



**MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 29th SEPTEMBER 2015 AT 09.00 - 11.30
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD**

DRAFT AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.00	1.	Welcome and apologies for absence Apologies received from:			
	2.	Staff Story To receive a presentation on the new operating model for Clinical Team Leaders – New Operating Model	Information	PW	
09.20	3.	Declarations of Interest To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	4.	Minutes of the public meeting held on 28th July 2015 To approve the minutes of the meeting held on 28 th July 2015	Approval	RH	TAB 1
	5.	Matters arising To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.30	6.	Report from Chief Executive To receive a report from the Chief Executive	Information	FM	TAB 3
QUALITY ASSURANCE					
09.40	7.	Integrated Board Performance Report – Month 5 To receive the integrated board performance report (inc Operational Performance)	Information	PW	TAB 4
	8.	To receive reports and assurance on the quality and safety of the service 8.1 Quality Report – Month 5 8.2 CQC update 8.3 Cardiac Arrest and STEMI Annual Reports 2014/15	Information	FW/ MW/ ZP	TAB 5
	9.	Quality Governance Committee Assurance Report To receive the Quality Governance Committee Assurance Report on 22 nd September 2015	Assurance	BMc	Oral
	10.	Workforce Report To receive an update on workforce items	Presentation	KB	
	11.	Finance Report – Month 5 To receive the finance report for Month 5 12.1 Finance Report 12.2 Report from Finance and Investment Committee on 24 th September 2015	Information	AG	TAB 6
	12.	Board Assurance Framework and Corporate Risk Register 13.1 To receive the Board Assurance Framework and Corporate Risk Register	Information	SA	TAB 7

	13.	Audit Committee Assurance Report To receive the assurance report from the Audit Committee meeting held on 7 th September 2015	Assurance	JJ	TAB 8
GOVERNANCE					
11.10	14.	Annual Revalidation & Statement of Compliance To receive assurance on the revalidation of doctors within the London Ambulance Service NHS Trust	Assurance	FW	TAB 9
	15.	Board Declarations – self certification, compliance and board statements To approve the submission of the Board declarations for September 2015	Approval	SA	TAB 10
	16.	Report from Trust Secretary To receive a report on use of the Trust Seal and tenders received	Information	SA	TAB 11
	17.	Report from the Trust Chairman To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	Oral
	18.	Trust Board Forward Planner To receive the Trust Board forward planner	Information	SA	TAB 12
	19.	Trust Board and Committee dates 2016 To note the proposed calendar of meetings in 2016	Information	SA	TAB 13
	20.	Register of Interest To note the register of interests	Information	SA	TAB 14
	21.	Questions from members of the public		RH	
	22.	Any other business		RH	
11.30	23.	Meeting Closed The meeting of the Trust Board in public closes		RH	
	24.	Date of next meeting The date of the next Trust Board meeting is 24 th November 2015		RH	

**LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING IN PUBLIC**

DRAFT Minutes of the meeting held on Tuesday 28th July 2015 at 09:30 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

Present:

Richard Hunt	Chairman
Fionna Moore	Chief Executive
Bob McFarland	Non-Executive Director
Nick Martin	Non-Executive Director
Theo de Pencier	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
Jason Killens	Director of Operations
Fenella Wrigley	Interim Medical Director
Zoe Packman	Director of Nursing and Quality

In Attendance:

Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation and Strategy
Paul Woodrow	Director of Performance
Mark Whitbread	Director of Paramedic Education and Development
Janice Markey	Head of Equality and Inclusion - for item 14)
Peter Nicholson	Head of Governance and Assurance (for item 20)
Ted Nyatanga	Governance Manager (for item 20)

Members of the Public:

London Ambulance Service Patients' Forum

Members of Staff:

Anna Macarthur	Communications Manager
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68. Welcome and Apologies

68.1 Apologies had been received from Jessica Cecil and John Jones, Non-Executive directors.

68.2 The Chairman welcomed Fionna Moore to her first Trust Board meeting following her substantive appointment as Chief Executive.

69. Declarations of Interest

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

70. Minutes of the Board meeting held on 2nd June 2015

70.1 The minutes of the meeting held on 2nd June 2015 were approved as a true record of the meeting subject to a minor amendment to 45.2 and to 54.10.

71. Matters Arising

71.1 51.5 – Zoe Packman would provide an update in item 9.

71.2 51.11 – SA had added the progress report on Lampard recommendations to the November planner.

71.3 51.12 – Karen Broughton confirmed that pre-employment checks and DBS would be built into the action plan from the review of the human resources function, for completion in quarter 4 of 2015/16.

71.4 53.6 – Paul Woodrow confirmed that the core metrics for the integrated performance report were under discussion and would be picked up under item 8.

- 71.5 54.12 – Fergus Cass asked for an update on the outcome of discussions with clinical commissioning groups (CCGs). Modelling of the ambulatory care pathways had not panned out as expected but there had been no detriment to the safety and outcome for patients or for hospitals' performance.
- 71.6 Andrew Grimshaw confirmed that the LAS was having discussions with commissioners about the category C underperformance. The Chairman stated that it was important to ensure that the LAS was adequately compensated for any performance pressures experienced as a result of changes and to ensure we were part of future such discussions. Fergus Cass asked if CCGs in North West London were content with the capacity provided by LAS and Andrew Grimshaw confirmed that a small but not material amount of capacity had been withdrawn and LAS was still performing in line with trajectory.
- 71.7 The Board heard that the application by Barking Havering and Redbridge and Queens to become a Vanguard had been successful.
- 71.8 60.8 – an update on delivery of the business plan would be covered in item 8.
- 71.9 63.2 - Theo de Pencier asked when the CQC inspection outcome report was expected and Zoe Packman responded that this was unlikely to be within September.
- 72. Report from the Trust Chairman**
- 72.1 Interaction with the NHS Trust Development Authority (TDA) – the Chairman welcomed the opportunity to build a relationship with the TDA. The Secretary of State had issued a letter regarding the Very Senior Manager (VSM) remuneration system and the Chairman had been invited to a meeting on this subject on 29th July.
- 72.2 The Chairman had attended a Chairs' meeting with the TDA where Bob Alexander had presented the London NHS financial picture within the national context.
- 72.3 Both the Chairman and Fionna Moore had attended an NHS Providers conference where the new NHS Finance Director had given a presentation and message about bringing NHS financial performance within budget in 2015/16.
- 72.4 The Chairman had attended a meeting of the NHS Providers quality reference group where there had been an interesting conversation about the effectiveness of antibiotics.
- 72.5 The Chairman had undertaken visits to the Control Room and some stations and planned to do so on a more regular basis. He found these valuable experiences and met with positive feedback wherever he visited.
- 72.6 The Chairman had presented at a Capita conference for the ambulance service sector.
- 72.7 The TDA was introducing a new initiative to expand the number of BME non-executive directors across provider Trusts and the Chairman had attended the launch event and offered support for an 'apprentice scheme' for potential directors.
- 72.8 He had participated in a round table event led by Saxton Bampfylde on research into future leadership and where those leaders might come from. Lord Kerslake had given his insight into government policy and the likely impact of public sector VSM pay.
- 72.9 The Association of Ambulance Chairs and Chief Executives had received a presentation from the Chairman as part of the 2020 Vision for the sector, and he would bring this to a future Strategy Review and Planning meeting.

73. Report from Chief Executive Officer

- 73.1 The LAS had supported two Vanguard bids of which one had been successful (see 71.7 above). LAS had had minor input to this.
- 73.2 This Board meeting was the last one for Jason Killens in his role as Director of Operations. This was a sad loss for the LAS after Jason's 19 years of service but a tremendous opportunity for him and the Board wished him the best of luck in his future role as Chief Executive of the South Australia Ambulance Service. The Chairman echoed this. Fiona added that this would also offer opportunities to build on the existing relationship with the South Australia Ambulance Service and the LAS.
- 73.3 The Lord Rose report on 'Better Leadership for Tomorrow' was published on 16th July. Fiona Moore drew attention to Recommendation 13 concerning the merger of the TDA and Monitor.

74. Integrated Performance Report

- 74.1 The Chairman asked whether it was intended that the report would be more fully integrated with the quality report. Paul Woodrow confirmed this to be the case and that more meaningful data was now being presented. It was also noted that there was some duplication with the finance report and Andrew Grimshaw stated that the reporting structure was 2-tier with more detailed reporting behind the integrated report.
- 74.2 Theo de Pencier said that he found the narrative easier to follow through the integrated performance report (IPR) and that the process was moving in the right direction. Andrew Grimshaw reported that Jill Patterson, interim Head of Performance, was reviewing the development of the IPR and the supporting reports so that these were being produced in concert. More time could then be spent on the IPR at Board meetings and more focus on the integrated nature of what was being reported.
- 74.3 The Chairman was due to attend the Board meetings of South East Coast Ambulance Service and Frimley Park Hospital and he would report back on how they manage the governance and their approach to reporting overall performance.
- 74.4 Paul Woodrow stated that the Trust remained safe and consistent with previous months. Lower acuity patients were waiting longer than we would wish due to capacity constraints and as a consequence of Category A activity increasing. Category A8 performance had been delivered slightly above trajectory in June. Overall demand had been lower than forecast.
- 74.5 The number of staff leaving had started to reduce however there were still 403 whole time equivalent frontline vacancies.
- 74.6 There was some emerging financial pressure on the plan with Category C activity lower than forecast and provision was also being made for in the event of a penalty being levied. CIP delivery was also adverse to plan. In addition, a high level of overtime was being funded in order to bridge the gap in resourcing and ensure the trajectory was achieved.
- 74.7 Paul Woodrow confirmed that although Category A activity had increased in June and into July, compared to the same period in 2014/15, performance was under contract plan. Actions were underway for the 3rd quarter, including managing lower acuity work differently which was having an impact including an increase in hear and treat.
- 74.8 Fergus Cass asked whether the 403 frontline vacancies was in line with plan and recruitment was on target. Karen Broughton confirmed this to be the case and referred to the graph on page 12 which showed that by early November recruitment for all frontline

vacancies would be 'filled', with full operational capability by June 2016. Richard Hunt asked about the 5% vacancy factor and Andrew Grimshaw responded that this included 150 vacancies that were always held with hours covered by overtime and bank and which allowed some flexibility. Jason Killens added that 5% allowed an element of overtime without causing pressure or causing staff to work excessive hours.

- 74.9 The Chairman asked whether this was benchmarked against other ambulance services. Jason Killens said that benchmarking last year had shown how this differed. There were 2000 vacancies nationally and 2-3 trusts were holding a similar number of vacancies proportionately. Vacancy rates were increasing nationally and recruitment was difficult. There was still a good market for paramedics and ambulance services were losing out to other parts of the NHS and other organisations with paramedics wanting to develop clinical practice and their careers.
- 74.10 Theo de Pencier asked whether this was becoming the normal position and thought needed to be given to setting up secondments with other parts of the NHS. Karen Broughton thought it was unlikely that this would become a national position but LAS had started talking about how such opportunities could be created. She also thought that we would see higher numbers of leavers than historically as the market for paramedics had changed. Paul Woodrow supported this and that a new norm would appear so the LAS Academy would be key for the LAS.
- 74.11 Workforce planning would recognise that paramedics would come into the LAS, gain experience and then move on. We needed to be able to respond to this through the clinical career structure and the LAS was working with Health Education England (HEE) to consider ways of improving the supply of paramedics in London. HEE were looking into this at a national level, with a 5-10 year forward look from ambulance services about the level of demand needed and then how to supply enough paramedics to meet those levels.
- 74.12 Paul Woodrow would be taking on the interim role of Director of Operations and the Board wished him success in taking on the portfolio.

75. Clinical and Quality Report

- 75.1 Zoe Packman stated that the report continued to develop and it was now easier to map the report to the graphs. The dashboard remained in draft form due to the sources of data however any significant changes would be highlighted in the report and would in future be discussed at the Quality Governance Committee with a high level summary provided in the front of the report. The quality report was shared with commissioners and at the Quality Governance Committee.
- 75.2 Fenella Wrigley reported on the Safety section. The process for reporting and managing adverse incidents had been reviewed to understand the reasons for delays and changes in reporting. Work was underway to develop DatixWeb which would be fully implemented in quarter 1, 2016/17, which would facilitate local reporting and focus on managing adverse incidents, addressing issues and feeding back to staff. DatixWeb would streamline processes and enable quicker turnaround of incident reports and identification of themes. Other ambulance trusts used DatixWeb and the system would include serious incidents, complaints and better streamlining of data. Data entry would be direct onto the system and not by paper form and a process would be worked up for frontline staff to make telephone referrals into a single point of contact. This works well in other areas such as safeguarding.
- 75.3 Two controlled drug incidents had been reported and investigated under Medicines Management and it was noted that this had become a theme during the CQC inspection preparation with areas identified for improvement. The Metropolitan Police controlled drugs team undertook unannounced inspections and the LAS responded to any recommendations made.

- 75.4 One Preventing Future Deaths (Regulation 28) report had been received from HM Coroner relating to a child who had sadly died from Meningococcal Septicaemia. There were two recommendations for the LAS and the response was being prepared together with mitigating action to prevent such an incident recurring. Fenella Wrigley reported that efforts were being made to promote awareness of signs and symptoms to coincide with the new school and university term in September when there were more huddles of people.
- 75.5 Theo de Pencier asked about the reference to the recruitment to the Driving Standards Manager post. Jason Killens stated that the issue raised in the report was one of primacy of care, clinical practice and seniority of clinicians, not relating to the post. Guidance would be reissued to staff to ensure new starters were aware on joining the LAS. The Driving Standards Manager role would be progressed to external advert now. It was noted that the Clinical Manager would oversee driver training whilst the Driving Standards Manager would ensure delivery.
- 75.6 Theo de Pencier asked whether the non-convey decision-making issue concerning the cycle response unit at Heathrow was being addressed. Jason Killens responded that the team are integrated within the Heathrow service delivery team. Zoe Packman was undertaking a clinical shift at Heathrow later in the week and would be able to review this issue.
- 75.7 Fergus Cass asked about the STEMI performance and Mark Whitbread confirmed that the LAS continued to take similar numbers to Heart Attack Centres each year, and that Clinical Skills Refresher training included STEMI in CSR 2. Patients received an expert assessment.
- 75.8 Bob McFarland asked about the timescale for the review of complaints processes and Zoe Packman confirmed that this was currently being scoped with the Strategy team and she would be able to give an update at the next Quality Governance Committee.
- 75.9 Zoe Packman reported that 67 patient and public education events had been covered and that staff undertook these in their own time which was tremendous and a remarkable amount of activity. The Trust Board extended thanks to those staff for their efforts. Jason Killens added that 800 or so such events had been covered in 2014/15 and that these were not funded but the LAS thought it was the right thing to be doing. Staff worked with schools and the harder to reach communities for example, almost on a daily basis to promote the work of the LAS and to encourage children and community groups. It was agreed that the Chairman and Fionna Moore would publish this acknowledgement and to extend thanks to those staff involved in the Shockingly Easy campaign and to volunteers.
- Action: RH and FM**
Date: 29th September 2015
- 75.10 The Chairman asked for an update on the launch of the LAS Academy and Mark Whitbread reported that we were waiting for confirmation from the HCPC before progressing.

76. Quality Governance Committee Assurance Report

- 76.1 The report was noted and Bob McFarland stated that the committee had received an interesting presentation from the Consultant Midwife and been assured about the work underway across the London maternity systems.
- 76.2 The timing of the committee now allowed for a written report to be given to the Trust Board and Bob McFarland confirmed that attendance was good, and that the 3 reporting committees had been restructured and each had met at least once.

77. Finance Report – Month 3

- 77.1 Andrew Grimshaw reported that the month 3 position was on plan whilst year to date the

Trust was reporting a variance of £0.75m. Based on this performance it would be challenging to achieve the year end forecast deficit of £9.5m. This position was driven by 3 factors:

- Income reduction provision of £0.5m relating to a >2% reduction in Category C activity as per the CCG contract
- Additional frontline pay spend relating to higher than expected incentive rates to maintain capacity and extended periods of unproductive time for new starters (supervision for international paramedics for example)
- £0.6m additional pressure due to unidentified CIP not being delivered.

