the IPC element in All-in-one, Corporate Induction, e-learning and training for other groups/contractors are currently not captured.)

3.6. Infection Control Champions (ICC)

3.6.1. The ICC role was previously introduced to provide all staff with a local link at complex, station or department level; having received additional training, in order to have an increased awareness of IPC procedures to support local operational staff.

3.6.2. The ICC role was to undertake audits to assist with data upload of IPC statistics to the Trust X:/ drive.

3.6.3. The role was not further developed in 2012 -2014, due to transformation within the service, staff vacancy levels, and capacity issues resulting from frequent REAP levels, resulting in the lack of support for the network.

4. Summary Performance against IPC Delivery Plan 2013/15

4.1. The IPC delivery plan was amended, approved by the November IPCC and extended to 2015, having taken account of the external/internal reviews and emerging issues:

- The Care Quality Commission inspection in August 2013 did not highlight concerns except for vehicle cleaning compliance.
- The National Ambulance IPC group external review (November 2013) revealed partial compliance in the following:
    - Audit and inspection – identified the lack of audits in ANTT, PPE, BBE, waste segregation, decontamination and inability to gather trends and themes from these audits, as development areas.
    - Cleaning section - partial compliance was identified in COSHH compliance with cleaning products; lack of colour coding and schedules for mopheads and lack of clarity with decontamination of equipment.
    - Team management - lack of supporting performance data/evidence to assure sub-contractors' have IPC standards/written into their contracts.
    - Communication - lack of IT infrastructure to support IPC role e.g. e-audit system.
    - Training - Four subsections of non-compliance (2 in Equipment and Uniform, and 2 in OH and Inoculation injuries)
    - No comment was made to the section on IPC team development as the HIPC was new in post.

4.2. Care Quality Commission inspection took place in August 2013; an external review by South Central Ambulance Service was undertaken in November 2013 as part of the national Quality, Governance and Risk Directors Group actions. Recommendations from the two external inspections were embedded into the current LAS IPC Delivery Plan 2013-2015, including lessons from internal inspections of 30 LAS sites.

4.3. Overall year-to-date compliance with the Hygiene Code is summarised in Table 1 and in full in Appendix 1, which shows the gaps in compliance in 2013/14. With the exception of Criteria 3 and 4, continued full compliance was not maintained at year-end. It should be noted that Criterion 7 principles should apply for the HART services when transporting Hazard Group 4 infectious diseases of consequence. Criterion 8 is not applicable to the Ambulance Service.

4.4. Monthly Performance of IPC compliance is reported to senior management and Quarterly to the Board through the IPCC; and year-end performance is highlighted in Table 2.It should be noted that the current monthly performance data excludes PTS, Community Responders, VAS and PAS, therefore lacks rigor.

4.5. The Performance Accelerator governance table to ensure that the Trust is meeting all its required criteria in 2012/13 is no longer in use.

Table 1 – Compliance status 2013-2014: Hygiene Code Criteria and Care Quality Commission Essential Standards

Hygiene Code Criterion and related CQC Outcome	Hygiene Code Requirement	Compliance Status	Compliance Status
		April 2013	April 2014
Criterion 1 *(Outcome 8, and Outcome 6, Regulation 24 Cooperating with other providers***)**	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	Compliant	Partial
Criterion 2 *(Outcome 8, and Outcome 10 Regulation 15 Safety and suitability of premises)*	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Compliant	Partial
Criterion 3 *(Outcome 8, and Outcome 1, Regulation 17 Respecting and involving service users)*	Provide suitable accurate information on infections to service users and their visitors.	Compliant	Compliant
Criterion 4 *(Outcome 8, and Outcome 6, Regulation 24 Cooperating with other providers***)**	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant	Compliant
Criterion 5 *(Outcome 8)*	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Compliant	Partial
Criterion 6 *(Outcome 8)*	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	Compliant	Partial
Criterion 7 *(Outcome 8)*	Provide or secure adequate isolation facilities.	N/A	N/A
Criterion 8 *(Outcome 8)*	Secure adequate access to laboratory support as appropriate.	N/A	N/A
Criterion 9 *(Outcome 8, and refers in part to * Outcome 6, Regulation 24 Cooperating with other providers * Outcome 10 Regulation 15 Safety and suitability of premises * Outcome 11, Regulation 16 Safety, availability and suitability of equipment * Outcome 12, Regulation 21 Requirements relating to workers*	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant	Partial
Criterion 10 *(Outcome 8, and Outcome 12, Regulation 21 Requirements relating to workers)*	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Not compliant	Partial

The rationale supporting the compliance status for April 2014, can be found in the commentary section in Appendix1.

Table 2: Year-end performance 2013/14

Scorecard	Mar-14														
	IPC Dashboard	Mar-14													
			Hand Hygiene		Training	Cleaning/Environment					Feedback			Policy	
	Complex	Trajectory	Hand Hygiene Monthly audit AOM	Hand Hygiene Other	CSR Infection Control Training	Vehicle Monthly Audits (4 Required) AOM	Premises Monthly Cleaning Audits AOM	Quarterly IC Audit compliance	VP Deep Clean A&E	ICT Team Inspection	Flu Vaccine Uptake	Razor Incidents	Used Sharps Incidents	Uniform compliance (BBE)	
Last Date of Data Set			Mar-14	Mar-14	2013/14	Mar-14	Mar-14	Q4	Mar-14	2013/14	2013/14	2013/14	2013/14	Mar-14	
West	Brent		100%		76.2%	6	97%	97%	84%		39 (25%)	3	1		
West	Camden		100%		73.5%	8	100.00%	96%	68%		94 (48%)	1	2		
West	Friern Barnet		100%	58%	75.0%	4	100.00%	97%	79%		60 (52%)	2	1	42%	
West	Fulham		100%		65.7%	7	100%	89%	67%		92 (64%)	1	0		
West	Hanwell		100%		63.0%	4	99%	89%	85%		55 (56%)	0	2		
West	Hillingdon		no data 5 months		75.7%	8	95.00%	98%	59%		48 (38%)	2	3		
West	Islington (Camden Complex)		100%		70.1%	4	100%		36%			0	0		
West	Isleworth		100%		77.1%	5	95%	96%	69%		51 (40%)	0	2		
West	Pinner/Kenton		100%		80.4%	12	95.20%	94%	81%		94 (67%)	0	2		
East	Chase Farm		100%		54.7%	no data	no data 2 months	81%	100%		39 (50%)	0	0		
East	Edmonton		no data 3 months		80.8%	no data	91.40%	94%	72%	83%	28 (18%)	1	4		
East	Homerton City & Hackney		100%		75.0%	4	97%	Q2 - 4 no data	65%		42 (29%)	0	0		
East	Newham		0% for 5 months		75.5%	8	94.10%	89%	87%		22 (21%)	0	2		
East	Romford		100%		80.8%	no data	no data 3 months	82%	78%	64%	76 (64%)	1	5		
East	Tower Hamlets		100%		85.9%	6	99.00%	96%	70%		27 (38%)	0	2		
East	Whipps Cross		100%		78.7%	6	100.00%	77%	50%		98 (51%)	1	4		
South	Barnehurst		no data 6 months		52.7%	no data	99.00%	87%	100%		74 (57%)	0	2		
South	Bromley		100%		61.9%	4	90.40%	83%	82%		72 (61%)	2	0		
South	Croydon		100%		76.8%	4	95.50%	95%	65%		36 (25%)	2	4		
South	Deptford		100%	50%	85.3%	4	97.50%	93%	80%		50 (63%)	0	1		
South	Greenwich		100%		59.9%	4	95.00%	94%	79%		67 (46%)	0	1		
South	New Malden		100%		80.6%	2	100.00%	96%	100%		76 (82%)	1	1		
South	Oval (Deptford Complex)		100%		60.3%	5	94.10%		71%		11 (15%)	1	4		
South	St Helier		100%		70.2%	5	100%	100%	79%		52 (46%)	0	4		
South	Waterloo (Deptford Complex)		100%		94.7%	7	95%	88%	77%	37%	25 (35%)	2	1		
South	Wimbledon		100%		84.2%	4	no data 3 months	98%	92%		41 (55%)	0	0		
LAS	Other										613 (31%)				
LAS	ED Centres							100%							
LAS	PTS														
COLUMN TOTAL					74%				75.96%		1982 (45%	20	48		

5. Infection Prevention and Control progress March 2013- April 2014

5.1. IPC Site inspections

Over 30 site visits have been undertaken since August to review infection control standards and to assist Logistics Directorate with their pilot storage project.

5.1. 2. Findings included challenging structure/layouts, cages of used/obsolete uniforms, obsolete/extraneous equipment, cages of used dirty equipment with no identified routine decontamination process and ownership, poor storage and management of supplies (sterile products, equipment, and new stab vests) with over-stocking. Expired products evident at each of the sites visited.

5.1.3. Many sites were cluttered with no clearly defined segregation of clean and dirty areas e.g. clean and dirty equipment, supplies, linen and blankets stored in the same place posing cross infection risks. Varying standards were observed in cleanliness

standards of environment, ambulance interiors and equipment. Cleanliness and waste issues are being addressed jointly by Estates, Infection Control and Operational staff. 5.1.4. Storage solutions are being explored through Estates, who continues to work closely with Logistics on the Storage Project in the South.

5.1.5. Thirty cages of old/obsolete uniforms are expected to be securely disposed of in April 2014, and a procurement process is being put in place for regular disposal. Numerous cages of used/obsolete equipment found during the site visits, will need a clear process for asset disposal, following decontamination.

5.1.5. The lack of a decontamination process for used equipment was highlighted during an external review of the LAS Infection Control Service in November 2013, as part of the national QGARD work stream, to provide additional assurance to our organization. This is a priority area and is highlighted as a risk in the Risk Register. A disinfection service was explored for contaminated equipment collected from A&E across London. IPC and Logistic Lead visited a potential provider in March 2014, and a list of equipment for decontamination has yet to be provided to the potential provider for a quote. A medical device decontamination policy is outstanding.

5.1.6. Waste streaming and disposal were found to be sub-optimal with completed PRF found in clinical waste bags at numerous sites. A significant percentage of clinical waste bags contained non-clinical waste. This practice was at odds with the Safe Disposal of Waste requirements. The suboptimal practice adds unnecessarily to waste disposal costs, and breaches Information Governance. Further evidence of poor adherence to waste segregation and disposal was confirmed by the Waste Contractor in their September 2013 report and again in 2014. Personal accountability for practice is essential and concerns were shared with station staff, Initial and Lakethorne staff. The waste management policy will require enhancement to ensure all waste are included, including old uniforms, equipment and not just clinical waste. This will need regular audit and review by the contract manager, station management and others who has a role in waste generation.

5.1.7. Suboptimal medicine management was also observed. Medication cabinets are often left unlocked. Medicines were not routinely locked away when taken off the ambulances, and can be found in the walkways of garages and in the supply area in boxes. In one main station, both garage doors were left unsecured with the public having potential easy access to the unlocked medicine cupboard and the locked Controlled Drug cupboard. Drug bags appeared grossly soiled, with a potential for cross contamination when drug bags are re-packed at Deptford Stores. It was unclear whether regular audits were undertaken for safe storage of medication at sites. .All medicine management issues were reported to the Lead of Medicine management to take forward, as they were not within the IPC remit.

5.1.8. Control of *Legionella* bacteria on premises: The premises cleaning contractor, Lakethorne, undertook regular water temperature testing for LAS and provided quarterly reports, which consistently highlighted non-compliance. An IPC inspection at Ruislip

site in August 2013 identified a lack of policy, oversight for this issue prior to 2013. A Legionella lead has been identified , policy is being drafted and a trust-wide action plan is in place; with oversight of progress being monitored by the Legionella Lead and scrutiny through the quarterly IPCC.

5.1.9. Infection control advice is rarely sought by other directorates e.g. for refurbishment or reconfiguration projects, change of use, development of service specifications, KPI setting and performance monitoring of contracts. This gap will need to be addressed in 2014/15, working collaboratively with other directorate leads.

5.1.10. All IPC findings from inspection were reported to the AOMs of each complex and latterly, to the ADOs. Since escalation to ADOs, improvement in completion of actions has been noted. Photographs provided a powerful tool to shift practice; and provided baseline evidence to assist with planning and monitoring of actions taken. Where relevant, reports were also shared with Estates (structural issues, premises cleaning, Legionella concerns), Logistics (storage, laundry, dirty equipment, dirty uniforms and Initial), Safety and Risk, Information Governance, and to Medicine Management. Key concerns were shared widely as appropriate. Reports were also presented at the quarterly IPCC meetings for further scrutiny and performance monitoring.

5.2. Annual audit programme

5.2.1. The IPC annual audit programme provides Board Assurance of compliance with the Health and Social Care Act 2008 (amended 2010).

5.2.2. The audit schedule is operated on a monthly basis, with each complex reporting compliance within a strict timeframe and populating the data on the infection control balance scorecard.

5.2.3. The audit programme enables the trust to identify key trends in non-compliance and take any required action to address in a swift and timely manner. The monthly audit results are RAG rated (see below) and published on the Trust X:/ drive:

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

5.2.4. Since 2012/13 complexes directly enters audit data for IPC compliance via their identified ICCs or delegated staff. A number of complexes did not submit data for hand hygiene, vehicle audits and premises cleaning, due to a variety of reasons: annual leave, lack of an ICC, suspension of training and support for IPC Champions during REAP levels.

5.2.5. Reporting of hand hygiene, cleaning and CSR training compliance in the last 12 months were variable. A few comparisons of average scores are shown in the table below in Table 3:

Table 3 – Comparison of Average Scores

Area of Audit	Year to end March 2012	Year to end March 2013	Year to end March 2014	Commentary/Trend
Hand Hygiene (Compliance)	85.6%	100%	94%	
IPC Training (CSR Compliance)	58.3%	3.2%	88%	
Vehicle Audits (Received)	880	4487	1711	
Premises Audits (Received)	209	291	96%	A number of sites did not submit data in Quarter 4

5.2.6. The IPC audit tools and system have been reassessed for functionality, inter-operability and ease of trend analysis. Currently, manual upload and trend analysis is not efficient and does not provide just in time data for oversight by management and operational staff to understand current performance overall, and in individual complexes.

5.2.7. A pilot of an e-system of audit (DocWorks) was authorized in Quarter 4. It is envisaged that tool development will continue in Quarter 1 and Quarter 2 of 2014/15 for the pilot to be undertaken during mid-year.

5.2.8. Meanwhile the IPC team continues to use the 5 audit tools and manually upload. (Some of the IPC audit questions are duplicated in the Quarterly Health and Safety Workplace Premises Inspection):

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

5.3. Education and training

5.3.1. IPC education forms part of the Trust's mandatory education programme and also for corporate induction of new starters. In addition there are a number of on-going training courses for all staff with a variety of IPC updates; these have been delivered face to face on Clinical Skills Refresher (CSR) courses for clinical staff, bulletins via The Pulse and Routine Information Bulletin, communication briefings and reinforced with the rollout of a new IPC Training Workbook from February 2103.

5.3.2. The e-learning module on the Skills for Life website was found to be inaccessible in January 2013. Pulse and station notice boards continue to be utilized to ensure that the key IPC information is easily accessible to all staff. E-learning accessibility is being taken forward by the Transformation team, as part of a larger work stream.

5.3.3. The HIPC and PLM, are responsible for ensuring that all IPC education material is up-to-date and reflects current best practice for the Trust, in line with national guidance and address any emerging issues.

5.3.4. Hand hygiene and 'bare below the elbow' remain core elements throughout all training packages. Practical demonstration such as donning and removing personal protective equipment are being included from September 2015. The IPC training packages have been updated to incorporate lessons from incidents, emerging issues such as antimicrobial resistance, novel organisms; reiteration of the high impact intervention bundles, placing a greater emphasis on getting the basic skills and competencies right every time for every patient..

5.3.5. The 'All-in-1' mandatory and refresher course for all non-clinical staff, organized by the Learning and Development team, was delivered successfully in 2012/13. However, in 2013/14 the training responsibility was temporarily transferred to the Governance team. A total of 26 staff in all were trained during that period, with a significant numbers not having had their refresher.

5.3.6. Training Officers, Clinical Tutors and Team Leaders have been given the responsibility for the delivery of IPC training packages at station level, however the record of local complex training is not captured in the Monthly Scorecard with the exception of CSR.

5.3.7. Training Officers and Clinical Tutors did not have access to planned and relevant contemporaneous IPC training updates. In March 2014, 76 education staff was provided with IPC training update by HIPC. It is envisaged that Clinical tutors and Training Officers will have access to IPC updates from the HIPC annually. The proposal will require agreement and support from the Director of Paramedic Education.

5.3.8. A Trust-wide IPC training plan (2014) to address these gaps were agreed by the IPCC early 2014. The HIPC contributed to the Trust-wide Training Needs Analysis carried out at year-end by the Transformation Team.

5.3.10. Infection control refresher training was disrupted by REAP levels; however to end of March 2014, 88% CSR training compliance was achieved - a significant improvement from the previous two years. CSR in 2014/15 will not address IPC issues until September 2014 as the focus shifts to Mental Health and Safety and Risk.

5.3.11. No training figures were available for other groups of staff e.g. non-clinical staff except for 26 staff who attended the All-in-One in 2013/14.

5.3.12. Overall there is a gap in capturing training compliance data for every staff group in LAS, PTS, Community Responders and private contractors. Oversight of all training compliance is being taken forward by the transformation team, and IPC will be taking forward the contractual issues with private contractors, with relevant contract managers.

5.3.13. In the interim, training compliance data for Induction and All-in-One sessions will be captured on a monthly basis for the first time from Quarter 2 in 2014. Plans are in place to address gaps identified regarding private contractors, PTS, Community Responders and others so that there is more rigor in the overall data presented for assurance.

5.3.14. There is a lack of a planned programnme to deliver fit testing for FFP3 respirators and this gap was raised on a LA167 by IPC and awaiting sign off by EPRR. In the interim, it was advised that FFP3 train-the-trainer sessions were recently initiated to train local station leads by the the Flu Lead (Fit Test Lead). It should be noted that LAS as an employer has a duty of care to ensure appropriate PPE and training are provided for staff to undertake their role.

5.4. Decontamination

5.4.1. The ADO Fleet and Logistics, (nominated Trust Decontamination Lead) left the LAS in 2013, resulting in a gap in service.

5.4.2. The Decontamination Lead worked in partnership with the AOM IPC/and latterly with the new Head of IPC, to ensure a comprehensive approach to medical devices management, procurement of, and the suitability of products. The lack of a Decontamination Lead was registered in the Corporate Risk Register.

5.4.3. There is a lack of a Medical Device Decontamination Policy, a current Management of Medical Devices Policy and a decontamination service for A&E equipment. This was registered in the Corporate Risk Register.

5.4.4. Since the AOM IPC left, the Chair of the Clinical Equipment Working Group was temporarily held by the Medicine Management Lead until Quarter 4, when the Director for Paramedic Education and Development was delegated responsibility.

5.5. Hand Hygiene

5.5.1. Effective hand hygiene continues to be promoted within the trust. Hand hygiene procedure is available to all staff via the Infection Prevention and Control page on The Pulse, the IPC Workbook, Induction and Education programmes.

5.5.2. Monitoring of clinicians compliance takes place via the IPC Observed Practice Audit Tool and Clinical Supervision and through spot check visits to hospitals by the IPC team; some external feedback from hospital staff conducting audits. Work is ongoing to address the issue of appropriate glove usage and enhance basic standards in IPC.

5.5.3. Hand hygiene (self-audits) demonstrated consistent compliance scores of 99-100%. The few external audit results highlighted marked discrepancy in scores achieved. Further work is required in this area to understand the discrepancy and to provide robust assurance.

5.5.3. It should be noted that, bare-below-the-elbows audit have ceased for the last 18 months due to lack of capacity. Furthermore, the Uniform Working Group has yet to review the policy. When audit re-commences, resources will need to be identified to the work stream.

5.6. Premises cleaning compliance

5.6.1. Achievement for premises cleaning compliance during 2013 often exceeds the target of 85%. However, there was a discrepancy in standards observed during unplanned visits to some sites. For example, sterile supplies store room was in poor condition in a few sites with water ingress, dust and dirt accumulation on ledges, debris, cobwebs, dirty wooden shelves and floors. It was discovered that the Lakethorne/Initial contract did not include the routine cleaning of storerooms.

5.6.2. A once-off deep clean of 24 main stations was facilitated and funded by IPC in March 2014, to ensure the Logistics Stores project was supported with a clean environment. Variable cleaning standards were achieved; some had to be re-done. Estates have made a bid for an additional £30K to fund a planned programme of cleaning for store rooms in 2014/15.

5.6.3. Audit tool questions relation to cleaning standards have been reviewed and there are plans in place to work with local IPC leads to enhance auditing skills, and triangulate data from independent sources in the future. Regular monthly meeting have been arranged between IC Lead and Estate team to ensure continued improvement in cleanliness standards, appropriate use of Chemex disinfectants, and appropriate waste segregation.

5.6.4. Chemex disinfectants review was requested by Procurement; this is delayed to due capacity issues.

5.6.5. Operational staff (via AOMs) were advised take ownership and to assist with improvements in cleanliness standards.

5.6.6. Quarter 1 (2014) Lakethorne Report highlighted that all 7 LAS London offices achieved overall cleanliness scores in excess of 90.5%, against a target of 85%. All stations achieved the target except – South Croydon at 79% and Woolwich at 73%.

5.6.7. Routine Adenosine Triphosphate (ATP) swabbing was discontinued in 2013/14, as ATP only measures proteins left on surfaces but did provide additional information as to the organism's viability. ATP however, may have a role when used in a test scenario e.g. when assessing the performance of potential service suppliers prior to awarding cleaning contracts. Current supplies of ATP swabs were lost when the fridge containing the supplies were removed from Pocock Street to support the Annual Flu programme.

5.4. Vehicle deep cleaning

5.7.1 The Trust recognised that cleanliness in the patient environment is paramount for patient safety and reducing the likelihood of Healthcare Associated Infections. A concern that was noted in the CQC August 2013 inspection, regarding vehicle deep clean compliance; suboptimal compliance with vehicle cleanliness were noted in IPC inspections internally and by the external NASIPCG peer review in November 2013.

5.7.2. A 6-weekly deep clean schedule for vehicles to maintain a high level of cleanliness in all patient carrying vehicles was instituted in February 2012. Every complex had access to staff to perform deep cleaning of all vehicles and its interior equipment Each complex had responsibility for ensuring that 90% of its vehicles were cleaned within the timeframe. Compliance data were monitored monthly and presented to the IPCC quarterly where any exception was scrutinised. The deep clean compliance figures form part of the IPC Key Performance Indicators (KPI) and are therefore key in attaining and maintaining compliance with the Hygiene Code.

5.7.3. The overall KPI of 90% for all vehicles (PTS and A&E) was achieved in 2013/14. However, the performance for A&E vehicles did not meet the 90% target, due to management issues within the contracted service provider and the lack of availability of A&E vehicles to be cleaned during high REAP levels. Data captured is focused solely on meeting the 6 weekly VP deep cleaning schedule and does not measure the quality of the deep clean.

5.7.4. CQC inspection report (September 2013) judged LAS to have met Outcome 8: Cleanliness and Infection Control during their inspection in August 2013.The report however, did highlight 2/5 dates on deep clean badges observed had expired. There has been much focus by the Initial Contract manager and IPC to ensure compliance with the 6 weekly deep clean schedule AND the cleanliness standards following routine cleaning.

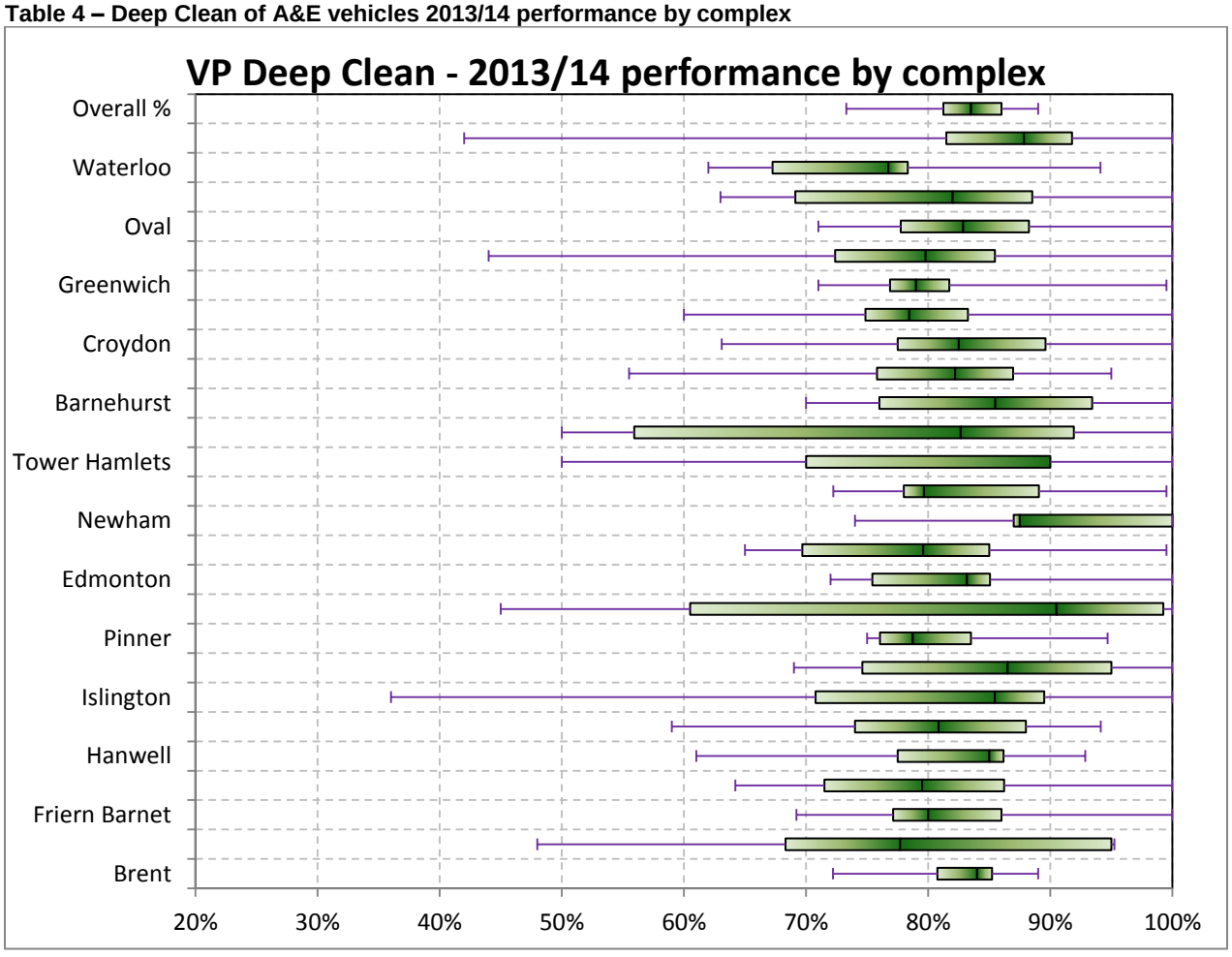
5.7.5. The Initial contract manager continued to work closely with Initial staff and daily monitoring is in progress. A mobile unit was initiated in 2014 as part of an action plan to improve the situation. The situation is monitored at the quarterly IPCC, and will require the contract KPI being reviewed.

5.7.6. FRUs in Education, HART vehicles and new vehicles were previously missed from the contract. These have now been added to the 6 weekly cleaning list. Currently there is no high level cleaning service by Initial for Category 4 transfers. This is being explored and work is on-going.

5.7.7. Achievement for 2013/14 for deep clean of A&E vehicle is demonstrated in the Table 4 box whisker plot below. The green bars show where 25% to 75% of results came in, the dark green line showing the median result, and the error bars show the lowest and highest results over the year.

5.7.8. Interquartile results in Table 4 demonstrated that significant numbers with result more than 90%, with median results lower; except for Chase Farm, with a median of 90%. It statistically demonstrated that significant numbers of complexes did not achieve the KPI of 90% apart from Chase Farm.

Table 4 – Deep Clean of A&E vehicles 2013/14 performance by complex



5.7.9. It was noted that vehicle audits were not analysed. There were a significant number of vehicle audit forms that were reporting missing items within the vehicles prepared. It is unclear how many vehicles are being taken out following deep cleaning without the full complement of the equipment on board. There is a need for audit forms completed to be analysed to gain a better picture of the quality of the service provided. Crew reported that the lack of equipment on board was a concern, and will need to be addressed by the contract manager.

5.8.Policy Review and Development

5.8.1. The IPC Workbook was launched in February 2013 to replace the Infection Control Manual. It is available both as a hard copy and on the 'Pulse' which has its own dedicated IPC section. It should be noted that this is an abridged version of the previous comprehensive manual and should be used as an aide memoire.

5.8.2. The staged roll out of this workbook was through the CSR in 2014. All attendees were given a copy and the content worked through with clinicians by the Tutors. 88% of clinical staff have been given a copy of the workbook..

5.8.3. A gap analysis was undertaken and a planned programme of review, development and amendment of policies aligning to national guidance and legislation, will commence, subject to capacity and priorities.

5.8.4. New policies have been drafted:

- Operational Framework between PHE London HPUs and LAS NHS Trust
- Workforce Immunisation
- Waste Management
- Legionella

Please note that there is an absence of a current Management of Medical Devices Policy within the trust. A specific section on Medical Device Decontamination is expected to be drafted by the Trust Decontamination Lead, when identified.

5.9. Annual .Flu programme

5.9.1.Staff annual flu programme - Overall uptake improved steadily, and achieved 48% at end of the program; the innovative use of minibuses from the EPRR fleet, to provide mobile clinics/ moving vaccine between complexes/stations, was recognised nationally as good practice.

5.9.2.Pandemic Flu programme – The EPRR Flu Lead and the HIPC both attended the LRPB Pandemic Flu Framework meeting in March 2014. A working Group has yet to be set up to review the Pan Flu management arrangements in LAS. There is currently no information available regarding FFP3 respirator mask allocation and compliance for fit testing of the same (see 5.17.3).

5.10. Needlestick (Sharps) Injuries

5.10.1 There were 136 sharps injuries to year end. There was a marked reduction of razor injuries following introduction of a new razor, 20 in 2013/14, compared to 58 in 2012/13 (Table 5).

5.10.2. Significant increase in numbers of clean needle injuries, were noted in 2013/14. 48/136 sharps injuries were derived from a dirty/used needle (Table 2, table 5) with no reduction from the year before. Majority of cases could be avoided by adhering to good practice.

Table 5.Sharps injuries 2010-2014

Count of recorded	Column Labels				
Row Labels	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**Grand Total**
Clean Needles	10	18	7	34	69
Dirty/Used Needle	48	67	48	48	211
na	64	44	48	34	190
Razor		4	58	20	82
Grand Total	**122**	**133**	**161**	**136**	**552**

5.10.4 It should be noted that the current process in place for management of sharps incident cases, including investigation, recording, interdepartmental/trust wide sharing of information, and formal closure of cases is not adequately rigorous and will require a review. An enhanced process is required to fully meet EU legislation (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the 'Sharps Regulations'). Implementation of the Management of Sharps and inoculation incidents Policy lies with the Safety and Risk Team, and is monitored quarterly by IPCC.

5.10.5. Risk assessment was undertaken and a safer needle needle rollout in accordance with the European Directive (Council Directive 2010/32/EU), to prevent injuries and infections to healthcare workers from sharps is being implemented. The cut-off date for withdrawal of old stocks of needles was deferred to 31 July 2014, to allow for a staged roll out of the new supplies and to provide adequate training to staff.

5.11. Communicable Disease Incidents

5.11.1. Post Infection Review investigation for MRSA Bacteraemia

LAS IPC participated in a multi-agency Post Infection Review of a case transferred by LAS crew in March 2014. It formed part of the Acute Hospital investigation into the subsequent acquisition MRSA bacteraemia by this patient. The case was initially taken to and treated in the ambulance at Central Middlesex, then transferred to St Mary's Hospital. Lessons to be learnt are expected in May, when the report is made available.

5.11.2. Communicable Disease Crew Exposure Incidents Oct 2013 to March 2014

Table 6. Communicable disease exposure October2013 to march 2014

Month	Communicable disease	Follow-up
October 2013	Meningococcal Meningitis	Yes – Station/IPC/OHD/HPU
	Possible MERS CoV	Yes – Station/IPC
	Hand Foot and Mouth	Yes – Station/IPC
December 2013	Meningococcal Meningitis	Yes - Station/IPC/OHD/HPU
	Pulmonary Tuberculosis	Yes - Station/IPC/OHD
	Severe Respiratory Syndrome ? Cause	Yes - Station/IPC
January 2014	Probable Meningococcal death	Yes - Station/IPC/OHD/HPU/Acute pathologist/Coroner – cause Pneumococcus
February 2014	Meningococcal Septicaemia	Yes - Station/IPC/OHD/HPU
March 2014	Measles	Yes - Station/IPC/OHD/HPU
April 2014	Pertussis	Yes – Station/ IPC/OHD/HPU

5.11.3.As a result of the above notifications of incidents (Table 6), bulletins on MERS CoV and Tuberculosis were published on the intranet to raise awareness and understanding of these diseases. Standard precautions were re-iterated and enhanced respiratory precautions were advised based on risk assessment of individual cases. There is a need to understand how staff is followed up and the information/feedback that is provided to LAS contract manager by OHS. This information is currently not being shared with IPC. Lessons from the exposure incidents have been incorporated into the CSR training from September 2014.

5.11.4. Communicable disease – working with partners

- The HART and IPC teams have visited RAF Brize Norton for lessons regarding Category 4 disease transfer and explore the use of isolators. Another visit is planned in May to the Royal Free Hospital to address common issues regarding safer transfers and decontamination of equipment and ambulance interiors.

- Working with PHE London HPUs – refer to 5.17.2.

5.12. Occupational Health Service provision

5.12.1. Occupational Health is provided to the Trust by Guys and St Thomas' Occupational Health Department and is performance managed through the Human Resources department.