77.2 The summary forecast paper had been reviewed at the Finance and Investment Committee on 23rd July and, whilst under review, it was still possible to achieve the planned deficit position. The cash balance was healthy as although it was below plan this wasn't a concern. There were some small debt issues being worked through with CCGs.

77.3 Fergus Cass asked for assurance about the delivery of the deficit and Andrew Grimshaw confirmed that, as discussed at the Finance and Investment Committee it was believed that limiting the deficit position to £9.5m was achievable based on the position as currently seen.

77.4 Paul Woodrow reported that all ambulance trusts, except South West, were seeing a reduction in activity. The LAS was represented on a national group that was looking into common trends.

77.5 Bob McFarland asked whether the Australian paramedics were taking longer to become operational than others. Mark Whitbread responded that some were but there tended to be groups within this, with some who were ready to operationalise, those who required some additional training, and some who required more training and the London experience. Each was working with another paramedic so they were not unproductive, and if we took a paramedic from another ambulance trust in England, they would still be required to undertake a London package.

77.6 Paul Woodrow reported that historically campaigns such as 'Don't call us' tended to drive up demand however we were now managing patients in a different way, through hear and treat and the clinical Hub, and with other health care professionals and 111. The national review (reference 77.4 above) would help to understand the position further. It was noted that the biggest decrease in demand was in the 21-30 years age group. A&E attendances were increasing although LAS wasn't conveying more patients to A&E.

78. Finance and Investment Committee Assurance Report

78.1 Nick Martin gave an oral report from the meeting held on 23rd July. It was noted that the Trust Board pack should have included the agenda for the meeting.

Action: SA

Date: 29th September 2015

78.2 The committee had heard from Andrew Grimshaw that the financial position was in stress and that this was likely to continue, for the reasons outlined in the finance and performance reports heard earlier in the Board meeting. The committee heard that contingencies and future improvements should cover the risk to achievement of the plan.

78.3 Discussion had been held on the proposal to buy out 70 DCA ambulances from the 5-year lease which reflected a changing approach to vehicle procurement. The Outline Business Case had been approved and sent to the TDA with the next stage being submission of the Full Business Case. This would be sufficient for the next two years whilst a 5-7 year plan was being developed. Annual procurement would ensure a smoother flow of vehicles into the service. Theo de Pencier stated that this position reinforced the point that circumstances

change and from an economic point of view now, purchase may be more sensible.

- 78.4 The committee had approved the annual effectiveness self-assessment review for the submission to the Trust Board.

Action: SA

Date: 29th September 2015

- 78.5 Nick Martin confirmed that he was content with the information received and the way the committee worked.

79. Board Assurance Framework and Corporate Risk Register

- 79.1 Sandra Adams reported that all but 13 risks had been updated since the last report to the Board, with a number of risks flagged for further review, and with one archive risk on the management of controlled drugs being reinstated on the risk register. The Finance and Investment Committee had reviewed the risks pertaining to finance and fleet and these had been added to the risk register as appropriate.

- 79.2 It was agreed that the Trust Board would undertake a more detailed review of risks at the October Strategy Review and Planning meeting. Fergus Cass commented on the risks presented by the areas discussed at today's meeting such as training, demand and vacancies. He also asked what further action needed to be taken to reduce the level of risk on vehicles and equipment so that this was no longer a red risk. It was noted that the IT security risks actions were on track and would cease to be red rated in due course.

- 79.3 Andrew Grimshaw reported that the issues of aged vehicles and management processes hadn't optimised efficient management and the risk had been compounded by access to and maintenance of equipment. Complex-based fleet was to be rolled out and would give greater responsibility to crews to manage their vehicles. The Trust needed to ensure that vehicles were appropriately equipped, clean and ready when they went out, and to then assess the condition on return of the vehicle to understand what was happening. The Out of Service project under the Performance Improvement Programme would oversee this and a raft of other actions were underway to manage equipment.

- 79.4 It was noted that older vehicles were being reviewed and thought given to how to maintain at optimum level. Theo de Pencier noted that there was shortage of workshop technicians nationally and asked whether this was hampering the actions being taken to mitigate that risk. Andrew Grimshaw thought not. The age of the workforce was expressed as a risk and we were looking into an apprenticeship programme. This was encompassed in the overall fleet review.

- 79.5 In terms of IT, Andrew Grimshaw reported that the interim Chief Information Officer was undertaking a fundamental review of IM&T and this included the risks and mitigating actions being taken. Actions would significantly relieve the pressure but it was not yet known whether these would fully mitigate the risks or not.

80. Annual Equality Report

- 80.1 Janice Markey attended for this item and to present the report. In summary the LAS had met its duties under the requirements of the Equality Act 2010 Public Sector Duty as well as implementing the objectives. Equality and Inclusion training continued to be delivered across a range of courses and a session on Unconscious Bias/Cultural Diversity Awareness was being delivered to the Australian and New Zealand paramedic recruits and will become embedded in the Trust's equality and inclusion training.

- 80.2 The Trust's LGBT Forum has continued to be at the forefront of a number of high profile initiatives including the annual applications to the Stonewall Workplace Equality Index and Health Equality Index. The LAS featured again in the former as a Top 100 Employer, at joint

62nd place, and as the top ambulance service in the country, and among the top five performing NHS Trusts.

80.3 The Trust had continued to look at ways of improving services to protected characteristic groups and the report described initiatives undertaken in patient and public involvement, safeguarding, mental health and disability. The Equality and Inclusion steering group would build on this work in the year ahead.

80.4 The Chairman thanked Janice for the comprehensive report and asked whether the Trust Board gave enough profile to equality and inclusion. Zoe Packman commented on the staff forums and national awards and how staff represented the LAS at events. The Trust made the most of the opportunities being presented and a comprehensive report was given to the Quality Governance Committee. Janice Markey confirmed that a lot of the good work done by LAS staff was being recognised elsewhere, for example Richard Webb-Stevens showcased the best of this kind of work with Deaf Awareness. The Chairman discussed the need to get the balance right and not allowing operational pressures to swamp all the other areas of work underway and which perhaps didn't get enough air time at Board meetings.

80.5 In terms of ethnic diversity in the workforce, the LAS benchmarked favourably against the other emergency services, with the Metropolitan Police at 10% and LAS at 11.2%; 9.9% of new starters this year were BME. Health Education England had launched a piece of work to look into why people of BME backgrounds were not attracted to the paramedic profession. Theo de Pencier asked for clarification as to why the unconscious bias awareness sessions were being offered to the Australian recruits and was this because they were not used to the UK. Janice Markey confirmed this to be the initial approach and that it was about developing an awareness of how individuals interacted with others. Janice had revised the programme and now delivered some of the training herself.

80.6 The Patients Forum had submitted a number of questions which were then taken in turn:

- LAS Board and the lack of diversity: the Chairman responded that he was participating in an LAS initiative to gain interest from colleagues in joining NHS boards and developing a readiness programme to improve people's chances of success through the application and selection processes. The intention was to increase the number of NHS board members from a BME background.
- Percentage of paramedics from a BME heritage: 9.9% on new starters came from a BME background and this was a positive move. Karen Broughton reported that this would have to be influenced at the point of entry nationally ie the universities, as the LAS and other services appointed from this pool of graduates.
- Appointment of a race champion: Janice Markey responded that this was one of the 4 equality objectives and champions had been appointed so far for age, disability, pregnancy and maternity. Two members of staff had agreed to be champions for race and gender, and this left a gap for religious beliefs which she was actively working on. She was working closely with the Employers Forum and the chair of the BME Forum chaired the national network group.
- Support at the right level was required to achieve what was needed to progress equality and inclusion: Janice Markey reported that much effort was being made to support staff at all levels. The Trust Board had received training in 2014 and the Disability Forum had trained the HR directorate.
- Appointment of an independent chair of the Equality and Inclusion Steering Group: Zoe Packman would discuss this further with Malcolm Alexander.
- The London population was trending towards 50% BME and the LAS clearly needed an objective to work towards this.

The Chairman thanked Malcolm Alexander for his continuing support on this issue.

80.7 Nick Martin commented that the figures shown on page 204 for bullying and harassment were reasonably low in terms of reasons for counselling.

80.8 Malcolm Alexander commented on the excellent outreach work in the community and the

opportunity this presented to link this with recruitment. Karen Broughton responded that the LAS was looking at this but there was also more that could be done for example with recruitment literature for use in local events. Janice Markey confirmed that a lot of ambassadorial work was underway in schools and it was intended that each of the staff forums would get involved in this kind of work. The new recruits were being encouraged to get involved in patient and public education work. Karen Broughton urged a note of caution as to how much the LAS could do itself.

81. Bullying and Harassment

81.1 Karen Broughton gave a presentation on the background to the review and the 11 main findings. There had been a poor organisational response to the review and it was believed this was due to a prevailing culture across all levels and functions; that there was a command and control management style; and positive people management wasn't seen as a way to get results.

81.2 In response to this, the Trust was taking the following action:

- Training for the executive and senior management teams
- Training for the HR team
- Training across the rest of the management team
- Scoping organisational Dignity at Work
- 11 members across the executive and senior management teams had expressed an interest in being champions.

81.3 Funding had been sourced and a Bullying and Harassment lead role identified; there had been 6 calls to date to the advisory service; and the Trust policy would be re-launched. Staff would be re-surveyed in six months and TeamTalk had asked whether the actions proposed were the most appropriate. An update would be given to the Trust Board in September. It was important to feedback to staff on the actions being taken.

81.4 Fiona Moore commented that there were no more referrals to the advisory line and she reflected as to whether the problem wasn't as large as initially thought. Bob McFarland asked whether bullying and harassment was distinguished and Karen Broughton confirmed this was covered in the training. It was important that the organisation understood that performance management wasn't a form of bullying and harassment. Some managers were now feeling that they couldn't manage and this couldn't be allowed to continue. A series of master classes were planned to support managers in this and this would be reiterated at a staff conference in the Autumn.

81.5 Nick Martin asked if it was possible to distinguish underlying causes, for example style or pressure of work. Karen Broughton said that a call to the advisory line concerned pressure of work. As recruitment and performance improved it was hoped that this pressure would start to ease. Jason Killens agreed with Nick Martin's comment. Some operational staff did translate pressure of work into harassment. Added to this were the changes to rotas and the management structure.

82. Board Declarations

82.1 The statements and declarations for July were approved.

83. Trust Secretary Report

83.1 The Trust Board noted the report from the Trust Secretary.

84. Trust Board Forward Planner

- 84.1 A presentation from Chris Hartley-Sharpe on community first responders would be added to the 2016 planner.
Action: SA
Date: 29th September 2015
- 84.2 The Trust Board noted the forward planner.
- 85. Trust Board Register of Interests**
- 85.1 The Trust Board noted the register.
- 86. Patient Story**
- 86.1 The Chairman introduced the context of the patient story for the Trust Board and Zoe Packman introduced the patient, Suzanna, and gave the following summary account:
- 86.2 On 1st October 2014 Suzanna's father rang 999 and asked for an ambulance. The call was triaged but a vehicle wasn't sent and Suzanna's father conveyed her to hospital himself. The circumstances on 1st October 2014 and since then have provided a number of lessons for the LAS. The introduction of the Family Liaison Officer role and the opportunity to rebuild the relationship with Suzanna has restored some of the trust she has in the service.
- 86.3 Suzanna then gave her account and stated from the outset that she was keen that the organisation should learn from this and not allow such an experience to occur again. Her father, who is a doctor, had called 999 and explained that she was experiencing heavy bleeding and had been discharged from hospital. He was advised to contact the GP or NHS 111 as Suzanna's condition didn't meet the criteria for an ambulance to be dispatched, which they considered irresponsible advice. Suzanna told the Board that the physical and mental scars from this experience were still present. She summarised the issue as:
- Failure to send an ambulance
 - Advice to contact the GP or 111
 - They had written a letter of complaint to the LAS and had been told that the incident would be investigated and a Family Liaison Officer (FLO) arranged. The FLO made an initial contact only once and did not respond to subsequent contact attempts by the family
 - No one was taking this incident seriously or taking responsibility
 - There was no proof of any learning.
- 86.4 Eight months later a meeting did take place at Suzanna's home and this was a positive meeting.
- 86.5 Learning from this incident:
- It became apparent that the previous FLO had left the organisation but not handed Suzanna's case over
 - No feedback had been given to the operator who would not therefore have learnt from their mistake and who had now left the LAS.
- 86.6 The Chairman thanked Suzanna for being candid and brave in coming to the meeting and he apologised for the lack of service response and the failure to respond to her complaint. He stated that there should be clear actions to minimise future risks and this type of event reoccurring.
- 86.7 Peter Nicholson reported that, in terms of triage of the call, this was a known AMPDS issue for which the solution will be tested from Q3 15/16 and will go live in Paramount in Q4. Suzanna would have received an ambulance if this was in place.

- 86.8 The Serious Incident policy had been updated and a new Duty of Candour policy was in place. Both were being managed with more rigour and the FLO role was formally incorporated and being managed with serious incidents now. Peter was confident that the same problem regarding FLO contact would not happen now and we were working hard to operate as an open and honest organisation for patient safety issues, for example, an FLO would now offer a meeting within 10 days of the LAS becoming aware of the incident.
- 86.9 Nick Martin asked how we take into account a professional opinion when triaging calls, such as that offered by Suzanna's father. Fenella Wrigley responded that the new version of triage would avoid confusion with serious/dangerous bleeding; any information given by the caller would be captured and reviewed and this should have happened in this case for which she apologised to Suzanna. Fenella confirmed that every member of staff who has been trained is registered so we would be able to contact that individual and give them feedback if they went back into an organisation that used the same system. She also said that the Academy (AMPDS) would use this as an anonymised case for national learning.
- 86.10 Fiona Moore reiterated the gratitude already expressed to Suzanna and her father for writing the complaint letter as the LAS would not have known about this otherwise, and this case re-emphasised how important feedback was. The case would be shared with medical directors of other ambulance services in the same way as a previous one on post-tonsillectomy bleeds had been. She asked Peter Nicholson for an update on recruiting FLOs. Peter responded that with the Quality Governance & Assurance Managers being appointed to each sector we would be able to build a list of reliable and responsive FLOs locally. A training programme was being formulated for the Autumn. Suzanna stated that the FLO had failed in their role in her case and asked why progress was not tracked, and she said that it was unacceptable that this wasn't managed. Karen Broughton asked how the FLO activity could be monitored and how others were kept up to date. Peter Nicholson responded that a checklist was in place with timeframes to follow, in line with the Duty of Candour policy. Ted Nyatanga stated that once an SI is declared all appointed FLOs are given support immediately about the expectations of their role as it is new in the organisation and this was now working well. Progress was communicated within the Governance department and there was a more robust process in place for preparing for the Serious Incident group meetings and for tracking serious incidents. The Governance department provided support for FLOs and in particular for those new to the role. The net between serious incidents and complaints had also been closed. Mark Whitbread confirmed that the process was far more robust now.
- 86.11 Fiona Moore asked whether the report had been shared with the Whittington Hospital as this had also been an adverse event for them. Fenella Wrigley responded that it had not yet been shared but would be once the report was finalised and if the family agreed to it being shared.
- 86.12 Sandra Adams apologised for the failure in governance processes in Suzanna's case and thanked her for being so candid with the Board. The Chairman summarised by saying that this was a lesson for the LAS to listen and learn from, and to remember that there were human stories behind what we do. We could learn from a distressing incident and failure on our part for what we should have done on the day. He was reassured by the action that had been taken to prevent a reoccurrence.
- 86.13 The Chairman thanked Suzanna again for bringing her story to the meeting.