5.12.2. Guys and St Thomas' Occupational Health Department are a contributing member of the Safety and Risk team providing quarterly data on needle stick injuries, vaccinations, post exposure prophylaxis and any skin allergies due to glove or alcohol gel usage.

5.12.3.To support frontline staff and reduce the incidence and impact of vaccine preventable illness in the work place, Guys and St Thomas' Occupational Health Service (GSTT OHS) liaised with Human Resources to ensure that staff were

appropriately immunised; there is an on-going risk regarding previous staff immunisation records prior to Guys and St Thomas' Occupational Health Department taking responsibility for the Trust.

5.12.4.GSTT OHS was commissioned to undertake a piece of work to scope the current problems re recording of immunisation data of staff . The results would ensure that the OHS have accurate records of staff immunity and for them to lead on immunisation and vaccination of staff in future. The exercise is expected to be completed by GSTT OHS in 2014/15.

5.12.5. The Workforce Immunisation Policy was drafted for consultation, which included an easy reference leaflet for staff.

5.12.6. Lessons from incidents highlighted difficulty in staff getting timely access to telephone advice, OHS appointments and lack of call back from OHS. In the interim, the HIPC and PHE local units provided support and advice until these concerns could be addressed by the OHS contract manager.

5.13. .Waste management

5.13.1 A number of non-compliant issues were identified in 5.1.6., in addition to the lack of process for the disposal of obsolete equipment and uniforms.

5.13.2. There were a number of gaps in the waste management policy. This is currently being enhanced by the waste contract manager, with support from IPC, IG and Medicine Management Leads. The enhancement should ensure that all elements of waste segregation and appropriate disposal are captured in the new draft document and with responsibilities clearly identified, including audit and reporting to the quarterly IPCC for oversight.

5.14. Third Party Contractors compliance with IPC standards

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

5.14.2. Through regular meetings and reviews the two contractors, Lakethorne (premises cleaning) and Initial (vehicle preparation), it is confirmed that infection prevention and control is a core part of the quality of their service provision. The Lakethorne IPC training package was reviewed by the HIPC, however Makeready (Initial) training package has yet to be reviewed.

5.14.3. Lakethorne quarterly reports were received and regularly discussed at IPCC since November 2013. The reports highlighted areas of non-compliance with Legionella

L8, and Trust wide remedial action plan has been put in place by Estates and a policy is being drafted to mitigate risks and improve the situation. The Legionella risk was registered in the Corporate Risk Register, and will be monitored at the IPCC from Quarter 1 in 2014/15.

5.14.4. Currently, third party VAS/PAS contractors for the provision of ambulance services do not have similar arrangements for robust performance monitoring and the shortcomings should be addressed in 2014/15, through the contracts manager.

5.15. IPC Communications

5.15.1. A mix of communication formats were utilized to ensure that key messages were shared across the organisation to assist in embedding IPC principles into daily practice. Staff had access to information both remotely and whilst on station. Key areas of information

- Hand Hygiene
- Sharps Awareness
- Seasonal Flu Vaccinations
- Audits data
- Personal Protective Equipment
- Vehicle Cleanliness
- Communicable Diseases (TB) and emerging organisms (MERS CoV, Avian Flu)

5.16. Risk Register

5.16.1. A number of risks were closed (Appendix 4) - Risk 327 and 332 were merged and action owner moved to Logistics; Risk 324 has been archived. Risk 326 the LAS Decontamination Lead was identified as the Director of Business Development.

5.16.2. A Medical Device Decontamination Policy has been drafted for consultation; and a validated process for decontamination of A&E (contaminated) equipment was explored with a third party provider. Information has yet to be provided by Logistics in order to obtain a quote for the service.

5.16.3. Two additional risks will be added in May i.e. lack of a formal programme of FFP3 Fit Testing and for lack of a disinfection service for contaminated equipment collected from A&E units around London.

5.16.4. The IPC risks recorded on the Corporate Risk Register continues to be rigorously scrutinised at the quarterly IPCC.

5.17. Working with external partners

5.17.1. The IPC team worked with a number of external sources to assist in the smooth implementation of the local policies and procedures and that these are contemporaneous and in alignment. Some of our IPC partners in 2013/14 include:

- NASIPCG – National Ambulance Service Infection Prevention and Control Group
- Public Health England
- NHS England
- IPS – Infection Prevention Society
- RCN – Royal College of Nursing
- NICE – National Institute for Clinical Excellence
- DH – Department of Health
- NARU – National Ambulance Resilience Unit
- RAF Brize Norton IPC team
- Locals leads in Emergency Departments
- LAS Patient Forum – the HIPC presented at a LAS Patient Forum meeting; a representative now attends the quarterly IPCC to provide a patient voice.

5.17.2.PHE South East London HPU and the LAS collaborated on drafting a working framework between LAS and Pan-London Health Protection Units. The framework will be presented at the April 2014 IPCC

5.18. IPC team development

5.17.1. The HIPC attended one NASIPCG meeting in Birmingham and a GovToday Reducing HCAI Conference in 2013/14.

6. Summary of Achievements in 2013-2014

The report has already identified a number of achievements in improving infection prevention and control within the Trust, as well as development areas.

- Gap analysis undertaken to develop 2013 -2015 Delivery Plan
- Care Quality Commission Inspection August 2013
- QGARD/NASIPCG External Review of the IPC standards November 2013
- 30 IPC inspections of stations undertaken
- Flu uptake increased to 48%; good practice by Flu Team nationally recognized.
- Hand hygiene (self-audited) 99-100%
- Premises cleaning consistently exceeds 85%
- CSR training uptake increased to 88%, highest in 3 years
- 35% reduction of razor injuries from previous year

7. Conclusion

Patient safety continues to be a priority for the Trust and IPC is an integral part in achieving this. The Trust has shown its commitment to IPC by having deeper scrutiny, implementing enhanced process during 2013/14. Trust staff has worked hard to achieve the IPC objectives for the year despite a period of significant challenges associated with transformation and high REAP levels. .Although the performance overall was not

sustained for 2013/14, the baseline information and foundations already set will be able to push the IPC agenda forward for 2014/15. The trust will continue to make improvements in the staff/patients' care and experience, by focusing on outcomes and safety and quality of our IPC services for the forthcoming year.

8. Recommended areas for improvement in 2014/15

It is recommended that sharing of data and communications are enhanced across directorates, working in a more inter-connected way. Horizon scanning and forwarding planning with timely escalation of risks to ensure continuous grasp and grip at Board level of infection control issues

Key areas to be incorporated into the 2013 -15 delivery plan:

- Address resource issues:
    - IPC team capacity issue
    - Effective system for audit
- Rigor of performance data management and reporting
- Internal and external joint up-working
- Comprehensive OHS service
- Planned programme of inspections and monitoring timely closure of actions
- Understanding and closing the theory-practice gap, focus on developing visual aids for practical skills; capture of comprehensive training compliance data
- Planned audit programme to include 'mystery shopper' audits to obtain true baseline of compliance
- Vehicle cleaning and re-stocking
- Legionella management
- Exemplar station – to include better stores management
- Policy amendment and development

ECH Draft 1 12 May 2014

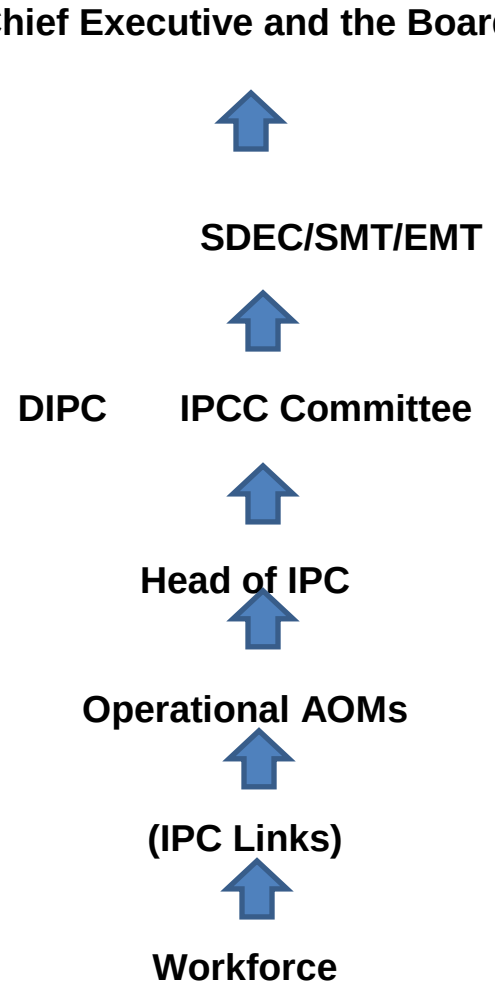
Draft 8 – 20 November 2014

Appendix 1 - Hygiene Code Criteria and Care Quality Commission Essential Standards

Hygiene Code Criterion and related CQC Outcome	Hygiene Code Requirement	Compliance Status	Compliance Status	Commentary 2014
		April 2013	April 2014	
Criterion 1 *(Outcome 8, and Outcome 6, Regulation 24 Cooperating with other providers)*	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	Compliant	Partial	Infrastructure in place, PRF for handover, HPA/LAS Framework Weak assurance of implementation- VAS PAS contractors – performance data lacking Capture of performance data lacks rigor
Criterion 2 *(Outcome 8, and Outcome 10 Regulation 15 Safety and suitability of premises, Outcome 11 Safety, availability and suitability of equipment*)	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Compliant	Partial	No provision for liaison ie overarching policy, between ICT and person with overall responsibility of the environment Environment – Stations, Vehicle underperforming. Store rooms, HART and Education Vehicles not within cleaning contract. Used equipment – lacks decontamination lead oversight and a policy/process for decontamination of A&E equipment Blankets – supply through Logistice Linen provision absent current from hospital stocks Uniform disposal – lacks process Cleaning standards variable Building and refurbishment – ICT not advised Waste management – requires enhancement Planned programme of maintenance – not comprehensive Legionella site management policy – not available and no oversight of trust action plan and report of water temperature achieved
Criterion 3 *(Outcome 8, and Outcome 1, Regulation 17 Respecting and involving service users)*	Provide suitable accurate information on infections to service users and their visitors.	Compliant	Compliant	Due to short transfers and condition of patients, verbal advice provided currently; ICT attends Patient Forum and Patient Forum rep attends IPCC IPC & Equality training to staff; complaints procedure available; staff survey
Criterion 4 *(Outcome 8, and Outcome 6, Regulation 24 Cooperating with other providers*)	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant	Compliant	IPC training Staff -Intranet IPC page; IPC workbook and training; PRF on handover to A&E; liaison with OHS/HPA/DH as appropriate; Working Framework
Criterion 5 *(Outcome 8)*	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Compliant	Partial	Not devolved to all groups in the organization. Inconsistently applied. Lack of comprehensive OHS service to contact trace. IPC training provided at Induction and to patient facing groups only. Not all groups are captured in performance data for training. VAS/PAS evidence lacking; Community Responders does

				not have access to OHS service
Criterion 6 *(Outcome 8)*	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	Compliant	Partial	All LAS staff attends Corporate Induction programme and IPC in JDs; Ccommunity Responders own induction includes Hand Hygiene Initial/Lakethorne include IPC training for their cleaning and Makeready staff Unclear VAS/PAS/CRs include IPC in JDs/training
Criterion 7 *(Outcome 8)*	Provide or secure adequate isolation facilities.	N/A	N/A	?Applicable in Category 4 transfers - HART
Criterion 8 *(Outcome 8)*	Secure adequate access to laboratory support as appropriate.	N/A	N/A	N/A
Criterion 9 (*Outcome 8, and refers in part to* • *Outcome 6, Regulation 24 Cooperating with other providers* • *Outcome 10 Regulation 15 Safety and suitability of premises* • *Outcome 11, Regulation 16 Safety, availability and suitability of equipment* • *Outcome 12, Regulation 21 Requirements relating to workers*	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant	Partial	IPC Policy in date; Workbook/aide memoire 2013; Comprehensive IPC manual not available; access to HPA website; HPA/LAS Framework Out of date policies – Outbreak, Waste. Policies in development – Workforce Immunisation, Legionella, Waste, Decontamination being drafted No identified Leads for Cleaning, Decontamination, Waste, Legionella. No linen policy or decontamination service; cleaning programme not comprehensive; Vehicle preparation standard for A&E not achieving 90% Lack of FFP3 training programme
Criterion 10 *(Outcome 8, and Outcome 12, Regulation 21 Requirements relating to workers)*	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Not compliant	Partial	Access to GSTT OHS Service; KPI for services to be enhanced; feedback data lacking Record of Immunisation for all staff – on-going Training compliance data of On-going IPC education available for patient facing staff only, locums, contracts, volunteers – identified gap in TNA trust –wide. VAS/PAS/CRs/PTS and non-patient facing – no data- Workforce Immunisation Policy – in development

Appendix 2 Organogram: Assurance structure



Appendix 3. Policy Review progress

Policy	Policy/procedure in place in place?	Review date	Gaps Additional information	Responsibility
Infection Control Policy	Yes	October 2014	To be reviewed 2014	Infection Prevention and Control
IC Manual replaced by IC Workbook Feb 2013	Yes	None	Not comprehensive; for review and enhanced 2014	Infection control and Control
Outbreak Policy	Yes	?2012	To be reviewed and aligned	Infection Prevention and Control (delayed due to capacity
Working Framework LAS and PHE HPU	None		Working framework required pan London – final document May 2014	IPC/PHE HPU
Waste Management Policy (Compliance with Hygiene Code, Waste Regulations 2005, HTM)	Yes	Sept 2013	Not comprehensive; needs to be enhanced. Gaps in management of confidential waste, WEEE waste e.g. batteries, oils, tyres, lights; Out-of-date pharmacy waste, old uniforms, obsolete medical equipment will need to be addressed. Currently there is a storage problem due to unclear process of cleaning patient equipment, disposing of medical and patient equipment (confirmed by the Head of Logistics). Regularly formal audits of different types of waste needs to be clearly identified including development of an audit tool; reporting structure for performance data; implementation of existing, update references to include HTM	Estates - Waste Contract Manager. Information Governance Lead and IPC (drafted May 2014)
Medical Devices Policy Decontamination Policy (Compliance with Hygiene Code, CQC Outcome 11. NHSLA Risk	None	N/A	New Medical policy required and drafted January 2014 - to include procurement, equipment register, training, responsible group (currently in place: Clinical Equipment Group); planned programme of maintenance, repair, decontamination (this section in IC Workbook being enhanced by Head of IC) and final disposal of assets; with link to existing COSHH policy	Procurement (January 2014) Decontamination Lead and Working Group (May 2014)

Management Standards Criterion 4.8, 4.9; Medical Devices Regulations)			Decontamination Policy – recorded on Risk Register Medical Devices Policy – yet to be recorded on Risk Register	
Legionella Policy (compliance with Hygiene Code, CQC Outcome 8, COSHH 2006)	None	N/A	New policy required. Drafted by the Legionella Lead and is currently being consulted widely.- internally and externally with PHE. Safety and Risk Team will add a link to the COSSH Policy when the Legionella Policy Recorded on Estates Risk Register.	Estates - Legionella Lead (May 2014)
COSHH Policy (compliance with COSHH, H&SaW)	Yes	Oct 2013	Being amended, awaiting Legionalla Policy to add link to.	Risk and Safety
Sharps and management Policy (Compliance with Hygiene Code, NHSLA Risk Management Standard Criterion 4.7, and EU Health and Safety (Sharps Instruments in Healthcare) Regulations 2013)	Yes	Sept 2015	Requires full implementation of Plan Page 17 of Policy as well as trend analysis; clear advice of safer needles to be used; auditing tool and process; contract performance and investigation feedback	Risk and Safety – to implement Policy Education, AOMs, Makeready – withdraw all non-safe product by 31 July 2015.
Uniform and work wear Policy	Yes	Jan 2015	Requires clear audit tool and process; define when bare below the elbow applies, needs to link to Waste Policy for secure final disposal of old uniforms ; contact person	Uniform Working Group
Internal Outbreak Policy	Yes	June 2011	Being reviewed; need to include single infectious incident eg measles, chickenpox, meningitis; requires internal and external communications to be clarified and algorithm	Infection Prevention and Control Delays due to lack of capacity
Workforce Immunisation Policy	Yes	ASAP	Presented at IPCC November 2013 and April 2014. Discrepancy in content – currently with OHD	HR /GH

Appendix 4 Risk Register

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
327	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen.		12-Oct-09	4	Infection Control	Major	Certain	20	1. The Trust has an adequate supply of blankets, however these are not always available. 2. Increased availability of blankets for A&E crews - Additional linen and disposable blankets added to stocks and circulated. 3. Improved collection of soiled blankets from hospitals and non-contract laundries - New laundry provider appointed and increased activity being established to collect blankets. Reduction in blanket loss.	Steve Lennox	07-Jan-13	Major	Likely	16	1. To understand the scale of the problem and to develop a sstrategic solution ot blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing. 1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 1 d) Small sub group to be formed to discuss options paper and endorse recommendations	1a. Trevor Hubbard 1b. Chris Vale 1c. Trevor Hubbard 1d. Karen Merritt	1a. Mar 2012 1b.Feb 2012 1c. June 2012 1d. Feb 2012	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	The IPCC propose that risks 327 and 332 are combined as they cover the same issues. LA167 to be raised to cover both risks.
324	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.		17-May-10	4	Infection Control	Major	Certain	20	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Audits of vehicles and premises. 4. Swabbing of vehicles by LSS. 5. Processes now in place to triangulate audit information.. 6. Opportunities within the PEAG initiative have been identified to support the audit process.	Steve Lennox	08-Feb-12	Major	Possible	12	1. To ensure Trust is consistently compliant across the service: a) conduct audit following implementation of contract.	1a. Trevor Hubbard	1a.	1a. Comprehensive dashboard	Minor	Unlikely	4	IPCC - This risk has reached its target rating and is proposed for archive and monitoring via the local risk register.

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	1, 2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	07-Jan-13	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process.	1. Steve Lennox	1. Feb 2012	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	PCC 1.11.12 - no amendments made
322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	1, 2, 4, 5	Infection Control	Major	Likely	16	1. Introduction of training programme for operational and non-operational staff. 3. Trust updates have been delivered to 1,600 staff including hand hygiene training 3. Use of Infection Control Communications Strategy to ensure that all staff are kept well-informed. 4. Training now being delivered across the Trust in CSR1	Steve Lennox	07-Jan-13	Moderate	Possible	9	1. To be fully compliant with CQC expectations and all staff to have up to date infection control training: a) Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) b) Monitor and implement hand hygiene training. c) Need to capture the training of contracted staff on the scorecard.	1a Carmel Dodson-Brown / Ian Bullamore 1b Steve Lennox 1c	1a Feb 12 1b Feb 12 1c Feb 12	Reports from the central training register	Minor	Unlikely	4	IPCC 1.11.12 - no amendments made

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	1, 2, 4, 5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	07-Jan-13	Major	Possible	12	1. To have a decontamination policy that meets CQC expectations: a) Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. b) Monitor decontamination compliance	1a C. Vale/ K. Merritt 1c Trevor Hubbard	1a Jan 2012 1b Sep 2012	1. Incident reporting. 2. Complaints/ claims monitoring.	Moderate	Rare	3	IPCC 1.11.12 - no amendments made
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	4, 7	Infection Control	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are now in use which should hopefully reduce the number of injuries. 3. H&S bulletin related to 'Disposal of Sharps' was issued in 2007/08. 4. This is part of the infection prevention and control action plan.	Steve Lennox	07-Jan-13	Moderate	Possible	9	1. Minimise the risk of sharps injury: a) Participate in national ambulance audit 2011. b) Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1a.T.Hubbard 1b T.Hubbard	1a May 2012 1b May 2013	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	IPCC 1.11.12 - no amendments made

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
332	There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient.		01-Mar-10	4	Infection Control	Minor	Likely	8	1. The matress is disinfected between each patient.	Steve Lennox	07-Jan-13	Minor	Likely	8	1. Identify - procure suitable disposable mattress covers; finalise assessment and make recommendation. 2. Improve returns from laundry of sheets and covers; agree process for returning sheets with the provider. 3. Eliminate soft repairs being undertaken with tape: a) Establish the incidence of repairs being undertaken to soft furnishings with tape. b) Instruct workshops to ensure spare mattresses are available to swap.	1 Chris Vale 2. Chris Vale 3.a Chris Vale 3b Chris Vale	1. Aug 2011 2. Mar 2012 3a Aug 2011 3b Aug 2011		Minor	Unlikely	4	The IPCC propose that risks 327 and 332 are combined as they cover the same issues. LA167 to be raised to cover both risks.

Appendix 5 – IPC Delivery Plan 2013 -2015

To Add

London Ambulance Service NHS
NHS Trust

INFECTION PREVENTION AND CONTROL ADDENDUM

April to December 2014

This interim report is to provide assurance that continual improvements are being made to address the gaps highlighted, in the Annual DIPC Report 2013/2014.

Infection Prevention and Control (IPC) Performance between April – October 2014

The IPC performance against the Delivery Action Plan continues to be vigorously monitored and challenged at the regular IPC Committee (IPCC) meetings held in April, May and July 2014.

Progress

1. The Infection Prevention and Control Committee
The committee is now functioning much better and focussing on assurance. The new style IPCC meeting drills down the standards of each area, appears to be working well with good engagement.

2. Vehicle preparation (VP) 6 weekly deep cleaning compliance
Overall KPI of 90% for was achieved for ALL vehicle categories collectively. However, VP deep cleaning compliance on A&E vehicles highlighted a pattern of under-performance for A&E vehicles for Q1 and Q2. A mobile unit was introduced to improve the situation, with the contract manager working closely with Initial (VP) and daily progress being monitored. The situation was compounded by other factors including high REAP levels. Performance was closely monitored monthly and challenged at each quarterly IPCC. Improvements have been noted for the last 2 months.

Table 1. Compliance against target of 90% April to December 2014

Months	April	May	June	July	August	Sept	Oct	Nov	Dec
VP deep clean (A&E)	84%	82.76%	89.76%	87%	87%	86.4%	87%	91.7%	91.5%

Current data excludes VAS and PAS contracts. Discussions have taken place with the LAS contract manager with a view to adding VAS, PAS data to the IPC performance scorecard in 2015.

3. Hand Hygiene compliance
Hand hygiene self-audits continually exceeds 90%, however has not achieved target of 100%. Education sessions continue to focus on the importance of hand hygiene and feedback provided.

Table 2. Hand Hygiene Compliance (self-audits) against target of 100%

Months	April	May	June	July	August	Sept	Oct	Nov	Dec
Hand Hygiene –self audits	99%	99.72%	90%	99.8%	91.7%	97%	95%	95%	95%

4. Environment and storage

- ***Legionella compliance***

The legionella lead has been identified and the identified gaps are being addressed through the trust wide legionella action plan. A legionella policy has been drafted.

- ***Premises cleaning compliance***

Achievement for premises cleaning compliance during last two quarters exceeds the target of 85% set (Table 3).

Table 3. Compliance with Premises Cleaning target of 85%

Months	April	May	June	July	August	Sept	Oct	Nov	Dec
Premises cleaning	96.72%	96.5%	92%	97%	97.2%	97.3%	97%	95%	95%

- ***The South Storage Project***

The project improved working environment at complexes with increased efficiency, provision of a better storage and stock management system for LAS and facilitated the cleaning process.

- ***Disposal of obsolete uniforms***

The disposal of obsolete uniforms was completed by Q2 and a process was introduced to securely dispose of these uniforms going forward.

5. Policy review and development

The Policy and procedure review was undertaken. Policy and procedure development continues to ensure gaps are addressed.

- The IPC Manual was replaced by the LAS IPC Workbook (February 2013) and the National Ambulance Guidelines.
- The following policies are awaiting approval: Legionella, Workforce Immunisation, Decontamination, Waste Management.
- A Working Framework between Public Health England London Health Protection Units and LAS (June 2014) and shared with the London Health Protection Units.

6. Infection control training compliance

- ***Standard IPC training***

The training packages were enhanced to address lessons from incidents with a focus on developing practical skills in IPC practices.

Compliance data is captured on a monthly basis from clinical and non-clinical refreshers and Trust inductions for all LAS staff. In addition, rigorous system to capture **all** training is being

explored by the Modernisation team. VAS and PAS providers will be monitored through the contracts manager from 2015

- ***Viral Haemorrhagic Fevers (VHF): Enhanced PPE Training and fit testing***

A tiered approach was agreed for VHF PPE training – core group being HART, Tier 2, local CBRN teams, and Tier 3, the remainder of the LAS clinicians.

The LAS VHF/Pan Flu groups have agreed on the continued use of personal issue FFP3 respirators. A decontamination regime has been agreed with staff and manufacturer.

Additional Enhanced PPE was procured in October 2014. In addition Fit testing, training and issue of personal respirators are being implemented within the current FitFlu programme.

7. Audit programme

Area Operations Manager (AOM) Top 10 audit data continue to be uploaded by staff with varying compliance with submission. Quarterly audits submission was poor in Q2 due to REAP levels. AOMs have been tasked with addressing the issues and their actions are being monitored each month and quarterly.

The suite of audit tools in use is currently being reviewed. A trial of an e-tool took place in September and October with a view to procurement in order to enhance the audit programme.

8. Incidents and outbreaks

- ***VHF (Ebola) Assurance***

The worksteam to ensure VHF assurance has developed well since August 2014, led by the VHF Task Group. An LA167 (LAS risk assessment and reporting form) has been completed and a Trust wide action plan is in place. Regular bulletins are issued by the task group and shared within LAS and London HPTs.

IPC/HART worked closely with RAF Brize Norton, Royal Free HLIU to ensure that Patient care pathways are aligned and good practice shared. Isolation equipment and alternative decontamination techniques were trialed. The HART and HIPC contributed to the NARU Transfer Guidance for VHF transfer in August. PPE has been reviewed by HIPC and enhanced PPE is being introduced.

- ***Communicable Disease Exposure Incidents/Body Fluid Exposure incidents***

An LA 67 has been completed for Occupational Health Risk, as staff was reported as not using appropriate PPE for Body Fluid Exposure procedures during their post exposure screening process with OHS. Standard precautions and enhanced respiratory precautions following dynamic risk assessment were reiterated at training session and through bulletins.

The OHS contract tender specification has been enhanced to include contact tracing for the new provider from April 2015.

There is gap in resilience for Out-of-hours and Out-of-office cover arrangements for IPC advice during such incidents continues. An LA 167 recently submitted was not approved.

9. Flu programme
Following the London Resilience Partnership Pandemic Influenza Framework meeting the LAS Pan Flu group met to review Pan Flu arrangements within LAS in August.

The 'Flufit' Programme for 2014/15 commenced in mid-October whereby staff was vaccinated and FFP3 fit tested, trained, before being issued with a personal FFP3 reusable respirator. This is led by the Flu Lead, EPRR. In addition VHF Bulletin is also provided to ensure staff is aware of the requirements for VHF case assessment and transfer. Flu uptake and Fit testing data is submitted to the IPC Scorecard from Q3.

10. Risk Register
The Risk Register is scrutinised by the IPCC on a quarterly basis. In addition to the two risks reported in May: lack of a formal programme of FFP3 Fit Testing and a lack of a disinfection service for contaminated A&E equipment, LA167s was completed for lack of IPC on-call cover, the VHF (Ebola) Assurance Risk, on behalf of EPRR, OHS Risk, Still outstanding: wider Pandemic Flu risk. The risk for re-use of linen and blankets was transferred to Logistics to take forward.

A progress report for a once-off procurement of a decontamination service for contaminated A&E equipment was not available in Q1 and Q2, however assurance has been provided in Q3 that a quote is being sought form the service provider.

Report by:
Director of Infection Prevention Control
January 2015

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27 January 2015**
Document Title:	**Integrated performance report**
Report Author(s):	**Paul Woodrow**
Presented by:	**Paul Woodrow**
Contact Details:	
History:	**Executive Management Team meeting**
Status:	**Information**

Background/Purpose

The integrated performance report provides an overview of organisational performance for month 9 of this financial year. The dashboard reports on the following domains:

1. Quality
2. Performance and activity
3. Workforce
4. Value for money

The current report provides the board with a visual dashboard covering the domains above supported by additional tabs providing additional commentary on each and actions currently being taken to address identified issues. The report also provides a series of graphs for each measure to provide the board with trend information on a rolling monthly basis since the beginning of this financial year. This format of this report is subject to further development.

Key points to note from the report are:

The Trust failed to achieve the national response time targets for Red 1 and Red 2 as well as A19 in month 9 and saw deterioration in performance against key metrics. This was principally driven by activity which for Category A incidents was 7.6% above contracted levels. Category A activity peaked in the week ending the 21 December and the Trust responded to over 11,200 Category A incidents, the busiest week in the Trust's history. Operational resourcing hours was broadly in line with our forecasted position but activity had a significant effect on our productivity ratio and performance outturn.

The Trust enacted surge Purple for 62% of the total hours in month 9 and the Clinical Hub dealt with over 18,000 calls without the requirement to send a resource.

The Trust escalated the REAP level to level 5 on the 11 December in light of the intense operational pressure the Trust was under. This was reviewed by the EMT on a weekly basis throughout the month.

There were 8 Serious incidents declared in month 9 which is an increase of four incidents on the previous month. The declaration of such incidents don't necessarily relate to calls attended in month 9. Complaints showed a reduction in month 9 but were significantly above the target measure. The majority of complaints were associated with delayed response times. Patients in Category C groups suffered a further degradation in the quality of service they received from the Trust.

Workforce metrics remained fairly static in month 9 compared to previous month. Whilst the number of Paramedics leaving decreased in month 9 the overall vacancy factor did increase. This is in part due to a number of new EAC recruits failing their training course and therefore leaving the Trust. Robust recruitment plans are now in place and are reviewed weekly. A new training facility has opened in SW London in order for the Trust to increase its capacity to deliver training to new recruits.

In month the Trust is reporting £0.3m adverse to plan and year to date the Trust is £1.2m adverse to plan. This is as a result of increased expenditure in support of frontline performance. This is partly supported by additional resilience monies from CCGs.
The Trust forecast has move to a reduced surplus position of £1.0m as a result of the need for additional spend in support of performance improvement. The Trust remains on track to deliver its £13.8m CIP. The Trusts cash position remains robust and is significantly ahead of plan, this is mainly due to underspend on capital. Capital Expenditure is expected to be on plan at £16.9m by the end of the year. Against the Continuity of Service Risk Rating used by Monitor to assess aspirant Foundation Trusts , LAS has scored a 3.5 which is a good score and in excess of the Trust's plans (3.5

Action required

To note the contents of this report.

Assurance

This report provides the Board with an overview of the current organisational challenges facing the Trust and the actions being taken to address these.

Key implications and risks arising from this paper	
Clinical and Quality	**Yes**
Performance	**Yes**
Financial	**Yes**
Legal	**No**
Equality and Diversity	**No**
Reputation	**Yes**
Other	**Yes**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**Yes**
Improve recruitment and retention	**Yes**
Implement the modernisation programme	**No**
Achieve sustainable performance	**Yes**
Develop our 111 service	**No**
Simplify our business processes	**No**
Increase organisational effectiveness and development	**No**

London Ambulance Service NHS Trust

Trust Board Integrated Performance report

December Data

15-Jan-15

LONDON AMBULANCE SERVICE NHS TRUST

INTEGRATED PERFORMANCE REPORT 2014/15: December 2014 (MONTH 9)

Quality Exceptions	0	**There were 8 Serious incidents declared in December, complaints reduced in month 9. Poor quality of service for Category C patients**
Performance Exceptions	0	**Performance against all three key response time standards worsened in month 9. Category A activity was 7.6% above contracted levels**
Workforce Exceptions	0	**Overall vacancy numbers increased in month 9 but Paramedic leavers reduced as is the seasonal trend. Sickness remains off target**
Value for Money Exceptions	0	

QUALITY

	Quality measures	Target	Current month	Previous month	Year end forecast
1	Serious Incidents declared	1	8	4	RED
2	Complaints received	69	102	159	RED
3	999 Call Answering - 5 secs	95.0%	89.8%	93.1%	GREEN
4	NHS111 Call Answering- 60secs	95.0%	90.0%	96.3%	GREEN
5	NHS 111 Transfer rate to 999	10.0%	7.4%	8.2%	GREEN
6	Aspects of care compliance (MH)	95.0%	88.0%	91.0%	GREEN
7	Deep Clean of vehicles % completed	90.0%	91.5%	91.5%	GREEN
8	Category C1 (20 mins)	75.0%	34.2%	41.6%	RED
9	Category C2 (30 mins)	75.0%	43.6%	50.9%	RED
10	CSR 2014 Delivery - % of Frontline	60.0%	67.6%	67.6%	GREEN
11	Red 1 - 75% reached in mins/secs	8 minutes	10:00	09:20	RED
12	Red 1 number of responses >10 mins		339	243	
13	Red 1 95th Percentile Time to respond		16.18	15.75	
14	Red 2 -75% reached in mins/secs	8 minutes	12:40	11:00	RED
15	Red 2 number of responses >10 mins		16946	12437	
16	Red 2 95th Percentile Time to respond		28.75	23.31	
17	Surge plan escalation > Red (Hours)		458	74	

** Please note Percentile time shown as a decimal **

PERFORMANCE / ACTIVITY

	Performance / activity measures	Target	Current month	Previous month	Year end forecast
1	Red 1 Performance	75.0%	59.3%	64.3%	RED
2	Red 2 Performance	75.0%	47.6%	54.9%	RED
3	Trust A19 Performance	95.0%	84.8%	89.2%	AMBER
4	FRU A8 Performance	80.0%	51.7%	59.6%	RED
5	Cat A Red 1 Incidents	1,385	1,436	1,228	GREEN
6	Cat A Red 2 Incidents	42,016	45,247	40,839	GREEN
7	Cat A Total Incidents	43,401	46,683	42,067	GREEN
8	Total incidents	94,711	87,212	84,634	AMBER
9	Total Activity against Plan	104,968	105,459	99,526	GREEN
10	Clinical Hub Discharges	10,083	18,489	14,953	GREEN

VALUE FOR MONEY

		Target	Current month	Previous month	Year end forecast
1	EBITDA (£000)	-2837.0	2,303	-368.0	RED
2	Net surplus (£000) (negative - deficit)	1,421	1,143	- 751	AMBER
3	Cost Improvement Programme (£000)	1,366	1,366	1,366	GREEN
4	Capital expenditure (£000)	5,936	3,974	1,779	AMBER
5	Monitor FRR	4	3.5	3.5	GREEN
6	Cash balance (£000)	12,597	35,051	36,512	GREEN

WORKFORCE

	Workforce measures	Target	Current month	Previous month	Year end forecast
1	Staff Turnover % All Trust	8.5%	14.0%	13.9%	RED
2	Vacancies (%) All Trust	5.0%	-17.2%	-16.4%	RED
3	Paramedic Vacancies against EST		358	360	RED
4	Vacancies as number for All Trust		905	858	RED
5	Paramedic Leavers	6 per week	11	17	RED
6	Sickness (%) All Trust	5.0%	6.5%	6.4%	RED
7	Sickness (%) Frontline	5.0%	7.2%	7.0%	RED

Supporting Commentary for exceptions against specific quadrants

QUALITY

Commentary: There were 8 Serious incidents declared in month 9 which is an increase of of four incidents on the previous month. The declaration of such incidents don't necessarily relate to calls attended in month 9. Complaints showed a reduction in month 9 but were significantly above the target measure. The majority of complaints were associated with delayed response times. Patients in Category C groups suffered a further degradation in the quality of service they received from the Trust. This was predominantly driven by the substantial increase in Category A activity in month 9. The increase in activity also hindered our ability to meet the national call handling targets for both 999 and NHS 111 in month 9. The overall response time distribution curve for both Red 1 and Red 2 patients deteriorated in month 9. Escalation of the surge plan was consistently required in month to try to manage demand and protect resources to send to the most serious and life threatening calls. The Trust escalated the REAP level to level 5 on the 11 December in light of the intense operational pressure the Trust was under. This was reviewed by the EMT on a weekly basis throughout the month.