87. Questions from members of the public

87.1 The questions from the Patients Forum had been addressed earlier in the meeting. Malcolm Alexander said that there was a lot of work to be done on Equality and Inclusion and what had been undertaken so far was impressive but limited. He suggested also that the LAS review the quality of the literature available to patients about complaints. Jason Killens commented that the aim of a new website would be to make it easier for people to give us feedback. Bob McFarland confirmed that the Board knew that the complaints process needed review and the issue was how a complaint became a serious incident.

88. Any Other Business

88.1 Bob McFarland asked for an update on recruitment to the Quality Governance Manager posts and Jason Killens confirmed that 5 had been appointed and two posts were to be advertised. The new sector management structure would go live from 3rd August and the Band 7 posts – Group Station Managers and Incident Response Officers would go live from 7th September. A period of transition would be managed and it was envisaged that it would take 8-10 weeks to recruit to the remaining posts.

88.2 The Chairman confirmed that the Strategy Review and Planning meeting would be held away from HQ in October.

88.3 The meeting of the Trust Board held in public was closed.

89. Date of next meeting

89.1 The next meeting of the Trust Board is on Tuesday 29th September 2015 at 09.00am in the Conference Room, Waterloo.

.....
Signed by the Chair.

ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
Date of schedule: September 2015

<u>Meeting Date</u>	<u>Minute No.</u>	<u>Action Details</u>	<u>Responsibility</u>	<u>Progress and outcome</u>
28/07/15	<u>75.9</u>	Patient and Public Involvement and Education – Richard Hunt and Fiona Moore to acknowledge the work undertaken by staff in their own time and to extend this to Shockingly Easy and volunteers.	RH/FM	To be included in the forthcoming roadshows
28/07/15	<u>78.1</u>	Finance and Investment Committee agenda to be included in the Trust Board pack.	SA/AG	Completed
28/07/15	<u>78.4</u>	Finance and Investment Committee annual effectiveness review to be submitted to the Trust Board.	SA	Completed – Part II
28/07/15	<u>84.1</u>	Presentation of community first responders to be added to the forward planner.	SA	On the planner – date to be confirmed
02/06/15	<u>55.4</u>	Sandra Adams to do a session on the BAF at the Strategy Review and Planning Committee meeting.	SA	27 th October 2015
<u>Completed actions from July 2015</u>				
02/06/15	<u>51.5</u>	Zoe Packman to provide an update on progress of the review of complaint processes.	ZP	Closed – covered in the 28 th July quality report
02/06/15	<u>51.11</u>	Sandra Adams to add a review of progress against the Lampard recommendations to the Forward Planner.	SA	Closed – November 2015
02/06/15	<u>51.12</u>	Karen Broughton to follow up on DBS and pre-employment checks.	KB	Closed

<u>Meeting Date</u>	<u>Minute No.</u>	<u>Action Details</u>	<u>Responsibility</u>	<u>Progress and outcome</u>
02/06/15	<u>53.6</u>	The Board to feedback to Andrew Grimshaw and Paul Woodrow on any core metrics that had not been included in the Integrated Board performance report.	ALL	Closed – within the discussion on the integrated performance report
02/06/15	<u>60.8</u>	KB to monitor the delivery of the Business Plan through the Integrated Performance report.	KB	Closed – within the discussion on the integrated performance report
24/03/15	<u>34.12</u>	Karen Broughton to present the Workforce report to the Strategy and Planning Committee.	KB	KB reported that the integrated information on workforce would be held in one place, with some aspects reviewed on a quarterly basis.
24/03/15	<u>34.14</u> <u>48.3</u>	Mark Gammage to extract key actions for each of the eight objectives and share with the Non-Executive Directors.	MG / KB	KB would follow up with Mark Gammage. KB noted that this would form part of the HR report.
27/01/15	<u>13.10</u> <u>48.4</u>	Mark Gammage to circulate to the Board the report of the Listening into Action surveys.	MG/ KB	KB to follow up with Mark Gammage.



LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 SEPTEMBER 2015

PAPER FOR APPROVAL/INFORMATION

Document Title:	Chief Executive Report to the London Ambulance Service (LAS) Trust Board
Lead Director:	Fionna Moore
Report Author(s):	Jacqui Galletta
Contact Details:	Jacqui.galletta@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:	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Executive Management Team <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Finance and Investment Committee <input type="checkbox"/> 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:	
<ul style="list-style-type: none"> • Major Drive to improve the health of NHS staff • Enabling closer working with other emergency services • Patient Care Conference 2015 • Australian High Commission Reception • Well Led Framework • Winter Planning & Flu 	
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 29 SEPTEMBER 2015

1. Major drive to improve the health of NHS staff

NHS England has announced [a major drive to improve the health and wellbeing of 1.3m health service staff](#), including a new nationally-specified occupational health service for GPs. NHS organisations will be supported to help their staff to stay well by providing healthier food options, promoting physical activity and reducing stress. Health checks will be available for targeted groups of staff and additional access to mental health and musculoskeletal services – tackling the two biggest causes of sickness absence across the NHS.

The detail of the publication can be viewed via the link above including Simon Stevens's statement.

2. Enabling closer working between the emergency services

The Government is consulting on a series of measures to transform the delivery of local fire and police services, and drive greater collaboration between the police, fire and rescue and NHS ambulance services.

The measures being consulted upon are:

- introducing a new duty on all three emergency services to actively consider collaboration opportunities with one another to improve efficiency and effectiveness;
- enabling Police and Crime Commissioners to take on the duties and responsibilities of fire and rescue authorities, where a local case is made;
- where a Police and Crime Commissioner takes on the responsibilities of a fire and rescue authority, enabling him or her to create a single employer for police and fire staff, facilitating the sharing of back office functions and streamlining management;
- in areas where a Police and Crime Commissioner has not become responsible for fire and rescue services, enabling them to have representation on their local fire and rescue authority; and
- abolishing the London Fire and Emergency Planning Authority and giving the Mayor of London direct responsibility for the fire and rescue service in London, as will be the case in Greater Manchester.

This consultation is open until 23rd October 2015.

[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459986/Consultation -
Enabling closer working between the Emergency Services w 2 .pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459986/Consultation_-_Enabling_closer_working_between_the_Emergency_Services_w_2_.pdf)

The CEO continues to meet with the heads of the Metropolitan Police Service and the London Fire Brigade.

3. Patient Care Conference 2015

The LAS Patient Care Conference takes place on 21st October 2015. The CEO stated:

“I am really proud of the clinical excellence that the London Ambulance Service demonstrates in a number of areas and this conference is an opportunity for us to showcase that. Some of the areas that the conference will cover are care in hazardous environments, the research we carry out to improve patient care, the huge benefits that we have seen through Hear & Treat as well as looking at some of the clinical advances we are making going forward.”

The conference will hear from a number of our frontline staff who will share their expertise and experiences.

4. Evening Reception with the Australian High Commission

The Australian High Commission is hosting a reception on 24 September 2015 to acknowledge the commitment which Australians have made to travel to London and work with us. Like the London Ambulance Service, the Australian High Commission recognises that the contribution which paramedics from Australia are making to the lives of Londoners is significant with countless examples of lives being touched and positively impacted. Amanda Coyle, Director of Health and Communities at the Greater London Authority (GLA) will be in attendance and will say a few words as will the Australian High Commissioner.

5. Well Led Framework

The National Programme Director, Anne Gibbs has advised that the trust is to be reviewed/assessed within this framework.

The review will fall into three key phases; data collection and self-assessment, site visits and feedback:

Phase 1	Trust Board Survey Trust Staff Survey Trust Self-Assessment
Phase 2	Board Observation Committee Observations Board Interviews
Phase 3	Staff Focus Groups Service (Quality) Visits Stakeholder Interviews

There will be a Board to Board meeting on the 3rd December 2015.

6. Winter Planning & Flu

As we are approaching the winter pressure period, a team is being developed to undertake the Service planning process to ensure we are prepared and able to respond to the potential increased demands placed upon the service.

We will be working with commissioners and stakeholders to explore alternative methods of meeting demand and looking to implement differing types of service delivery where this is proved to be viable in terms of impact on staffing and normal ambulance provision.

This team will also be including the planning of significant events that occur during this winter period such as New Year's Eve, to ensure a coordinated approach is taken across the organisation and preventing the planning for one event impacting on that of another.

The Central Operations Division will be leading on this planning but will be seeking assistance and the involvement of most areas of the Service to ensure our responsiveness is appropriate, proportionate and well planned.

The 2015/16 Seasonal Influenza Vaccination Programme begins in earnest in early October with the intention of vaccinating as many frontline staff as possible against the flu virus, so that we can protect our most vulnerable patients.

Each Group main station will have a vaccine fridge, vaccine consumables and vaccine as well as portable vaccine carriers to get out to satellite stations. Team leaders and restricted duties paramedics will be trained to take part in our peer to peer vaccination clinics. Supporting these local clinics will be a small number of 'flu buses' which were very popular last year. They will be visiting low uptake areas, busy A&E Departments and large events such as the Chief Executive Road shows to capture staff.

As a responsible employer, all staff will be encouraged to have their flu vaccine, not just frontline staff, and vaccine will be available in key support services areas as well as both emergency operations centres.

The communications department are poised with a range of media supporting this year's campaign including videos, tweets, posters and the 'jabometer' on the intranet showing how we are doing in terms of vaccine uptake compared to last winter.

Fionna Moore
Chief Executive

September 2014



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Integrated Performance Report – Trust Board Executive Summary.
Report Author(s):	Jill Patterson
Presented by:	Andrew Grimshaw
Contact Details:	0207 783 2037 / 07825733445
History:	Executive Management Team – 22/09/2015
Status:	Information Assurance and Discussion.
Background/Purpose	
<p>This High –Level Integrated Performance Report serves to provide an Executive Summary for Trust Board and give organisational oversight of all key areas across London Ambulance Service.</p> <p>It brings together the areas of Quality, Operations, Workforce, Finance and the Trust Service Improvement Programme. Key messages from all areas are escalated on the front summary page.</p> <p>This Integrated Report benchmarks Trust-wide performance against Key National, Local and Contractual Indicators.</p> <p>This Executive Summary is designed to inform the business decisions of the Trust.</p>	
Action required	
<p>For Trust Board to note the Integrated Performance Report and receive it for information, assurance and discussion.</p>	
Assurance	
<ul style="list-style-type: none">▪ To assure the provision of high quality data and intelligence to support the Trust's decision making processes.▪ To provide an integrated and comprehensive picture of the Trust's overall performance.▪ To ensure that the Trust Board receives early oversight of trends and issues.	

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



London Ambulance Service



NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

SEPTEMBER 2015

- * All available data is correct as of the 15th of every month.
- * Please note that this report relates to performance throughout August 2015 unless otherwise stated.



Delivery of care continues to be safe, but quality remains challenged at times. Some patients experience longer waits due to capacity constraints.

The financial position continues to be stressed with pressure on the forecast outturn.

August A8 performance ended at 65% which was significantly off the contractual trajectory (target 73.9%) but remained consistent with previous months performance levels.

Sickness continues to fall in A&E operational areas.

OUR PATIENTS

- ↑ There were 5 LAS declared serious incidents in August 2015, a decrease from last month with 2 preventing future deaths reports received since the last report.
- ↑ CPI completion has continued to increase in August with all CPI audits achieved in excess of the 95% requirement, except mental health which remains below the required level.
- ↑ Cardiac Arrest survival to discharge demonstrates good outcome data. The Cardiac Arrest Annual Report has been released demonstrating the impact of public access defibrillators.

OUR MONEY

- ↓ Surplus – The TDA has requested an improvement of £2m in the financial plan. To date only £0.5m has been identified.
- ↓ Year to date - The Trust continues to report a £1m adverse variance from plan. Based on this performance achieving the year end forecast deficit of £9.0m is stressed.
- ↓ Cost Improvement - CIP is £0.5m adverse to plan due to unidentified savings programmes required due to the reduction in CBRN funding (£3.0m).
- ↔ Cash - £3.1m below plan. The Trust cash position remains robust but risk still remains in terms of delivering the financial plan and outstanding debt.

OUR PERFORMANCE

- ↓ A8 Performance was 65% for August. Whilst this is consistent with previous months it has not reflected the expected upturn required for the performance improvement trajectory.
- ↔ The vehicle hours deployed during August were 5% down on planned levels. This was due to lower than expected levels from substantive staff – which was partly driven by increased annual leave.
- ↔ The LAS forecasting rule was 3% below actual performance (pessimistic) during August, with the business case rule being 5% above performance (over optimistic).

OUR PEOPLE

- ↑ Frontline vacancy rate continues to improve, now 12.0% down from 12.5% in July.
- ↑ There are currently 711 active applications for frontline staff in the recruitment pipeline.
- ↑ The current total trust yearly sickness level is 6.1%, having peaked at 6.6% in March.

OUR PATIENTS

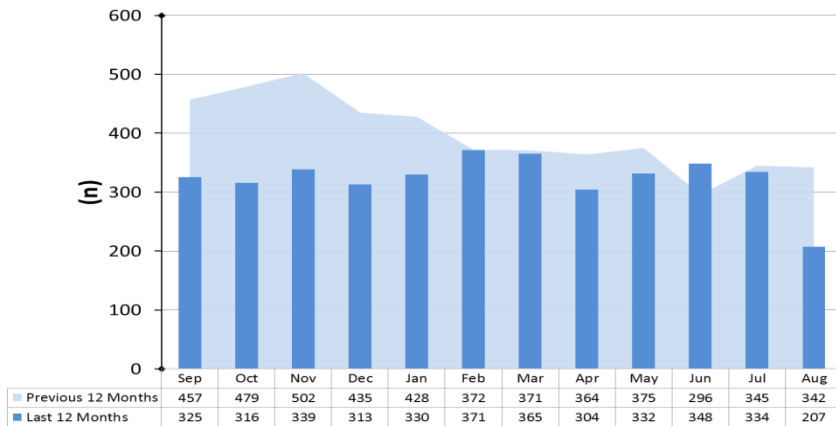


Sub-Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	Historic RAG
Safety	<ul style="list-style-type: none"> • 5 serious incidents declared during August 2015. • 2 drug incidents reported. • 2 preventing future deaths reports received. • Locality Alert Register - The Deputy Director of Operations and the Deputy Director of Nursing are working together to ensure all category 4 patients have a care plan in place. 	<p>All RAG status to be determined</p>		
Effective	<ul style="list-style-type: none"> • Cardiac Arrest survival to discharge demonstrates good outcome data. • The Cardiac Arrest Annual Report has been released and demonstrates the impact of public access defibrillators. • A DARZI fellow has started with the Trust, concentrating on frequent callers. 			
Caring	<ul style="list-style-type: none"> • In excess of 95% compliance to each of the audits aside from mental health. • The mental health audit remains an issue, with compliance at 90%. • CPI feedback sessions remain low. 			
Responsive	<ul style="list-style-type: none"> • 15 hours were spent at Surge Purple or above. • As agreed the Trust continues to operate at Surge Red. The lowest acuity 999 calls receive an enhanced clinical assessment through NHS111 or the Clinical Hub. 			
Well Led	<p>The Deputy Director of Nursing and Quality replied to the Monitor paper requesting views on agency nursing rules.</p>			



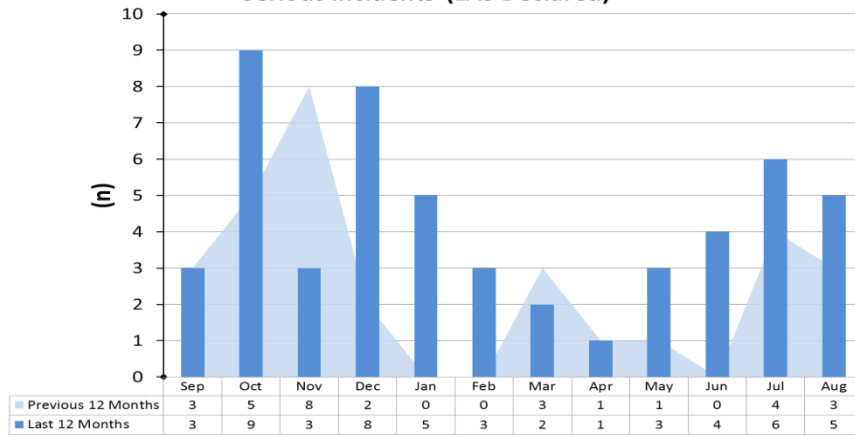
Serious & Adverse Incidents

Adverse Incidents Reports



- The number of adverse incidents reported for August is 207. It should be noted that there are on-going, although reducing, issues with data entry. The backlog of LA52 and LA277 forms awaiting entry onto the system have reduced and now total 55. These are being entered in date order to ensure issues are identified as quickly as possible despite the backlog.
- The top 5 patient safety incident themes are: patient treatment, clinical assessment, resource dispatch, removal of patient from scene and conveyance.
- The top 5 staff safety incident themes are: abusive behaviour, physical violence, manual handling incidents, exposure to harmful substances and sharp objects.
- These incidents and themes are reviewed in more detail at the Clinical Safety and Standards Committee.

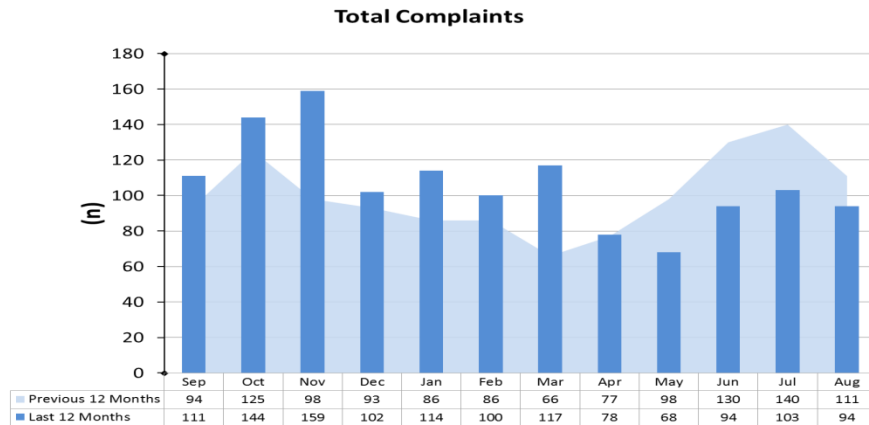
Serious Incidents (LAS Declared)



- 5 new SIs were declared during August. 14 SIs are outstanding. 2 are overdue with commissioners; 1 being dependant on an end to end review with 111 and the other awaiting comment with the SMT lead. 12 are within timescale and are at varying stages; 1 with EMT for review with a FLO meeting arranged, 1 a de-escalation has been requested and 10 are in the report preparation stage and on track.
- The first SI/FLO/Duty of Candour training session has been booked. This will initially focus on the Quality Governance and Assurance Managers.
- The SI policy is being reviewed to reflect the SI framework 2015 and to make the investigation process more explicit following feedback from HM Coroner.



Complaints (1) – Volume & Response Time

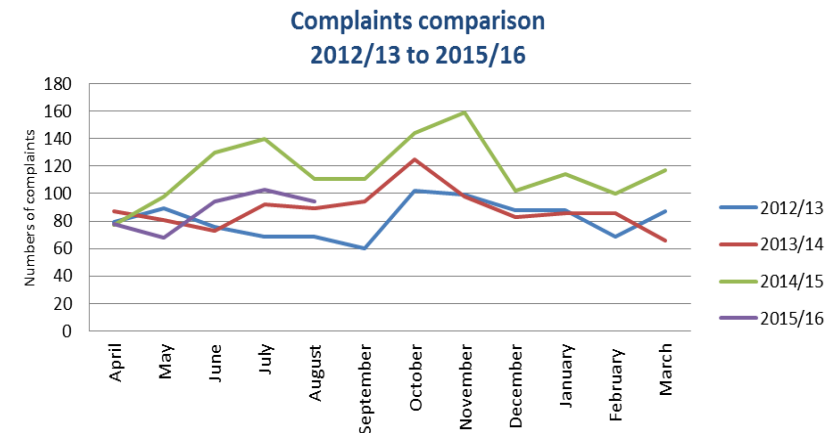


94 complaints were received in August compared to 103 in July, 94 in June and 68 in May.

This reflects the general trend of complaints at this time of year, complaints are invariably affected by the weather. August was unseasonably poor with call rates being slightly lower.

The monthly average for 2014/15 was 117 complaints (compared with 90 in 2013/14, 81 in 2012/13 and 50 in 2011/12). The current monthly average for 2015/16 is 88.

Trust	Complaints received 2014/15	Percentage of national total (rounded)
North West Ambulance Service	2133	25%
London Ambulance Service	1403	17%
East of England Ambulance Service	974	11%
South West Ambulance Service	882	10%
North East Ambulance Service	658	8%
Yorkshire Ambulance Service	611	7%
South Central Ambulance Service	599	9%
South East Coast Ambulance Service	535	6%
West Midlands Ambulance Service	522	6%
East Midlands Ambulance Service	117	1%
Total all	8434	100%





Complaints (2) – by Area and Subject of Complaint & PALS

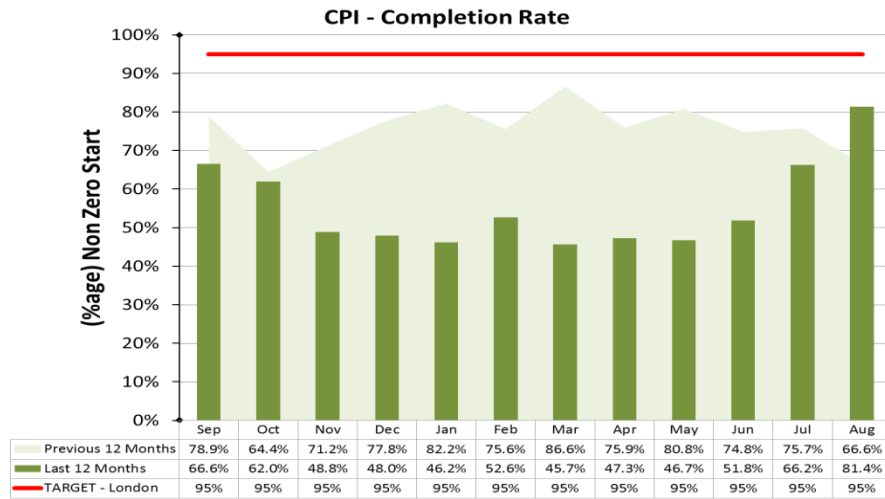
Complaints by subject 2014 -2015	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	August	Totals
Delay	65	87	95	71	70	50	55	33	22	47	40	44	679
Conduct	23	33	37	19	32	25	34	21	29	25	28	24	330
Road handling	7	7	10	4	5	8	8	7	5	8	8	10	87
Non-conveyance	8	6	5	3	2	5	2	9	4	3	10	3	60
Not our service	0	3	1	0	2	3	1	1	0	4	1	5	21
Treatment	4	1	5	1	3	5	10	4	5	5	7	3	53
Patient Injury or Damage to Property	2	3	1	0	0	3	3	0	1	1	1	1	16
Location Alert referral	0	2	1	1	0	1	0	0	1	1	2	2	11
Conveyance	1	1	2	3	0	0	2	2	1	0	2	1	15
Clinical Incident/Equipment	0	0	0	0	0	0	1	1	0	0	4	1	7
Assisting with external agency	0	0	1	0	0	0	0	0	0	0	0	0	1
Disputes safeguarding referral	0	1	1	0	0	0	1	0	0	0	0	0	3
Aggravating factors	1	0	0	0	0	0	0	0	0	0	0	0	1
Totals	111	144	159	102	114	100	117	78	68	94	103	94	1284

- Complaints about delays are attributed to Control Services when the problem may actually represent less than optimum operational resourcing.
- Complaints relating to delay (44) and staff conduct (24) continue to be the main themes.
- The 'complaints review' by the Transformation team is underway and will be reported on in October.

- PALS specific enquiries = 275.
- Average monthly PALS for 2013/14 = 287.
- Current average for 2014/15 = 298.
- Current average for 2015/16 = 305
- At the time of writing there are 99 x PALS cases remaining open; this includes 36 requests for medical records awaiting consent from the patient, 63 cases awaiting QA reports/further supporting information and cases under liaison with the Consultant Midwife.



CPI Completion, Feedback Sessions and Compliance (JULY 2015)



- The new 50:50 role for team leaders should begin to improve the completion rates LAS wide.
- Completion rates at Brent, Camden and New Malden remain below 50%.
- The change in complex areas and teams has created an issue with the CPI system. The CPI system requires updating. Although some areas had completed all of their CPI audits, under the new structure there are still some audits required.
- 14 (old structure) complex areas achieved 100% completion.

CPI Compliance

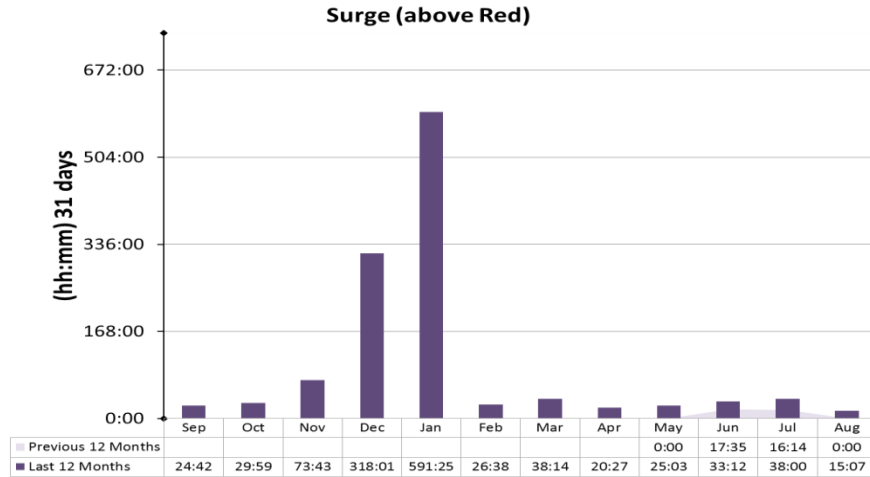
- Compliance to the non-conveyed, acute coronary syndrome, cardiac arrest, glycaemic emergencies, stroke and general documentation remains high, with LAS wide average scores in excess of 96%.
- The Mental Health CPI remains a concern, with the LAS wide average compliance currently at 90%. Areas for improvement are:
 - Safeguarding concerns
 - Appearance
- Mental Health appeared on CSR last year, and some improvements have been seen. However, this CPI remains the lowest in compliance.

CPI Feedback Sessions

- 4 (old structure) complexes achieved 100% of their expected feedback sessions.
- 75% of frontline operational staff are yet to receive their first face to face feedback session for this financial year.
- Friern Barnet, Isleworth, New Malden and the Volunteer Responders provided <10% of the expected feedback sessions.



EOC Surge Status



- 15 hours were spent at Surge Purple or above during August. This is a decrease from the previous month.
- The implementation of Surge Red operating 24/7 has enabled the Trust to respond to the highest priority calls within the required timeframe. The lowest acuity 999 calls receive an enhanced clinical assessment through NHS111 or the Clinical Hub. However, there is significant risk associated with increasing Surge level, and the Trust has seen some extended delays for lower priority calls, as well as delays for some of the higher priority calls. This risk is mitigated by the Clinical Hub and senior clinical and operational oversight.



CARU Reports (Cardiac, Stroke, Trauma), Airway Management/ETC02

CARDIAC (July 2015)

- Resuscitation efforts were commenced on 41% of cardiac arrest patients attended.
- Approximately 10% of the cases had a defibrillator download submitted – the highest figure to date.
- The average time from 999 call to arrival on scene for STEMI patients has increased by 2 minutes to 13 minutes. It is important to note that a number of STEMIs present as C1 priority calls not R2 calls at the call taking stage.
- The average on-scene time for STEMI patients has increased by 1 minute to 44 minutes. This is being addressed through Clinical Team Leader feedback, and via the job cycle time project.

STROKE (July 2015)

- 98% of stroke patients were provided with the full pre-hospital care bundle.
- 99.6% of FAST positive patients had the time of onset recorded or a reason why this could not be documented.
- 99.5% of FAST positive patients were conveyed to a HASU. 5 patients were taken to an ED instead of a HASU.
- Average response from call to arrive on scene time was 14 minutes, a reduction of 1 minute.
- Average on scene time is 35 minutes.
- 62.7% of patient eligible for thrombolysis arrived at a HASU within 60 minutes. One issue impacting on this figure is the lack of access to a HASU from some areas of London.

AIRWAY MANAGEMENT

- An advanced airway was placed successfully in 87% of cardiac arrest patients where resuscitation was attempted.
- 99% of these patients had end-tidal CO₂ measured and documented.
- 3 patients had no end-tidal CO₂ level documented on their PRF, nor an accompanying capnography printout.
- Cases with no end-tidal CO₂ monitoring undertaken are sent for review by the area governance lead, and reported back to the Safety and Standards Committee.
- The Medical Directorate will produce a flowchart to ensure that feedback on each case is undertaken.

TRAUMA (Q1 2015/16)

- 1372 patients were treated as major trauma patients.
- On scene times for blunt and penetrating trauma are 36 minutes and 17 minutes respectively. Blunt trauma shows a reduction of 4 minutes. Penetrating trauma shows an increase of 2 minutes.
- 124 patients were conveyed to a MTC despite not being indicated. This may impact on patient experience due to protracted journey times.
- Feedback is provided to crews regarding inappropriate conveyance to MTCs and on scene times.



Workforce (Nursing)

- The Director of Nursing and Quality has responded to Monitors paper requesting the Trusts views on nursing agency rules: initial engagement setting out new agency control proposals.
- NHSE have establishment a London Nursing Workforce Board and supporting structures to Address the London Nursing Workforce Issues
- The LAS is engaged in the 'Securing a sustainable nursing workforce for London Programme' which aims to get employers, HEIs and commissioners to work together to build a compelling vision of the Capital Nurse.

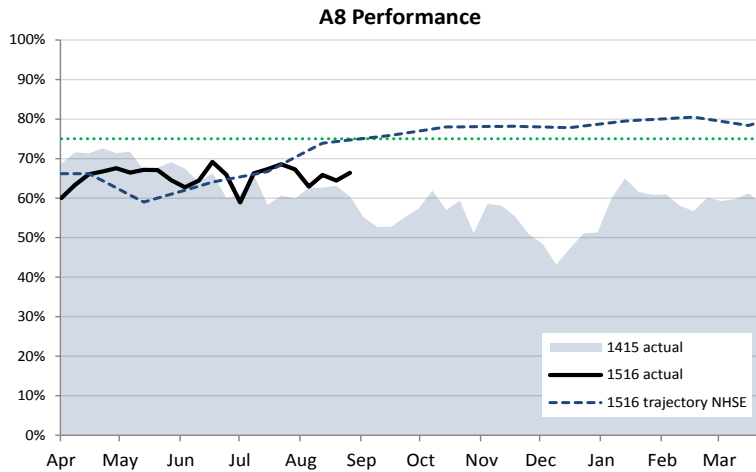
OUR PERFORMANCE



Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current A	Historic RAG J J M		
A8 Performance	A8 Performance was 65% for the month. Whilst this is consistent with previous months it has not reflected the expected upturn required for the performance improvement trajectory.				
Other Performance	Performance has been relatively consistent despite the increased Demand and the lower then expected Capacity.				
Demand	Demand has returned to forecast levels (i.e. has increased from previous months). This is partly due to NETS not yet having the expected impact.				
Capacity	The vehicle hours deployed during August were 5% down on planned levels. This was due to lower than expected levels from substantive staff – partly driven by increased annual leave.				
Efficiency	JCT is on track for the original business case target, but not meeting the stretch target. There was an improvement in MAR seen towards the end of the month due to realignment of target.				
Forecasting	The forecasting model continues to be accurate and tracked at 3% below performance for the month of August.				