WORKFORCE

Commentary: Workforce metrics remained fairly static in month 9 compared to previous month. Whilst the number of Paramedics leaving decreased in month 9 the overall vacancy factor did increase. This is in part due to a number of new EAC recruits failing their training course and therefore leaving the Trust. Robust recruitment plans are now in place and are reviewed weekly. A new training facility has opened in SW London in order for the Trust to increase its capacity to deliver training to new recruits. Sickness continues to pose a challenge to the Trust particularly in frontline operations.

PERFORMANCE / ACTIVITY

Commentary: The Trust failed to achieve the national response time targets for Red 1 and Red 2 as well as A19 in month 9 and saw a deterioration in performance against key metrics. This was principally driven by activity which for Category A incidents was 7.6% above contracted levels. Category A activity peaked in the week ending the 21 December and the Trust responded to over 11,200 Category A incidents, the busiest week in the Trust's history. Operational resourcing hours was broadly in line with our forecasted position but activity had a significant effect on our productivity ratio and performance outturn. The Trust enacted surge Purple for 62% of the total hours in month 9 and the Clinical Hub dealt with over 18,000 calls without the requirement to send a resource. This is the highest level of Hear and Treat delivered by the Trust to date. A bespoke 3 week operational plan was implemented as part of Christmas and New Year preparedness on the 15 December and ran through to the 4 January 2015.

VALUE FOR MONEY

Commentary: In month the Trust is reporting £0.3m adverse to plan. and year to date the Trust is £1.2m adverse to plan. This is as a result of increased expenditure in support of frontline perfomance. THis is partly supported by additional resilience monies from CCGs.
The Trust forecast has move to a reduced surplus position of £1.0m as a result of the need for additional spend in support of performance improvement. The Trust remains on track to deliver its £13.8m CIP. The Trusts cash position remains robust and is significantly ahead of plan, this is mainly due to underspend on capital. Capital Expenditure is expected to be on plan at £16.9m by the end of the year. Against the Continuity of Service Risk Rating used by Monitor to assess aspirant Foundation Trusts , LAS has scored a 3.5 which is a good score and in excess of the Trust's plans (3.5

Supporting Action for exceptions against specific quadrants

QUALITY

Actions: Actions within the Improvement programme will drive up quality as we start to see increased operational capacity and decreased demand as is the case in the first part of Q4. We are focussing on having sufficient clinical staff on duty in the clinical hub and these staff will be further supported by an additional 12 nurse that have been recruited to also work on the Clinical Hub. We have been working with NHSE (London) to reduce the number of Category C calls from NHS 111 providers to assist us in managing inappropriate demand for ambulance resources. We are also piloting a different way of managing calls from Healthcare professionals. We continue to utlise PTS vehicles to provide transport to those patients who do not require any clinical intervention but do need transportation to protect our frontline resources to attend those patients who are most serios and life threatened.

PERFORMANCE / ACTIVITY

Actions: The Performance Improvement programme continues to deliver against the projects contained within it and is subject to formal review through the Programme Board chaired by the CEO. The majority of demand management actions are routinely delivering the expected benefits. The main focus is on actions to increase capacity in the short term as the Trust recruits new staff. This is being achieved by procuring additional PAS resource (subject to availability) and incentivising key shifts made available on overtime. There has been a comprehensive review of the Trusts bank system and we are now actively recruiting to this to provide more capacity. Another area of focus is FRU performance and a number of actions are underway to provide additional FRU hours at key times to improve overall performance. The Trust is also developing a more spohisticated predictve model to use as part of operational planning. We are working with subject matter experts from an external consultancy to achieve this

WORKFORCE

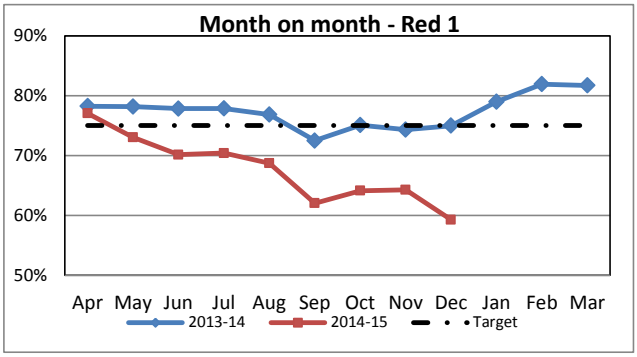
Actions: The Trust now has robust recruitment plans in place for both Paramedics and Trainee Emergency Ambulance Crew. The Director of Strategy and Transformation is now the executive lead in recruitment and reviews the delivery of the plan on a weekly basis with EMT. Quarter 4 will see in the region of 200 new staff of both grades joining the Trust. There are also robust plans in place for further recruitment in 2015/16. This includes a second trip to Australia scheduled to take place in March to continue our current plans to recruit graduate Paramedics. Currently there are 109 existing Australian Paramedics that will join the Trust between now and the end of March. These recruits will receive a three and a half week induction before becoming fully operational. Actions to improve attendance are now built in to the Performance improvement programme and will deliver actions to deal with both short term and long term sickness in frontline operations

VALUE FOR MONEY

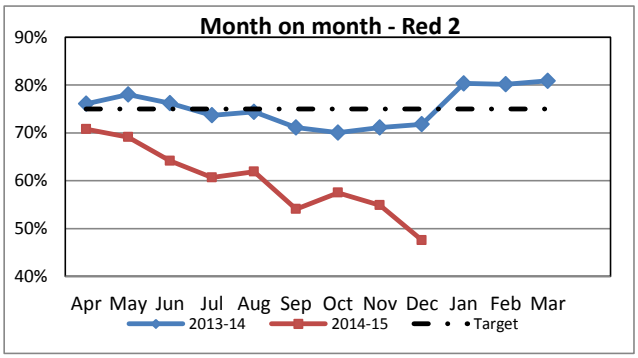
Actions: Continued monitoring of the financial position as the Trust approaches year end is essential, to ensure all available funding is used to support frontline activities. Capital expenditure plans are expected to be fulfilled by year end, where appropriate support needs to be provided to ensure this happens.

PERFORMANCE / ACTIVITY

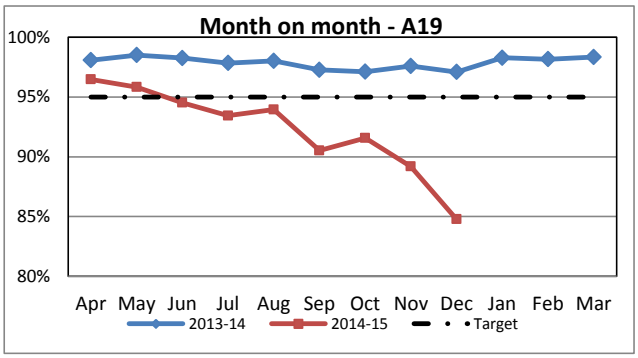
1. Cat A - Red 1 Performance



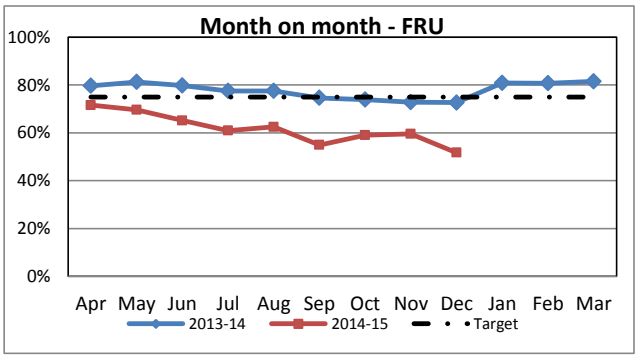
2. Cat A - Red 2 Performance



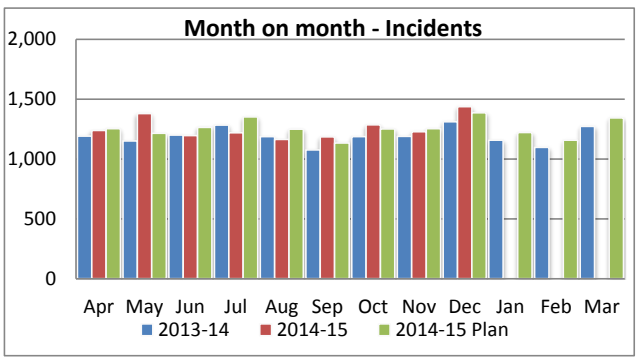
3. Trust A19- Performance



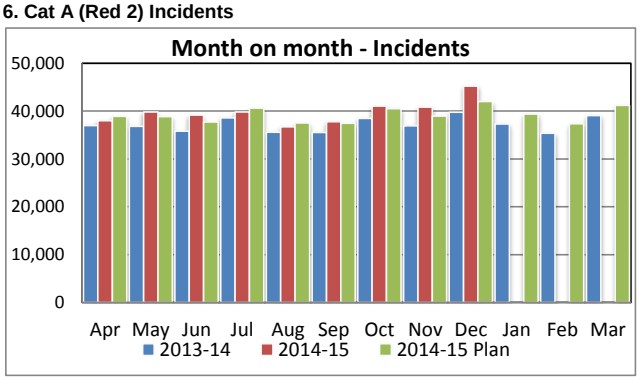
4. FRU A8 - Performance



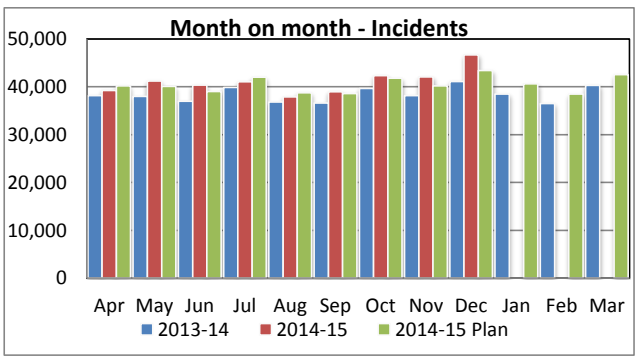
5. Cat A - (Red 1) Incidents



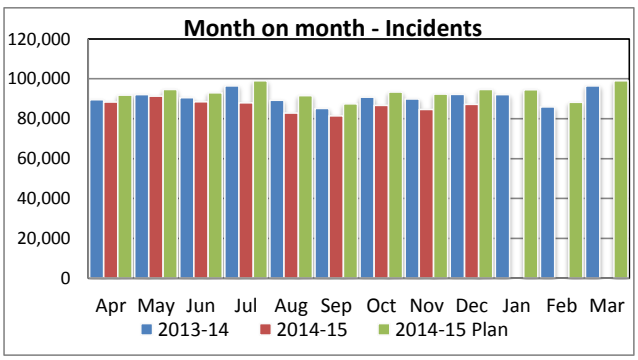
6. Cat A (Red 2) Incidents



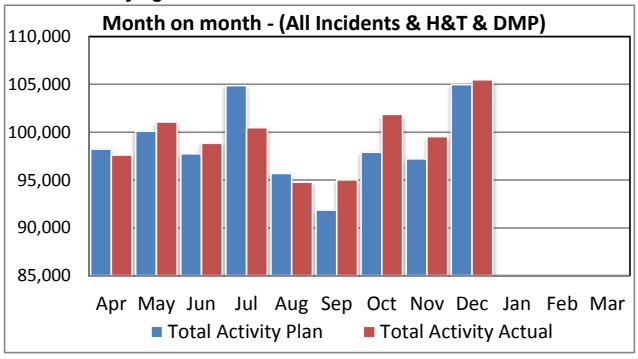
7. Cat A - Total Incidents



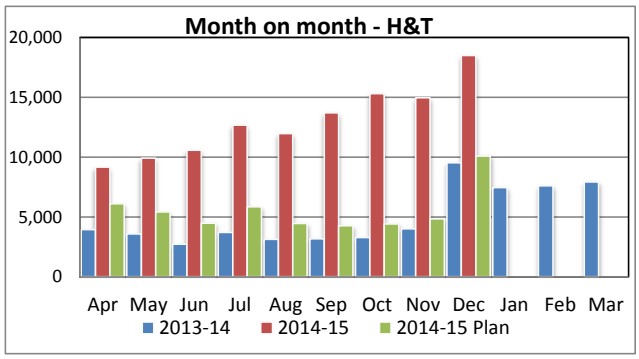
8. Total Incidents



9. Total Activity against Plan

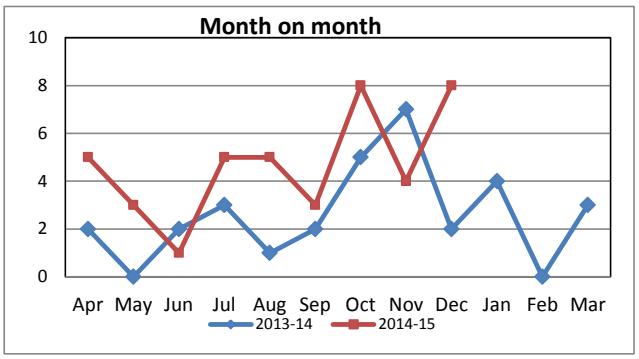


10. Clinical Hub H&T Discharges

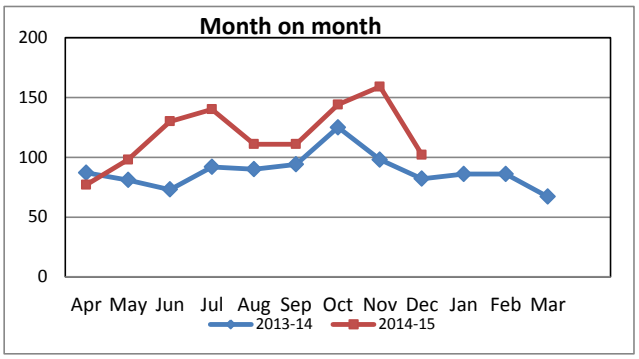


QUALITY

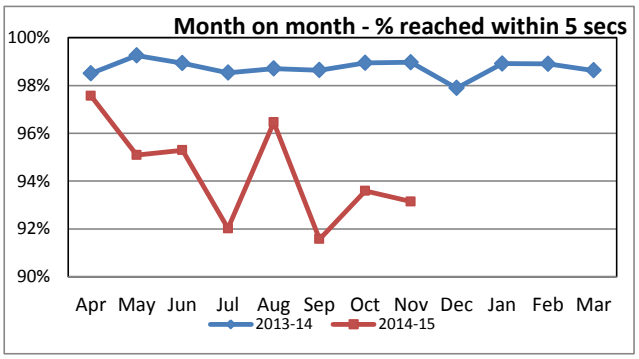
1. Serious Incidents declared



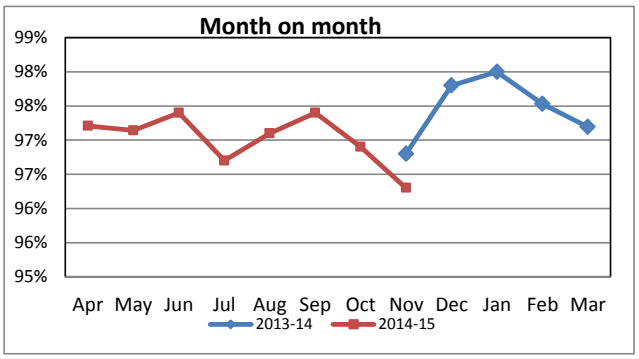
2. Complaints received



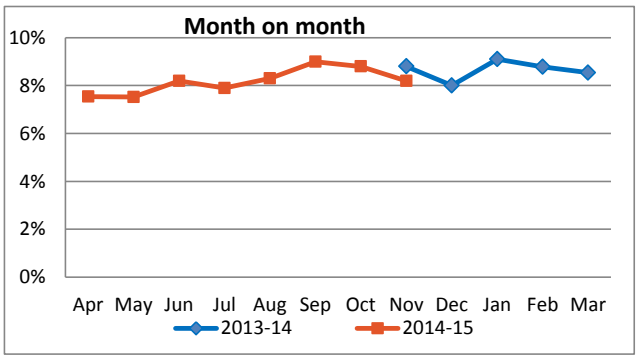
3. 999 Call Answering - 5 secs



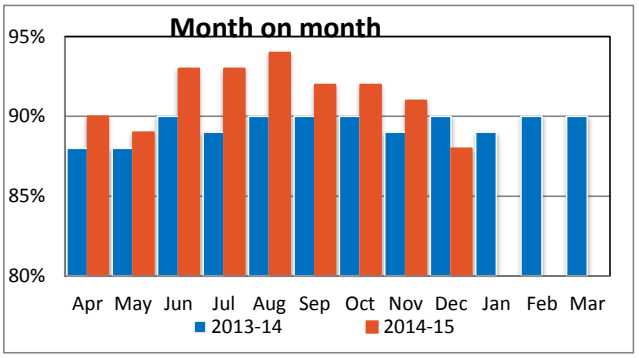
4. NHS111 Call Answering- 60secs



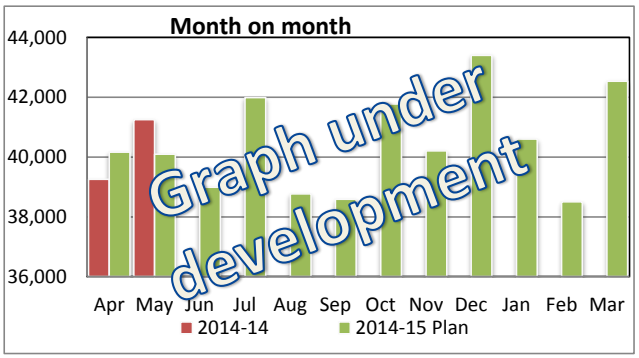
5. NHS 111 Transfer rate to 999



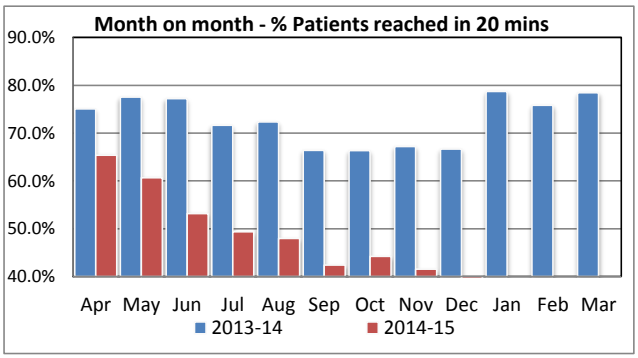
6. Aspects of care compliance (MH)



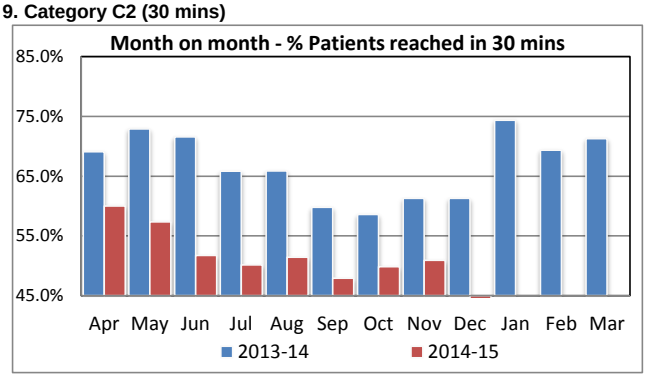
7. Deep Clean of vehicles % completed



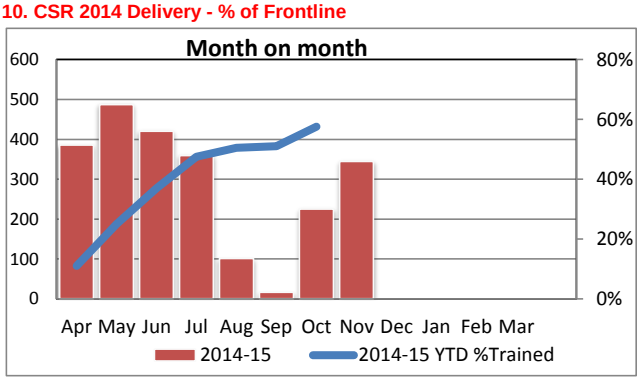
8. Category C1 (20 mins)



9. Category C2 (30 mins)

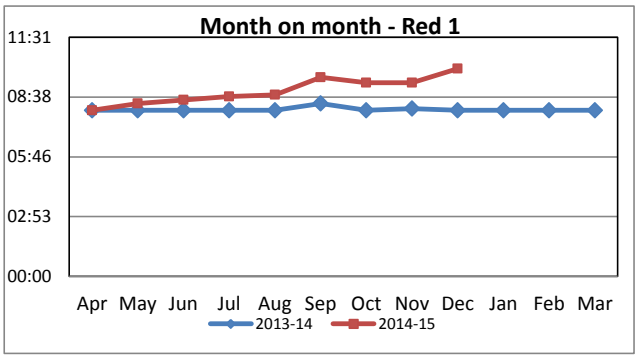


10. CSR 2014 Delivery - % of Frontline

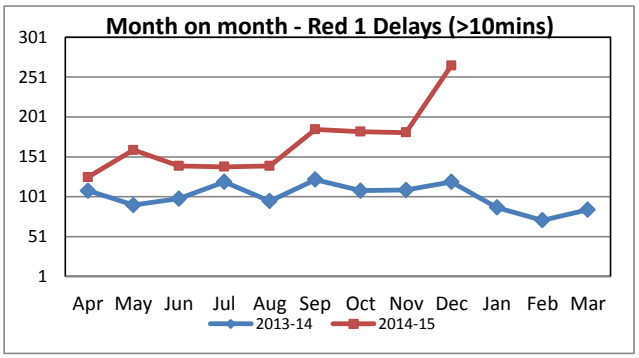


SAFETY

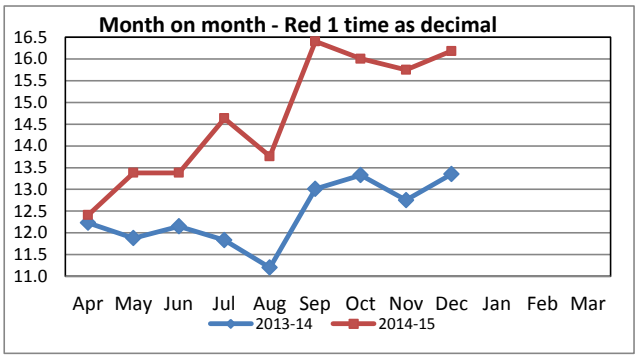
1. Red 1 - 75% reached in Mins/secs



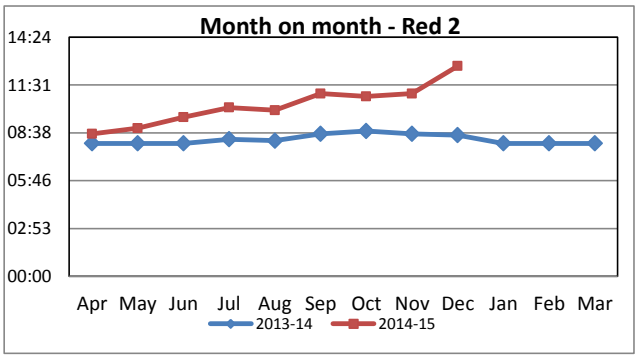
2. Red 1 - number of responses>10mins



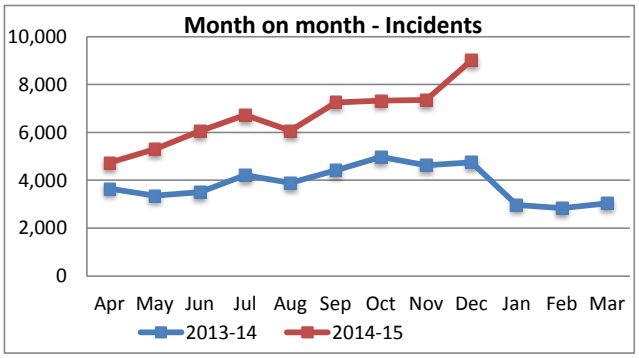
3. Red 1 - Time to get to 95th Percentile



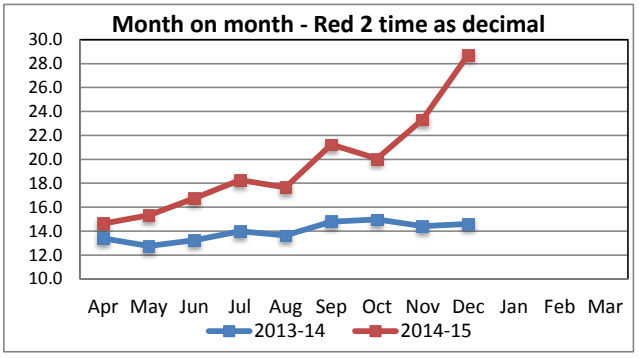
4. Red 2 - 75% reached in Mins/secs



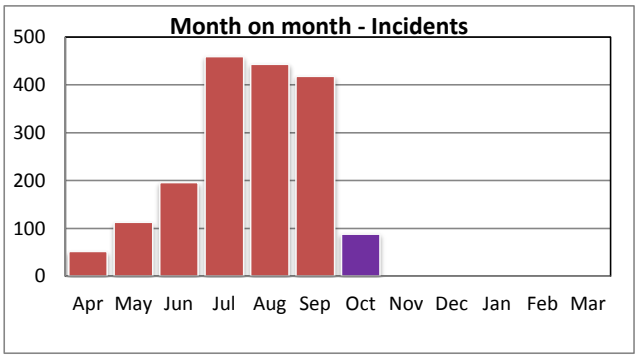
5. Red 2 - number of responses>10mins



6. Red 2 - Time to get to 95th Percentile

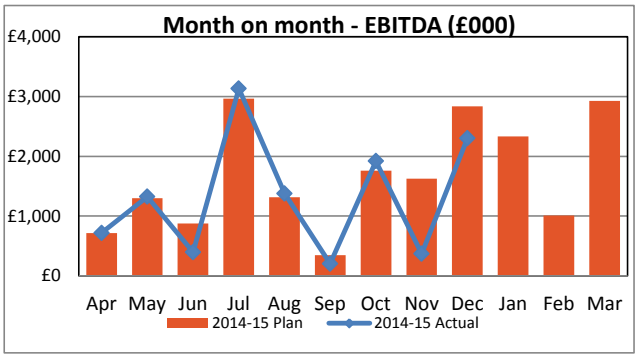


7. Surge plan escalation > Amber (Hours)

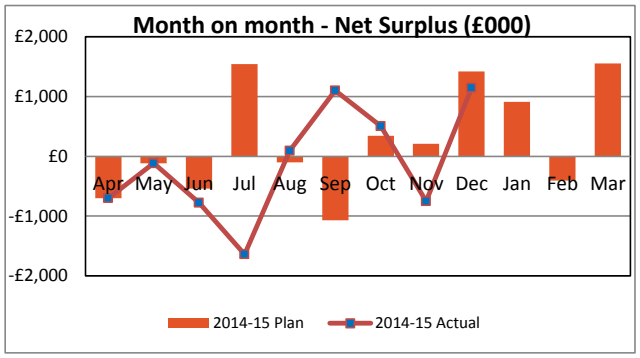


VALUE FOR MONEY

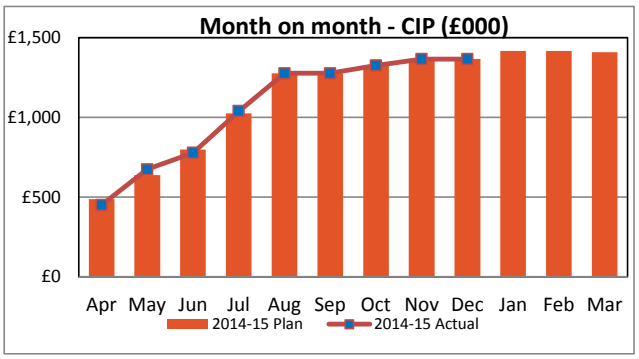
1. EBITDA (£000)



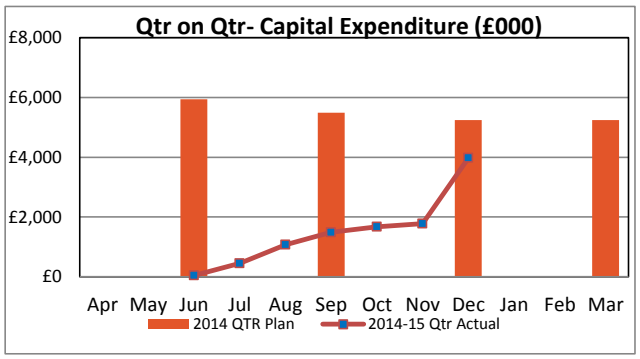
2. Net Surplus (£000)



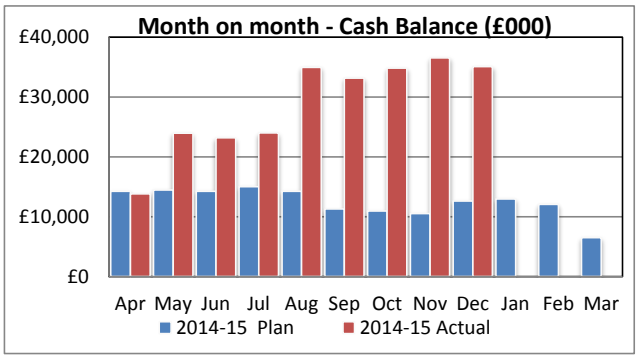
3. Cost Improvement Programme (£000)



4. Capital Expenditure (£000)

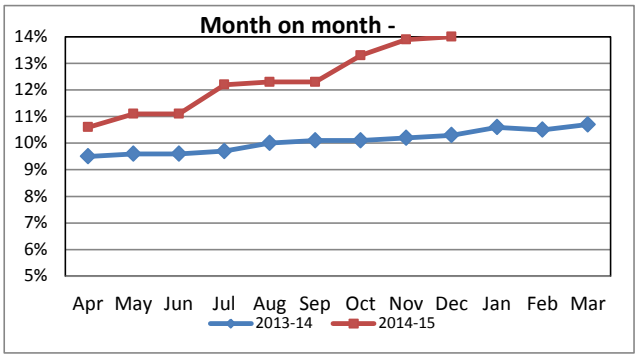


5. Cash Balance

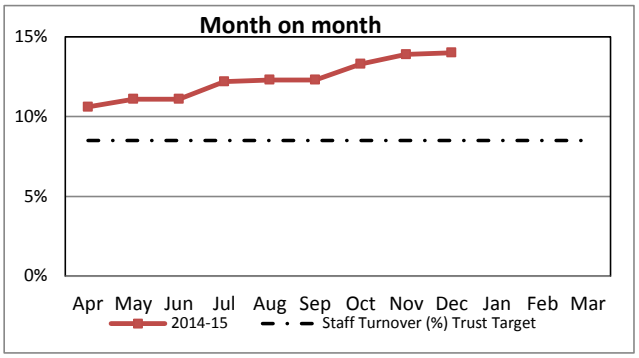


WORKFORCE

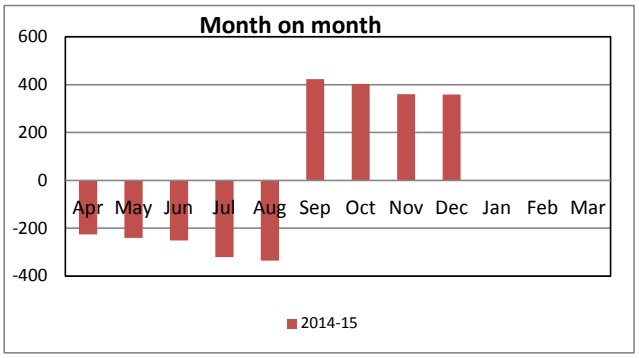
1. Staff Turnover



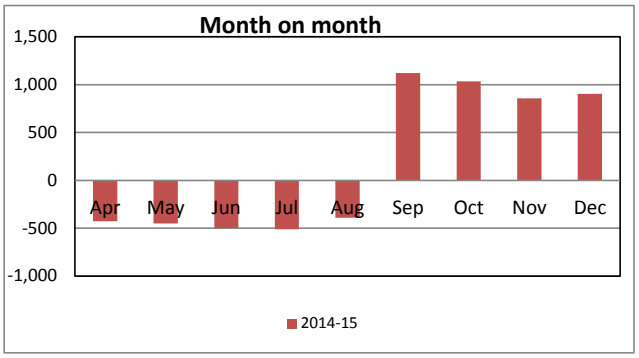
2. Vacancies (%)



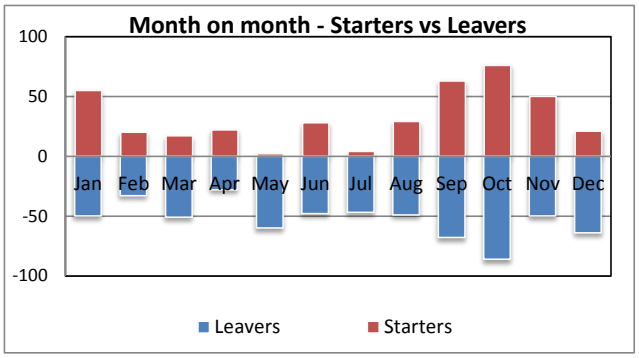
3. Vacancies (WTE) - Paramedic



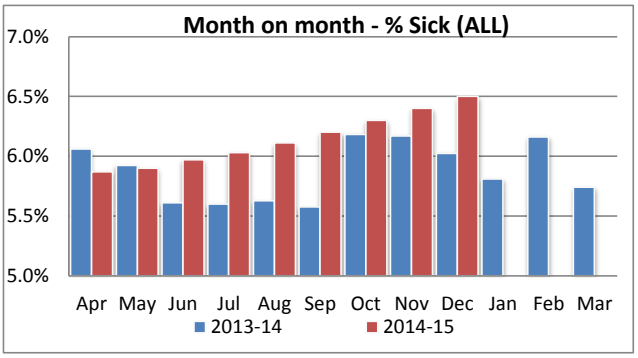
4. Vacancies (WTE) - All Trust



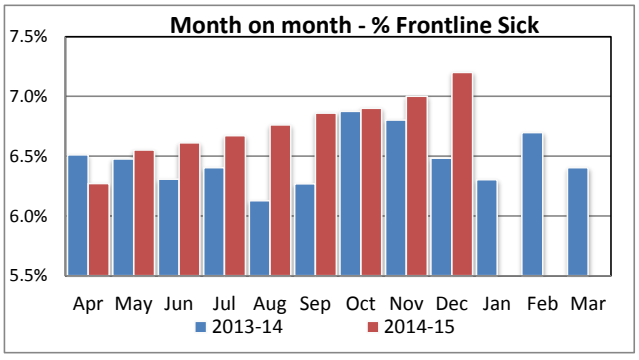
5. Starters vs Leavers



6. Sickness - All Staff (%)



7. Frontline Sickness (%)



London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Board Assurance Framework and Trust Risk Register (Strategic Risks)**
Report Author(s):	**Frances Field, Risk and Audit Manager**
Presented by:	**Sandra Adams, Director of Corporate Affairs**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
History:	**Quality Committee** **Audit Committee** **Executive Management Team**
Status:	**Board Assurance Framework and Trust Risk Register (Strategic Risks) updated to reflect current status of risks - January 2015**

Background/Purpose

Board Assurance Framework

The attached Board Assurance Framework (BAF) was updated in January 2015 and changes to the BAF since November 2014 are set out in the tables below:

a) The following new strategic risk has been added to the Trust Risk Register since November 2014 and now appears on the BAF.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	Change to rating since last review
427	There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots around pay arrangements.	5	4	20		5	1	5		5	3	15	

b) The following strategic risks have been re-graded since November 2014.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	rating prior to last review
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.	4	5	20		4	3	12		4	3	12	⇩ 4 4 16 (net rating)
The Medical Directorate reviewed the risk on 18/12/14 and proposed to regrade net rating from major x likely = 16 to major x possible = 12.													
382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	5	4	20		5	2	10		5	3	15	⇧ 5 1 5 (target rating)
The Medical Directorate reviewed the risk on 18/12/14 and proposed to increase to a target rating which was more realistic, from catastrophic x rare = 5 to catastrophic x unlikely = 10.													

Board Assurance Framework (BAF)

Draft Risks Mapped to 2014/15 Business Objectives

The attached iteration of this document also includes draft risks prepared by directors with responsibility for key pieces of work mapped to the business objectives. These risks are being formalised by the individual risk owners and will be brought to the Executive Management Team or Senior Management Team for approval and addition to the Trust Risk Register as appropriate. They will therefore not appear on the next iteration of the BAF unless they are formally identified as high risk and qualify for inclusion on it.

Risks Mapped to the Modernisation Programme

It is proposed that going forward the risks that link with the implementation of the modernisation programme are reflected on the BAF within the six other business areas. The rationale for this is that the key pieces of work that were being managed within the programme have now been incorporated into business as usual. For example any residual risk relating to these i.e. the implementation of new rotas, revised clinical career structure, annual leave arrangements, rest break policy etc. are articulated within other risks on the BAF. The next version of the BAF will therefore not include 'Implement the modernisation programme' as a distinct reference point.

Current risk activity on the BAF

With the exception of risk 427 set out above (BAF reference 17) there have been no other risks

added to the Trust Risk Register since November 2014 which qualify for inclusion on the BAF.

Future risk activity on the BAF

There are a number of risks that are currently being worked through with risk owners i.e. the risk relating to category 4 infectious disease organisms and other infectious diseases, increased pressure on the clinical hub, delays on ring backs, the development of a 111 service which will be incorporated into the next iteration of the BAF.

Risk 355 (BAF reference 6) has been split into two risks and has been discussed at the Senior Management Team Meeting. One risk focuses on operational/clinical staff not receiving statutory and mandatory training for and the other on support staff not receiving statutory and mandatory training. These risks were referred back to the risk owners for further development and will be brought back to the SMT in January 2014 for review and approval. These may be reflected in the next iteration of the BAF dependent on their grading.

Trust Risk Register (Strategic Risks)

The attached risk register details all of the strategic risks that have been included in the current BAF with any additions, amendments and deletions set out in the tables above.

Action required

For information and noting.

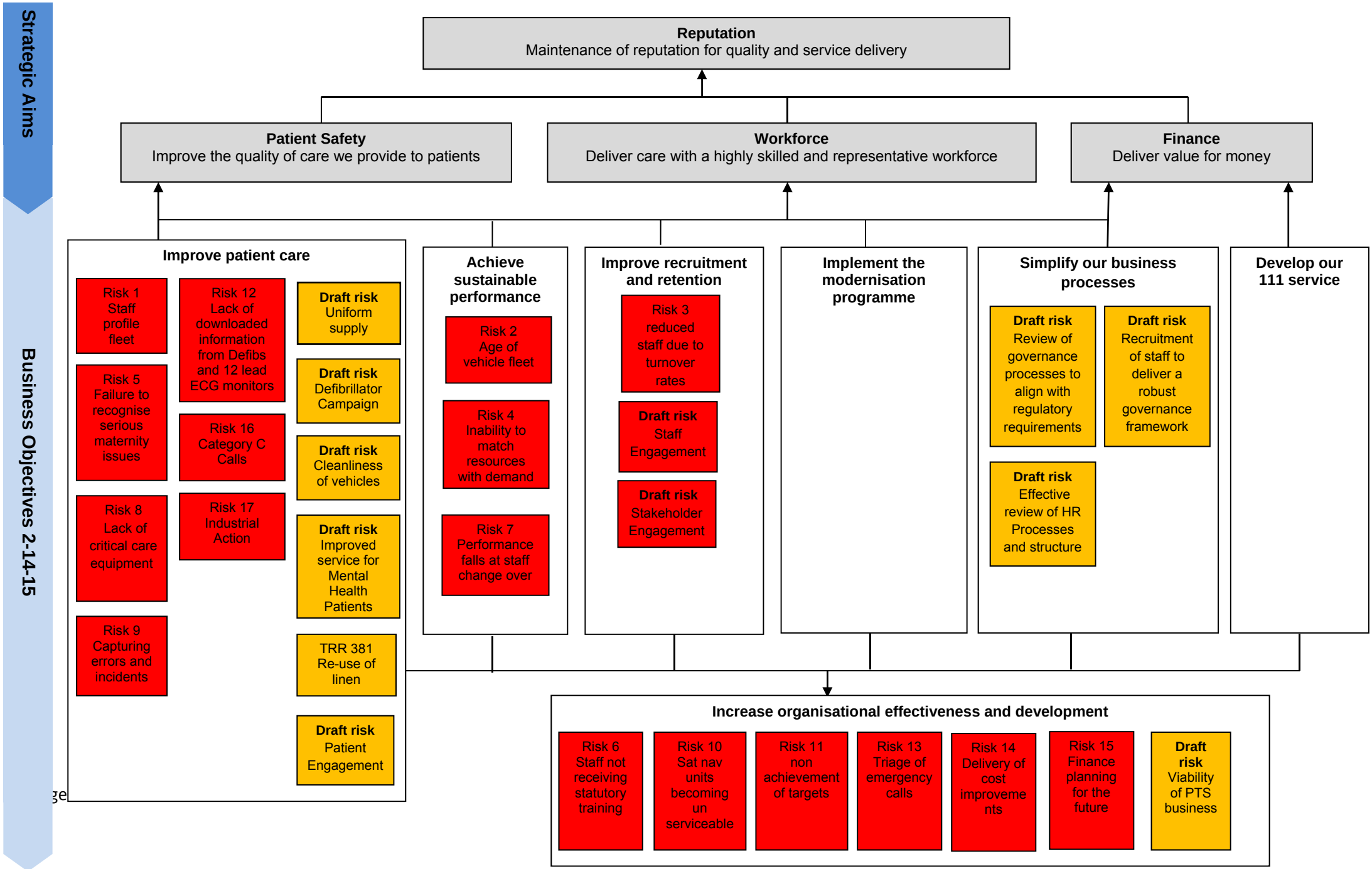
Assurance

To take assurance from the management of the key risks currently facing the organisation and to highlight any potential gaps that need to be addressed.

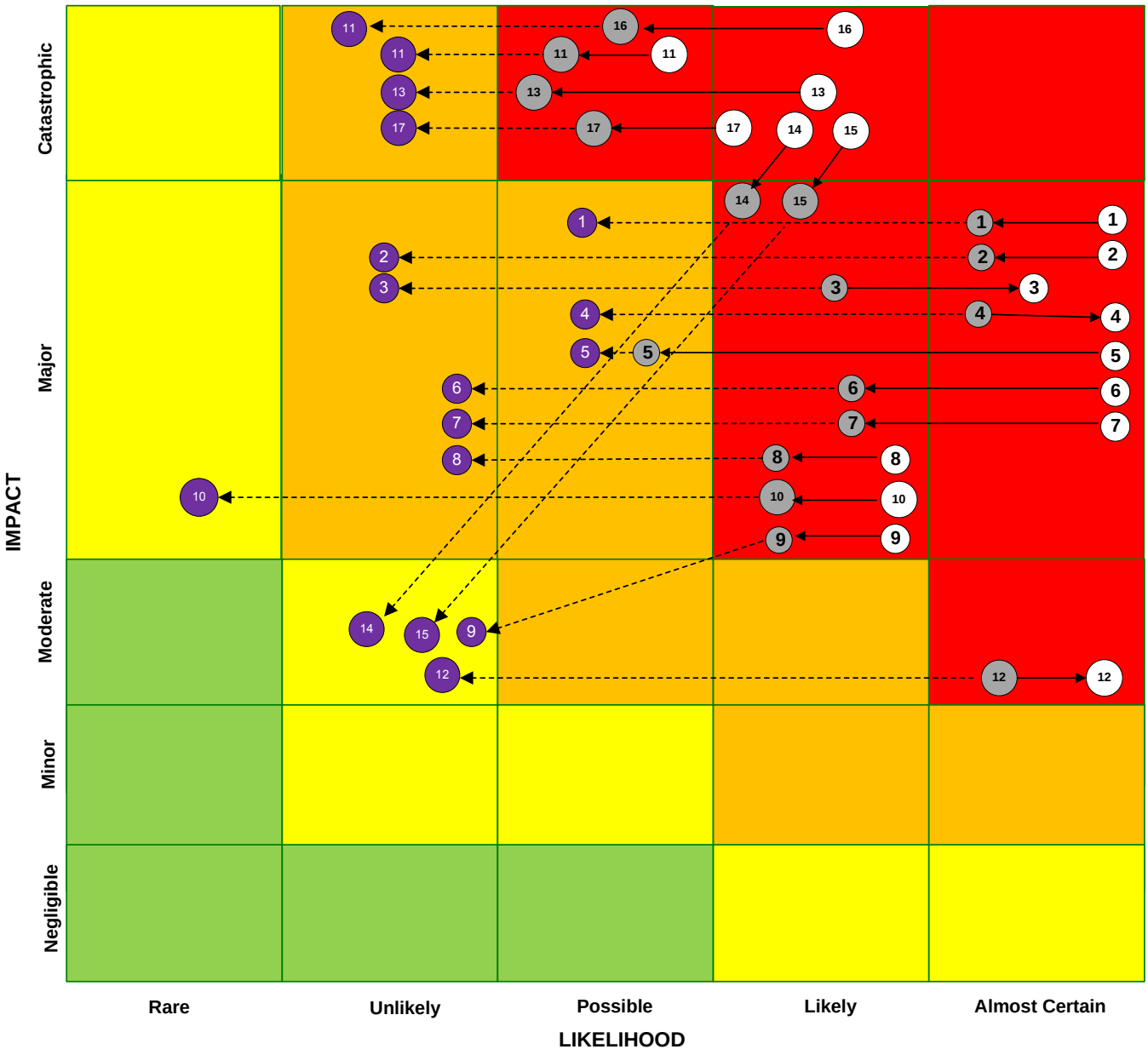
Key implications and risks arising from this paper	
Clinical and Quality	*
Performance	*
Financial	*
Legal	*
Equality and Diversity	*
Reputation	*
Other	* The Board Assurance Framework sets out the key risks to the organisation achieving its strategic objectives. These will need to be closely managed and monitored by the risk owners and timely action taken to mitigate them
This paper supports the achievement of ALL of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

Board Assurance Framework – January 2015

Key Risks to the Strategic Plan



Board Assurance Framework – January 2015



Key:

- Gross risk assessment
- Net risk rating
- Target risk rating

- High Risk
- Significant Risk
- Moderate Risk
- Low Risk

Risk trajectory since October 2014

	BAF Risk 1	RR 402	Potential loss of skills of fleet Workshop Managers and Technicians
	BAF Risk 2	RR 401	Current age profile of the LAS Vehicle Fleet will result in increased downtime
	BAF Risk 3	RR 388	Reduced staff due to turnover
	BAF Risk 4	RR 265	Service Performance affected by the inability to match resources to demand
	BAF Risk 5	RR 31	Failure to recognise serious maternity issues
	BAF Risk 6	RR 355	Staff not receiving statutory training
	BAF Risk 7	RR 269	Performance falls at staff changeover times
	BAF Risk 8	RR 399	A lack of critical equipment on ambulances
	BAF Risk 9	RR 404	Accurately and effectively capturing errors and incidents in accordance with national guidelines
	BAF Risk 10	RR 400	Satellite navigation units becoming unserviceable
	BAF Risk 11	RR 329	Non achievement of contractually agreed targets
	BAF Risk 12	RR 207	Staff not being able to download information from Defibrillators and 12 lead ECG monitors
	BAF Risk 13	RR 382	MPS calls are incorrectly triaged (target rating regraded)
	BAF Risk 14	RR 394	Developing and delivering cost improvements
	BAF Risk 15	RR 396	Finance – effective planning for the future
	BAF Risk 16	RR 410	Patient safety for category C patients
New Risk	BAF Risk 17	RR 427	Patient safety during periods of industrial action

Board Assurance Framework – January 2015

BAF Risk 1 – CRR 402	Potential loss of skills of Fleet Workshop Managers and Technicians					
Risk consequences	Impact on the future resilience of the Fleet Operation					
Risk owners	Director of Finance and Performance / Head of Fleet and Logistics					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Regular cycle of recruitment of Workshop Technicians. This is to ensure that we maintain a robust technical staffing level to deliver the required Planned and Unplanned maintenance activity.		S. Westrope	On-going		
Recruitment aimed at long term temporary staff. This is to ensure that Staff that are trained by the LAS remain and the value of the Training can be realised by the Trust.		S. Westrope			
Overall assessment of control effectiveness –.					

Net risk	Likelihood	5	Impact	4	Score	20
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
Establishment of apprenticeship scheme. This is to ensure that the Trust effectively manages the demographic profile of its Workshop Staff against a national shortage of Technical Engineers.			September 2015	S. Westrope		
Continuing recruitment into vacancies.			On-going	S. Westrope		
Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: Director of Finance and Performance / Head of Fleet and Logistics Signed: ..... Date: 6th January 2015

Board Assurance Framework – January 2015

BAF Risk 2 – CRR 401	Current age profile of the LAS Vehicle Fleet will result in increased downtime					
Risk consequences	Impacting on operational performance and implementation of the modernisation process.					
Risk owners	Director of Finance and Performance / Head of Fleet and Logistics					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Capital programme for 2014/15 includes 104 replacements of vehicles that are over 7 years old		S. Westrope			
Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that Unplanned Maintenance levels do not adversely affect Fleet Capacity and the provision of a safe environment to Operational Staff		S. Westrope			
Monitoring the productivity of planned maintenance and throughput of unplanned maintenance against backlog. This is to ensure that the Fleet asset condition remains in a safe condition.		S. Westrope	On-going		
Overall assessment of control effectiveness –.					

Net risk	Likelihood	5	Impact	4	Score	20
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
Agree comprehensive 5 year replacement plan.			March 2015	S. Westrope		
Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: Director of Finance and Performance/ Head of Fleet and Logistics **Signed: .....** **Date: 6th January 2015**

Board Assurance Framework – January 2015

BAF Risk 3 – CRR 388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers					
Risk consequences	Impacting the Trust's ability to deliver safe patient care.					
Risk owners	Interim Director of HR					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
NHS staff benefits (e.g. pensions, T&Cs, etc.)	Yes	Mark Gammage	Annual	Currently EMT. Possible new Workforce Committee to report Finance and Improvement Committee	Ineffective
LAS staff benefits (e.g. cycle scheme)	Yes	Mark Gammage	Annual	Currently EMT. Possible new Workforce Committee to report Finance and Improvement Committee	Unknown
LAS retention staff benefits (EMT suggestions)	No	Mark Gammage	Quarterly	Currently EMT. Retention Strategy action plan via Performance Improvement Board	Unknown
Listening into Action - to understand staff improvements.	Yes	Charlotte Gawne	Annual	Reviewed at EMT	Effective
~~Developing the modernisation programme – including rota reviews and development of a clinical career structure.~~	~~Yes~~	~~Paul Woodrow~~	~~2014/15~~	~~Modernisation Programme Board~~	
Actively recruiting university and registered paramedics and emergency ambulance crew	Yes	Karen Broughton	Weekly	Recruitment activity reviewed fortnightly at EMT	Effective
Monitoring and developing plans to address trends in turnover. Retention Strategy agreed in principle at EMT 7 January 2015. Data to include establishment, vacancies, stability, turnover (split between paramedics and other), and sickness rate. To include trends and benchmarked data.	Yes	Mark Gammage	Monthly	Currently EMT. Retention Strategy action plan via Performance Improvement Board	Unknown

The use of overtime, private and voluntary ambulance services to increase the number of available resources. Impact on utilisation rate, i.e. to reduce it.	Yes	Jason Killens	Fortnightly	Performance Improvement Board	Partial
Clinical support structure provides career progression opportunities, with on-going training development	Yes	Mark Whitbread	Monthly	Training Committee ?	Partial
Revision of the Exit Surveys to provide accurate information on staff who leave, i.e. NHS, competitors, etc. and reason for leaving	Yes	Mark Gammage	Monthly	EMT/PIB (from 1 Feb)	Partial
Retention data of resignations, projected leavers, projected joiners to identify reasons for resignation and opportunity to take intervention action.	Yes	Mark Gammage	Weekly	Report to CEO (from 1 Nov 2014)	Partial
~~**June 2014 - David Prince agreed escalation of risk rating from major x likely = 16 to major x almost certain = 20 due to current levels of staff turnover**~~ **Proposal to downgrade net rating from major x certain = 20 to major x likely = 16, to be approved by EMT.**					
Overall assessment of control effectiveness					

Net risk	Likelihood	5	Impact	4	Score	20

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Development of Clinical Career Structure.	Completed	Fionna Moore		
Skill mix review.	On-going	Jason Killens		
Review exit interview process and data capture.	On-going	Mark Gammage	Currently EMT. Possible new Workforce Committee to report to Finance and Improvement Committee	As part of Retention Strategy
Review and update rewards and retention strategy. Discussion at EMT regarding framework / strategy to address 5 key actions that assist retention.	2014/15	Mark Gammage	Currently EMT. Possible new Workforce Committee to report to Finance and Improvement Committee	Draft Retention Strategy to EMT 7 Jan 2015

Promote learning and development opportunities.			TBC	Karen Broughton		
Recruitment drive to fill vacant established posts. Recruitment group meeting fortnightly identified 6-7 streams from which paramedics can join the service, also establishing the process to enable this.			On-going	Karen Broughton		
~~Implementing the modernisation programme~~			~~December 2014~~	~~Paul Woodrow~~		
Exercise taking place to look at a sample of leavers to assess reasons for leaving			~~December 2014~~ - Completed	Mark Gammage	Weekly – joiners, leavers, reasons for leaving, intervention interview details	Weekly data report to CEO since 1 Nov 2014
Develop a Health and Wellbeing Strategy			March 2015	Tony Crabtree	Currently EMT. Possible new Workforce Committee to report Finance and Improvement Committee	TBC
Target rating	Likelihood	2	Impact	4	Score	8
Risk assigned to: Interim Director of HR	**Signed:**		**Date**: 3rd January 2015			

Board Assurance Framework – January 2015

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

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
On-going recruitment to vacancies.	Yes	Karen Broughton	Weekly	Recruitment activity reviewed fortnightly at EMT	Partial
Use of voluntary and private sector at times of peak demand. Increased as of September 2014.	Yes	Jon Goldie	On-going	Weekly performance monitoring meetings with PA consulting	Effective
Use of agency Paramedics to enhance bank scheme.	Yes	Nikki Fountain	On-going		Partial
New rosters implemented successfully.	Yes	Steve Kime	One off		Effective
Targeted use of overtime and increased bonus payments.	Yes	Paul Cook	As necessary		Effective
Surge plan was reviewed again in December 2014	Yes	Jason Killens	Weekly	ADO's review surge plan as required	Effective
Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories. This enables us to carry out an enhanced clinical assessment in the clinical hub on an additional 90,000 calls a year. A percentage of these circa 35% will be discharged through Hear and Treat	Yes	Fionna Moore			Effective
Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls. This reduction when achieved will provide capacity to respond to a further 300 calls a day within our existing capacity.	Yes	Katy Millard	One off		Effective
An extension in the operating hours for active area cover was implemented on the 21st July 2014.	Yes	Jason Killens	Completed		
METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.31.	Yes	Katy Millard	On-going		

Overall assessment of control effectiveness	

Net risk	Likelihood	5	Impact	4	Score	20

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Sickness management. A performance management dashboard is being developed. The occupational health contract is being reviewed.	On-going	Paul Woodrow	Weekly	
Roster review: Rosters for all complexes have been agreed and implemented.	Completed	Mick Pearce		IPG minutes.
Skill mix: the skill mix model has been updated in December 2014 to include international recruits.	Completed	Jason Killens / Mark Whitbread	As required	
Annual leave review: a revised annual leave policy is in its final draft stage. We are revisiting the proposed draft policy with a view to consult with trade unions with a view to implementing a revised annual leave arrangements as defined in the policy by the end of Q2 2015.	~~September 2014~~ September 2015	Steve Sale		
The new response model: a request for change (RFC31) has been approved and is under developed by the CommandPoint supplier. The software was delivered in August but did not pass testing and there have been several re-releases since. We expect the final release, with all known errors corrected, to be delivered 24/12. Testing will recommence but is constrained by release of testers (CAD trained staff) from the control room. Implementation of the software will only occur once testing has been successfully completed (anticipated end of February 2015).	April 2015	Jason Killens		
Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role (December 2014), overseas recruitment of paramedics (on-going), in-house conversion from EMT to paramedic 2014/15, university paramedic recruitment (October 2014), military recruitment. Retention; exit interviews, research reasons for leaving, consider reward and recognition initiatives, career progression and support.	Q4 2014/15	Karen Broughton / Tony Crabtree		
Improve provisioning and reduce calls through the use of PTS and taxi service.	On-going	Jon Goldie/ Katy Millard	Weekly	Performance Improvement Meetings with PA Consulting
Clinical triage of Red 2 calls.	On-going	Katy Millard	Weekly	
Activation desk – to manage incidents.	On-going	Katy Millard	Weekly	

Target rating	Likelihood	3	Impact	4	Score	12

Risk owned by: Director of Operations **Signed:** ..... **Date:** 22nd December 2014

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

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development.	Yes	Consultant Midwife	On-going	Serious Incidents Clinical Audit	Partial
A deep dive audit was carried out which was reported to the Quality Committee in Autumn 2014. To be repeated as required.	Yes	Clinical & Quality Directorate / Consultant Midwife	One-off		Partial
Review incidents reported through LA52's, Patient Experiences and legal Claims relating to problematic obstetric incidents.	No	Consultant Midwife	Quarterly	Patient Voice & Service Experience Report CQSEC Learning from Experience Group	Partial
Maternity care update articles in the Clinical Update.	Yes	Clinical & Quality Directorate / Consultant Midwife	As required		Effective
Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife.	Yes	Director of Paramedic Education & Development	One-off	CSR completion rate	Partial
Pan-London Maternity Divert Policy (Updated Sept. 2013): Robust framework to limit temporary closures of maternity units and to organise redirection.	Yes	NHS England (London)	On-going	EBS Maternity Alert Report (detailing maternity unit activity and closure); Review by Consultant Midwife and Deputy Medical Director	Effective
POETS e-learning programme in place.	Yes		On-going for one year		Partial
Drop in sessions arranged by new consultant midwife.		Consultant Midwife			Partial

Board Assurance Framework – January 2015

Risk reviewed by Medical Directorate 18th December 2014 proposed to re-grade net rating from major 4 x likely 4 = 16 to major 4 x possible 3 = 12. Approved by the SMT group on 14/01/15.						
Overall assessment of control effectiveness						
Net risk	Likelihood	~~4~~ 3	Impact	4	Score	~~16~~ 12
Plan to improve controls where control effectiveness is ranked red or amber			Due	Who will perform	Frequency	Evidence
Director of Paramedic Development & Education to directly oversaw delivery of CSR 2013/2014.			Completed	Director of Paramedic Education & Development	One-off	Training records CSR completion rate
Consultant Midwife appointed to provide professional advice and education. Update post from 0.2 WTE to 0.6 WTE to increase availability and impact through obstetric education.			Substantive Consultant Midwife starts in January 2015	Medical Director	One-off	Appointment made
Obstetric emergency decision tool to be put in place.			From December 2014	Fiona Scarlett		
Target rating	Likelihood	3	Impact	4	Score	12
Risk owned by: Medical Director	Signed:		Date: 5th January 2015			

Board Assurance Framework – January 2015

BAF Risk 6 – CRR 355	There is a risk of staff not receiving clinical and non-clinical statutory training.					
Risk consequences	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills					
Risk owners	Director of Paramedic Education and Development					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Agreement with operations that there will be an agreed abstraction of up to 90 staff per week to attend CSR during agreed periods.	Yes	Resource Centre	Training periods are set to achieve agreed quotas of staff training	Modernisation Recruitment and Training Group	Effective
Paramedic registration.	Yes	Individual Paramedics and HCPC		Local managers monitor registration	Partial
Bill O'Neil and Jane Thomas have reassessed the risk following a session to review statutory and mandatory training. The two new risks will be reviewed by SMT in early November. Two risks taken in December to SMT, who requested further detail is added and brought back for approval.					
Overall assessment of control effectiveness					

Net risk	Likelihood	4	Impact	4	Score	16
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
The TNA which applies to April 2014 to be reviewed and agreed by TSG.			May 2014	Jane Chalmers	One off	
A workbook has been developed for Infection prevention and control it will be launched shortly.			Complete	Jane Thomas		
Use of OLM for recording of CSR 1 will commence from October 2012.			Complete	Pat Billups		
Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.			On-going	Paul Cook		
Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by:	Director of Paramedic Education and Development	**Signed:**	.....	**Date**:	28th October 2014

BAF Risk 7 - CRR 269	There is a risk that at staff changeover times, LAS performance falls					
Risk consequences	Fall in performance					
Risk owners	Director of Operations					
Gross risk	Likelihood	5	Impact	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Daily monitoring of rest break allocation to resolve end of shift losses.	Yes	Duty Area Operations Manager	Daily	By Area Operations Manager reporting to on call Assistant Director of Operations	
Use of bridging shifts for VAS/PAS.	Yes	Jon Goldie			
Roster reviews/changes include staggered shifts.	Yes	Steve Kime	Completed		Effective
Incident management control desk within EOC	Yes	Katy Millard	Weekly	Performance Project Meeting PA Consulting	
Overall assessment of control effectiveness					

Net risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Agree and implement changes to rest break arrangements.	2015/16	Tony Crabtree / Jason Killens		
Rota changes to be implemented as result of ORH review	Completed	Jason Killens		
Recruitment	Q4 2014/15	Karen Broughton		
Skill mix: the skill mix model has been updated in December 2014 to include international recruits.	Completed	Jason Killens		Modernisation Programme Board minutes
On-going vigorous management of out of service. J. Killens to set improvement trajectory to get out of service levels back within target.	On-going	Kevin Brown / Sean Westrope		Weekly tracking report

Proactive use of the surge plan			On-going	Assistant Directors of Operations	Continuous	
Out of service being HUB implemented			On-going	TBC		
Target rating	Likelihood	2	Impact	4	Score	8
Risk owned by: Director of Operations	**Signed:**	.....	**Date**: 22nd December 2014			

Board Assurance Framework – January 2015

BAF Risk 8 – CRR 399	A lack of critical equipment on an Ambulances					
Risk consequences	This potentially affects the ability of a crew to provide the appropriate response at a scene which may delay treatment to the patient.					
Risk owners	Director of Finance and Performance					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Vehicle Daily Inspection completed by the VP Teams		VP Teams	Daily	Vehicle Daily Inspection Sheet/Checked by crew and/or Initial Auditor/Supervisor	Impact is limited as the VDI sheet is for advice purposes only.
~~Crew to check for critical equipment~~		~~AEU crew staff~~	~~At start of shift~~	~~If equipment missing AEU crew staff to advise EOC who would log in command point. EOC would determine if a crew should be Out of Service and/or a dispatch warning would be attached to the call sign indicating what equipment is missing. EOC to inform DSO to resolve.~~	~~Limited effectiveness as a crew may still be sent to render aid, if not categorised as Out of Service, without critical equipment.~~
Equipment exchange by LSU team, to exchange faulty equipment on a regular basis.		Logistics Support Unit	Daily	Recorded on equipment database and reflected in the F&L weekly KPI performance information.	Availability of equipment on station s will be improved due to improved turnaround times.
Overall assessment of control effectiveness –.					

Net risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	Due	Who will perform	Frequency	Evidence
Assign vehicles to stations	In place	VRC	Once	Allocation of vehicle to crew at start of shift will provide record of use to identify potential source of equipment removal for traceability. VRC to inform DSO.
A process will be put in place advising how equipment can be relocated to a frontline vehicle and an education process to crews by a "leadership" group including a lead DSO from each area.	Project not started	Project not started	Project not started	Project not started
Logistics now holds a central budget to replace broken equipment which is processed through the Logistics Support Unit. This will provide an improved and speedier replacement/exchange service.	In progress	Logistics Support Unit	As and when required due to equipment being sent to Logistics Support Unit either for repair and/or replacement	Recorded on equipment database.
Joint education on equipment issues and continuous declaration of spare equipment. A process will be put in practice advising how equipment can be relocated to a frontline vehicle. A group needs to be set up including a lead DSO from each area.	In progress	Fleet and Logistics and Estates		
Joint site visits by Logistics/Estates advising relevant process involving equipment.	In progress	Fleet and Logistics and Estates		
Improved equipment exchange by the LSU team. Equipment will be carried on their vehicles enabling a swifter exchange. This is dependent upon time of visit by LSU team.	Karen Merritt	~~October 2014~~		
Procurement of additional equipment to equip shells. Further procurement of additional equipment taking place before end of March 2015.	Karen Merritt Karen Merritt	Equipment delivered November 2014 March 2015		

Target rating	Likelihood	2	Impact	4	Score	8

Risk owned by: **Director of Finance and Performance** **Signed:** ..... **Date:** 28th October 2014

BAF Risk 9 – CRR 404	The Trust does not accurately and efficiently capture errors and incidents and process them in accordance with national guidelines and within specified internal procedures (LA52 reporting).					
Risk consequences	Insufficient recorded evidence of reported incidents (total number and quality).					
Risk owners	Director of Corporate Affairs					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
All incidents are reviewed at an internal weekly meeting within the Governance Team and key stakeholders for example Head of Legal, Head of Complaints, Safeguarding Lead, Quality Assurance and Medical Directorate. 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 Incident.	Yes	Governance Team	Weekly		Ineffective
A detailed Serious Incident process 'New Ways of Working' has been developed and approved by Quality Committee on 22nd August 2014.	Yes	Interim Head of Governance	One off		Partial
Weekly Serious Incident Group meetings to review outstanding and pending cases has been moved to bi-weekly meetings which allows the necessary information to be reviewed in more detail.	Yes	Serious Incident Group	Bi-weekly		Partial
Standing agenda item at bi-weekly Senior Management Team meetings.	Yes	Interim Head of Governance	Bi-weekly		Partial
Weekly reports to the Executive Management Team.	Yes	Interim Head of Governance	Monthly		Partial
Weekly reports on individual Serious Incident status to Executive Lead, SMT Lead and Lead Investigator.	Yes	Governance Team	Weekly		Partial
Monthly report to Commissioning which details the whole Serious Incident status and details individual status of each open serious incident and status of de-escalation and closure.	Yes	Governance Team	Monthly		Partial

Progress summary to Audit Committee on the current status of the KPMG August 2013 audit.	Yes	Interim Head of Governance	As requested by Audit Committee		Partial
Training needs analysis has been undertaken and a planned schedule of training within the organisation is being developed, for example Family Liaison Officers and Root Cause Analysis and Lead Investigation.	To be developed				
Regular meetings with KPMG to discuss progress	Yes	Interim Head of Governance			Effective
Overall assessment of control effectiveness –.					