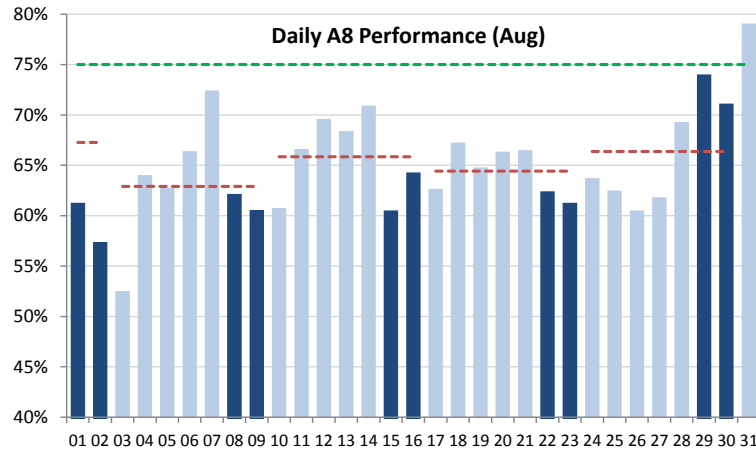
A8 Performance



A8 performance for August was 65.0% Whilst this performance level has remained consistent throughout the year to date – it means that the organisation is now moving away from its agreed performance improvement trajectory.

There have been a number of meetings with commissioners to discuss this, particularly around the fact that the original forecast trajectory was created using a model which has now proven to be over optimistic.

There is currently an exercise underway with McKinsey to review the performance trajectory. This will be completed before next month.

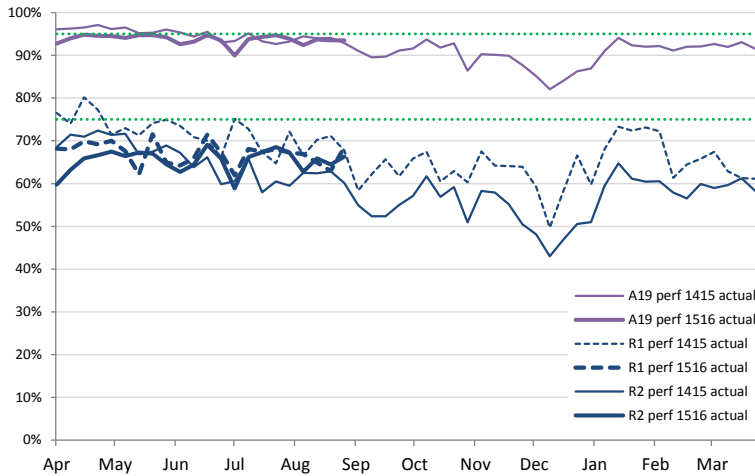


Daily performance was lower at weekends throughout the month and 53% on Monday the 3rd due to high levels of demand over the whole weekend. Performance on the bank holiday weekend at the end of the month was very strong with one day over 75%. This was due to high levels of staffing for the Notting Hill Carnival, and relatively low activity levels.



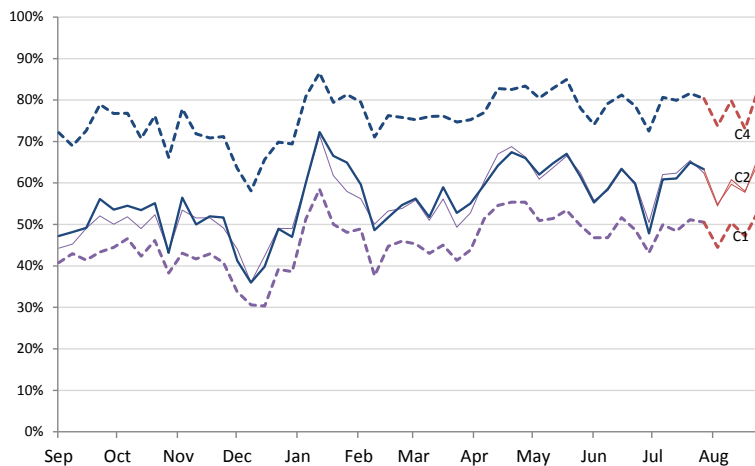
Other Performance

A19, R1 & R2 Performance



A19 performance continues to be strong, although just below target, at 93%. All performance targets have continued to be steady. The challenge moving forward is to ensure these increase in line with the performance trajectory rather than decreasing when activity increases over Q3.

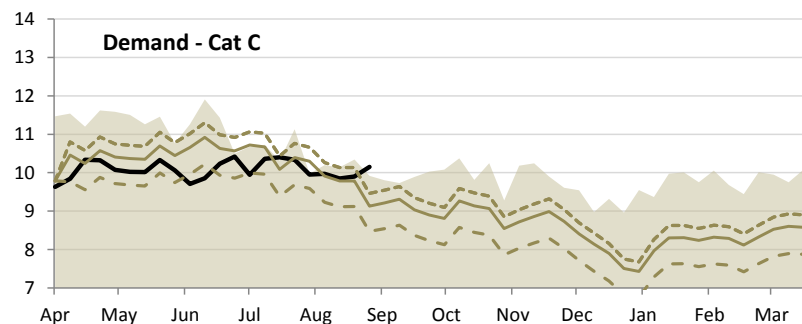
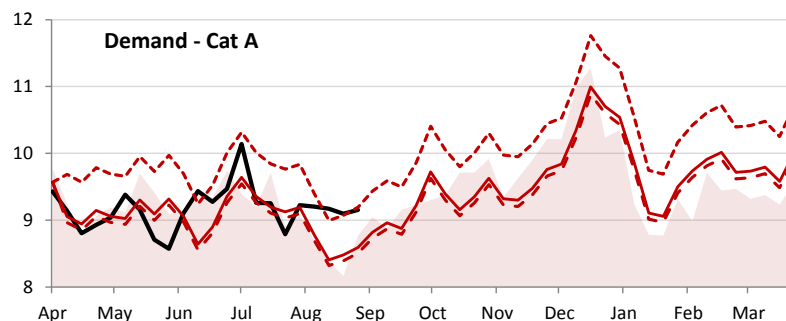
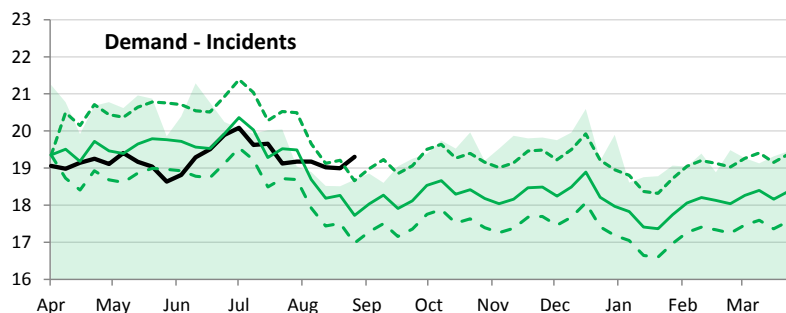
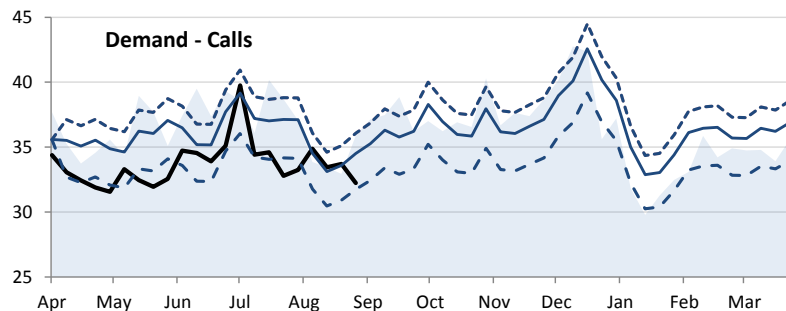
C1, C2, C3, C4 Performance



wk ending	A8	A19	R1	R2	C1	C2	C3	C4
02-Aug	67	94	67	67	51	62	80	63
09-Aug	63	92	67	63	44	54	74	55
16-Aug	66	94	65	66	50	61	80	60
23-Aug	64	94	63	64	47	58	73	58
30-Aug	66	94	69	66	53	65	83	67
Aug	65	93	66	65	49	60	78	60
Jul	65	94	67	65	50	60	80	61
Jun	65	93	67	65	48	59	77	59
May	66	95	67	66	52	64	82	65



Demand



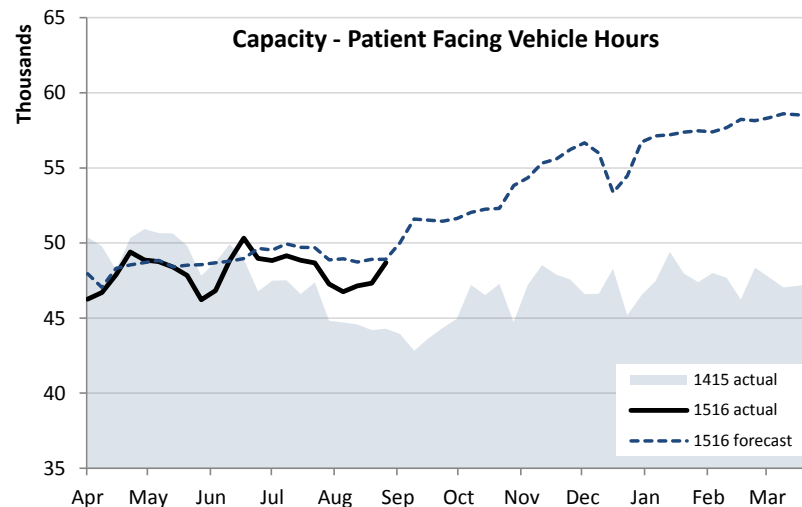
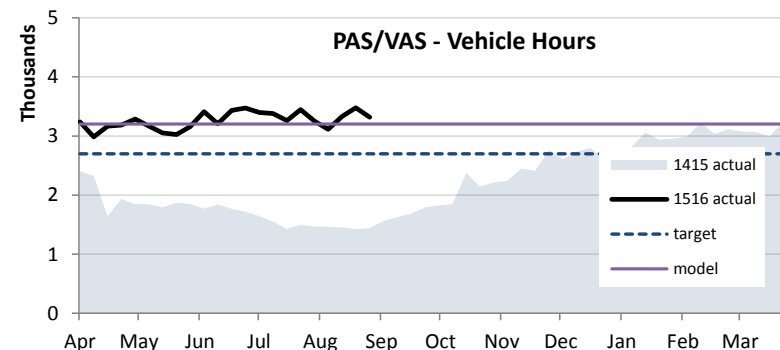
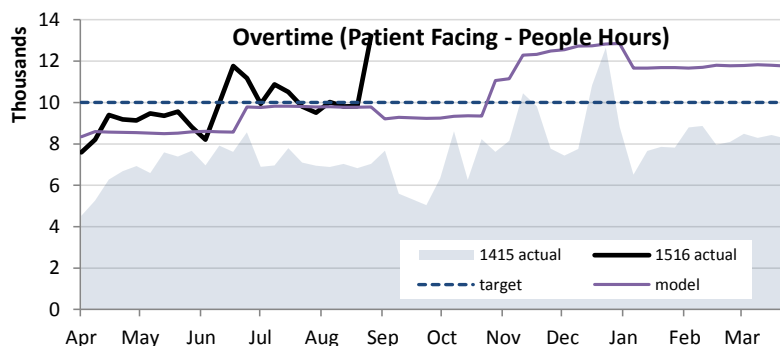
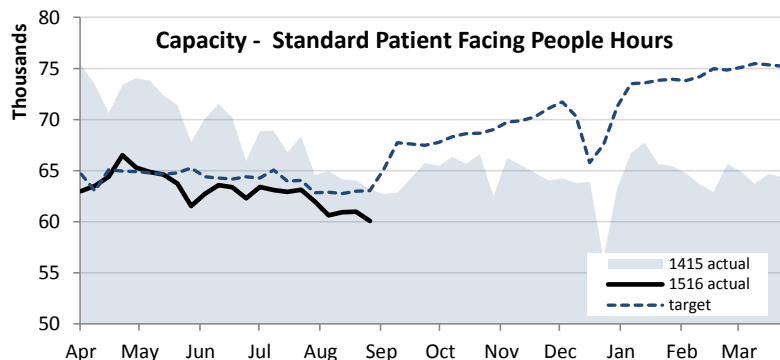
Demand has remained relatively consistent with previous months throughout August. In previous years there has been a dip in activity over the summer, and as this was not really seen this year it means that demand levels have effectively come back into line with forecast (having previously been lower than forecast).

Incidents in particular are now above forecasted levels and this is mainly due to the impact of NETS not occurring as expected.

Cat A demand was also higher than forecast in August, due to there not having been the expected historic dip.



Capacity

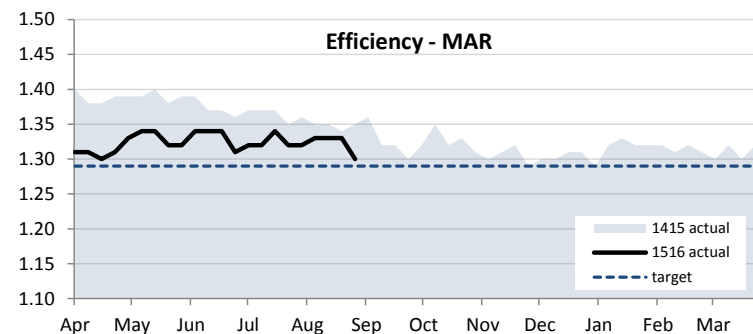
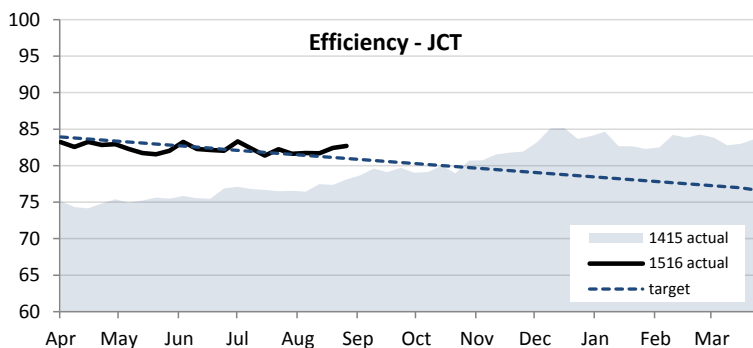
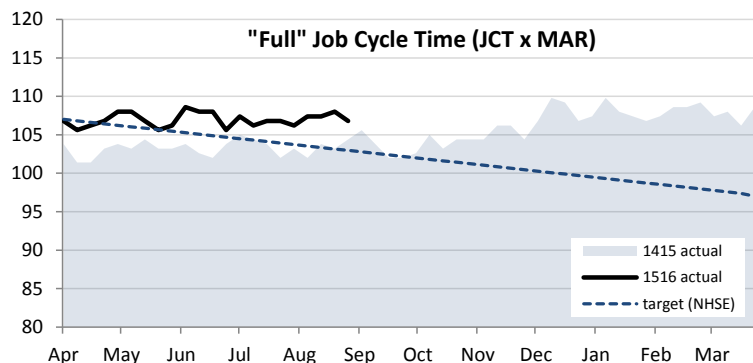


Overall hours put out in August were lower than expected. This is due to the number of hours from substantive staff not coming through as expected during the month.

This is being monitored closely as there is expected to be an increase in substantive hours during September which need to be realised in order for performance to move towards the agreed trajectory.