Net risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
The review of the Serious Incident Policy has been undertaken and the draft policy has been completed . It has been agreed that a governance framework will be developed to give a robust foundation and all governance policies and procedures will be linked to the framework	~~End Oct 2014~~ February 2015	S.Adams / D. Halliley		
The review of the governance arrangements to support the incident management process has been undertaken. A deep dive of all Serious Incidents / potential serious incidents from March 2013 to date (August 2014).	Complete	S. Adams / D. Halliley		
The commencement of a review of incidents below 15 is about to commence.	Commence Jan 2015	S. Adams / D. Halliley		
Implement quarterly / 6 monthly of non-escalated incidents for a quality review.	Q4 2014/15	S. Adams / D. Halliley		
Complete the Incident Reporting Project (Phase 2) leading to the roll-out of Datix Web.	Start to scope in Q4 2014/15	S. Adams / D. Halliley		

Target rating	Likelihood	2	Impact	3	Score	6

Risk owned by: Director of Corporate Affairs **Signed: .....** **Date: 3rd January 2015**

Board Assurance Framework – January 2015

BAF Risk 10 – CRR 400	Sat nav units in fleet vehicles becoming unserviceable					
Risk consequences	The impact of failures and inability to repair will build gradually (a rising tide) with increasing effect on fleet maintenance and availability.					
Risk owners	Director of IM&T					
Gross risk	Likelihood	4	Impact	4	Score	16

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party.	Yes	Telent	One Off	Ass Dir IM&T	Partial
Assessment of fault quantities and failure frequencies	In progress	Contract Mgr	Monthly	Contractor report	Contributory information
Overall assessment of control effectiveness –.					

Net risk	Likelihood	4	Impact	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
An early action of the eAmbulance project is to review the specification and carry out market sounding to identify alternative SatNav products. An alternative SatNav device has been identified and a sample has been now acquired	Complete	CAD Support	One Off	Summary report on potential devices.
Software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 4	~~30/8/14~~ June 2015	CAD Support	One Off	Documented development proposal. Initial high level feasibility complete full redevelopment underway (significant project), additional developer resource funding sought.
If a satisfactory alternative device is identified ***AND*** the MDT software development is viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process.. If full functionality can be achieved then action 3 funding and procurement will be progressed.	~~31/10/14~~ Q2 2015	Ass Dir IM&T	One Off	Gating Templates submitted to SMT. Procurement engaged.

~~Development of software &~~ Retrofitting of solution to fleet			TBC	CAD Support	One Off	Retrofitted Satnav device to fleet fully integrated with MDT with no loss of functionality.
eAbmulance project to refine current requirements and procure viable commercial (h/w & s/w) solution, which is likely to require in-house bespoking contribution to ensure overall facilities are not compromised.			TBC	eAmb ProjMgr	Set of project activities	Fully featured MDT/Satnav equipment deployed meeting full operational functional and non-functional requirements.
Target rating	Likelihood	1	Impact	4	Score	4
Risk owned by: **Director of IM&T**	**Signed:**	.....	**Date: 17th December 2014**			

Board Assurance Framework – January 2015

BAF Risk 11 - CRR 329	Non-achievement of contractually agreed targets					
Risk consequences	Financial penalties will be levied on the Trust					
Risk owners	Director of Strategy and Transformation					
Gross risk	Likelihood	3	Impact	5	Score	15

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Continue working with specific mitigation of financial risk. (clarify control with Andrew Grimshaw)					
Monthly finance reports reviewed by Trust Board and SMG.					
Extra financial provisions included for contract risk in 2013/14					
Communications with commissioners.					
May 2014 - Karen Broughton to review risk with a view to reassessing and replacing with a new risk that reflects the current position.					
Overall assessment of control effectiveness					

Net risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Review by Finance and Investment Committee		Andrew Grimshaw / Andy Bell		
Review capacity vs. demand		Jason Killens		
Develop a programme of sustainable performance and performance management (clarify action with Paul Woodrow)		Paul Woodrow		
Develop clear escalation procedures when measuring performance (clarify action with Paul Woodrow)		Paul Woodrow		
Establish relationship with Commissioners (clarify action with Karen Broughton)				
Negotiate suitable operating contract with Commissioners. (clarify action with Karen		Karen		

Broughton)				Broughton		
Recruitment (clarify action with David Prince)				David Prince		
Target rating	Likelihood	2	Impact	5	Score	10
Risk owned by: Director of Strategy and Transformation **Signed:** ..... **Date:** 1st May 2014						

Board Assurance Framework – January 2015

BAF Risk 12 – CRR 207	Staff not being able to download information from Defibrillators and 12 lead ECG monitors					
Risk consequences	Clinical information may not be available when required for patient handover / inquest					
Risk owners	Director of Paramedic Education and Development					
Gross risk	Likelihood	5	Impact	3	Score	15

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Mark Whitbread is the Trust lead for the card readers project,	N				
Card reading and transmission is performed by team leaders	N				
Messages given out at Team Leaders Conferences.	Y				
Encourage more routine downloading of information from data cards.	Y				
LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units.	Y				
New Malden pilot has trialled the transmission of data from the LP15	Y				
A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to pub into a lap top to establish the benefits that come of out of it. The evaluation of this exercise will be reviewed in February 2015.					
Overall assessment of control effectiveness –.					

Net risk	Likelihood	5	Impact	3	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Establish the current resources of LP 1000, how many in use, which complexes carry them,	Complete	M. Whitbread		
Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on.	Complete	M. Whitbread		

Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area.			Complete	M. Whitbread		
Consider roll out of transmittable data from LP15 once vehicle on station. This is not being taken forward.			On-going post N/Malden pilot	M. Whitbread		
A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to pub into a lap top to establish the benefits that come of out of it. The evaluation of this exercise will be reviewed in February 2015			Commence mid December 2014	M. Whitbread		
Put a suggestion forward for it to be included as a CQUIN in the next financial year to the CQRG.						
Target rating	Likelihood	2	Impact	3	Score	6
Risk owned by:	Director of Paramedic Education and Development **Signed:**		.....	**Date: December 2014**		

Board Assurance Framework – January 2015

BAF Risk 13 – CRR 382	Emergency calls from Metropolitan Police Service are incorrectly triaged by the MPS					
Risk consequences	Affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.					
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.31.	Yes	Katy Millard	Weekly	Performance Meetings with PA Consulting	Effective
The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated.	Yes	Katy Millard			
EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately.					
The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning.					
Police have put message on their intranet regarding pressure on the LAS					
August 2014 - J.Killens proposes to review risk grading once METDG is in operation 24 hours a day. CSDEC meeting reviewed in October 2014 and suggested that the status of the impact of these calls is reviewed before proposing to archive this risk. Medical Directorate propose regrading of target rating from catastrophic x rare = 1 to catastrophic x unlikely = 10. Approved by the SMT group on the 14/01/15.					
Overall assessment of control effectiveness					

Net risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.	Completed	Paul Woodrow / Fenella Wrigley		

Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS.			Completed	Paul Woodrow		
Target rating	Likelihood	~~1~~ 2	Impact	~~5~~ 10	Score	~~5~~ 10
Risk owned by: Director of Operations		**Signed:**	**Date:** 22nd December 2014			

Board Assurance Framework – January 2015

BAF Risk 14 - CRR 394	Developing and delivering Cost Improvements					
Risk consequences	**It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the on-going viability and solvency of the Trust.**					
Risk owners	Dof, DDoF, HMA, HFA					
Gross risk	Impact	5	Likelihood	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Appropriate supporting evidence available for CIP.		Executive Lead	Monthly	Report to CIP Programme Board	Partial
All CIPs supported by detailed milestone plan.		Executive Lead	Monthly	Report to CIP Programme Board	Partial
All CIPs embedded in budgets.		DDoF	Monthly	Report to CIP Programme Board	Partial
All CIPs owned by relevant manager.		Executive's	On-going	Report to CIP Programme Board	Limited
Benchmarking of CIP opportunity.		DoF	On-going	Report to CIP Programme Board	Partial
CIP governance clearly defined and in place.		DoF	On-going	CIP Programme Board	Complete
Board/FIC scrutiny of CIP planning and delivery in place.		DoF	On-going	Reporting to FIC	Complete
CIPs delivering in line with expectations.		Executive's	On-going	Report to CIP Programme Board	Partial
Capacity and capability available to support delivery.		DoF / Executive's	On-going	Report to CIP Programme Board	Partial
Overall assessment of control effectiveness					

Net risk	Impact	4	Likelihood	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	Due	Who will perform	Frequency	Evidence
Engage additional support to drive the CIP Programme.	Confirm by 30/10/14	DoF	On-going	Report to CIP Programme Board
Ensure all schemes have clear project plans.	Confirm by 30/11/14	DoF	On-going	Report to CIP Programme Board
Embed all CIPs in budgets.	Confirm by 30/10/14	DDoF	On-going	Report to CIP Programme Board
Review CIP reporting to the EMT, FIC and Trust Board to ensure it is adequate and appropriate.	Confirm by 30/10/14	DoF	Monthly	Revised Report
Review current benchmarking information.	Confirm by 30/10/14	DoF	Monthly	Report to CIP Programme Board

Target rating	Impact	3	Likelihood	2	Score	6

Risk owned by: Andrew Grimshaw **Signed:** **Date: October 2014**

Board Assurance Framework – January 2015

BAF Risk 15 - 396	Planning for the future					
Risk consequences	**If the Trust does not plan effectively it will not be aware of risks and threats. These could result in significant risk to the on-going viability of the organisation, operations and clinical safety.**					
Risk owners	Dof, DDoF, HMA, HFA					
Gross risk	Impact	5	Likelihood	4	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
An LTFM is in place but needs revision – not a live tool		DoF	Quarterly	Reports to FIC	Partial
Regular reports are provided to the FIC on forward financials.		DoF	Quarterly	Reports to EMT and FIC	In place
Future assessments take account of low level (departmental) plans as well as high level (organisational) issues.		DoF	Quarterly	Report to EMT and FIC	In place
Plans include I&E, balance sheet, capital and cash.		DoF	Quarterly	Reports to FIC	Partial
Future CIP plans are scoped and where possible identified, 2-3 year ahead.		All execs	Quarterly	Report to CIP Programme Board, EMT and FIC	Not in place
Overall assessment of control effectiveness					

Net risk	Impact	4	Likelihood	4	Score	16

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Further development of LTFM required. Make live tool. Internal resources are being mobilised to support this.	End November	DoF	Monthly reports	LTFM
Review format and frequency of reports to FIC on future planning. Financial Planning policy now going to FIC for approval.	From Sept	DoF	Monthly	Reports
Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan. New data collection tools have been developed for collecting budget setting data in the 15/16 planning round.	Starting sept	DDOF	On-going	Report to EMT
Develop future cash capital and balance sheet planning.	End November	DoF	Monthly reports	LTFM
Develop future CIP planning. Future CIP planning is part or the CIP programme board	End of November	All execs	Reports to CIP Prog	Reports

remit and is on-going.					Board	
Target rating	Impact	3	Likelihood	2	Score	6
Risk owned by: Andrew Grimshaw	**Signed:**		**Date: October 2014**			

Board Assurance Framework – January 2015

BAF Risk 16 - CRR 410	**There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.**					
Risk consequences	40% total volume of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.					
Risk owners	Director of Operations					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Undertaking ring backs within set time frames for held calls.	partially	EMDs and Clinical Hub	Continuous		Partial
Fully trained workforce with 20 minute education breaks throughout shift.	partially	Practice Learning Manager and AOMs	Continuous		Partial
C3 calls passed to hub for enhanced assessment C1 and C2 held calls are reviewed by hub	Yes	Clinical Hub	As required		Partial
LAS Surge Management Plan.	Yes	EOC AOM and Gold	Continuous		Partial
Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime.	Yes	Resource Centre	Weekly Review		Partial
C1-C4 buckets have been redefined based on clinical outcomes.	Yes				Partial
Removal of exit message and clarity to patients regarding time delays.	Yes				Partial
Additional focus on safety reporting.	Yes				
Falls care is being introduced.					
METDG to be in place 24/7.	Yes				
The CHUB now have a Clinical Manager overseeing each shift	Yes				
Implementation of VP and CP screen to monitor higher risk patients.					

EMT 01/10/14 approved new risk assessment to replace CRR – 379.						
Overall assessment of control effectiveness						
Net risk	Likelihood	3	Impact	5	Score	15
Plan to improve controls where control effectiveness is ranked red or amber			**Due**	**Who will perform**	**Frequency**	**Evidence**
Recruit to Establishment minus agreed vacancy factor of 4%.			2015/16	M. Gammage	On-going	
Reviewing the determinants to best maximise resource availability, to assist with reduction multiple attendance ratio for single incidents.			Complete	Jason Killens	Q1 efficiency actions	Reduction in MAR
Deliver efficiencies in full from Capacity Review and complete Roster Implementation.			Q4 14/15	Jason Killens	Managed via Modernisation Programme	
Recruit to establishment in the clinical hub.			Q3 14/15	Katy Millard	On-going until establishment target is reached	
Allocate EMDs to clinical hub to assist with ring backs – Service Development put in for additional staff to undertake this work			Q2 14/15	Katy Millard	As required	
Offer near misses for APP and CTL to spend 6 months in the clinical Hub in preparation for next tranche of recruitment			2014/15	Katy Millard	One off	
Introduce surge plan and make appropriate revisions			On-going	Katy Millard	As required	
More accurate reporting of category C delays and monitoring of safety incidents						
Target rating	Likelihood	2	Impact	5	Score	10
Risk owned by: Director of Operations		**Signed:**	.....	**Date:** 5th January 2015		

Board Assurance Framework – January 2015

BAF Risk 17 – CRR 427	There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots around pay arrangements.					
Risk consequences	On-going industrial action relating to continuing dispute relating to national pay arrangements.					
Risk owners	Assistant Director of HR					
Gross risk	Likelihood	4	Impact	5	Score	20

Ideal mitigating controls	Performed	Performed by	Frequency	Monitoring Method	Effectiveness
Incident reporting process in place.					
Serious incident arrangements in place.					
Set up of Clinical Cell in EOC.					
Overall assessment of control effectiveness –.					

Net risk	Likelihood	3	Impact	5	Score	15

Plan to improve controls where control effectiveness is ranked red or amber	**Due**	**Who will perform**	**Frequency**	**Evidence**
Activation of the operational plan (Operation Phoenix)	Activated on days of industrial action	J. Killens		

Target rating	Likelihood	1	Impact	5	Score	5

Risk owned by: Director Signed: Assistant Director of HR Date: Risk approved November 2014

London Ambulance Service NHS Trust
Trust Risk Register - 15+
Trust Board - January 2015

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	Recruitment Attrition Growing vacancy factor Increased demand	31-Jul-06	4		Operational	Major	Almost Certain	20	1 .On-going recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. Increased as of September 2014. 3. Use of agency Paramedics to enhance bank scheme. 4. New rosters implemented successfully. 5. Targeted use of overtime and increased bonus payments. 6. Surge plan was reviewed again in December 2014 7. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories. This enables us to carry out an enhanced clinical assessment in the clinical hub on an additional 90,000 calls a year. A percentage of these circa 35% will be discharged through Hear and Treat 8. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls. This reduction when achieved will provide capacity to respond to a further 300 calls a day within our existing capacity. 9. An extension in the operating hours for active area cover was implemented on the 21st July 2014. 10. METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.31.	Jason Killens	22-Dec-14	Major	Almost Certain	20	1. Sickness management. A performance management dashboard is being developed. The occupational health contract is being reviewed. 2. Roster review: Rosters for all complexes have been agreed and implemented. 3. Skill mix: the skill mix model has been updated in December 2014 to include international recruits. 4. Annual leave review: a revised annual leave policy is in its final draft stage. The revised annual leave arrangements as defined in the draft policy are under discussion between trust management and trades unions. 5. The new response model: a request for change (RFC31) has been approved and is under developed by the CommandPoint supplier. The software was delivered in August but did not pass testing and there have been several re-releases since. We expect the final release, with all known errors corrected, to be delivered 24/12. Testing will recommence but is constrained by release of testers (CAD trained staff) from the control room. Implementation of the software will only occur once testing has been successfully completed (anticipated end of February 2015). 6. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role (December 2014), overseas recruitment of paramedics (on-going), in-house conversion from EMT to paramedic 2014/15, university paramedic recruitment (October 2014), military recruitment. Retention; exit interviews, research reasons for leaving, consider reward and recognition initiatives, career progression and support. 7. Improve provisioning and reduce calls through the use of PTS and taxi service	1. P. Woodrow 2. M. Pearce 3. J. Killens / M. Whitbread 4. S. Sale 5. J. Killens 6. K. Broughton / T. Crabtree 7.J. Goldie / K. Millard 8. K. Millard 9. K. Millard	1. On-going 2. Completed 3. Completed 4. Sep 2014 5. April 2015 6. Q4 2014/15 7. On-going 8. On-going 9. On-going		Major	Possible	12	Reviewed by ADO's December 2014 J. Killens 21/08/14 approved regrading of risk from major x likely = 16 to major x almost certain = 20 Updates provided by P.Woodrow 8/08/14
402	There is a risk that the current age profile of Fleet Workshop Managers and Technicians will impact on the future resilience of the Fleet Operation	Age profile of Fleet Workshop Managers and Technicians	09-Jul-14	1		Business Continuity	Major	Almost Certain	20	1. Regular cycle of recruitment of Workshop Technicians. This is to ensure that we maintain a robust technical staffing level to deliver the required Planned and Unplanned maintenance activity. 2. Recruitment aimed at long term temporary staff. This is to ensure that Staff that are trained by the LAS remain and the value of the Training can be realised by the Trust.	Sean Westrope	06-Jan-15	Major	Almost Certain	20	1. Establishment of apprenticeship scheme. This is to ensure that the Trust effectively manages the demographic profile of its Workshop Staff against a national shortage of Technical Engineers. 2. Continuing recruitment into vacancies.	1. S. Westrope 2. S. Westrope	1. September 2015 2. On-going		Major	Unlikely	8	Risk reviewed by S. Westrope January 2015. Risk Approved by SMT at meeting on 9th July 2014
401	There is a risk that the current age profile of the LAS Vehicle Fleet will result in increased downtime impacting on operational performance and implementation of the modernisation process.	Age profile of the LAS Vehicle Fleet	09-Jul-14	2		Operational	Major	Almost Certain	20	1. Capital programme for 2014/15 includes 104 replacements of vehicles that are over 7 years old 2. Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that Unplanned Maintenance levels do not adversely affect Fleet Capacity and the provision of a safe environment to Operational Staff 3. Monitoring the productivity of planned maintenance and throughput of unplanned maintenance against backlog. This is to ensure that the Fleet asset condition remains in a safe condition.	Sean Westrope	06-Jan-15	Major	Almost Certain	20	1. Agree comprehensive 5 year replacement plan.	1. S. Westrope	1. March 2015	5 year plan to be managed by Fleet Procurement Board and monitored by Vehicle Working Group	Major	Unlikely	8	Reviewed by S. Westrope January 2015. Risk Approved by SMT at meeting on 9th July 2014
388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care.	1. Competitive recruitment market for Paramedics 2. Increasingly mobile workforce with a multitude of recruitment possibilities 3. Cost of living pressures in London coupled with increasing travel costs for commuting 4. Opportunities for clinical career progression in other organisations, which do not exist within the LAS, such as 111 and other public, private and voluntary healthcare providers 5. Staff morale 6. Perceptions of access to funding for personal development and study leave 7. Concerns about job security 8. National shortage of registered paramedics 9. Relocation packages elsewhere	10-Apr-14	3		Clinical	Major	Likely	16	NHS staff benefits (e.g. pensions, T&Cs, etc.) LAS staff benefits (e.g. cycle scheme) LAS retention staff benefits (EMT suggestions) Listening into Action - to understand staff improvements. Developing the modernisation programme – including rota reviews and development of a clinical career structure. Actively recruiting university and registered paramedics and emergency ambulance crew Monitoring and developing plans to address trends in turnover. Retention Strategy agreed in principle at EMT 7 January 2015. Data to include establishment, vacancies, stability, turnover (split between paramedics and other), and sickness rate. To include trends and benchmarked data. The use of overtime, private and voluntary ambulance services to increase the number of available resources. Impact on utilisation rate, i.e. to reduce it. Clinical support structure provides career progression opportunities, with on-going training development Revision of the Exit Surveys to provide accurate information on staff who leave, i.e. NHS, competitors, etc. and reason for leaving Retention data of resignations, projected leavers, projected joiners to identify reasons for resignation and opportunity to take intervention action.	**Mark Gammage / Rainy Faisey**	06-Jan-15	Major	Almost Certain	20	1. Development of Clinical Career Structure. 2. Skill mix review. 3. Review exit interview process and data capture. 4. Review and update rewards and retention strategy. Discussion at EMT regarding framework / strategy to address 5 key actions that assist retention. 5. Promote learning and development opportunities. 6. Recruitment drive to fill vacant established posts. Recruitment group meeting fortnightly identified 6-7 streams from which paramedics can join the service, also establishing the process to enable this. 7. Implementing the modernisation programme 8. Exercise taking place to look at a sample of leavers to assess reasons for leaving 9. Develop a Health and Wellbeing Strategy	1. F.Moore 2. J. Killens 3. M. Gammage 4. M. Gammage 5. K. Broughton 6. K. Broughton 7. P.Woodrow 8. M. Gammage 9. T. Crabtree	1. Completed 2. Ongoing 3. Ongoing 4. 2014/15 5. TBC 6. Ongoing 7. Dec 14 8. Dec 14 9. March 15	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for on-going cohorts of A&E support and Paramedic staff. 5. Development of reward strategy. 6. Development of clear clinical career structure. 7. Review of flexible	Major	Unlikely	8	Risk reviewed by Rainy Faisey 06/01/15. 23/07/2014 - Action 1 now complete - APP and CTL recruitment now complete. Agreed by SMT 11/06/14. June 2014 - Proposal to escalate net rating to major x almost certain = 20 due to current levels of staff turnover. (DP agreed in principle as risk owner).

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31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	5		Clinical	Major	Almost Certain	20	1. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 2. A deep dive audit was carried out which was reported to the Quality Committee in Autumn 2014. To be repeated as required. 3. Review incidents reported through LA52's, Patient Experiences and legal Claims relating to problematic obstetric incidents. 4. Maternity care update articles in the Clinical Update. 5. Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife. 6. Pan-London Maternity Divert Policy (Updated Sept. 2013): Robust framework to limit temporary closures of maternity units and to organise redirection. 7. POETS e-learning programme in place. 8. Drop in sessions arranged by new consultant midwife.	Fionna Moore	05-Jan-15	Major	Possible	12	1. Director of Paramedic Development & Education to directly oversee delivery of CSR 2013/2014. CSR to be delivered to >85% clinical staff. 2. Appointment of Consultant Midwife (post vacant) to provide professional advice and education. Update post from 0.2 WTE to 0.4 WTE to increase availability and impact through obstetric education.	1. M. Whitbread 2. F. Moore	1. Review during each quarter and any serious or recurrent themes highlighted through updates to operational and/or control staff and CQSEC. 2.Completed	1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services. 2. Incident reporting. 3. Reports to CQSEC, SI group, Learning from Experiences	Major	Possible	12	F. Moore reviewed 5/01/15. Medical Directorate reviewed risk December 2014 and proposed to regrade net rating from major x likely = 16 to major x possible = 12 to go to SMT for approval January 2015. Approved by SMT 14/01/15 CSDEC 27/10/14 reviewed risk - substantive mid wife post in place 3 days per week from December 2014. Rating remains the same and review rating following take up of post. 23/07/14 - Interim Consultant Midwife now in post for 6/12, which will be followed by advertisement and recruitment to the permanent position. Requires regrading. SMT 14/05/14 agreed rating to remain at major x likely = 16. FM 14/04/14 suggested that net rating remains at 16 until the consultant midwife is in post and will review in 6 months time. the recruitment
355	There is a risk of staff not receiving clinical and non-clinical statutory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills	23-Nov-11	6		***Corporate***	Major	Almost Certain	20	1. Agreement with operations that there will be an agreed abstraction of up to 90 staff per week to attend CSR during agreed periods. 2. Paramedic registration. 3. Individual Learning Accounts implemented for all operational staff from September 2014. This will increase attendance on CSR training. 4. Comprehensive review of statutory and mandatory training delivery, including All In One, under way, due for completion late November 2014 5. E-learning packages under development to provide staff with access to on-line achievement for core statutory elements	Mark Whitbread	28-Oct-14	Major	Likely	16	1. The TNA which applies to April 2014 to be reviewed and agreed by TSG. 2.A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commence from October 2012. 4. Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.	1. J. Chalmers 2. J.Thomas 3. P. Billups 4. P. Cook	1. May 2014 2. Complete 3. Complete 4. Ongoing	1. TSG review and agree TNA on an annual basis. 2. TNA used as basis for agreeing service training plan. 3. TSG review regular reports of uptake on training.	Major	Unlikely	8	Two new risks presented to SMT in December 2014 and asked for further detail to be added and brought back. SMT 09/04/14 suggested that current risk rating remains until the risk is reviewed for splitting between clinical and non clinical. Update control sheet. Propose risk owners made up of Directors within TSG / or its successor for principal risk.
269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	7		Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts. 4. Incident management control desk within EOC.	Jason Killens	22-Dec-14	Major	Likely	16	1. Agree and implement changes to rest break arrangements 2. Rota changes to be implemented as result of ORH review 3. Recruitment 4. Skill mix: the skill mix model has been updated in December 2014 to include international recruits. 5. Ongoing vigorous management of out of service. J. Killens to set improvement trajectory to get out of service levels back within target. 6. Proactive use of the surge plan. 7. Out of service being HUB implemented.	1. T. Crabtree / J. Killens 2. J. Killens 3. K. Broughton 4. J. Killens 5. K. Brown / Sean Westrope 6. ADO's 7. TBC	1. 2015/16 2. Completed 3. Q4 14/15 4. Completed 5. Ongoing 6. Ongoing 7. Ongoing		Major	Unlikely	8	December 2014 Risk reviewed by ADO group. Updated provided by P.Woodrow and J.Killens August 2014
394	There is a risk that CIPs may not be identified or delivered which would impact our credibility with the NTDA and the DH and would adversely impact on our FT Application. There may also be a loss of control on the Income and Expenditure position.	• Appropriate supporting evidence not available • CIPs not supported by detailed milestone plan. • CIPs not embedded in budgets. • CIPs not owned by relevant manager. • Benchmarking of CIPs not undertaken. • CIP governance not clearly defined and in place. • Board/FIC scrutiny of CIP planning and delivery not in place. • CIPs not delivering in line with expectations. • Capacity and capability not available to support delivery.	10-Apr-14	14		Finance	Catastrophic	Likely	20	1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. Board/FIC scrutiny of CIP planning and delivery in place. 7. CIPs delivering in line with expectations. 8. Capacity and capability available to support delivery.	Andrew Grimshaw	28-Oct-14	Major	Likely	16	1. Engage additional support to drive the CIP programme. 2. Ensure all schemes have clear project plans. 3. Embed all CIPs in budgets 4. Develop a clear governance structure to manage CIP delivery. 5. Review CIP reporting to the EMT, FIC and Trust Board to ensure it is adequate and appropriate. 6. Review current benchmarking information.	1. A. Grimshaw 2. A. Grimshaw 3. K. Hervey / A. Bell 4. A. Grimshaw 5. A. Grimshaw	1. In place 2. Completed 3. Partially complete - finalise Q3 14/15 4. In place 5. Complete 6. Q3	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	Reviewed by FIC October 2014. FIC papers dated 29/09/14 changes in ratings to: gross catastrophic x likely = 20, net major x likely = 16 and target moderate x unlikely = 8. K. Approved by SMT 09/04/14 for inclusion on the risk register. To be cleared during Q3

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Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
396	There is a risk that no disciplines exist for planning ahead which would impact our credibility with the NTDA and the DH and would adversely impact on our FT Application	• An LTFM is not in place. • Regular reports are not provided to the FIC on forward financials. • Future assessments do not take account of low level (departmental) plans or high level (organisational) issues. • Plans exclude I&E, balance sheet, capital and cash. • Future CIP plans are not scoped and where possible identified, 2-3 years ahead.	10-Apr-14	15		Finance	Catastrophic	Likely	20	1. An LTFM is in place but needs revision – not a live tool 2. Regular reports are provided to the FIC on forward financials. 3. Future assessments take account of low level (departmental) plans as well as high level (organisational) issues. 4. Plans include I&E, balance sheet, capital and cash. 5. Future CIP plans are scoped and where possible identified, 2-3 year ahead.	A.Grimshaw	28-Oct-14	Major	Likely	16	1. Further development of LTFM required. Make live tool. Internal resources are being mobilised to support this. 2. Review format and frequency of reports to FIC on future planning. Financial Planning policy now going to FIC for approval. 3. Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan. New data collection tools have been developed for collecting budget setting data in the 15/16 planning round. 4. Develop future cash capital and balance sheet planning. 5. Develop future CIP planning. Future CIP planning is part or the CIP programme board remit and is on-going.	1. A. Grimshaw 2. A. Grimshaw 3. K. Hervey / A. Bell 4. A. Grimshaw 5. All Execs.	1. Actions addressed through 2014/15 financial planning exercise. 2. Updated sent to FIC during Q1 & Q2 3. Budget setting meetings in place 4. Balance sheet projections included in NTDA return. 5. FD is formulating the methodology with SMT 6 LTFM submitted to NTDA in June 2014	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	Reviewed by FIC October 2014. FIC papers dated 29/09/14 changes to ratings: gross from major x likely = 16 to catastrophic x likely = 20, net from major x unlikely = 8 to major x likely = 16 target from major x rare = 4 to moderate x unlikely = 6. Updates to FIC in June 2014 and LTFM sent to NTDA in June 2014. Approved by SMT 09/04/14 for inclusion on the risk register.
399	There is a risk that a lack of essential (*) equipment on an Ambulance may impact on the crew's ability to respond ~~to all category A calls and /or any calls requiring specialist equipment to be deployed at the scene.~~ * essential equipment as defined in TP091 - Out of Service (OOS) Policy and Procedure - sections 7.9 and 7.10.	Underlying causes are varied and emanate from various functions of the Trust. This potentially affects the ability of a crew to provide the appropriate response at a scene which may delay treatment to the patient. Due to the equipment either being: Defective Contaminated Impounded Missing Replaces Risk 303 & 362	11-Jun-14	8		Fleet and Logistics	Major	Likely	16	1. Vehicle Daily Inspection completed, as part of the Vehicle Preparation process, by the Vehicle Preparation complex Team indicating which items are missing. ~~2. The crew will also check for critical equipment and try to source. (OP/026)~~ 2. Crews should advise EOC/DSO which equipment they are missing, this should also be reflected in their LA1 (OP/026).	Sean Westrope	28-Oct-14	Major	Likely	16	1. Improved equipment exchange by the LSU team. Equipment will be carried on their vehicles enabling a swifter exchange. This is dependant upon time of visit by LSU team. 2. Joint site visits by Logistics/Estates advising relevant process involving equipment 3. Joint education on equipment issues and continuous declaration of spare equipment. A process will be put in practice advising how equipment can be relocated to a frontline vehicle. A group needs to be set up including a lead DSO from each area. 4. Logistics Support Unit now hold a central budget to replace broken equipment which is processed through Deptford Stores. This will provide an improved and speedier replacement/exchange process. 5. Procurement of additional equipment to equip shells	1. Karen Merritt 2. Fleet & Logistics / Estates 3. Fleet & Logistics / Estates 4. Karen Merritt 5. Karen Merritt	1. October 2014 2. Ongoing 3. Ongoing 4. Ongoing 5. November 2014	Continuous review of the actions	Major	Unlikely	8	Reviewed risk with MW 9/12/14 - proposed rewording and regrading of net rating from major x likely = 16 to major x possible = 12 28/10/14 risk reviewed by Fleet and Logistics team. Approved by SMT 11/06/14
354	There is a risk of on-going industrial action due to national ballots leading to disruption of service provision.	There could be an impact on service delivery, patient care and the Trust's reputation.	23-Nov-11			Human Resources	Major	Likely	16	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff. 5. Activation of operation Phoenix during the periods of industrial action.	Tony Crabtree	12-Nov-14	Major	Likely	16	1. Implement recommendations from N30 review. Note - Actions from N30 internal review are all complete, and actions from the NHSL integrated action plan are on track. National meetings currently taking place with staff side regarding issues of payment of unsocial hours during sickness absence. At this point any changes are on hold. 2. Activation of operation phoenix during next period of industrial action.	1. Tony Crabtree 2. Jason Killens	1. During period of industrial action 2. 24/11/14		Major	Unlikely	8	This risk is not included on the BAF as the Patient Safety Risk - BAF ref 17 CRR 427 represents this risk on the BAF T. Crabtree / K. Millard / D. Halliley 4/11/14 Review gross rating from major x possible = 12 to major x likely = 16 and review of net rating from major x possible = 12 to major x likely = 16. Approved by SMT 12/11/14. T. Crabtree 14/08/14 - An industrial action group has been established. Initial engagement with staff side has commenced with a view to provide emergency cover during industrial action. SMT 09/04/14 agreed change of target rating to major x unlikely = 8. Note - AB requested target rating to be reduced from major x possible to major x unlikely = 8 DP 7/4/14 - proposed change of wording to 'There is a risk of industrial action due to national ballots leading to disruption of

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404	There is a risk that the Trust does not accurately and efficiently capture errors and incidents and process them in accordance with national guidelines and within specified internal procedures (LA52 reporting).	Insufficient recorded evidence of reported incidents (total number and quality).	09-Jul-14	9		Corporate	Major	Likely	16	All incidents are reviewed at an internal weekly meeting within the Governance Team and key stakeholders for example Head of Legal, Head of Complaints, Safeguarding Lead, Quality Assurance and Medical Directorate. 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 Incident. A detailed Serious Incident process 'New Ways of Working' has been developed and approved by Quality Committee on 22nd August 2014. Weekly Serious Incident Group meetings to review outstanding and pending cases has been moved to fortnightly meetings which allows the necessary information to be reviewed in more detail. Standing agenda item at bi-weekly Senior Management Team meetings. Weekly reports to the Executive Management Team. Weekly reports on individual Serious Incident status to Executive Lead, SMT Lead and Lead Investigator. Monthly report to Commissioning which details the whole Serious Incident status and details individual status of each open serious incident and status of de-escalation and closure. Progress summary to Audit Committee on the current status of the KPMG August 2013 audit. Training needs analysis has been undertaken and	Sandra Adams	06-Jan-15	Major	Likely	16	1. The review of the Serious Incident Policy has been undertaken . It has been agreed that a governance framework will be developed to give a robust foundation and all governance policies and procedures will be linked to the framework. 2. The review of the governance arrangements to support the incident management process has been undertaken. A deep dive of all Serious Incidents / potential serious incidents from March 2013 to date (August 2014) . 3. The commencement of a review of incidents below 15 is about to commence. 4. Implement quarterly / 6 monthly of non-escalated incidents for a quality review. 5. Complete the roll-out of Datix Web and training plan. 6. Launch workshop currently being agreed (before the end of September 2014)	1. S. Adams / D.Halliley 2. S. Adams / D. Prince 3. S. Adams / D. Prince / D. Halliley 4. S. Adams / D. Halliley 5. S. Adams / D. Halliley / A. Essome	1. End Oct 2014 2.Complete 3. Commence Oct 2014 4. Q3 2014/15 5. Commenced July 2014 6. Commence Sept 2014	Serious Incident Policy reviewed annually. Internal Governance audits, and external audits by accredited providers highlighting gaps in our processes Incident reporting procedure being developed	Moderate	Unlikely	6	Risk Approved by SMT at meeting on 9th July 2014
400	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	SatNav's were originally specified and procured in 2001. The selected manufacturer was Siemens VDO, distributed in the UK by MixTelematics Ltd. Over time the unit design has evolved (CD to DVD to SDcard) but fundamentally they have remained backward compatible as far as the interface to the MDT was concerned. The device is no longer manufactured and spare parts are becoming scarce. Alternative SatNav devices from other manufacturers are not a simple retrofit and will require reengineering of the MDT interface. The impact of failures and inability to repair will build gradually (a rising tide) with increasing effect on fleet maintenance and availability, ultimately the impact will become	11-Jun-14	10		Operational	Major	Likely	16	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies.	Jason Killens	22-Dec-14	Major	Likely	16	1. An early action of the eAmbulance project is to review the specification and carry out market sounding to identify alternative SatNav products. An alternative SatNav device has been identified and a sample has been now acquired 2. Software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 4 3. If a satisfactory alternative device is identified AND the MDT software development is viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process.. If full functionality can be achieved then action 3 funding and procurement will be progressed. 4. ~~Development of software &~~ Retrofitting of solution to fleet 5. eAbmulance project to refine current requirements and procure viable commercial (h/w & s/w) solution, which is likely to require in-house bespoking contribution to ensure overall facilities are not compromised.	1. CAD support 2. CAD support 3. Assistant Director of IM&T 4. CAD support 5. eAmbulance Project Manager	1. Complete 2. June 2015 3. Q2 2015 4. TBC 5. TBC		Major	Rare	4	Risk reviewed by IM&T December 2014. 01.09.2014. Telent Ltd, the supplier contracted to maintain MDT/SatNavs , have entered now into an agreement with Jazz Auto Repairs to repair LAS Sat Nav's . Approved by SMT 11/06/14
410	There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	40% total volume of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.	01-Oct-14	16		Clinical	Catastrophic	Likely	20	1. Undertaking ring backs within set time frames for held calls. 2. Fully trained workforce with 20 minute education breaks throughout shift. 3. C3 calls passed to hub for enhanced assessment C1 and C2 held calls are reviewed by hub 4. LAS Surge Management Plan. 5. Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime. 6. C1-C4 buckets have been redefined based on clinical outcomes. 7. Removal of exit message and clarity to patients regarding time delays. 8. Additional focus on safety reporting. 9. Falls care is being introduced. 10. METDG to be in place 24/7. 11. The CHUB now have a Clinical Manager overseeing each shift	Jason Killens	03-Dec-14	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 4%. 2. Reviewing the determinants to best maximise resource availability, to assist with reduction multiple attendance ratio for single incidents. 3. Deliver efficiencies in full from Capacity Review and complete Roster Implementation. 4. Recruit to establishment in the clinical hub. 5. Allocate EMDs to clinical hub to assist with ring backs – Service Development put in for additional staff to undertake this work 6. Offer near misses for APP and CTL to spend 6 months in the clinical Hub in preparation for next tranche of recruitment 7. Introduce surge plan and make appropriate revisions 8. More accurate reporting of category C delays and monitoring of safety incidents	1. M. Gammage 2. J. Killens 3. J. Killens 4. K. Millard 5. K. Millard 6. K. Millard 7. K. Millard 8.	1. Ongoing 2. Complete 3. Q4 14/15 4. Q3 14/15 5. Q2 14/15 6. 2014/15 7. On-going 8.	1. Operational Demand and Capacity Review Group 2. Senior Management Team 3. Medical Directorate senior clinical advice; Clinical risk and Patient safety 4. The weekly SI group review patient safety incidents.	Catastrophic	Unlikely	10	F. Moore reviewed risk 5/02/15 FW / DSW 03/12/14 Additional measures to mitigate risk are increased number of CHUB QA mangers to ensure 24/7 and implementation of VP and CP screen to monitor higher risk patients Trust operating at increased Surge level without regular review conference calls New risk proposed to replace previous risk ID 379. Approved by EMT 1/10/14

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382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	In 2001 CAD link was developed, which enabled the MPS and LAS to exchange emergency calls and other messages directly via each organisation's CAD system. This process bypasses the standard triage system that all other 999 calls are subject to. To request the LAS, the MPS complete a basic triage of the call, known as the SEND protocol (Secondary Notification of Dispatch). SEND requires the MPS to answer five key questions to determine the medical priority of the call. Requests for the LAS from the MPS may be incorrectly triaged as a result of the limitations of the medical triage system used by the MPS Central Communications Command (SEND protocol). Erroneous	07-May-13	13		Clinical	Catastrophic	Likely	20	1. METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.31. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated. 3. EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately. 4. The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning. 5. Police have put message on their intranet regarding pressure on the LAS	Jason Killens	18-Dec-14	Catastrophic	Unlikely	10	1. ~~A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.~~ ~~2. Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS~~	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. Completed 2. Completed		Catastrophic	Rare	5	Medical Directorate commented 18/12/14. Proposed to increase target rating from catastrophic x rare = 5 to catastrophic x unlikely - 10. Approved by the SMT 14/01/15. 24/10/14 - CSDEC - proposed to review the status of MPS calls prior to archiving the risk. Review in 3 months. J.Killens August 2014 - propose to review risk rating when METDG is running 24hours a day.
427	There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots around pay arrangements.	Ongoing industrial action relating to continuing dispute relating to national pay arrangements.	12-Nov-14	17		Clinical	Catastrophic	Likely	20	1. Incident reporting process in place. 2. Serious incident arrangements in place. 3. Set up of Clinical Cell in EOC.	Tony Crabtree		Catastrophic	Possible	15	1. Activation of the operational plan (Operation Phoenix)	1. J. Killens	1. Activated on days of industrial action		Catastrophic	Rare	5	Risk Approved by SMT at meeting on 12th November 2014
329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10	11		Finance	Catastrophic	Possible	15	1. 2013/14 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and EMT. 3. Regular communication with commissioners. 4. The contract of the Director of Modernisation and OD has been extended to end of June 2014 to maintain focus on the Modernisation Programme.	Karen Broughton	01-Apr-14	Catastrophic	Possible	15	1. Review by Finance Investment Committee 2. Review capacity vs demand 3. Develop a programme of sustainable performance and performance management 4. Develop clear escalation procedures when measuring performance . 5. Establish relationship with Commissioners 6. Negotiate suitable operating contract with Commissioners. 7. Recruitment	1. K.Hervey 2. J. Killens 3. P. Woodrow 4. P. Woodrow 5. K. Broughton 6. K. Broughton 7. M. Gammage		1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board. Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed. 3. Monthly meetings with PCT commissioners were performance is reviewed against targets and agreement is reached and findings are documented. 4. Performance is reported to the SHA monthly. 5. The Finance and Investment	Catastrophic	Unlikely	10	This risk is under review for re-assessment and proposal of new risk to replace it. K. Broughton - May 2014.
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	12		Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from data cards. 5.LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units. 6. New Malden pilot has trialled the transmission of data from the LP15	Mark Whitbread	22-Dec-14	Moderate	Almost Certain	15	1. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 2. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 3. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area. 4. Consider roll out of transmittable data from LP15 once vehicle on station 5. A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to pub into a lap top to establish the benefits that come of out of it. The evaluation of this exercise will be reviewed in February 2015. 6. Put a suggestion forward for it to be included as a CQUIN in the next financial year to the CQRG.	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread	1. Complete 2. Complete 3. Complete 4. Ongoing post N/Malden pilot evaluation 5. Commence Mid Dec 14	EOC briefings undertaken	Moderate	Unlikely	6	18/12/14 - Risk reviewed by medical directorate. 23/07/2014 - If the fleet was less "flexible" it would allow for modems to be used to assist with downloads. SMT 14.05.14 approved regrading to moderate x almost certain = 15 M.Whitbread to raise with EMT regarding mitigating actions. Proposed increasing current rating to moderate x almost certain = 15 APPs will be conducting a feasibility study using laptops to download data at two sites - Brent and Westminster with the intention of reviewing the outcomes with the attending crew in order to establish any learning from the event.

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426	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to manage the increased workload, notably Marac requests for information.	The Trust will fail in its statutory responsibilities to respond to safeguarding requests within time scales. There continues to be an increase in the requirement for LAS partnership involvement as Multi-Agency Risk Assessment Conferences (MARACs) these are being introduced across London and require the LAS to provide data on our involvement with individuals over a given timescale and attendance at regular meetings. The LAS is seen as a key partner in these meetings.	10-Sep-14			Governance	Moderate	Almost Certain	15	1. Local managers running own reports in absence of safeguarding officer. 2. Out of office message to manage expectations.	Zoe Packman		Moderate	Almost Certain	15	1. Increase in members of safeguarding team to provide support across trust and partners (pending agreement of funding). 2. Develop an administrator post for safeguarding to cover increase workload and also support Safeguarding Officer when off (pending agreement of funding).	1. Z. Packman 2. Z. Packman	1. TBC 2. TBC		Minor	Possible	6	Agreed by SMT 10/09/14
417	There is a risk that unauthorised access and threats to the Trust's network will not be detected, and, after a breach occurs, it will not be possible to identify and pursue the attackers. This could lead to serious security breaches not being identified and action not taken to prevent such attacks happening in the future. Ultimately, this could impact on the operational delivery of services.	There is no intrusion detection process in place for the Admin network (internal network of the Trust). Unless a user identifies and reports an incident, this is not brought to the attention of the IM&T team. Networking devices such as routers and switches (which help interconnection within a network) have a limited set of logs that are stored locally on the devices. These include logon attempts and other key security information, but they are not aggregated or analysed for trends. Some monitoring is done on the Command and Control network (specifically of the Oracle database and the CAD system). (highlighted by KPMG Cyber Audit- October 2013)	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks. 2. Enterprise antivirus monitoring LAS infrastructure.	Vic Wynn	18-Dec-14	Catastrophic	Possible	15	1. Deploy an intrusion detection system along with associated processes to ensure that any incidents are logged and acted upon. As a minimum, the last 12 months of logs should be stored and be readily available after a breach for analysis.	1. R. Clifford	1. April 2015	1. Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	18/12/2014 IM&T approved the purchasing/deployment of an Intrusion Detection System (IDS) to monitor LAS networks ; procurement is currently processing the request. Risk Approved by SMT at meeting on 8th October 2014
418	There is risk that a malware outbreak or a hacking attack originating from LAS admin network is propagated to the CAC network area. This could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services.	Firewalls exist only on the interface to the internet, and not between the virtual networks, (such as the one to segregate the CAC network from the rest of the Trust network). The internal network is flat and open, meaning that there is no separation between groups of computers and all devices on the network are treated with the same level of trust. This allows easy access within the network once an unauthorised individual has accessed the network. Once a device is compromised in one section of the network, the rest of the network is available to the attacker. (highlighted by KPMG Cyber Audit – October	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks 2. Enterprise antivirus monitoring LAS infrastructure	Vic Wynn	18-Dec-14	Catastrophic	Possible	15	1. Introduce strategic firewalls to segregate sensitive sections of the network, particularly the CAC. 2. Additionally, consider placing a firewall or similar between the two main CAC physical networks located at Bow and Waterloo.	1. R. Clifford 2. R. Clifford	1. Dec 2014 2. Dec 2014	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	18/12/2014 : New firewalls purchased and delivered - pending deployment . Risk Approved by SMT at meeting on 8th October 2014

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420	Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services	Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. As the CAC network does not have access to the internet or email, it is less likely that attacks will come directly from these external sources, but it may be possible to introduce an attack through infected USB drives, CD/DVDs, or other removable media (even if LAS-approved devices). Alternatively, an attacker could leverage one of the security vulnerabilities present on the other networks (external	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Enterprise antivirus monitoring CAC desktops 2. Desktop ports disabled (i.e. USB, DVD) 3. No access to internet /email for CAC desktops	Vic Wynn	18-Dec-14	Catastrophic	Possible	15	1. 1.Liaise with the supplier of the Comandpoint software to ensure that patching is undertaken regularly. This needs to include updating the software to be compatible with the latest versions of software used by the CAC Network, in particular the Microsoft Operating System and Office products.	1. E Beqiri	1. Dec 2014	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	18/12/2014 CommandPointV2.6 passed final test and was implemented August. LAS is currently testing CP clients on W7. Risk Approved by SMT at meeting on 8th October 2014
416	There is a risk that the Trust might not satisfy IGT 11-313 requirements concerning network security.	The Trust does not have a Network Security policy in place. Information Governance Toolkit (IGT) attainment 313 requires a network security in place (formally approved by LAS SIRO (Senior Information Risk Owner). Until the policy is formally approved/deployed LAS will not achieve the necessary score target to satisfy DH requirements and to avoid any possible penalties or reputational damage. The network security policy is intended to reduce risks to LAS systems and data by defining a common security policy for the management of the LAS network infrastructure.	08-Oct-14			Information Governance	Moderate	Almost Certain	15	1. Local network operating procedures.	Vic Wynn	18-Dec-14	Moderate	Almost Certain	15	1. Draft and formally approve a Network Security policy.	1. E. Beqiri	1. Dec 2014	1. Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	18/12/2014 First draft of the Network Security policy approved by IM&T - policy to approved by SMT **:propose to downgrade the risk to 12.** Risk Approved by SMT at meeting on 8th October 2014

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Report from the Quality Governance Committee on 13th January 2015**
Report Author(s):	**Bob McFarland, Non-Executive Director and Chair of the Quality Governance Committee**
Presented by:	**Bob McFarland**
Contact Details:	
History:	**Assurance report from meeting held on 13th January 2015**
Status:	**For information**

Background/Purpose

The purpose of this report is to update the Trust Board on the key items of discussion at the Quality Governance Committee meeting on 13th January 2015.

Action required

The Trust Board is asked to note the report from the Quality Governance Committee meeting on 13th January 2015.

Assurance

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

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

Report from the Quality Governance Committee on 13th January 2015

The Board should be aware that our current governance processes for quality and safety will come under scrutiny during the forthcoming CQC Chief Inspector of Hospitals' Inspection.

- The Quality dashboard is not being used effectively in all areas and is under review.
- The executive Clinical Safety, Development and Effectiveness (CSDE) committee has been established for 6 months and needs to be evaluated as an effective assurance body.
- There are some quality and safety risks which are not being reviewed and addressed in a timely manner and we particularly draw the Board's attention to Risk 8 (critical equipment) which may indicate a more general area of concern regarding the Fleet and equipping of ambulances.

Concern was again expressed that while we are still at REAP4 and above, operational managers were not participating in the governance process, including CSDE and this committee. However the committee was told that there was frequent contact with the operational teams in other meetings and the pressure was starting to improve.

INTERNAL ASSURANCE

Quality Dashboard

The Quality Dashboard is used to monitor quality across the service and we were told is regularly reviewed by the Executive and Senior Management teams, CSDE, and the sector operational managers. The Quality Governance Committee reviews the dashboard to take assurance that our processes are effective but has not seen an up to date dashboard since its July meeting. Zoe Packman gave a verbal update at the meeting but it was clear that, although the Clinical Safety section was being maintained and used, the other sections (Education and Patient experience) were still to be fully populated. Zoe was in the process of reviewing the dashboard to make it more relevant to the ambulance service and 111; to make it possible to benchmark and identify themes and trends; to work with the performance team to make the data entry more automatic and less labour intensive; and where appropriate at the same time to align our dashboard criteria with those of external bodies (TDA, CQC, CCGs for example) who also need to be assured our processes are working effectively.

Board Assurance Framework (BAF)

The framework incorporates the highest level risks for the Trust however the committee has asked for information on the amber (and therefore potential) risks that were present on the risk register but not given the same level of scrutiny as those on the BAF.
There were a number of risks not being moved forward as planned and Sandra Adams was chasing these through the Executive team.
There was again no clear understanding of Risk 8 ("lack of critical care equipment"). This has been a "top twenty" risk now for over six months and been raised at this committee, the Audit committee and the Board. In discussion it was suggested there may be a more general problem around equipment and the fleet with staff reporting issues concerning vehicle cleaning and infection control. It was noted that the change to a "flexible fleet" had exacerbated the issue as stations no longer had ownership of either vehicles or their equipment however the service was moving away from this model now. The committee felt that this area of concern should be reported to the Board and the Chair should contact Andrew Grimshaw, the director responsible, and ask him to report on the issue to our next meeting.

Report from Clinical Safety, Development and Effectiveness (CSDE)

The Clinical Safety committee provided a report but the other committees (Development & Effectiveness) had not met since October. The new structure had been in place for six months so it was time to re-evaluate the committees and how the various bodies report to it. Although we were not aware of any particular problems the new structure did not yet provide the necessary assurance. The newly appointed Director of Nursing and Quality, Zoe Packman, will report back when she has had the opportunity to review the quality governance structure with colleagues.

Serious Incidents (SI)

There had been a demonstrable improvement in the timeliness of investigation and reporting. The relationship between the LAS team and commissioners was supportive and the Senior Management Team was managing the actions resulting from SIs and would present these at a future meeting. The SI policy was being updated and a training programme for Family Liaison Officers was in development and would be implemented once the operational pressures had alleviated. The Duty of Candour was being applied to relevant patient safety incidents.

EXTERNAL ASSURANCE

Care Quality Commission (CQC) Chief Inspector of Hospitals' Inspection

A summary report was provided on the CQC inspection report for the North West Ambulance Service NHS Trust (NWAS) and the committee noted that the report for South Central Ambulance Service NHS Foundation Trust was due to be published. The CQC had announced the inspection date for the LAS and this was likely to take place in June 2015. We reviewed the NWAS report and its recommendations give a helpful indication of the current criteria against which we would be assessed. We were told that we would be preparing for the inspection and making use of the experience of those within and outside the service who had been involved in other inspections. It was emphasised, in the light of our discussions at this meeting, that our current governance processes would be carefully scrutinised.

DEEP DIVE

Clinical Safety Review

Dr Fionna Moore, Medical Director, gave a presentation on the outcome of the safety review that she had undertaken in October 2014. This had been a deep dive review, similar to that undertaken by Yorkshire Ambulance Service, to test a sample of 336 patient report forms of patients who had experienced significant delays in one 5 day period. The headline findings were:

- The PRF sample only identified one patient who had been at "High" risk of deterioration because of a delay in attendance (Red2 - 33 minutes)
- All patients disadvantaged by delays were already picked up by our routine safety monitoring systems; none were missed.
- Although the percentage of PRFs which had been reviewed as part of the Clinical Performance Indicator process was less than ideal (about 60%) the standard of care found in those which were scrutinised was still good.
- The mitigating systems (MPDS, Surge, Ringbacks, Clinical Hub, Monitoring of vulnerable patients, METDG team) seem to be containing the risk when the service is under pressure.

The committee was able to take assurance from this.

External Safety Review

NHS England (London) undertook an external clinical review in December and the committee was able to review the draft report and recommendations at this meeting.

It was important that the actions taken by the London Ambulance Service to manage the current situation were externally validated and the external review by Prof. Benger had provided that positive assurance There were actions already underway in the service and by other areas of the London health economy which would require further discussion and support from other parts of the health system. It was emphasised in discussion that although we focus on our delays, that was only the beginning for some patients. For an individual patient an LAS delay could followed by delay in handover at hospital, delayed assessment in A/E, delay in investigation, delay in finding an appropriate bed, which is some recent reported incidents could total 18 hours or more.

FUTURE COMMITTEE MANAGEMENT

Date of next meeting

The next meeting of the Quality Governance Committee is on Tuesday 14th April 2015.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Finance Report – Part 1 – 2014/15 Month 9: December**
Report Author(s):	**Andy Bell**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andy.bell@lond-amb.nhs.uk (02077832793)**
History:	***The Part 1 report is reviewed by EMT and SMT on a monthly basis***
Status:	***information***

Background/Purpose

The report contains the key financial results and statements outlining the in month and year to date financial position as at the 31st December 2014. Additional, commentary has been provided to provide insight into the figures.

This Report is intended for Part 1 of the Trust Board Meeting

Action required

The Trust Board is asked to note the Financial Results for Month 9

Assurance

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

London Ambulance Service NHS Trust
Finance Report - Part 1 – 2014/15
Month 9: December

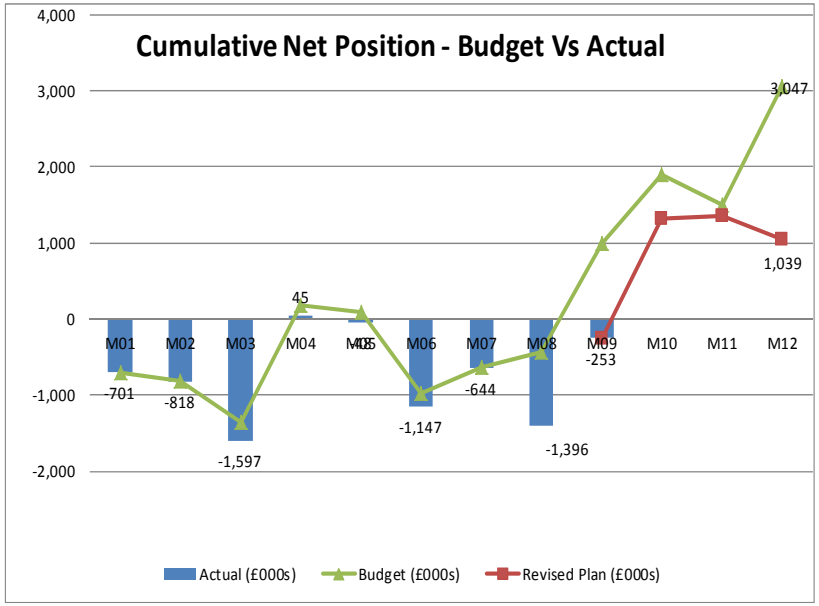
Trust Board – 27th January 2015
FIC – 26th January 2015

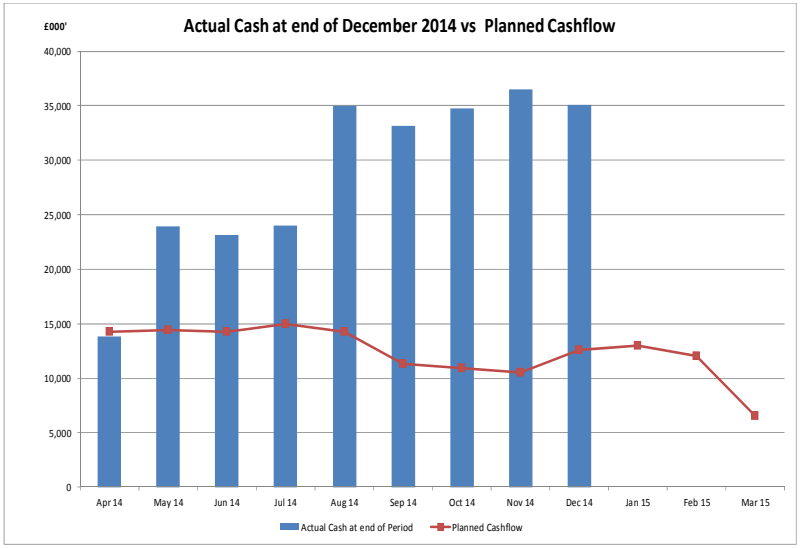
Andrew Grimshaw
Finance Director

Finance Summary: M09 (2014/15)

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the Trust is reporting a result £0.3m adverse to plan. YTD the Trust is reporting a £1.2m adverse variance to plan. This is as a result of pressures related to additional resources to support performance. At month 9 the forecast surplus has been reduced to £1.0m for the financial year. This reflects the planned investment in additional capacity agreed with commissioners, NHSE and the TDA. The RAG rating is shown as AMBER as the Trusts financial position is in line with revised plans but not in line with the original plan for the year. Commissioners have indicated that any penalties will be reinvested. Formal confirmation of this is pending.	**AMBER**	**RED**
Income	Income is £3.5m favourable to plan in month and £4.3m favourable YTD. £3.3m has been recognised in month relating to Resilience income. Other favourable variances are derived from ongoing PTS over-performance (£0.7m) and higher than expected LETB income (£0.5m).	**GREEN**	**GREEN**
Expenditure	In month total spend is £3.9m adverse, YTD there is a £5.5m adverse position. This is being driven by additional resources to support performance and relates primarily to additional incentivised overtime and expanded Private Ambulance usage. Revised expenditure plans based on achieving an improved run rate in Cat A performance across the remainder of the financial year have now been and will continue to be implemented. The Trust has committed to significant additional expenditure across the remainder of the year and this has manifested itself in the adverse in month and YTD position at Month 9. Additional funding is now being partially recognised to support the position and the final income settlement is being finalised with the NTDA and NHSE.	**AMBER**	**RED**
CIPs	Currently reporting on plan.	**GREEN**	**GREEN**
Balance Sheet	Capital expenditure remains below plan at this point of the year. Milestone plans have been developed and agreed with Directorates to ensure that the capital programme is completed by year end. Further capital projects are being assessed. The MABER RAG rating is driven by the slower than expected capital expenditure position; this is expected to recover to plan by year end.	**AMBER**	**AMBER**
Cashflow	Cash is £22.5m above plan.	**GREEN**	**GREEN**

Executive Summary - Key Financial Metrics





Description	2014/15 - Month 9			Year to Date			FY 2014/15
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	1,421	1,143	(278)	989	(253)	(1,243)	1,000
EFL				(3,033)	(29,237)	26,204	3,692
CRL				16,661	3,961	(12,700)	20,900
Suppliers paid within 30 days - NHS	95%	78%	(17.0%)	95%	78%	(17.1%)	95%
Suppliers paid within 30 days - Non NHS	95%	91%	(3.8%)	95%	91%	(3.8%)	95%
Monitor							
EBITDA %	10.8%	7.7%	(3.1%)	6.1%	5.1%	(1.0%)	6.0%
EBITDA on plan	2,839	2,303	(536)	13,751	11,775	(1,976)	18,016
Net Surplus	1,421	1,143	(278)	989	(253)	(1,243)	1,000
Return on Assets	2.90%	1.80%	(1.1%)	2.90%	1.80%	(1.1%)	5.10%
Liquidity Days	0.52	0.50	0.0	0.52	0.50	0.0	0.52
Continuity of Service Risk Rating	3.5	4.0	0.5	3.5	4.0	0.5	3.5

- In month £0.3m adverse, YTD overall position is £1.2m adverse to the original plan. However, the Trust expects to achieve its revised £1.0m year end surplus target..
- On-going pressures are:
  - Additional spend in support of performance improvement
  - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
  - Servicing an ageing fleet whilst new vehicles are on order
  - Management of operational staff – particularly relief factor
- Cash is £22.5m above plan. This is mainly due to an increase in trade and other payables and lower than planned capital expenditure at this point in the year.
- The EFL variance is due to higher than planned cash balances, and PDC funding for the CommandPoint resilience capital project not having been received as the project has been deferred to 2015/16.
- The Trust would expect to score a Continuity of Service Risk Rating (CSRR) of 4 for the YTD results based on the current Monitor metrics (maximum rating).
- CRL position – The capital plan is currently £12.7m behind plan The underspend is due to programme delays but capital expenditure will accelerate in the latter part of the year.

Statement of Comprehensive Income

2014/15 - Month 9			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Income				
23,149	26,442	3,292	Income from Activities	196,250	199,381	3,131	263,370
3,219	3,510	292	Other Operating Income	28,835	29,998	1,162	38,504
26,368	**29,952**	**3,584**	**Subtotal**	**225,085**	**229,378**	**4,293**	**301,874**
			Operating Expense				
17,963	20,386	(2,422)	Pay	160,370	159,764	605	216,155
5,565	7,264	(1,698)	Non Pay	50,965	57,839	(6,874)	67,704
23,529	**27,649**	**(4,121)**	**Subtotal**	**211,335**	**217,603**	**(6,269)**	**283,858**
2,839	**2,303**	**(536)**	**EBITDA**	**13,751**	**11,775**	**(1,976)**	**18,016**
10.8%	7.7%	3.1%	**EBITDA margin**	6.1%	5.1%	1.0%	6.0%
			Depreciation & Financing				
1,111	816	295	Depreciation	10,001	9,200	801	13,334
301	297	4	PDC Dividend	2,705	2,674	32	3,607
6	47	(41)	Interest	55	154	(99)	74
1,418	**1,160**	**258**	**Subtotal**	**12,762**	**12,028**	**733**	**17,016**
1,421	**1,143**	**(278)**	**Net Surplus/(Deficit)**	**989**	**(253)**	**(1,243)**	**1,000**
5.4%	3.8%	1.6%	**Net margin**	0.4%	-0.1%	0.6%	0.3%

- The Trust has submitted a revised year end forecast to the TDA of £1.0m surplus. This results from the need to spend more to support performance improvement.

- The YTD result is £1.2m adverse due to pressures on cost from the implementation of measures to improve performance.
- This position is in line with the revised forecast.

Income

- YTD £4.3m favourable due to partial recognition of resilience income (£3.3m), and continuing over performance on PTS (£0.7m). In addition the Trust has received more LETB income than planned (£0.5m). All this additional income is non-recurrent.

Operating Expenditure

- Overall £6.3m adverse YTD primarily due to increased incentivised Overtime spend in pay on the frontline and continuing high levels of PAS in non-pay.
- In month there is a £4.1m adverse variance that relates primarily to additional measures to improve performance (overtime and PAS usage).
- Pay is favourable by £0.6m ytd due mainly to frontline vacancies. International Paramedics are due to start work from Month 10 and there will be 111 new Paramedics by the end of March.
- There remains extensive use of Private Ambulances offsetting this position (Non Pay).
- Spend on Frontline resourcing is above plan overall in Q3 & will continue to accelerate in Q4. Additional funding and mitigation has been agreed in principle to deliver performance improvements and income for this has been partially recognised.
- CIPs are seen as delivering on plan YTD.

Depreciation and Financing

- Currently £0.8m favourable to plan. The depreciation plan has been revised down due to timing delays in the Capital programme against plan. This will continue to be reviewed each month.

Divisional Expenditure (excludes Income)

2014/15 - Month 9			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Operational Divisions				
12,851	15,082	(2,231)	Core Frontline	117,710	122,286	(4,576)	156,113
285	251	35	Other Frontline	2,568	2,211	357	3,425
750	686	64	EPRR	6,750	6,171	579	9,000
214	238	(24)	Resource Centre	1,923	1,963	(40)	2,564
1,870	2,346	(476)	EOC	17,389	17,998	(610)	22,999
311	386	(75)	PTS	3,532	3,786	(255)	4,538
598	461	137	111 Project	5,380	4,538	842	7,173
16,879	**19,449**	**(2,570)**	**Subtotal**	**155,251**	**158,953**	**(3,702)**	**205,812**
			Support Services				
1,892	2,219	(327)	Fleet & Logistics	17,023	19,017	(1,994)	22,714
951	633	318	IM&T	8,625	7,834	790	11,478
354	386	(33)	HR	3,173	3,015	158	4,233
0	(0)	0	Education & Development	0	(1)	1	0
799	811	(12)	Estates	7,472	6,818	654	9,869
36	50	(14)	Support Services Management	324	447	(124)	432
4,032	**4,098**	**(66)**	**Subtotal**	**36,616**	**37,130**	**(514)**	**48,726**
			Corporate				
229	257	(28)	Chief Executive & Chair	2,123	2,078	45	2,810
225	268	(43)	Corporate Services	2,209	2,276	(67)	2,885
12	21	(8)	Business Development	110	181	(72)	146
99	132	(33)	Strategic Communication	862	846	16	1,158
211	412	(201)	Finance	1,903	2,917	(1,014)	2,534
139	152	(13)	Nursing & Quality	1,255	1,151	104	1,673
163	220	(57)	Transformation & Strategy	1,465	1,579	(114)	1,953
602	521	81	Clinical Education & Standards	5,266	4,910	356	7,084
97	106	(9)	Medical	874	853	21	1,165
1,777	**2,088**	**(311)**	**Subtotal**	**16,067**	**16,790**	**(723)**	**21,409**
			Central				
2,252	3,185	(933)	Central Corporate	16,099	16,647	(549)	22,793
7	(10)	17	Other Central Costs	63	110	(47)	84
2,259	**3,174**	**(915)**	**Subtotal**	**16,161**	**16,757**	**(596)**	**22,877**
24,947	**28,810**	**(3,863)**	**TOTAL**	**224,096**	**229,631**	**(5,535)**	**298,824**
26,368	*29,952*	*3,584*	*Income Memorandum*	*225,085*	*229,378*	*4,293*	*301,874*
1,421	***1,142***	***(279)***	***NET POSITION MEMORANDUM***	***989***	***(253)***	***(1,242)***	***3,050***

Operational Divisions

- Expenditure is currently £3.7m adverse due to additional spend to support performance. This additional pressure will be mitigated through management of internal resources and additional external funding (The Trust has recognised £3.3m resilience income in month 9).
- Operational spend is under pressure due to ongoing high levels of activity, industrial action, a shortage of substantive staff (leading to a reliance on overtime and PAS) and transition to a revised operating model.
- EOC underspends primarily occur in the Clinical Hub due to ongoing vacancies.
- NHS 111 will report a small surplus as agreed with Commissioners. The decrease in 111 costs are offset against decreases in income.