Efficiency

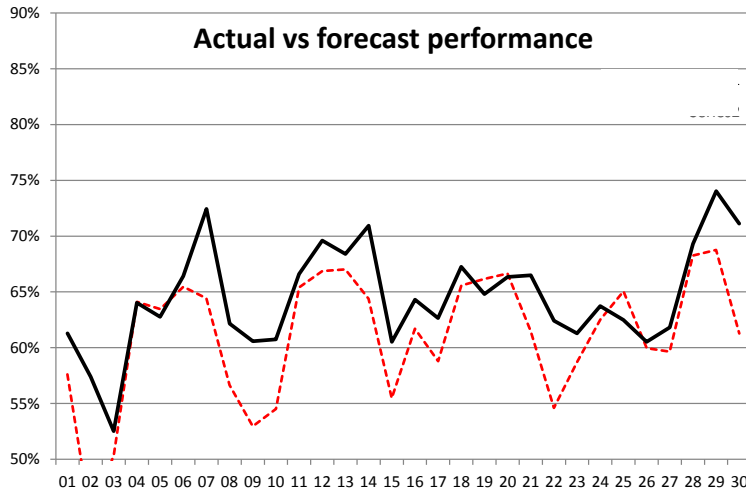


Full Job Cycle Time remains above the stretch target trajectory (to 97) although the JCT element is in line with the original business case target. (The stretch target of 97 is shown on these charts, rather than the 101)

Changes were made during the month to the MAR targets displayed in the control room. This should have a material impact on MAR for September – this can already be seen in the last week of August.

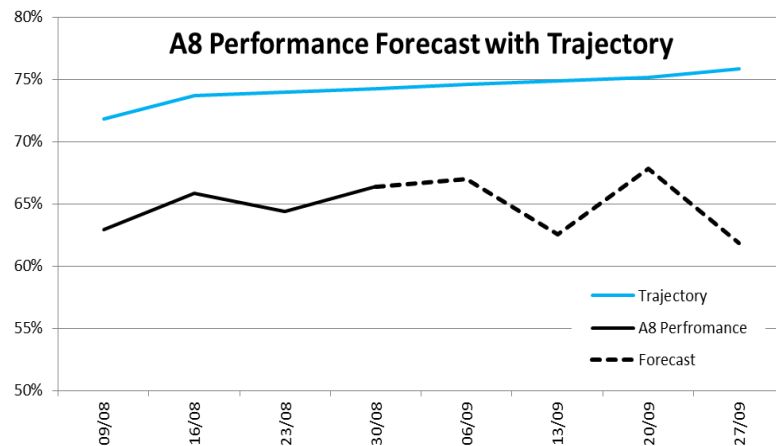


Forecasting



The Performance rule continues to be accurate, veering on the side of caution. During August the rule forecast 3% below actual performance.

Black line show actual performance for each day. Red line shows LAS performance forecast rule given the actual levels of demand, capacity and efficiency seen each day.



Current forecasts show performance improving during September (except week 4, but this is low due to rotas not being fully planned for week 4).

However the forecast is still below agreed trajectory. There is an ongoing piece of work to look at whether trajectory has been overstated.

OUR MONEY



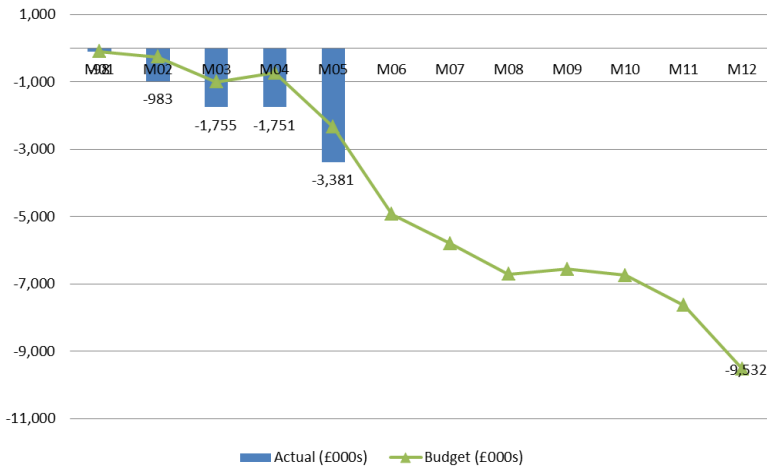
Finance Summary: M5 – August (2015/16)

Financial Indicator	Summary Performance	Current Month	Previous month
Surplus	The TDA has requested an improvement of £2m in the financial plan. To date only £0.5m has been identified. In Month the position is on plan while year to date the Trust is reporting a £1m adverse variance from plan. Based on this performance achieving the revised year end forecast deficit of £9.0m is stressed.	RED	RED
	The adverse position is driven by: <ul style="list-style-type: none"> Income reduction provision of £0.7m related to a >2% reduction in Cat C activity as per the CCG contract Additional Frontline Pay spend related to higher than expected incentive rates to maintain capacity and extended periods of unproductive time for new starters (e.g. supervision for international paramedics) £0.5m due to unidentified CIP not delivered. 		
Income	Income is £0.2m adverse in Month and £0.7m adverse year to date. The key drivers for this position are: <ul style="list-style-type: none"> Income reduction provision of £0.75m related to a >2% reduction in Cat C activity as per the CCG contract Adjustments to projected 111 and PTS income. These are partially offset by reduced expenditure. 	AMBER	AMBER
Expenditure (incl. Financial Charges)	In Month expenditure is £0.2m favourable to plan, and year to date £0.3m adverse. The key drivers for this position are: <ul style="list-style-type: none"> Additional Frontline Resourcing costs (Primarily overtime in Frontline and EOC Rosters, Incentives and PAS) £0.5m due to unidentified CIP. Partially offset by £1.75m of planned creditors released to support the position. 	AMBER	AMBER
	The Trust's main cost pressures arise from additional frontline resourcing costs. There are 2 key drivers for the additional expenditure: <ul style="list-style-type: none"> Additional incentive rates being offered to maintain capacity to deliver required performance trajectories. Higher than expected rates of unproductive time relating to the training and supervision of EACs and international paramedics. This has required the use of flexible resource to maintain capacity (Incentives, overtime and PAS). 		
CIPs	CIP is £0.5m adverse to plan due to unidentified savings programmes required due to the reduction in CBRN funding (£3.0m). The full year plan of £8.4m is still expected to be achieved once additional schemes are implemented. Further, efficiencies and cost control are being developed to close the remaining gap and help meet the improvement in financial position requested by the TDA.	RED	RED
Balance Sheet	Capital Expenditure is as planned. The Capital position is currently under review as the Trust is considering not taking the planned £6.0m loan and managing within its internally generated resources.	AMBER	AMBER
Cashflow	Cash is £3.1m below plan. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July resulting in lower than expected cash being received in this period. Payment is expected in September. CBRN funding is still being negotiated. The £18m transformation funding is contracted to be paid quarterly in arrears, this will place additional stress on our cash flow throughout the year.	AMBER	AMBER

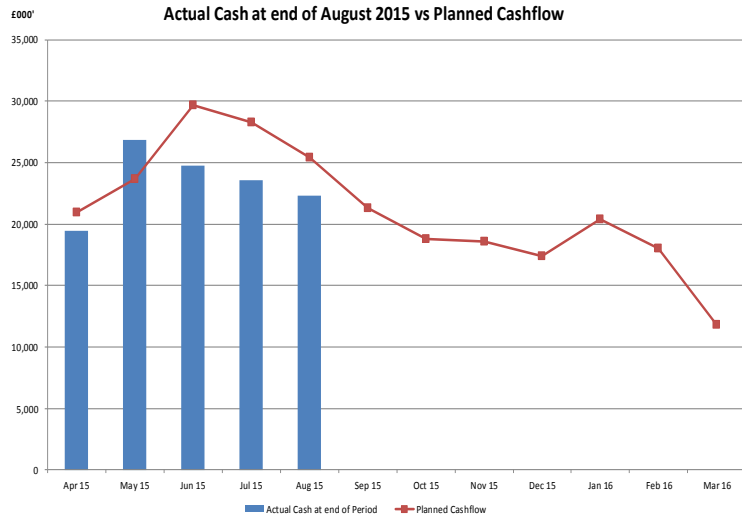


Executive Summary - Key Financial Metrics

Cumulative Net Position - Budget Vs Actual



Actual Cash at end of August 2015 vs Planned Cashflow



Description	2015/16 - Month 5			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000	£000	£000	£000	£000
Dept Health							
Surplus / (Deficits)	(1,608)	(1,629)	(21)	(2,345)	(3,378)	(1,033)	(9,531)
EFL				(10,747)	(7,612)	(3,135)	8,648
CRL				4,482	4,480	2	20,664
Suppliers paid within 30 days - NHS	95%	84%	(11.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	91%	(4.0%)	95%	88%	(7.0%)	95%
Monitor							
EBITDA %	-0.5%	-0.8%	(0.4%)	3.8%	2.7%	(1.0%)	6.3%
EBITDA on plan	(123)	(212)	(88)	4,921	3,581	(1,340)	8,356
Net Surplus	(1,608)	(1,629)	(21)	(2,345)	(3,378)	(1,033)	(9,531)
NRAF (net return after financing)				-1.69%	-2.44%	(0.8%)	-6.90%
Liquidity Days				0.80	(0.53)	(1.33)	(10.86)
CSRR (Continuity of Service Risk Rating)				4.0	3.0	1.0	3.0

- In Month the position is on plan while year to date the Trust is reporting a £1m adverse variance from plan. Based on this performance achieving the year end forecast deficit of £9.0m is challenged.
- On-going pressures are:
 - Additional spend in support of performance.
 - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
 - Identification and delivery of CIPs.
 - Reduced income recovery due to Cat C under-performance.
- Cash is £3.1m below plan. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July resulting in lower than expected cash being received in this period. Payment is expected in September. CBRN funding is still being negotiated.
- The EFL variance is due to lower than planned cash balances.
- The Trust would expect to score a Continuity of Service Risk Rating (CSRR) of 3 for the YTD results based on the current Monitor metrics (maximum rating). The cause of the variance from plan is that the current asset (excluding inventories) to current liabilities ratio has become negative in August.
- CRL position – The capital plan is on target.

OUR PEOPLE



Section	Key Headlines From Each Section.	Current RAG	Historic RAG	Historic RAG
Vacancy	<ul style="list-style-type: none"> Frontline vacancy rate continues to improve, now 12.0% down from 12.5% in July. Total vacancy rate continues to improve, 9.3% in August from 10.3% the previous month. 		Not Applicable – RAG status will trend going forward.	
Turnover	<ul style="list-style-type: none"> Trust turnover is unchanged this month at 14.9% (12 month rolling figure). The turnover figure for frontline paramedics and for frontline technicians fell Turnover is expected to fall next month. 			
Recruitment	<ul style="list-style-type: none"> There are currently 711 active applications for frontline staff in the recruitment pipeline. Recruitment are forecasting to hit the frontline establishment of 3004 WTEs in November. Three significant intakes of frontline staff are scheduled between September and the end of November 2015. 			
Sickness	<ul style="list-style-type: none"> Sickness levels are reducing compared to earlier this year. The current total trust sickness level is 6.1%. 12 month sickness for operational sectors varies between 9.46% for North East and 6.18% for South West. 			
Equality and Diversity	<ul style="list-style-type: none"> BME representation in the workforce is currently 11.6% compared to 39.3% in the London working age population. The workforce has a higher proportion of male staff in older cohorts. Disability and other protected characteristics require improvement in recording. 			
Training and Development	<ul style="list-style-type: none"> Section in Development. 			



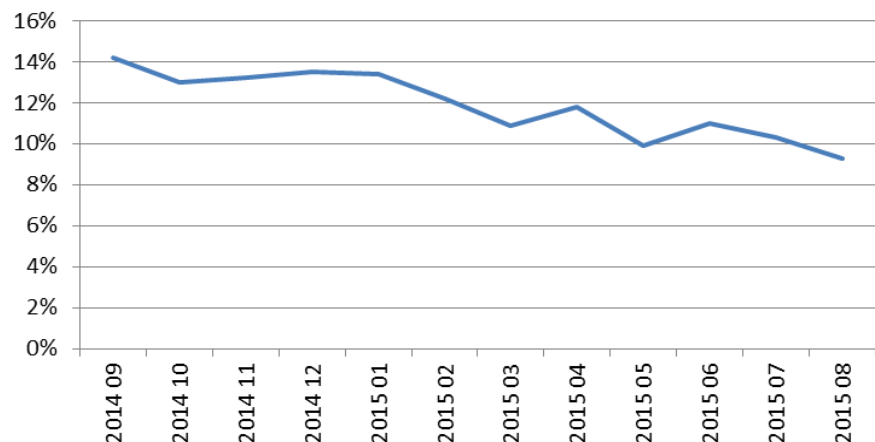


Vacancy – Trust wide

	Established	In post	Vacancy	Vacancy %
Frontline Paramedics	1769.8	1406.08	363.72	20.6%
Apprentice Paramedics	140.32	127	13.32	9.5%
Frontline EAC / TEAC	642.98	676.24	-33.26	-5.2%
Frontline EMT/A&E Ops support	498.42	474.58	23.84	4.8%
Total Frontline Staff	3051.52	2683.9	367.62	12.0%
Non-frontline Paramedics	373.32	344.64	28.68	7.7%
EOC staff on watches	399	403.77	-4.77	-1.2%
All other staff	1135.25	1066.45	68.8	6.1%
All staff	4959.09	4498.76	460.33	9.3%
Total Qualified Paramedics	2143.12	1750.72	392.4	18.3%

- Frontline vacancy rate continues to improve, now 12.0% down from 12.5% in July 2015.
- Frontline paramedic vacancy rate fell this month to 20.6% from 21.3% in July 2015.

Trust total vacancy rate



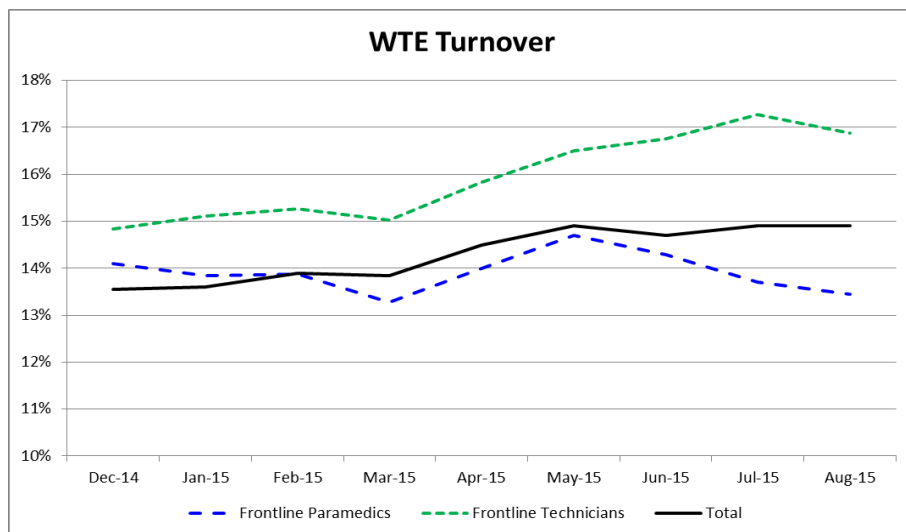
- Total vacancy rate continues to improve, likely to reach 5% target early in 2016-17 financial year.
- This month's total vacancy was 9.3%.
- Last month's report understated vacancy percentages due to in post WTEs in account code lines for bank staff being included in error. The true rate for July was 10.3%.



Turnover – Trust wide

12 month rolling turnover	Jul-15	Aug-15
Frontline Paramedics	13.7%	13.5%
Apprentice Paramedics	11.4%	10.8%
Frontline Technicians	17.3%	16.9%
non-frontline paramedics	8.4%	10.1%
PTS and Ambulance Persons	23.2%	23.6%
EOC staff on watches	28.6%	29.1%
All other staff	8.3%	8.9%
Total	14.9%	14.9%

- Trust turnover is unchanged this month at 14.9% (12 month rolling figure).
- Turnover is expected to fall next month. This is due to high numbers of leavers in September 2014 which will no longer be included in the 12-month rolling figure.
- The turnover figure for frontline paramedics and for frontline technicians fell this month.