Support Services

- Support Services is adverse to plan £0.5m YTD due to pressures arising from maintenance on ageing vehicles in Fleet and non delivery of CIPs, offset by underspends in IM&T relating to Telecoms, computer hardware and software contract benefits
- Estates is underspent (£0.7m) due to timing variations against plan and ongoing cost savings and cost recovery schemes.

Corporate

- Overall Corporate divisions are £0.7m adverse
- Currently Corporate Services is overspent YTD due to agency costs exceeding vacancies and to Staff & Public liability claims.
- Business Development is overspent due to costs associated with the defibrillator campaign that will be funded centrally
- Finance is overspent due to external support costs for performance analysis (£1.0m) which offsets with income.
- Transformation & Strategy has overspends related to the usage of agency support in the Contracts team. This is an agreed investment by EMT that was not in the original plan.
- Clinical Education and Standards is £0.4m favourable due to timing delays in recruiting and training new staff. This cost is expected to pick up in Q4.

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Central

- Central Corporate includes non divisional and corporate costs.

Income

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

Cost Improvement Programme

2014/15 - Month 9			Description	Year to Date			FY 2014/15		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
		fav/(adv)	**Core CIP**			fav/(adv)			fav/(adv)
800	800	0	Frontline staffing - Volume	5,450	5,450	0	8,000	8,000	0
94	0	(94)	Fleet	732	108	(624)	1,000	108	(892)
65	65	0	Estates	305	305	0	500	500	0
47	47	0	IT	359	313	(46)	500	500	0
33	33	0	Corporate	198	198	0	300	300	0
47	47	0	EOC	359	357	(2)	500	500	0
150	150	0	Ops Management	1,050	1,050	0	1,500	1,500	0
47	224	177	Procurement and Equipment	359	1,779	1,420	500	2,392	1,892
83	0	(83)	Collaboration	747	0	(747)	1,000	0	(1,000)
1,366	**1,366**	**0**	**Total Core CIP**	**9,559**	**9,560**	**1**	**13,800**	**13,800**	**0**

- CIPs have currently delivered on plan overall.
- Key items to note:
  - Fleet - operational pressures are making delivery challenging. The Trust now has a 3 year plan to reduce the average fleet age below 7 years old and as a result reduce maintenance costs.
  - Collaboration is unlikely to deliver benefit in year.
  - Procurement - Additional savings on procurement (price and usage have been achieved in year)
- A detailed review is underway to assess the evidence that CIPs are being delivered.
- The CIP forecast is under review; current operational pressures may cause some pressure to some plans. In all cases mitigations will be sought.

Statement of Financial Position: YTD

	Mar-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Dec-14		
	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000			
Non Current Assets										
Property, Plant & Equip	121,627	118,758	118,266	117,764	117,001	116,507	128,097	121,068	7,029	5.81%
Intangible Assets	12,296	11,393	11,372	11,165	11,004	10,791	10,579	14,198	(3,619)	-25.49%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	
Subtotal	133,923	130,151	129,638	128,929	128,005	127,298	138,676	135,266	3,410	2.52%
Current Assets										
Inventories	3,498	3,510	3,501	3,502	3,497	3,505	3,533	3,257	276	8.47%
Trade & Other Receivables	22,804	23,976	13,406	11,863	11,016	11,306	17,784	16,564	1,220	7.37%
Cash & cash equivalents	6,436	23,988	34,959	33,163	34,793	36,512	35,051	12,597	22,454	178.25%
Non-Current Assets Held for Sale	0	101	101	101	101	101	106	0	106	
Total Current Assets	32,738	51,575	51,967	48,629	49,407	51,424	56,474	32,418	24,056	74.21%
Total Assets	166,661	181,726	181,605	177,558	177,412	178,722	195,150	167,684	27,466	16.38%
Current Liabilities										
Trade and Other Payables	(22,840)	(37,756)	(37,708)	(35,307)	(34,661)	(36,513)	(42,354)	(29,541)	(12,813)	43.37%
Provisions	(4,750)	(4,750)	(4,750)	(4,750)	(4,750)	(4,750)	(3,747)	(1,272)	(2,475)	194.58%
Borrowings	0	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(622)	(622)	(622)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,834)	(43,750)	(43,702)	(40,679)	(40,033)	(41,885)	(47,345)	(32,057)	(15,288)	47.69%
Non Current Assets plus/less net current assets/Liabilities	137,827	137,976	137,903	136,879	137,379	136,837	147,805	135,627	12,178	8.98%
Non Current Liabilities										
Trade and Other Payables	0	0	0	0	0	0	0	0	0	
Provisions	(9,114)	(9,219)	(9,238)	(9,313)	(9,309)	(9,519)	(9,967)	(10,572)	605	-5.72%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(3,099)	(3,099)	(3,099)	(3,099)	(3,099)	(3,099)	(2,477)	(2,477)	0	0.00%
Total Non Current Liabilities	(12,320)	(12,425)	(12,444)	(12,519)	(12,515)	(12,725)	(12,551)	(13,156)	605	-4.60%
Total Assets Employed	125,507	125,551	125,459	124,360	124,864	124,112	135,254	122,471	12,783	10.44%
Financed by Taxpayers Equity										
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	66,266	(3,750)	-5.66%
Retained Earnings	22,674	22,718	22,626	21,527	22,031	21,279	22,421	21,582	839	3.89%
Revaluation Reserve	40,736	40,736	40,736	40,736	40,736	40,736	50,736	35,042	15,694	44.79%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	125,507	125,551	125,459	124,360	124,864	124,112	135,254	122,471	12,783	10.44%

A key issue driving the balance sheet variances has been movements in the 2013/14 year end position which were not known in time to inform the 2014/15 plan (forecast on the 2013/14 month 10 position).

Non Current Assets

- Non current assets stand at £138.7m, a £3.4m increase against plan.
- The movement from plan is related to variances between the plan (set in February 2014) and the actual year end position following the property revaluation exercise carried out at the year-end. Fixed assets increased by £7.7m. The property revaluation exercise performed by the valuation office has started earlier this year and an estimated revaluation value of £10m as at 30 November 2014 has been included in the accounts. Work still needs to be undertaken to finalise the values.

Current Assets

- Current assets stand at £56.5m, a £32.4m increase against plan.
- Cash position as at December is £35.1m, a £22.5m increase against plan. This is due to a higher than planned trade & other payables and provision balances , and lower than planned capital spend in both 2013/14 and 2014/15.
- Receivables (debtors) at £7.3m are £0.5m below plan , accrued Income at £4.9m is £0.3m above plan, prepayments at £5.6m are £1.4m above plan, stocks at £3.5m are £0.2m above plan and assets held for sale are £0.1m above plan.

Current Liabilities

- Current liabilities stand at £47.3m, a £15.3m increase on plan.
- Payables and accruals at £40.0m are £10.5m above plan.
- Deferred Income at £2.4m is £2.3m above plan; this includes £7.2m CBRN income for the year to 31/3/15 being raised in June. The Trust has a high volume of unapproved trade payables at £4.0m. Current provisions at £4.8m are £2.5m higher than plan. The Trust is still waiting for a decision to be made by the HMRC on its liability relating to contracted out services VAT due to back-dated changes in rules.

Non Current Liabilities

- Non current provisions are £0.6m lower than planned. This is due to a re-allocation of provisions for VAT between current and non-current .

Taxpayers Equity

- Taxpayers Equity stands at £122.5m, a £12.8m increase on plan.
- PDC is £3.8m lower than planned due to slippage on the capital programme. PDC was the budgeted source of funding for the CommandPoint capital project.
- The revaluation reserve and retained earnings increase is due to the property revaluation exercise at the 2013/14 year-end. The data was not available when the plan was prepared. Also the reserves includes a £10m estimate for the increase in property values as at 30 November 2014 prepared by the valuation office.

Cashflow Statement YTD

	In Month Movement						YTD Move	YTD Plan	Var
	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Dec-14	Dec-14	Dec-14
	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	23,163	23,988	34,959	33,163	34,793	36,512	**6,436**	**6,436**	**0**
Operating Surplus	3,136	1,377	201	1,916	367	2,266	11,728	13,741	(2,013)
(Increase)/decrease in current assets	(1,334)	10,579	1,542	852	(298)	(6,506)	4,985	2,860	2,125
Increase/(decrease) in current liabilities	(773)	(398)	(816)	(602)	1,557	4,003	17,807	5,912	11,895
Increase/(decrease) in provisions	(143)	(43)	61	(18)	196	(569)	(326)	(895)	569
Net cash inflow/(outflow) from operating activities	886	11,515	988	2,148	1,822	(806)	34,194	21,618	12,576
Cashflow inflow/outflow from operating activities	**886**	**11,515**	**988**	**2,148**	**1,822**	**(806)**	**34,194**	**21,618**	**12,576**
Returns on investments and servicing finance	0	3	0	8	3	3	12	(27)	39
Capital Expenditure	(61)	(547)	(379)	(526)	(106)	(658)	(3,186)	(16,755)	13,569
Dividend paid	0	0	(1,783)	0	0	0	(1,783)	(1,803)	20
Financing obtained	0	0	0	0	0	0	0	3,750	(3,750)
Financing repaid	0	0	(622)	0	0	0	(622)	(622)	0
Cashflow inflow/outflow from financing	**(61)**	**(544)**	**(2,784)**	**(518)**	**(103)**	**(655)**	**(5,579)**	(15,457)	**9,878**
Movement	825	10,971	(1,796)	1,630	1,719	(1,461)	28,615	6,161	22,454
Closing Cash Balance	**23,988**	**34,959**	**33,163**	**34,793**	**36,512**	**35,051**	**35,051**	**12,597**	**22,454**

Cash funds at 31 December stand at £35.1m, which is £22.5m above plan.

Current Assets

- The ytd movement on current assets is £11.5m, a £2.1m increase on plan.
- Current assets movement was higher than planned due to an increase in accrued income £2.3m and prepayments £1.2m, off-set by decrease in receivables £1.4m.

Current Liabilities

- The ytd movement on current liabilities is £5.0m, a £11.9m increase on plan.
- Current liabilities movement was higher than planned due to increases in accruals £9.1m, deferred income £2.3m and trade and other payables £0.5m. The Trust has a high volume of unapproved invoices. The increase in deferred income includes a £7.2m CBRN invoice for the year to 31/3/15 raised in June 2014.

Provisions

- The ytd movement on provisions is £0.3m, a £0.6m increase on plan.
- The HMRC has made a decision in favour of the Trust and the Vat provision for £0.8m was released in the period. The Treasury issued the new discount rates in December and these have been applied to the provisions. The effect was an increase in provision of £0.4m.

Capital Expenditure

- The ytd movement on Capital Expenditure payments is £3.2m, £13.6m lower than plan.
- The lower than planned capital expenditure payments is due to slippage on the 2014/15 capital programme. Capital expenditure to December 2014 is £4.0m.
- The ytd movement on financing obtained is nil, £3.8m lower than planned. The application for PDC funding for the CommandPoint capital project will not take place in 2014/15.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27 January 2015**
Document Title:	**e-Ambulance Strategic Outline Case (SOC)**
Report Author(s):	**IM&T Division**
Presented by:	**Director of Finance**
Contact Details:	**020 7783 2041**
History:	**The strategic outline case for E-ambulance has been reviewed and approved by both EMT and the FIC.**
Status:	***For approval***

Background/Purpose

The document sets out the strategic case for investment in a vehicle-based mobile technology solution. The SOC has been approved at the LAS Executive Management Team and Financial Investment Committee, and has been updated to include comments and clarification requested by the TDA.

Approval of the strategic outline case does not commit the Trust to the Project, what it does do is lay out in a structured way the case for the project and provides clear demonstration that the development of a outline and then full business case can be justified.

Upon approval by the Trust Board the SOC will be submitted to the Trust Development Authority for approval. This is required as the overall potential value of the investment exceeds the Trust's delegated limit for approval.

Action required

The Trust Board is requested to review and approve the strategic outline case. Based on this the Trust will start to develop the outline Business Case for review.

Assurance

The SOC for e-ambulance has been reviewed by the EMT and FIC. The TDA has seen a draft and made comments which have been incorporated into the case presented.

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

London Ambulance Service e-Ambulance Strategic Outline Case

The e-Ambulance Strategic Outline Case (SOC) is presented to the Board for approval to move to the Outline Business case (OBC) stage.

The document sets out the strategic case for investment in a vehicle-based mobile technology solution. The SOC has been approved at the LAS Executive Management Team and Financial Investment Committee, and has been updated to include comments and clarification requested by the TDA. The following is a summary of the case.

INTRODUCTION

The London Ambulance Service (LAS) provides a world class service to population of over 8.4 million; the LAS is a key pathway for Londoners, visitors and commuters alike and is often the main gateway to accessing urgent and emergency care to all those in need - caring for the capital.

The LAS has a mature electronic Ambulance dispatch capability, known as the MDT, however, it currently operates paper based systems for the capture of patient and clinical care information, transferring information to Emergency Departments and other care pathways and for patient and reference information used on scene.

The LAS seeks to revolutionise the way it treats its patients. A key element of this vision is to sustainably improve care by harnessing technology to develop a modern integrated digital ambulance capability which includes a digital patient record. This is to be delivered through the LAS's e Ambulance Programme.

THE CASE

The following are the high level drivers for change, to be addressed in line with the vision.

- Improvements in the quality of patient care are held back as paramedics cannot access and add to care records or other relevant information needed to treat and provide a better care pathways, rather than convey to an ED (where appropriate), for more patients.
- The existing paper based processes are in-efficient and time consuming.
- There are risks to patients due to the current use of manual paper based processes, and the inability to digitally transfer patient information to onward locations.
- Individual and Trust Clinical performance monitoring is severely hampered by a lack of linked information related to the patient care journey.
- There is a risk that the age and sustainability of the existing MDT solution will impact on patient care.

In 2013-14 the LAS responded to 1.1 million incidents within the London area, conveying almost 900,000 patients to hospital, generating over 5 million pieces of paper. These are all produced by ambulance staff, from when patient begins their care journey in the ambulance to their arrival at EDs and are then shared as paper, scanned and stored. When patients are eventually discharged these vital records need to be shared across organisational boundaries to inform better care decisions across health and social care, meeting the future needs of the population.

The programme directly supports both the London Pioneer and National Integration Programmes which are developing strategies to improve the integration of care across primary and secondary and eventually social care.

The integration is underpinned by sharing data and care plans for health service users. Significant gains have been made in the last two years in achieving near real time handover documentation and sharing diagnostic results through integrated patient care records. The programme will allow the LAS to use and contribute to the integrated care record of patients they serve.

In line with other similar business cases across the UK, it can be shown that conveyance and admittance to Emergency Departments can be reduced as a result of implementing and linking digital patient and care information.

Whilst over time the LAS's e-Ambulance Programme will reduce overall costs for the LAS and the Acute Trusts and Local Commissioners it serves, it is more significantly a key enabler, radically changing and improving the way we treat and diagnose patients through the use of modern technology and systems putting the patient at the centre of Emergency and Urgent care.

BENEFITS AND DELIVERY

The Programme aims to deliver benefits to patients, the LAS and in particular the wider health care system including:

Improved quality of care across the patient journey
Reduction of Ambulance based load on EDs
Improved linkage between Ambulance activity and patient outcome information
Improving the utilisation of existing resources to focus on patients.
Enabling a consistent integrated digital record of care across London

The solution provided will enable our clinicians to have digital access to care records and other key information and so improve clinical treatment and patient outcomes. They will also be able to share their observations and interventions electronically with EDs and other partners as appropriate.

The Programme aims to unlock pan-London digital integration to enable the sharing and linking of LAS patient data with the London care community, as well as providing a gateway to other services. The LAS will be able to sign post people to partner services facilitated by the digital technology and integration. In the longer term this will enable clinicians to make appointments .

Aside from process and business changes and the training of staff, the four main deliverables are,

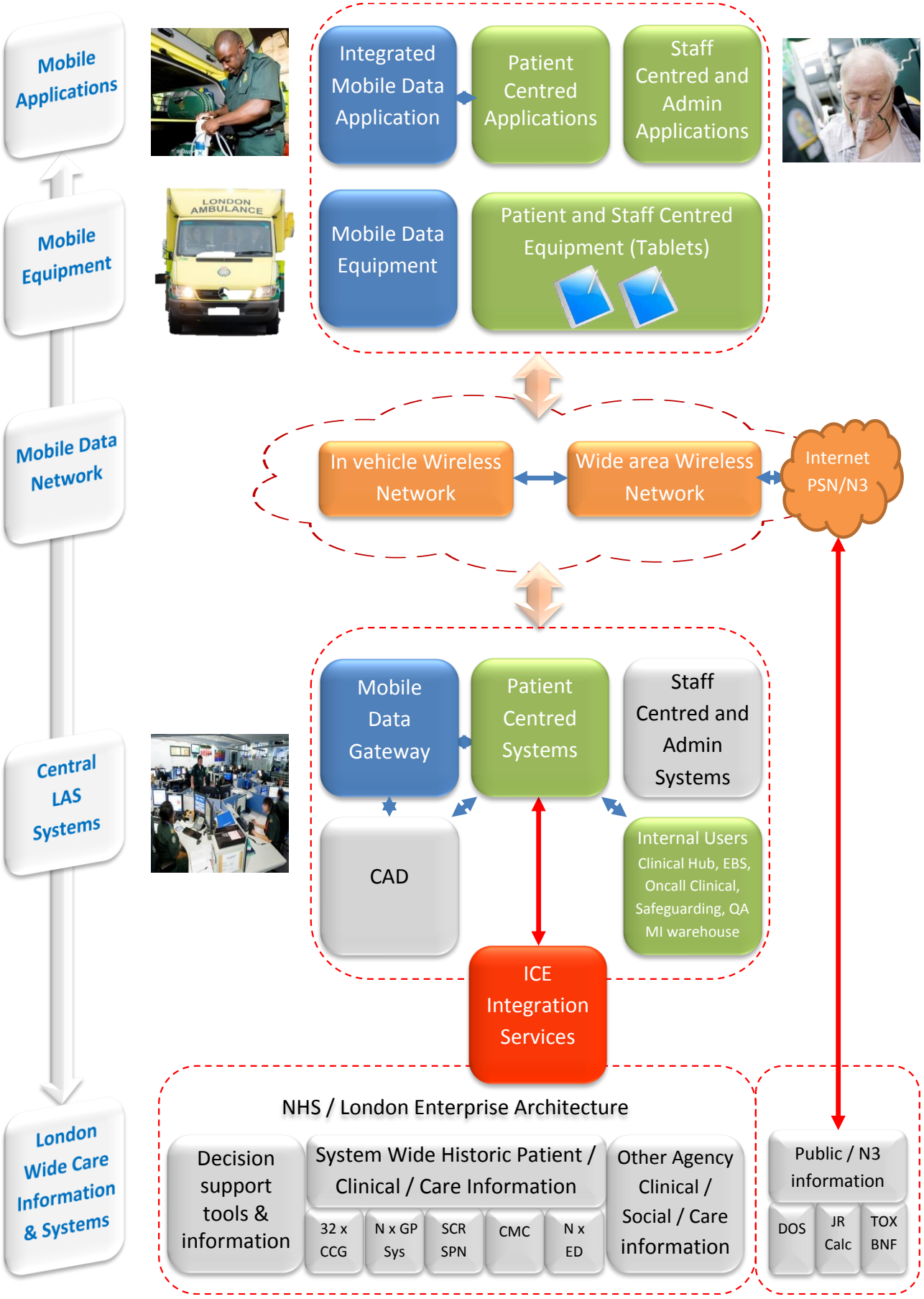
1. A set of new patient and staff centred systems, linking to existing LAS systems, to be used at the patient's side, in vehicles and in control rooms. This is the most significant element which will be delivered through an OJEU procurement process
2. An integration digitally linking these new systems with pan London urgent and emergency care records and other relevant systems/information. This will be delivered using a partnership approach using CMC's Integrated Care Exchange.
3. A mobile data network which can be migrated onto emerging technologies being provided for all emergency services at a future date. Procurement will be based on frameworks or existing Contracts.
4. A solution to ensure sustainability of an effective and integrated Mobile Data (Dispatch) capability. Using an integrated new or refreshed solution.

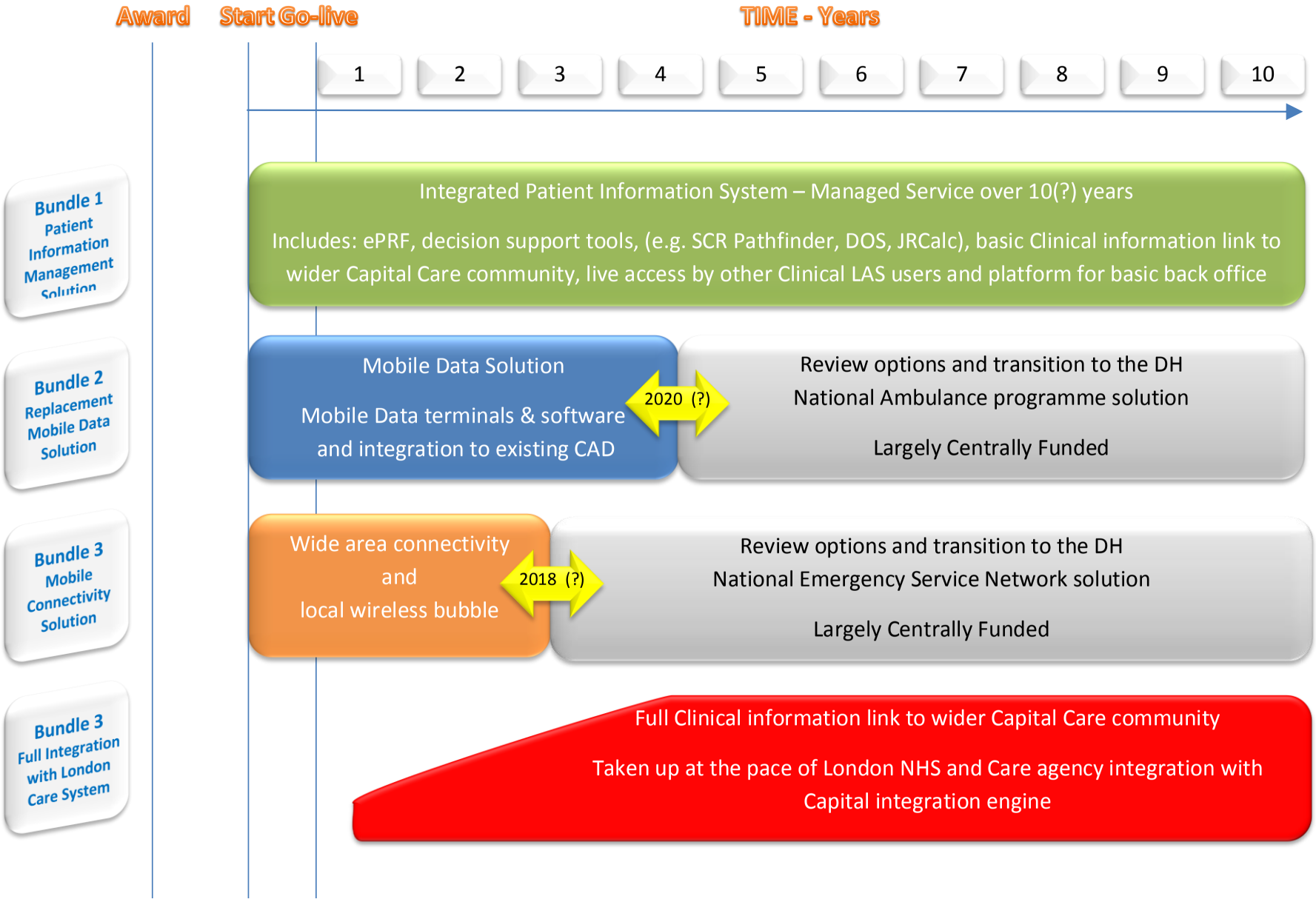
Diagrams are included below to depict further the solution and the deliverable framework.

COST AND AFFORDABILITY

Whilst approval of the SOC does not commit the Trust to invest in this solution it does approve the investment in the work required to produce the OBC, where cost and affordability will be explored in more detail, start the procurement process and with subsequent approval, to move to tender and Final Business Case (FBC).

The estimated cost is predicted to be significant, and the Trust has sought external funding from the Digital Care Fund and will be liaising with Commissioners once more refined costs are identified in the OBC and FBC stages along with evidence of patient benefits.


Mobile Applications
Mobile Equipment
Mobile Data Network
Central LAS Systems
London Wide Care Information & Systems
Integrated Mobile Data Application
Patient Centred Applications
Staff Centred and Admin Applications
Mobile Data Equipment
Patient and Staff Centred Equipment (Tablets)
LONDON AMBULANCE
In vehicle Wireless Network
Wide area Wireless Network
Internet PSN/N3
Mobile Data Gateway
Patient Centred Systems
Staff Centred and Admin Systems
CAD
Internal Users
Clinical Hub, EBS, Oncall Clinical, Safeguarding, QA MI warehouse
ICE Integration Services
NHS / London Enterprise Architecture
Decision support tools & information
System Wide Historic Patient / Clinical / Care Information
32 x CCG
N x GP Sys
SCR SPN
CMC
N x ED
Other Agency Clinical / Social / Care information
Public / N3 information
DOS
JR Calc
TOX BNF


Award
Start Go-live
TIME - Years
1
2
3
4
5
6
7
8
9
10
Bundle 1
Patient Information Management Solution
Integrated Patient Information System – Managed Service over 10(?) years
Includes: ePRF, decision support tools, (e.g. SCR Pathfinder, DOS, JRCalc), basic Clinical information link to wider Capital Care community, live access by other Clinical LAS users and platform for basic back office
Bundle 2
Replacement Mobile Data Solution
Mobile Data Solution
Mobile Data terminals & software and integration to existing CAD
2020 (?)
Review options and transition to the DH National Ambulance programme solution
Largely Centrally Funded
Bundle 3
Mobile Connectivity Solution
Wide area connectivity and local wireless bubble
2018 (?)
Review options and transition to the DH National Emergency Service Network solution
Largely Centrally Funded
Bundle 3
Full Integration with London Care System
Full Clinical information link to wider Capital Care community
Taken up at the pace of London NHS and Care agency integration with Capital integration engine

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27TH January 2015**
Document Title:	**Business case for the procurement of Double Crewed Ambulances**
Report Author(s):	**Director of Finance**
Presented by:	**Director of Finance**
Contact Details:	**Andrew.Grimshaw@lond-amb.nhs.uk 020 7783 2041**
History:	**This case provides a more detailed version of an outline case previously reviewed by the FIC. The FIC will review the full business case presentation of this case on the 26th January 2015.**
Status:	

Background/Purpose

To demonstrate the case for the ongoing replacement of LAS's double crewed ambulances. This case requests the approval for the procurement of 50 vehicles in 2014/16.

Action required

The Trust Board is requested to approve this case for submission to the TDA. The chair of the FIC will provide an update on the review of the full case at the Trust Board meeting. Once approved by the Trust Board this case will be submitted to the TDA for review and approval as the value of the investment exceeds the £5m delegated limit for the Trust.

Assurance
The summary presented here represents the executive summary of the Full Business Case presentation. This case has been developed in accordance with the requirements of the TDA.

Key implications and risks arising from this paper	
Clinical and Quality	**Maintain operational fleet.**
Performance	**Reduced out of service**
Financial	**Funding the investment and revenue costs**
Legal	
Equality and Diversity	
Reputation	
Other	**TDA business case approval process**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**Yes**
Improve recruitment and retention	**Yes**
Implement the modernisation programme	
Achieve sustainable performance	**Yes**
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	**Yes**

London Ambulance Service NHS Trust

Trust Board 27th January 2015

Business case for the procurement of Double Crewed Ambulances

1.1 Introduction

1.1.1 Explanation of case approach

The London Ambulance Service NHS Trust (LAS) faces a significant number of strategic and operational pressures as set out in the following sections. For that reason this case has been prepared as part of a package of cases to be submitted over the next year and including 54 vehicles for which approval was granted last year.

What is proposed is a three case strategy for the current and future needs covering the following years.

Table	Number of Vehicles	Approval Document
2014/15	50	This Case
2015/16	70	OBC to be submitted later this year
2016/17 to 20/21	Currently Unknown	To be included in a wider fleet strategy case submitted as OBC later next year

The intent is to allow a rapid refresh of the oldest elements of the current fleet together with a programme of planned replacement to ensure that sufficient vehicles of the right type and age are reached and maintained as part of the Trusts overall strategy.

1.1.2 Urgent Need for Current Case

The need to ensure that there is a steady flow of Double Crewed Ambulances (DCAs) to inject fresh stock into the aging fleet is part of the overall fleet maintenance strategy but is more urgent than for other types of vehicle. The age of the current stock and the pressures on performance together with the current levels of support available mean that not only do DCAs need to be replaced as quickly as possible but also in a controlled manner over time to fit with constraints on capital and budgets, production capability and commissioning capacity. Merging this case with the next would lead to unacceptable delays in the delivery of the capacity and merging the second case with the longer term procurement would have a similarly detrimental effect.

1.1.3 The TDA

The TDA have agreed that rather than present an strategic Outline Case (SOC), Outline Business Case (OBC) and then a Full Business Case (FBC) the Trust can move directly to an FBC. This reflects the fact that this procurement represents part of the Trust's normal capital programme.

1.1.4 Future Strategy and Case

While the need for the current and subsequent case are based on urgent requirements for one class of vehicle there is an explicit acknowledgement that the Trust needs to move to a sustainable fleet strategy linked to other operational areas of Trust activity and the overall Trust strategy for future years. Work on this is already underway but as yet the required numbers of DCA are not yet specified as the fleet size and mix will be part of the overall analysis that is not yet completed.

1.2 Strategic Case

LAS is the only pan-London health provider and as a first contact service is integral to the delivery of all healthcare across the capital. LAS's A&E contract covers 100% of the population within our

service area and is commissioned by the North West London Commissioning Partnership, representing a conglomerate of 31 PCTs and six commissioning sectors across London.

From the emergency response point of view the Trust answers over 1.7mn calls every year and the number of Category A and Non Category A incidents has increased significantly over the last years.

While there has been an average of just under 3% per annum increase in incidents over the 6 years to 2014 there has been a 6.5% increase in category A incidents each year on average with nearly an 8% rise from 2009/10. The projected figure for Category A incidents for the year to March 2015 is 485,000, an increase of 5.4%.

The last year has seen a drop in performance due to a number of factors. This has led to performance against the 8 minute target dropping to 62.3% and against the 19 minute target to 93.4% on a year to date basis by the middle of November. While it is not the only, or even the main, factor in this drop the quality and availability of the DCA fleet is an important part of the Trusts ability to deliver successfully against its targets.

The current fleet of DCAs comprises 428 vehicles, at the start of the year almost 17% were over 10 years old and over 46% were in excess of the 7 year optimal life that the Trust is targeting.

This is not the first time that fleet age has caused problems for LAS and the Trust is committed to breaking out of this cycle and moving towards a more efficient and cost effective approach to lifecycle management of the whole fleet.

The scope of this case covers the procurement of 50 Chassis and their Modular conversion together with associated commissioning and equipping. These vehicles will be the same as the 54 currently in production and offer the best level of overall mechanical and clinical operational capability together with lower carbon emissions.

1.3 Economic Case

A number of critical success factors were developed to support the options development and appraisal process. They have been chosen to complement the Investment Objectives in determining the best approach. These are:

- Strategic fit with the Trusts Business and Operational need
- Deliver Value for Money including maximising benefits and minimising risks
- Achievability in both operational and maintenance terms
- Affordability of solution over the investment period.

The options were developed in accordance with relevant guidance and covered the following areas:

- Implementation – Timing
- Solution – Fleet Mix
- Funding
- Scoping – Fleet Size
- Service

A number of options were considered as part of the process which for the sake of completeness included a Do Nothing which involved not replacing the older vehicles at all. This has been discounted due to the complete impracticality of retaining vehicles which by the end of the analysis period would be up to 19 years old.

Two options were selected to be taken forward:

Option 2: Do Minimum: Retain the existing fleet for an additional 2 years and replace on a like for like basis as part of the delivery of the longer term fleet strategy using a Capital purchase approach.

Option 3: Preferred: Purchase replacement of older vehicles in current year using a Capital purchase approach.

Both of these options involve procuring vehicles with a latest design specification, employing a box body mounted to a chassis cab and tail-lift for stretcher loading, with minimal changes to existing ambulance working standard that affect crew familiarisation/retraining.

There are a considerable number of benefits to the Project but they are generally part of the wider fleet improvements or items which do not deliver measurable cash release. For this reason they have been weighted and scored with score generated of 561.9 for Option 2 and 895.24 for Option 3.

Most of the difference between the scores is therefore down to the delay in getting the new vehicles not the difference in ability to deliver the benefits.

In relation to risk there are 2 elements of cost which are certain to change before the procurement of replacement vehicles considered in Option 2. Both the cost of the Chassis and the conversion will increase and, as the precise amount is not known, weighted costs of £114,570 for the cost of the Chassis and £166,750 for the increased cost of Conversion have been included in the appraisal.

Optimism Bias assessment has been applied to both options as shown below.

Option 2 Capital Bias: 17.54%

Option 3 Capital Bias: 9.74%

No adjustment has been made for Service costs as this is a replacement case for existing assets and neither option differs from current operational procedures.

The outcome of the appraisal is shown below:

		2014/15	2015/16	2016/7	2017/18	2018/19	2019/20	2020/21	2021/22	Total
Preferred		0	1	2	3	4	5	6	7	
Option 3										
	Capital Costs	3,631,045	1,946,195	-	-	-	-	-	- 75,000	5,502,239
	Revenue Cost	261,549	1,453,313	1,215,982	1,236,082	1,232,382	1,267,732	1,262,082	1,272,907	9,202,029
	Capital Optimism Bias	357,295	191,506							
	Service Cost Optimism Bias									
	Other risk costs									
	Total Cost	4,249,888	3,591,013	1,215,982	1,236,082	1,232,382	1,267,732	1,262,082	1,197,907	15,253,068
	Discount	1.000	0.966	0.934	0.902	0.871	0.842	0.814	0.786	
	NPC	4,249,888	3,469,578	1,135,132	1,114,875	1,073,950	1,067,396	1,026,705	941,544	14,079,068
Do Min										
Option 2										
	Capital Costs	120,108	-	5,688,450	-	-	-	-	-	5,808,558
	Revenue Cost	-	1,267,933	2,060,597	1,191,765	1,215,982	1,236,082	1,232,382	1,267,732	9,472,472
	Capital Optimism Bias			997,754						
	Service Cost Optimism Bias									
	Other risk costs			281,320						
	Total Cost	120,108	1,267,933	9,028,120	1,191,765	1,215,982	1,236,082	1,232,382	1,267,732	16,560,104
	Discount	1.000	0.966	0.934	0.902	0.871	0.842	0.814	0.786	
	NPC	120,108	1,225,056	8,427,847	1,074,903	1,059,658	1,040,748	1,002,544	996,426	14,947,290

The results a show that it would require a 15% increase in the capital cost, or an 11% increase in the revenue cost of Option 3 to reverse the NPV position.

Given that the costs and triggers for change are the same for both options it does not appear that any likely occurrence would cause a narrowing of the difference.

1.4 Commercial Case

The services involved are to provide 50 new Double Crewed Ambulances (DCAs) based on a Mercedes chassis and a converted box body including integrated tail-lift and all requisite equipment, that conforms to [Insert relevant standard] together with trolley bed and Mobile Data Terminal.

The new Ambulances will include enhancements over earlier models including increased capacity electrical systems, air-conditioning for the patient saloon, supply of 240v electrical capability for the conveyance of High dependency/Critical care patients, Mangar Elk patient lifting system, increased tail-lift and ambulance payload with an advanced stretcher capable of handling heavier patients.

The new vehicles will comply with Euro 6 emission standards (deemed the lowest emission/cleanest emergency ambulances being operated in the UK) as opposed to the earlier fleet of Euro 4 standard.

All capital elements of the proposed solution can be procured using existing Crown Commercial Service (formerly Government Procurement Service Frameworks). CCS frameworks are the recommended procurement mechanism for all public bodies for non-complex procurements of goods and services included within their spectrum.

- For the Chassis there will be a single supplier tender as only Mercedes Benz has Type Approval for the chassis needed to support the Modular box body used. Discussion have already been held with Mercedes and a fixed price quote obtained together with a provision to hold stock from an early production run which would lead to significantly reduced delivery times subject to approval of this case.
- For the Modular Body Conversion there are multiple suppliers on the framework and when a competitive mini tender was run in the summer for the previously purchased 54 vehicles conversions they sought responses for up to 104 conversions as it was always the Trusts intention to try and procure extra vehicles this year. Therefore, if approval can be obtained swiftly, the conversions can be carried out under the existing contract and advantages can be gained from reduced pricing for the conversion of all 104 vehicles not just the current 50.
- Trolley Beds will be procured under an existing contract with Stryker. This contract was awarded under an LAS tender which runs to Feb 2016.
- The procurement of the Mobile Data Terminals would be carried out under single tender call off as due to design based intellectual property there is only one supplier for the equipment used by the LAS.

All contracts will be on the Standard Framework or Call-Off terms with all but the conversion element on fixed price payment on delivery.

The Modular Box Body conversion is a custom build with payment following testing and acceptance.

Manufacturer’s warranties are included on all items.

The LAS retains ownership of the assets throughout and will dispose of them following the end of the 7 years planned lifecycle and all items will be on the Trusts balance sheet.

1.5 Financial Case

A £1.525mn surplus in 2013/14 led to an improvement on the cumulative position for the thirteenth year running, and remained well within the limit of 0.5% of turnover permitted by the Department of Health.

On income and expenditure the Trust reported a surplus of £262,000 for the year, and therefore performed better than the break-even target set by the Department of Health for 2013/14.

The current year outturn is showing that a surplus of between £1mn and £3mn is likely depending on the outcome of strategic operational decisions.

The overall capital value of the project is £6.7m including VAT. This will be spread over two years as detailed in the above table below, with a £90,000 residual value assumption in year 7. The basis of the split of cost is as follows;

2014/15. Procure 50 chassis and undertake 25 conversions - £4.36mn

2015/16. Undertake 25 conversions - £2.34mn

The phasing across two years reflects available capacity within the vehicle converters.

Non Recurrent Revenue is split across 2 years in line with the Capital and is made up of Trust commissioning and equipping costs.

Recurring Revenue occurs across the full life of the project and has been inflated in line with the indices used in the Trusts LTFM.

		2014/15	2015/16	2016/7	2017/18	2018/19	2019/20	2020/21	2021/22	
	Year	0	1	2	3	4	5	6	7	
Total Capital Consequences		**4,357,253**	**2,338,899**	-	-	-	-	-	**- 90,000**	**6,606,153**
Total Recurrent Revenue		-	1,453,157	1,531,407	1,608,798	1,662,426	1,764,224	1,820,720	1,899,980	
Total Non-Recurrent Revenue		350,393	310,393	-	-	-	-	-	-	
Total Capital Charges		-	1,051,217	1,143,661	1,110,180	1,076,700	1,043,219	1,009,738	974,682	
Total Revenue Consequences (including Capital Charges)		**350,393**	**2,814,766**	**2,675,068**	**2,718,978**	**2,739,125**	**2,807,443**	**2,830,458**	**2,874,662**	**19,810,893**

The Trust included £4.5m within the 2014/15 capital expenditure plan for the replacement of DCAs and a further £2.5m in 2015/16.

Although Recurrent Revenue costs are slightly higher than the current costs, due to higher fuel consumption in order to deliver the reduced emissions using active regeneration technology, this is capable of being managed within the Trust's existing revenue budgets.

In addition lower maintenance costs will be expected as the new vehicles will replace the oldest (and most costly to run) vehicles in the fleet.

The capital allocation has been included in both the planned capital resource limit (CRL) and cashflow. This request does not represent any additional costs above the agreed financial plan.

1.6 Management Case

The project will be managed within in the Operational Support/Fleet Department and follows the structures and controls of PRINCE 2.

This project follows on from the conversion of the 54 Ambulance chassis purchased last year and therefore existing management, resourcing and governance are in place already.

The procurement elements can be completed within one week of Business case approval and delivery of the chassis and other ordered components can take place within 2 weeks due to prior discussions as described earlier.

The plan for delivery of converted vehicles will be updated following approval but, subject to approval within the requested timescale, it is anticipated that the vehicles will be delivered in batches of 4 with the work commencing around the middle of February with a targeted completion of the end of May. Each batch takes 6 weeks and batches will be commenced on a weekly basis meaning that 24 vehicles will be going through the process at any one time.

An operational risk assessment will be carried out during the vehicle build and approval phases and any risks that are identified will be entered into the project Issue Log. The identified "project risks" are monitored and managed by the Project Manager as part of the regular checkpoint meetings.

Training will be appropriate and limited to any significant new additions on the vehicle. This will be carried out as part of the implementation of the previous 54 which are identical.

Whilst there are no specific cash releasing Benefits as stated in the economic case the Fleet Manager and Operations representative on the Programme Board will track the metrics set out to ensure that the benefits are being delivered as the overall fleet strategy is delivered.

A review will be carried out within 6 weeks of the close of the projects and the findings including what has gone well and badly, and the lessons that need to be learnt, will be prepared by the Project Manager for incorporation in the future procurements of fleet requirements as set out in the Executive Summary.

1.7 Conclusion

Given the results of the Economic appraisal together with the superior Benefits score it is recommended that the Trust be allowed to proceed with the preferred option – Option 3. It is therefore proposed that Option 3 is endorsed and the Trust procure the chassis and equipment as soon as possible under the relevant Framework Agreements and confirm with the selected conversion supplier for the Modular box bodies to be converted using the current call off.

1.8 Action

The Trust Board is requested to approve this Full Business Case. The Chair of the Finance and Investment Committee will provide an update on the review of the full FBC at the Trust Board meeting.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 27 JANUARY 2015

PAPER FOR APPROVAL/INFORMATION

Document Title:	Chief Executive Report to the London Ambulance Service (LAS) Trust Board
Lead Director:	**Chief Executive**
Report Author(s):	**Adam Levy**
Contact Details:	**Adam.Levy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To keep the board informed of key issues**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	To note
Key issues and risks arising from this paper Nil	
Executive Summary This report covers the following items: • Dalton Review • Changes to Health Education England and new workforce plan for England • CQC Inspection & Publication of Provider Handbook • Outcome of Cancer Drugs Fund Review	
Attachments **Nil**	

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes for each constituent project
- ☐ No

Key issues from the assessment: Nil

CHAIRMAN AND CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 27 JANUARY 2015

1. Dalton Review

The Dalton Review was published on 5 December 2014. It explored options for providers of NHS care to see how they can reduce variations in clinical standards, financial performance and patient safety. The review identified a number of overall recommendations and within those recommendations outlined how different organisations could act on them. The overall recommendations and those specifically directed to Trust Boards are:

1. One size does not fit all
    - As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their population.
    - Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

2. Quicker transformational change and transactional change is required

3. Ambitious organisations with a proven track record should be encouraged to expand their reach and have a greater impact across the sector
    - Trust boards should consider new operational and strategic leadership roles required in order to support the new organisational models, and put development plans in place accordingly.

4. Overall sustainability for the provider sector is a priority

5. Change must happen and implementation must be supported.

The Dalton review and its recommendations will be considered by Trust Board and any strategic issues or developments identified will be included in the planning of LAS's long term strategy.

Changes to Health Education England and new workforce plan for England

As of 1st April 2015 Health Education England (HEE) will become a Non-Departmental Public Body. This puts HEE and the LETBs on a firm statutory footing and will not affect how we work with them.

HEE have also published their workforce plan for England. It specifically talks about the significant national shortage of paramedics and HEE's plan to increase

paramedic training by 70% over two years starting from 2016/17, with a more gradual period of growth beforehand. Overall HEE are committed to providing 1,902 fte growth in available paramedic supply over the next five years. However, because of the time-lag in training paramedics, the HEE has stated that it supports the inclusion of paramedics on the Government's Shortage Occupation List.

The workforce plan states that HEE will continue to plan for rationalising paramedic training to an all bachelor degree profession whilst ensuring it does not create any future supply shortage.

The workforce plan (currently in draft form) can be found on the HEE website.

2. CQC Inspection & Publication of Provider Handbook

The Care Quality Commission (CQC) draft Provider Handbook, published on 28th November 2014, outlines the five key questions that the Key Lines of Enquiry will be centred around:

- **Safe –** that people are protected from abuse and avoidable harm
- **Effective –** that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- **Caring –** that staff involve and treat people with compassion, kindness, dignity and respect
- **Responsive –** that services are organises so that they meet people's needs
- **Well led –** that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The main sources of evidence will be through ongoing local information, local and national data, pre-inspection information gathering and an on-site inspection.

As this is a new CQC inspection regime it is still being refined and two pilot inspections have been carried out with learning being shared, especially around logistics of organising the pre-inspection information and the on-site visit. The draft provider handbook can be found here.

3. Outcome of Cancer Drugs Fund Review

On Monday 12th January, the NHS Cancer Drugs Fund (CDF) published the outcome of its review of drugs included in the Fund. The budget for the CDF will grow from £200m in 2013/14, to £280m in 2014/15 and to an estimated £340m from April 2015.

The CDF also announced that approximately £80m of savings will be made through 'negotiated price reductions and improved clinical effectiveness.' As a result 59 of the 84 most effective currently approved indications (clinical 'uses') of drugs will continue and three new ones will be added.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27TH January 2015**
Document Title:	**Charitable Funds Annual Report & Annual Accounts for 2013/14**
Report Author(s):	**Michael John**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andrew.Grimshaw@lond-amb.nhs.uk 020 7783 2041**
History:	**The Annual Report and Annual Accounts for 2013/14 were reviewed by the Charitable Funds Committee on 14th January 2015 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 2013/14.**

Background/Purpose

To present the London Ambulance Service NHS Trust Charitable Funds Annual Report and Annual Accounts for 2013/14 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 2015.

The Charitable Funds Committee has reviewed and endorsed the accounts for approval by the Trust Board.

Action required

Approve the accounts as presented.

Assurance

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

London Ambulance Service NHS Trust

TRUST BOARD

Paper on Charitable Funds Annual Report and Annual Accounts for 2013/14.

Purpose

To present the London Ambulance Service NHS Trust Charitable Funds Annual Report and Annual Accounts for 2013/14 for approval.

Background

As the corporate trustees of the LAS Charity, we have a statutory requirement to produce and publish an Annual Report and Accounts comprising the Annual Report, the primary financial statements and notes; a statement on the Trustee's responsibilities for the Trust's charitable funds.

The Annual Report is 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 2015.

Financial Performance of Charity

The Charity had a deficit of £65,000 for the year; the deficit was funded from surpluses from previous periods.

The income for the year was £12,000; this was £59,000 lower than last year's income of £71,000. Last year's income included a donation of £44,408 to purchase two vehicles for the voluntary responder group (VRG) and a legacy of £12,000.

The expenditure for the year was £77,000; this was £43,000 lower than last year's expenditure of £121,000. Last year's expenditure included £44,408 for cost of purchasing two vehicles for the voluntary responder group (VRG).

In 2013/14 the Charity liquidated its remaining investments of £66,000 held by Investec to fund its on-going expenditure.

At the end of 31st March 2015 the Charity had a balance of £20,000 in its unrestricted general purpose fund.

The Finance Director and Charity Committee have reviewed the Annual Report and Annual Accounts for 2013/14 and confirm that there are no issues that should be brought to the attention of the Trust Board.

Independent examination of the Charity Accounts

In this financial year the income has fallen below the Charity Commission's de minimis limit of £15,000 for a compulsory independent examination to be carried out. The Charitable Funds Committee has decided not to have an independent examination performed on the charity at a cost of £2,700, on the grounds that

- There have not been any significant financial transactions in year.

- It did not offer value for money when compared with the low value of assets held by the Charity.

Looking Forward

The Charity's income has fallen over the years and resources are now at a very low level. It has been agreed that the costs relating to staff would be taken on by the Trust.

Recommendations

The Trust Board is asked to approve the Charitable Funds Annual Report and Annual Accounts for 2013/14.

LONDON AMBULANCE SERVICE CHARITABLE FUND

ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2014

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENTS OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2014

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2014

Foreword

The Charity's annual report and accounts for the year ended 31 March 2014 have been prepared by the Corporate Trustee in accordance with the Statement of Recommended Practice by Charities (SORP 2005) issued in March 2005, 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
Ann Radmore	Chief Executive
Jessica Cecil	Non-Executive Director
Nicholas Martin	Non-Executive Director
John Jones	Non-Executive Director
Robert McFarland	Non-Executive Director (appointed 1st May 2013)
Fergus Cass	Non-Executive Director (appointed 1st March 2014)
Theo De Pencier	Non-Executive Director (appointed 1st March 2014)
Beryl McGrath	Non-Executive Director (resigned 30th April 2013)
Roy Griffins	Non-Executive Director (resigned 31st March 2014)
Caroline Silver	Non-Executive Director (resigned 31st March 2014)
Fionna Moore	Medical Director
Andrew Grimshaw	Director of Finance (Interim 9th June 2013; appointed 10th June 2013)
Jason Killens	Director of Operations (appointed 1st October 2013)
Caron Hitchen	Director of Human Resources (resigned 18th September 2013)
Steve Lennox	Director of Health Promotion & Quality

REFERENCE AND ADMINISTRATIVE INFORMATION

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:

Caroline Silver (Non-Executive Director)
Caron Hitchen (Director of Human Resources) (resigned 18th September 2013)
Michael John (Head of Financial Services)
Eric Roberts (UNISON representative)
Tony Crabtree (Head of Employee Services)
Francesca Guy (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 quarterly basis to review grant applications for the quarter and financial performance of the fund.

Principle Charitable Fund Adviser to the Board

Caron Hitchen, Director of Human Resources was the budget holder from 1st April 2013 - 18th September 2013) and Tony Crabtree was budget holder from 19th September 2013, 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/her or their 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
South Bank Branch
2 York Road
London SE1 7IZ

Investment Managers

Investec Wealth & Investment Limited
2 Gresham Street
London EC2V 7QN

STRUCTURE, GOVERNANCE AND MANAGEMENT

The majority of the charity's funds are held in an unrestricted fund, which 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. Almost all of the subsequent donations and gifts received by the charity have all been attributable to that fund and have been added to the existing balance.

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 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.

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. The most significant risk identified was possible losses from the fall in the value of investments and the level of reserves available to mitigate the impact of such losses. This has been carefully considered and there are procedures in place to review the investment policy and also to ensure that both spending and firm financial commitments remain in line with income.

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 STRATEGY

The Charity has the following objective:

"the trustee shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, 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 has agreed that the main purpose of the fund is to fund projects for the benefit of all employees of the London Ambulance Service NHS Trust.

The Corporate Trustee has given due consideration to Charity Commission published guidance on the operation of the public benefit requirement.

ANNUAL REVIEW

The majority of donations received by the 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, long service awards and contributions towards retirement and Christmas parties.

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 these projects to be undertaken at short notice.

The policy of the Corporate Trustee is to maintain expenditure at its current level for as long as possible. The level of expenditure has exceeded income in recent periods. The strategy of the Corporate Trustee is to continue to utilise fixed assets to fund the level and type of expenditure experienced in the current and recent periods.

The level of reserves are monitored and reviewed by the Corporate Trustee, usually once every 5 years (free reserves at 31 March 2014 was £14,000).

The net assets of the Charity as at 31 March 2014 were £20,000 (31 March 2013: £85,000). Overall net assets decreased by £65,000 due to the net expenditure of £66,000 and a gain on the value of investments of £1,000.

The main sources of income of the charity are donations and investment income. Total incoming resources for the year were £12,000 (2012/2013: £71,000).

Expenditure totalled £78,000 during the year, with the largest items of expenditure being Christmas grants of £32,000 and £45,000 on other amenities.

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. In addition, the Charitable Funds Committee reviews and manages the performance of the Charity's investments in accordance with the investment policy.

Investments

The Corporate Trustee invests the charitable funds with Investec Wealth & Investment Limited. The investment fund was closed on the 19th September 2013.

The Corporate Trustee operates an ethical investment policy. Investments are not made in companies dealing predominantly in the tobacco trade or in the manufacture and sale of arms.

OUR FUTURE PLANS

The future plans for the London Ambulance Service Charitable Fund are to continue to fund projects for the benefit of staff in line with the current level of funding.

The London Ambulance Service Voluntary Responder Group 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 London Ambulance Services community resuscitation training. Dame Helen Mirren is the patron of the group. The group holds a number of funding raising event.

Signed: ……

Richard Hunt, Chairman of the Trust Board on behalf of the Corporate Trustee

Date: ……

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENTS OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2014

	Note	2013-14 Unrestricted Funds £000	2013-14 Restricted Funds £000	**2013-14 Total Funds £000**	2012-13 Total Funds £000
Incoming resources					
Incoming resources from generated funds:					
Voluntary Income:					
Donations		4	6	10	54
Legacies	10	-	-	-	12
Subtotal voluntary income		**4**	**6**	**10**	66
Investment income	5.3	1	-	**1**	4
Other income		1	-	**1**	1
Total incoming resources		**6**	**6**	**12**	**71**
Resources expended					
Costs of generating funds:					
Investment management costs		1	-	**1**	2
Charitable activities:					
Staff education and welfare – grants payable	3	77	-	**77**	114
Governance costs	4	-	-	**-**	5
Other resources expanded		-	-	**-**	-
Total resources expended		**78**	**-**	**78**	121
Net outgoing resources		**(72)**	**6**	**(66)**	(50)
Other recognised gains and losses					
Gains/(losses) on investment assets		1	-	**1**	8
Net movement in funds		**(71)**	**6**	**(65)**	(42)
Reconciliation of Funds					
Fund balances brought forward at 31 March 2013		85	-	85	127
Fund balances carried forward at 31 March 2014		**14**	**6**	**20**	85

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 10 to 16 form part of these accounts.

LONDON AMBULANCE SERVICE CHARITABLE FUND

BALANCE SHEET AS AT 31 MARCH 2014

	Note	2013-14 Unrestricted Funds £000	2013-14 Restricted Funds £000	**2013-14 Total Funds £000**	2012-13 Total Funds £000
Fixed assets					
Investments	5	-	-	**-**	66
Total fixed assets		**-**	**-**	**-**	66
Current Assets					
Stocks	6	-	-	**-**	2
Debtors	7	3	-	**3**	1
Cash at bank in hand		12	6	**18**	23
Total current assets		**15**	**6**	**21**	26
Creditors: Amounts falling due within one year	8	1	-	**1**	7
Net current assets/(liabilities)		**14**	**6**	**20**	19
Total assets less current liabilities		**14**	**6**	**20**	85
Total net assets		**14**	**6**	**20**	85
Funds for the charity					
Income Funds:					
Unrestricted – general purpose fund		14	6	**20**	85
Total charity funds		**14**	**6**	**20**	85

The accounts set out on pages 8 to 16 were approved by the Corporate Trustee on 27th January 2015 and signed on its behalf by

Signed: ……

Richard Hunt, Chairman of the Trust Board on behalf of the Corporate Trustee

Date: ……

BALANCE SHEET AS AT 31 MARCH 2014

1. Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with the Statement of Recommended Practice by Charities (SORP 2005) issued in March 2005 and applicable UK Accounting Standards and the Charities Act 2011.

1.2 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;
- certainty - when there is reasonable certainty that the incoming resource will be received; and
- measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

1.3 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is reasonably certain; This will be once 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.

1.4 Resource expended

Liabilities are recognised as resources are expended as soon as there is a legal or construction 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. Cost of generating funds

These are the costs associated with generating income for the charity. They include fees paid to the charity’s investment managers.

b. Charitable activities

Costs of charitable activities comprise all costs identified as wholly or mainly incurred in the pursuit of the charitable objectives.

c. Grants payable

Grants payable 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.

d. Government costs

These comprise all costs identifiable as wholly or mainly attributable to ensuring the public accountability of the charity and its compliance with regulation and good practice. These costs include costs related to independent examination fees together with a recharge of overhead and support costs from London Ambulance Services NHS Trust.

1.5 Structure of funds

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 9.

1.6 Investment Fixed Assets

Investment fixed assets are shown at market value at the balance sheet date. Quoted stocks and shares are included in the balance sheet at mid-market price, ex-dividend. Common Investment Fund Units are included in the balance sheet at the closing dealing price at the balance sheet date.

1.7 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.8 Stocks

Stock is included at the lower of cost and net realisable value.

2. Allocation of support costs and overheads

All support costs and are allocated to governance costs.

The total value of support costs and overheads was £0 (2012/2013: £5,200).

3. Analysis of charitable expenditure

	2013-14 Unrestricted Funds £000	2013-14 Restricted Funds £000	**2013-14 Total Funds £000**	2012-13 Total Funds £000
Staff welfare and amenities				
Grants payable to individuals	77	-	**77**	70
Grants payable to London Ambulance Service NHS Trust	-	-	**-**	44
	77	**-**	**77**	144

All grant applications are considered and approved by a sub group of the Charity Funds Committee on behalf of the Corporate Trustee.

4. Analysis of governance costs

	2013-14 Unrestricted Funds £000	2013-14 Restricted Funds £000	**2013-14 Total Funds £000**	2012-13 Total Funds £000
Independent examination fee	-	-	**-**	3
Apportioned overheads	-	-	**-**	2
	-	**-**	**-**	5

The independent examiners remuneration of £0 (2012/2013: £2,700) related solely to the independent examination with no other work undertaken (2012/2013: £nil).

5. Analysis of Fixed Asset Investments

5.1 Movement in fixed asset investments

	2014 £000	2013 £000
Market value at 1 April 2013	**66**	131
Less: Disposals at carrying value	**(67)**	(123)
Add: Acquisitions at cost	**0**	68
Net (loss)/gain on revaluation	**1**	(10)
Market value a 31 March 2014	**0**	66
Historic cost at 31 March 2014	**0**	60

5.2 Market value at 31 March 2014

	Held In the UK £000	Held outside UK £000	**2014 Total £000**	2013 Total £000
Investments listed on Stock Exchange:				
Bonds	-	-	-	12
Investments in a Common Deposit Fund or Common Investment Fund	-	-	-	54
Cash held as part of Investment Portfolio	-	-	-	-
	-	-	-	66

	2014 Total £000	2013 Total £000
Individual holding representing more than 5% of the market value of the portfolio at the balance sheet date:		
F & C Ethical Bond	-	12
AXA Ethical Distribution	-	10
F & C Stewardship	-	23
Kames Ethical Equity	-	6
Standard Life Ethical	-	5
Aberdeen Unit Trust Ethical	-	10

5.3 Market value at 31 March 2014

	Held In the UK £000	Held outside UK £000	**2014 Total £000**	2013 Total £000
Investments listed on Stock Exchange	-	-	-	3
Investments in a Common Deposit Fund or Common Investment Fund	-	-	-	1
	-	-	-	4

6. Analysis of Stocks

	2014 Total £000	2013 Total £000
Analysis of Stocks		
Award Vouchers	**0**	2
Total Stocks	**0**	2

7. Analysis of Debtors

	2014 Total £000	2013 Total £000
Analysis of Debtors		
Amounts falling due within one year:		
Other debtors	3	1
Total debtors	**3**	1

8. Analysis of Creditors

	2014 Total £000	2013 Total £000
Analysis of Debtors		
Amounts falling due within one year:		
Accruals	**1**	7
Total creditors	**1**	7

9. Analysis of Charitable income funds

a. Restricted funds

	Balance 1 April 2013 £000	Resources expended £000	Incoming resources £000	Balance 31March 2014 £000
Voluntary Responders Fund	-	-	6	6
	-	**-**	**6**	**6**

Name of Fund	Description, nature and purpose of the fund
London Ambulance Voluntary Responders	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 2013 £000	Resources expended £000	Incoming resources £000	Balance 31March 2014 £000
London Ambulance Service General Fund	85	(77)	6	14
	85	**(77)**	**6**	**14**

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.

10. Material legacies

There was a legacy of £Nil during the year (2012/2013: £11,420).

11. 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.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Board Statements and Monitor Compliance**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**Monthly report to the Trust Board**
Status:	**For approval**

Background/Purpose

The Trust Board is held to account by the NHS Trust Development Authority (TDA) for compliance with the provider licence requirements and Board statements. The Trust Board can confirm compliance with each statement and requirement with the exception of the following:

Board statement 10 requires the Board to sign off that: it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the TDA oversight model; and a commitment to comply with all known targets going forward.

The Board is unable to declare compliance with this statement having carefully reviewed performance since quarter one, together with current trending information for activity and capacity in the second and third quarters, and has put urgent work in train to seek to address the issues and produced a revised plan. We continue to work closely with the TDA, NHS England and local commissioners in the approach to improving performance.

Attached is the list of statements and provider licence requirements for information.

Action required

To approve the submission of the above statement for January 2015.

Assurance

The Board continues to meet the monthly submissions for oversight requirements and has the opportunity to review and take assurance on all the statements at points during the year.

Key implications and risks arising from this paper	
Clinical and Quality	Risk of non-compliance with Board statements on clinical quality
Performance	Monthly declaration of non-compliance with Statement 10
Financial	Risk of non-compliance with Board statements on finance and Monitor Compliance
Legal	
Equality and Diversity	
Reputation	Risk of non-compliance with Board statements and Monitor Compliance
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	x
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	x
Develop our 111 service	
Simplify our business processes	x
Increase organisational effectiveness and development	

NHS Trust Development Authority: Monthly self-certification requirements – Board Statements

CLINICAL QUALITY, FINANCE, GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

For CLINICAL QUALITY, **that**

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements;

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution;

6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate;

7. The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans;

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily;

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk);

10. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards;

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit;

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies;

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability;

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

Monthly self-certification requirements - Compliance Monitor

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. Condition G7 – Registration with the Care Quality Commission.

3. Condition G8 – Patient eligibility and selection criteria.

4. Condition P1 – Recording of information.

5. Condition P2 – Provision of information.

6. Condition P3 – Assurance report on submissions to Monitor.

7. Condition P4 – Compliance with the National Tariff.

8. Condition P5 – Constructive engagement concerning local tariff modifications.

9. Condition C1 – The right of patients to make choices.

10. Condition C2 – Competition oversight.

11. Condition IC1 – Provision of integrated care.

Further guidance can be found on Monitor's website:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285009/Annex_NHS_provider_licence_conditions_-_20120207.pdf

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**27th January 2015**
Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**For information**

Background/Purpose

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

Tenders received

One new tender has been received since 25th November 2014:

1. Electrical Remedial Works
   Tenders received from:
   - Avatar Electrical
   - Turnstone Electrical Services
   - Calbarrie Compliance Services
   - MAS Systems.
2. There have been two entries to the Register for the use of the Trust Seal since 25th November 2014
   - LAS NHS Trust and Norland Managed Services Ltd - JCT Minor Building Works to cover work completed at LAS HQ
   - London Fire and Emergency Planning Authority and LAS NHS Trust – lease for part 1st floor and part lower ground floor, 169 Union Street.

Action required

To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 25th November 2014 and to be assured of compliance with Standing Orders and Standing Financial Instructions.

Assurance

Compliance with Standing Orders and Standing Financial Instructions.

Key implications and risks arising from this paper	
Clinical and Quality	**None**
Performance	**None**
Financial	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs; 2014/15 Financial Plan**
Legal	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs**
Equality and Diversity	**None**
Reputation	**None**
Other	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

London Ambulance Service NHS
NHS Trust

TRUST BOARD FORWARD PLANNER 2015

27th January 2015

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Finance Report M9** **Report from Finance and Investment Committee** **BAF and Corporate Risk Register**	SOC for eAmbulance 2015/16 Business and financial planning process Fleet Replacement business case	Board Declarations Report from Trust Secretary Trust Board Forward Planner Annual Report and Accounts of the Charitable Funds 2013/14	Quality Governance Committee on 13th January 2015 Finance and Investment Committee on 22nd January 2015	

24th March 2015

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Risk Management Strategy and Policy review** **Finance Report M11** **Report from Finance and Investment Committee**	2015/16 Integrated Business Plan and 5-year workforce and finance plan sign off 2015/16 Operating Plan sign off 2015/16 Corporate Objectives sign off 2015/16 Equality Objectives sign off Staff Survey results	Board Declarations Report from Trust Secretary Trust Board Forward Planner Register of interests	Finance and Investment Committee on 19th March 2015 Audit Committee on 2nd February 2015	

2nd June 2015

Standing Items	Annual Reporting	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Annual Report and Accounts 2014/15 including Annual Governance Statement** **Quality Account 2014/15 for approval** **Audit Committee Assurance Report** **Annual Report of the Audit Committee 2014/15** **BAF and Corporate Risk Register** **Patient Voice and Service Experience Annual Report 2014/15** **Infection Prevention and Control Annual Report 2014/15** **Annual Safeguarding Report 2014/15**	Integrated Board Performance Report Clinical Directors' Joint Report Quality Governance Committee Assurance Report Finance Report Report from Finance and Investment Committee		Board Declarations Report from Trust Secretary Trust Board Forward Planner	Quality Governance Committee on 14th April 2015 Finance and Investment Committee on 21st May 2015 Audit Committee on 21st May 2015	

28th July 2015

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M3** **Report from Finance and Investment Committee**	Q1 Business Plan review	Annual Equality Report 2014/15 Board Declarations Report from Trust Secretary Trust Board Forward Planner	Quality Governance Committee on 14th July 2015 Finance and Investment Committee on 23rd July 2015	

29th September 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Audit Committee Assurance Report** **Annual Audit Letter 2014/15** **BAF and Corporate Risk Register** **Finance Report M5** **Report from Finance and Investment Committee**	Business planning 16/17	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee on 24th September 2015 Audit Committee on 7th September 2015	

24th November 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M7** **Report from Finance and Investment Committee**	6 month review of business plan	Board Declarations Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Quality Governance Committee on 13th October 2015 Finance and Investment Committee on 19th November 2015 Audit Committee on 9th November 2015	

2015 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**27**		**24**			**2**	**28**		**29**		**24**		9.00 - 14.00
Board Strategy and Planning	Trust Chair		**24**		**28**		**30**				**27**		**15**	9.00 - 16.00
Annual General Meeting	Trust Chair									**29**				14.00 - 15.30
Annual C/Funds Committee	Non-executive director													
Remuneration Committee	Trust Chair													
Audit Committee	John Jones		**2**		**17**	**21**	**1**			**7**		**9**		14.00 - 17.00
Finance and Investment Committee	Nick Martin	**26**		**19**		**21**		**23**		**24**		**19**		14.00 - 17.00
Quality Committee	Bob McFarland	**13**			**14**			**14**			**13**			14.00 - 17.00
Clinical Safety, Development and Effectiveness Committee	Clinical Directors	**20**	**17**	**17**	**21**	**19**	**16**	**21**	**18**	**22**	**20**	**17**	**22**	14.00 - 16.00
Executive Management Team (EMT)	CE	**Every Wednesday 9.00 - 12.00**												9.00 - 12.00