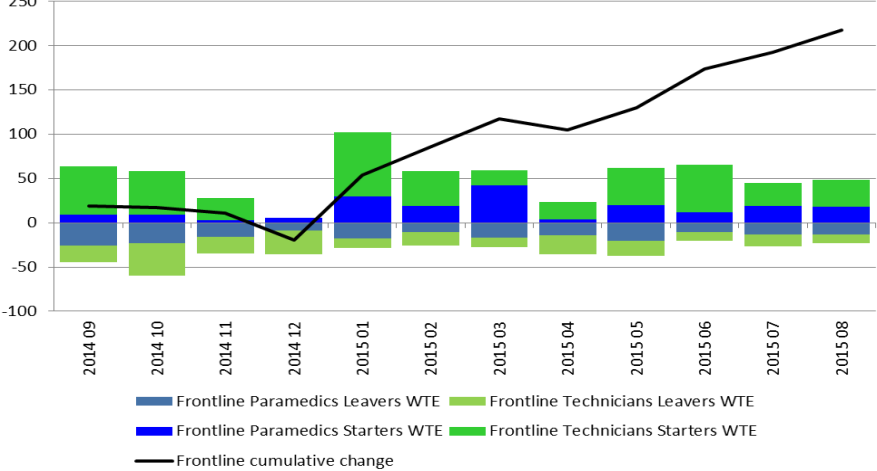


- Turnover has risen for technicians over the last nine months.
- Much of the rise in technician turnover is due to dismissals following failure to obtain C1 driving qualifications.



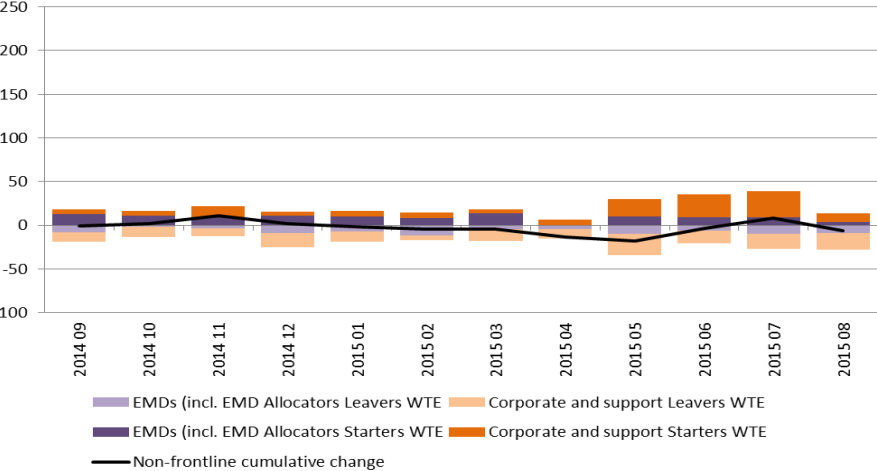
Staff Movement

Frontline WTE starters vs. leavers



- Frontline numbers have risen consistently month on month since December 2014
- There were 217 WTEs more frontline staff starting in the Trust than leaving the Trust in the past year.
- The actual frontline change since August 2014 has been around 120 WTEs because of staff moving internally from frontline to non-frontline roles.

Non-frontline starters vs. leavers

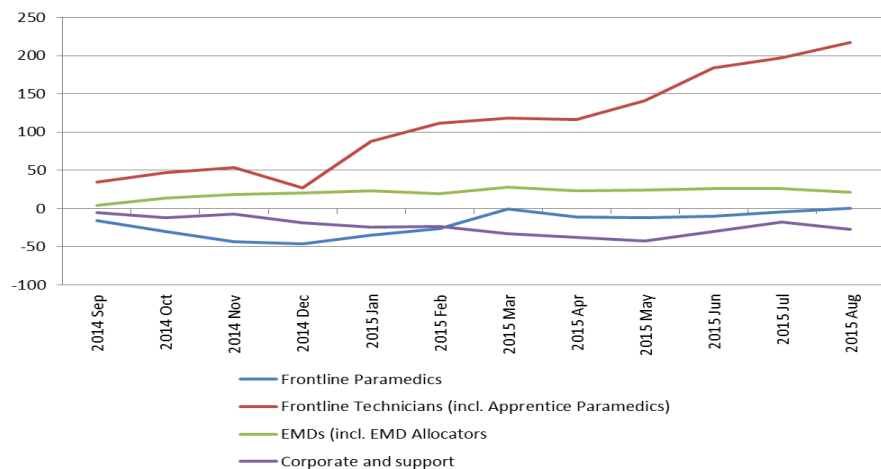


- Cumulative starters vs. leavers statistics for non-frontline staff show little change on twelve months ago.



Staff Movement

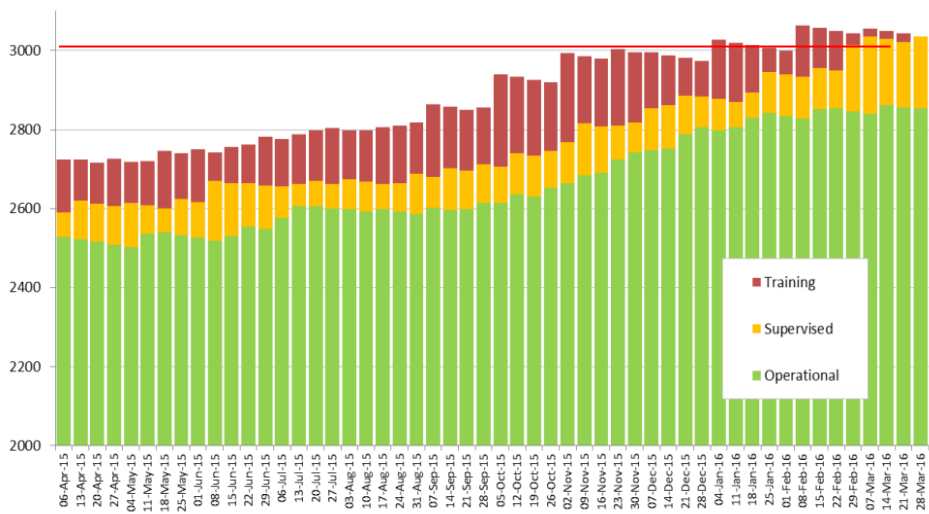
WTE cumulative starters minus leavers



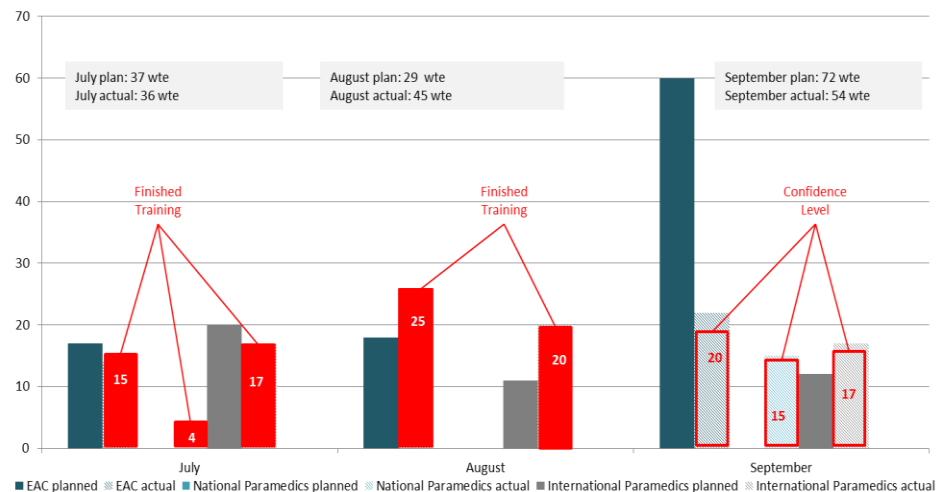
- Cumulative frontline tech starters in the trust minus leavers from the trust over the last twelve months was +200 WTEs
- Paramedic numbers have recovered to the levels of twelve months ago from their minimum in December 2014



Recruitment



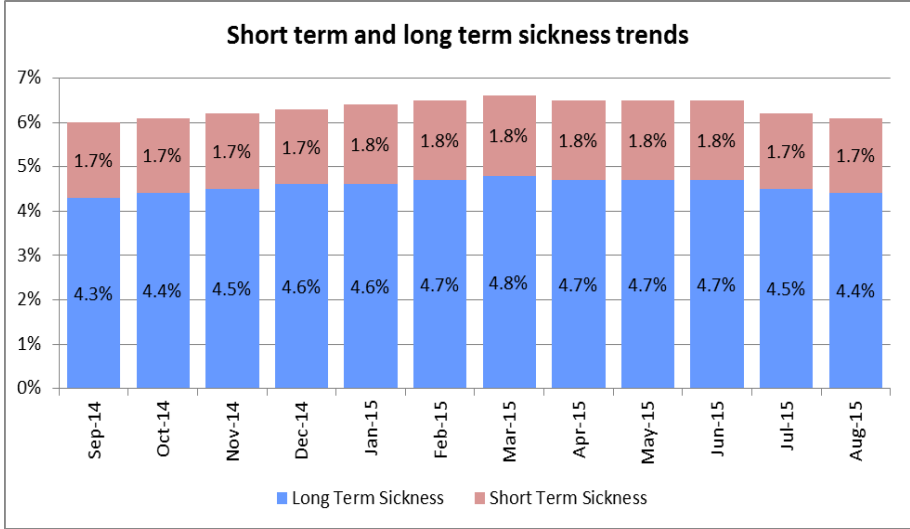
- The graph shown on the left illustrates new **frontline** starters, staff in training and staff starting operationally against an establishment target of 3004 WTE (red line).
- We are forecasting to hit frontline establishment in November, however some will still be under supervision. All staff will become operationally ready at the end of Q1 in 2016/2017.
- The frontline shortfall at March is currently anticipated to be approximately 139 FTEs and we are exploring options to address this.
- There are currently 711 active applications for frontline staff in the recruitment pipeline. 114 of these are in the national paramedic graduate pipeline, 397 in the TEAC pipeline and 200 are international paramedics.



- The graph on the left shows the frontline recruitment position over the three months up to and including the current calendar month.
- We are currently expecting 135 starters against a plan of 138 and have illustrated our confidence levels for these starters.
- International starters continue to fluctuate between months.
- TEAC confidence levels are based on a 80% pass rate.



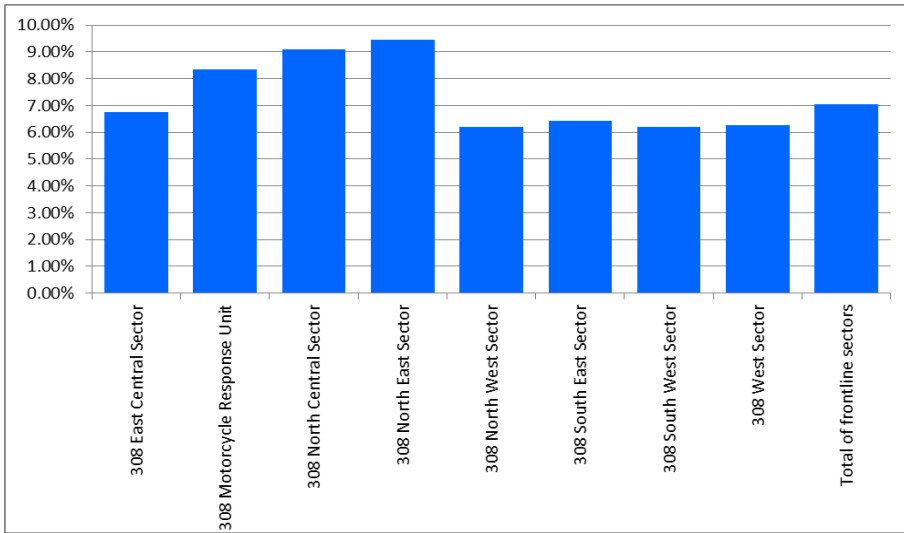
Short and Long Term Sickness



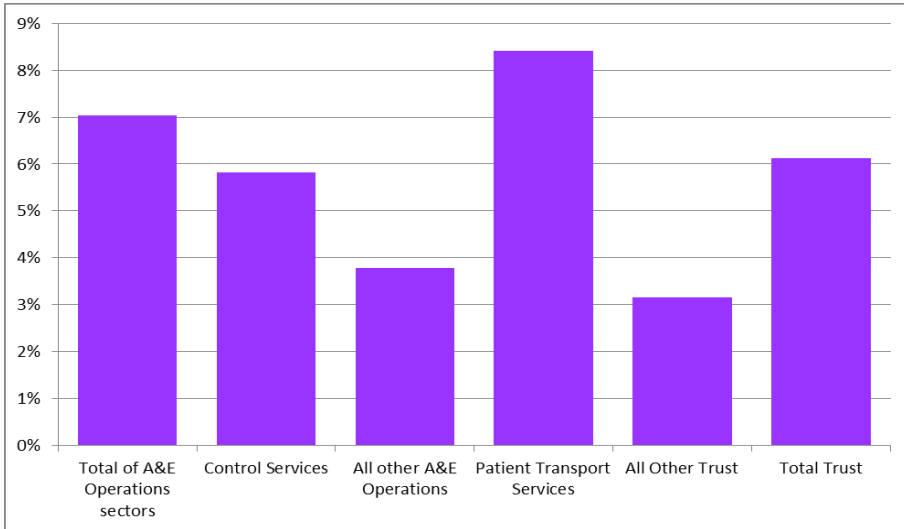
- Long term and short term sickness are declining.
- The current total trust sickness level is 6.1% over the last twelve months. Target is 5.5%.



Operational and Business Area Sickness



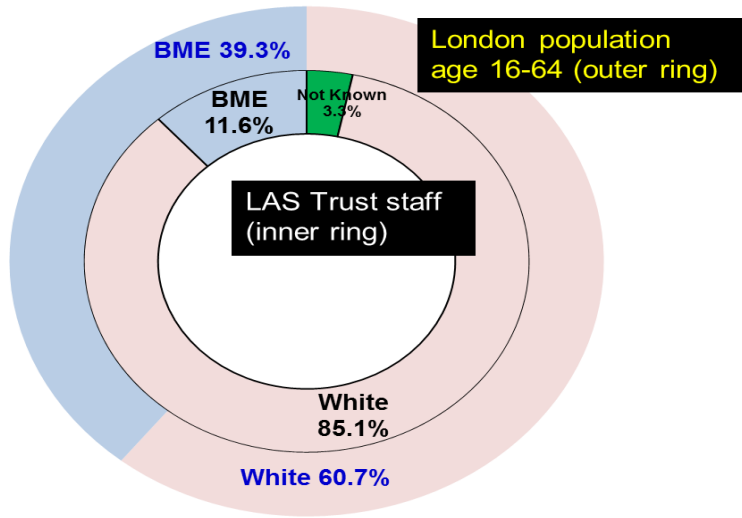
- 12 month sickness for individual sectors varies between 9.46% for North East to 6.18% for South West.
- In future months a series will be built up to show how sickness is moving over time.



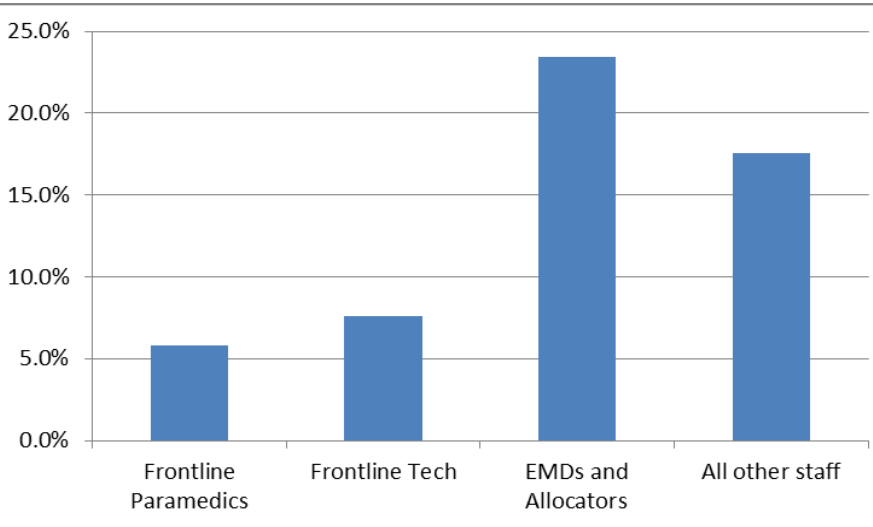
- 12 month sickness for individual business areas varies between 8.40% for Patient Transport Service to 3.15% for corporate and central areas of the trust.



Black, Minority and Ethnic Information



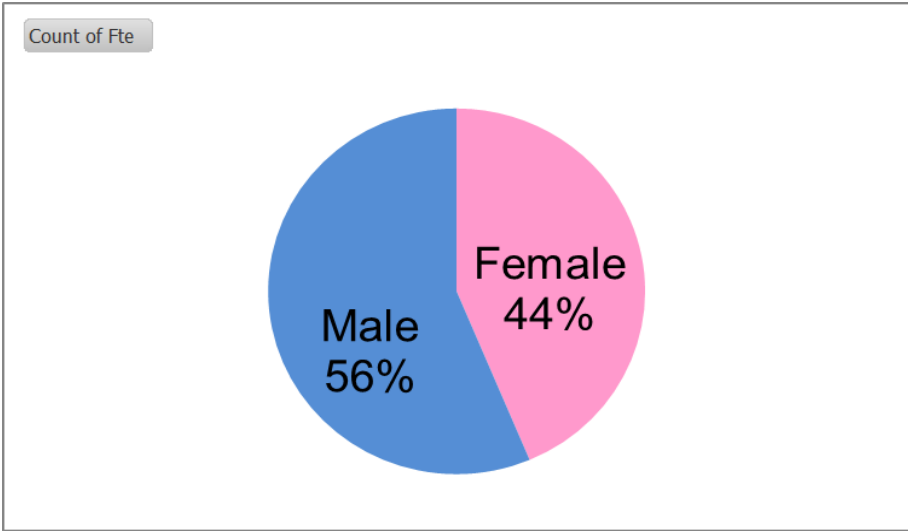
- BME representation in the workforce is currently 11.6% compared to 39.3% in the London working age population.
- BME representation amongst starters is currently 16.8%.



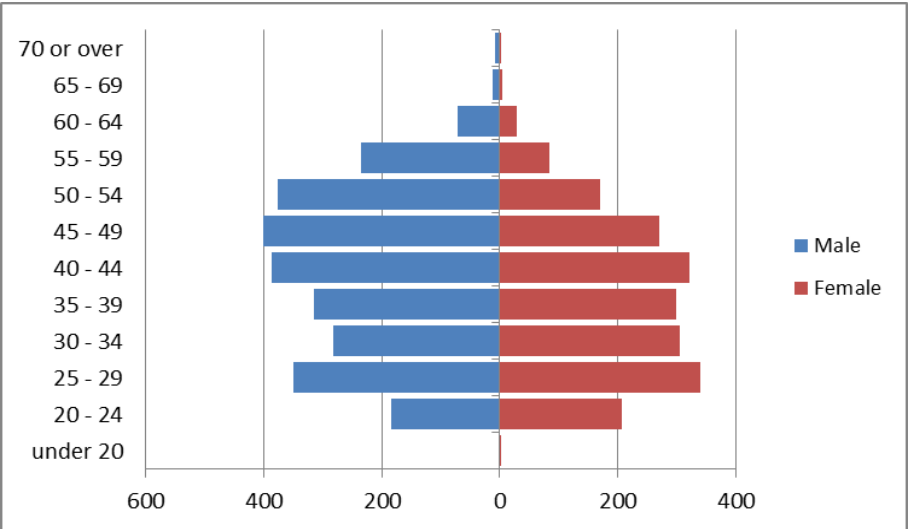
- BME representation in staff groups varies, from 23.4% amongst EMDs to 5.8% in frontline paramedics.



Age and Gender



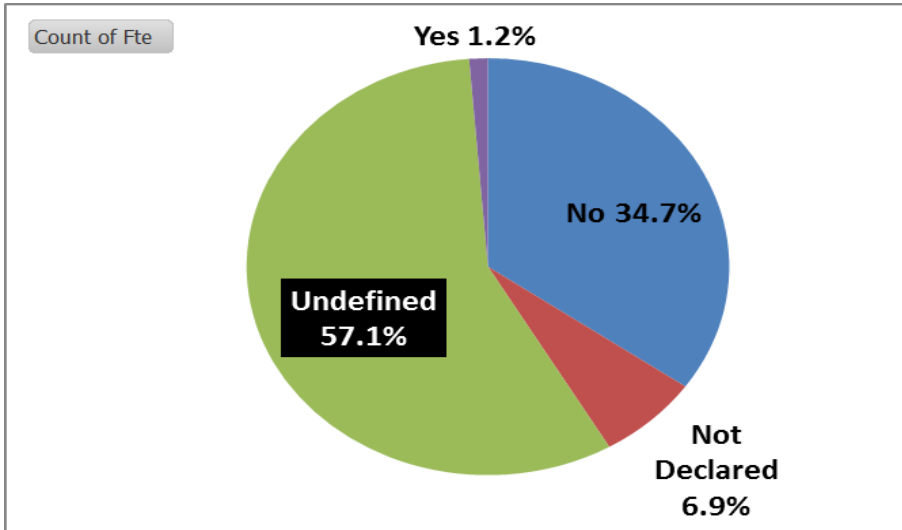
- Female staff make up 44% of the workforce.



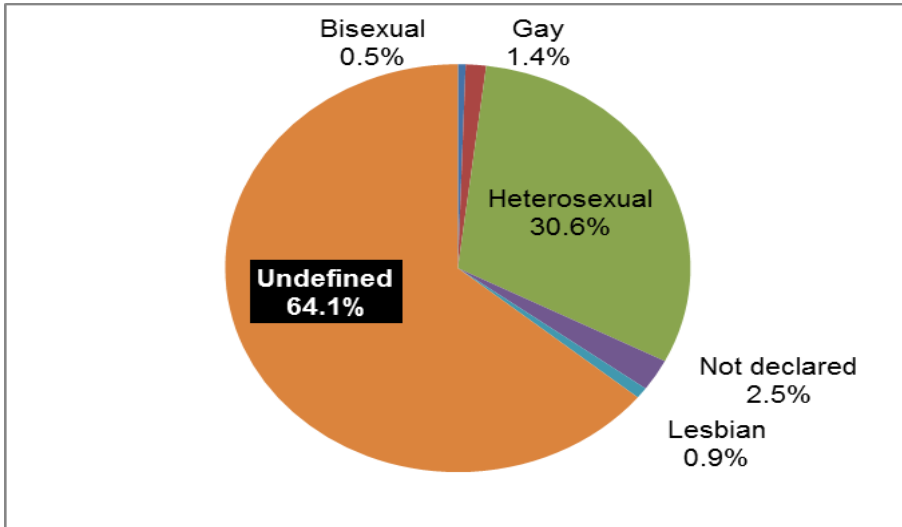
- The workforce has a higher proportion of male staff in older cohorts.
- New starters in clinical roles are predominantly male, but in admin & clerical roles new female starters feature.
- Part time workers make up 11.5% of the workforce.



Disability and Other Equalities Characteristics



- Disability recording requires improvement. 57.1% of staff do not have their disability status defined.
- Disability seems under reported. 17% of those replying to the staff survey considered themselves to have a disability but only 1.2% of staff have such a status recorded.



- Other protected characteristics similarly require improvement in recording. The example given on the left is sexual orientation with the undefined category accounting for 64.1%.
- Equalities information is routinely collected for new starters.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Quality Report
Report Author(s):	Zoe Packman, Fenella Wrigley, Mark Whitbread
Presented by:	Zoe Packman
Contact Details:	Zoe.Packman@ond-amb.nhs.uk
History:	EMT, Quality Governance Committee
Status:	For information and assurance
Background/Purpose	
The monthly quality report and associated dashboard are produced to give organisational assurance that quality standards are being met. The September 2015 reports, reviewing August 2015 data are attached for review.	
Action required	
Note the report	
Assurance	
Quality remains safe and consistent with previous months. Some patients experience longer waits due to capacity constraints.	

Key implications and risks arising from this paper	
Clinical and Quality	<ul style="list-style-type: none"> • Cardiac Arrest survival to discharge demonstrates good outcome data • The Cardiac Arrest Annual Report has been released and demonstrates the impact of public access defibrillators. • A DARZI fellow has started with the Trust, concentrating on frequent callers. • In excess of 95% compliance to each of the audits aside from mental health • The mental health audit remains an issue, with compliance at 90% • CPI feedback sessions remain low
Performance	<ul style="list-style-type: none"> • 15 hours were spent at Surge Purple or above
Financial	N/A
Governance and Legal	<ul style="list-style-type: none"> • 5 SIs declared during August which is less than last month • 2 drug incidents reported • 2 preventing future deaths reports received • Category 4 Locality Alert Register addresses require a care plan which are currently not in place
Equality and Diversity	N/A
Reputation	<ul style="list-style-type: none"> • Some patients experience longer waits due to capacity constraints
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Yes
To make LAS a great place to work	Yes
To improve the organisation and infrastructure	Yes
To develop leadership and management capabilities	Yes



London Ambulance Service

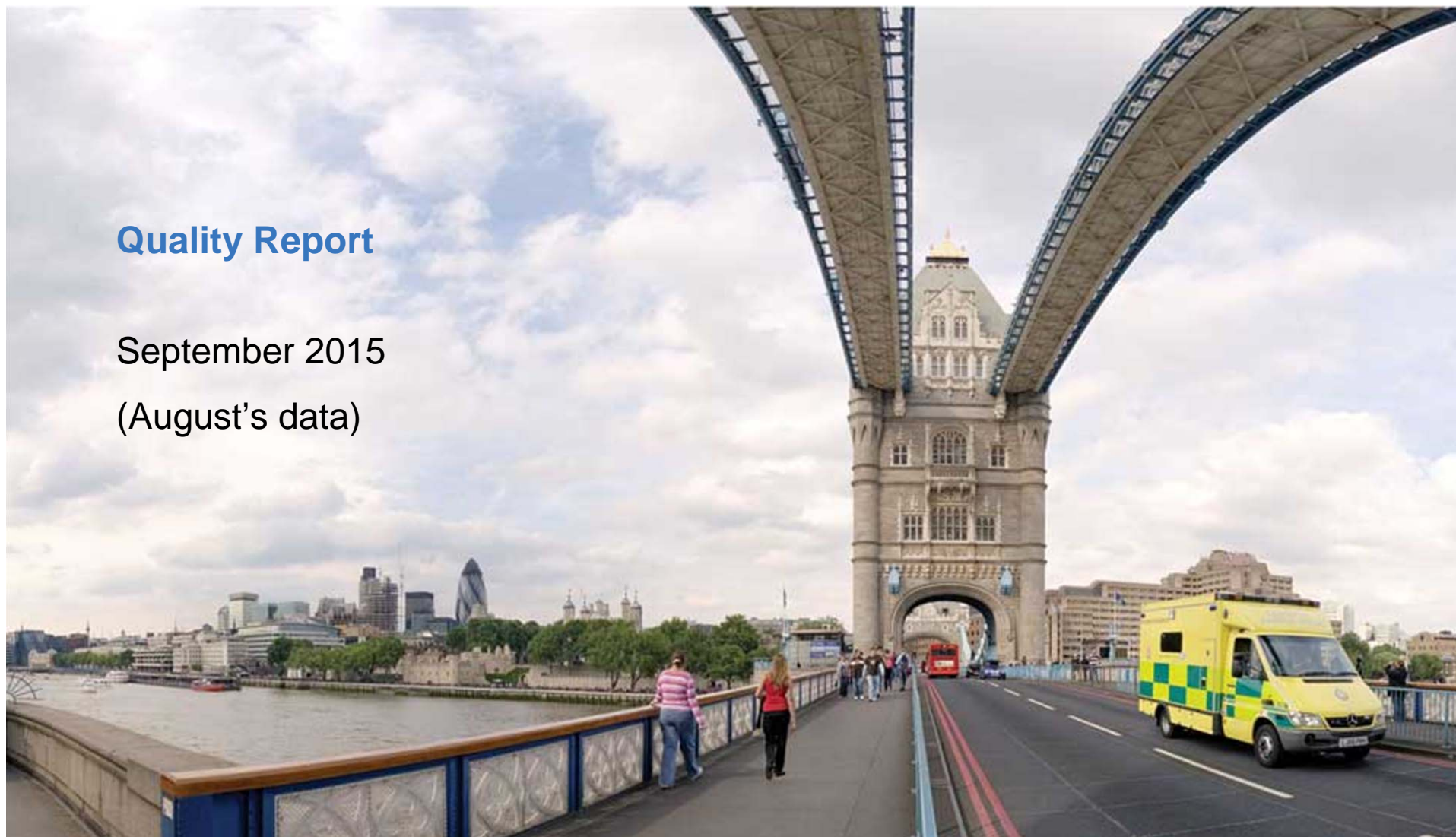


NHS Trust

Quality Report

September 2015

(August's data)





OVERALL

- Clinical care remains safe but quality is at times challenged
- There is an intention to RAG rate each of the sub sections under each domain in future reports.

EFFECTIVENESS

- Cardiac Arrest survival to discharge demonstrates good outcome data
- The Cardiac Arrest Annual Report has been released and demonstrates the impact of public access defibrillators
- A DARZI fellow has started with the Trust, concentrating on frequent callers.

RESPONSIVENESS

- 15 hours were spent at Surge Purple or above
- As agreed the Trust continues to operate at Surge Red. The lowest acuity 999 calls receive an enhanced clinical assessment through NHS111 or the Clinical Hub.

SAFETY

- 5 SIs declared during August
- 2 drug incidents reported
- 2 preventing future deaths reports received
- Category 4 LAR addresses require a care plan, and currently don't have them.

CARING

- In excess of 95% compliance to each of the audits aside from mental health
- The mental health audit remains an issue, with compliance at 90%
- CPI feedback sessions remain low.

WELL LED

- The Director of Nursing and Quality replied to the Monitor paper requesting views on agency nursing rules.
- Further information relating to the Well Led domain is evidenced in the integrated performance report.

SAFETY



Sub-Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	RAG
Training & CSR	<ul style="list-style-type: none"> 310 frontline staff have undertaken CSR since August 2015 (10% of the frontline workforce so far). 13 CSR course have been cancelled due to low subscription levels. 			
Adverse Incidents	<ul style="list-style-type: none"> Reported adverse incidents remain artificially low due to data entry issues, however this is resolving. 207 incidents during August, although likely to increase due to the data entry issue. 			
Serious Incidents	<ul style="list-style-type: none"> 5 SIs declared during August. 14 SIs outstanding at various stages of completion SI/FLO training arranged 			
Medicines Management	<ul style="list-style-type: none"> 2 drug incidents to report A medications safety officer has been appointed 			
Total Complaints	<ul style="list-style-type: none"> 94 complaints received in August Monthly average for complaints during 2015/16 is currently 88. 			
PALs	<ul style="list-style-type: none"> 275 PALs enquiries in August Monthly average for PALs enquiries during 2015/16 is currently 305 			

SAFETY



Sub-Section	Key Headlines From Each Sub-Section.	Current RAG	Historic RAG	RAG
NHS CAS Alerts	<ul style="list-style-type: none"> • One CAS alert remains outstanding, relating to the re-call of the safety syringes in use by the Trust. • All other alerts have been assessed and acknowledged but are of no relevance to the Trust. 			
Prevention of Future Deaths	<ul style="list-style-type: none"> • 2 preventing future deaths reports have been received by the Trust since the last report. 			
Locality Alert Register	<ul style="list-style-type: none"> • The Deputy Director of Operations and the Deputy Director of Nursing are working together to ensure all category 4 patients have a care plan in place. 			



Training and CSR

Non-Clinical Training

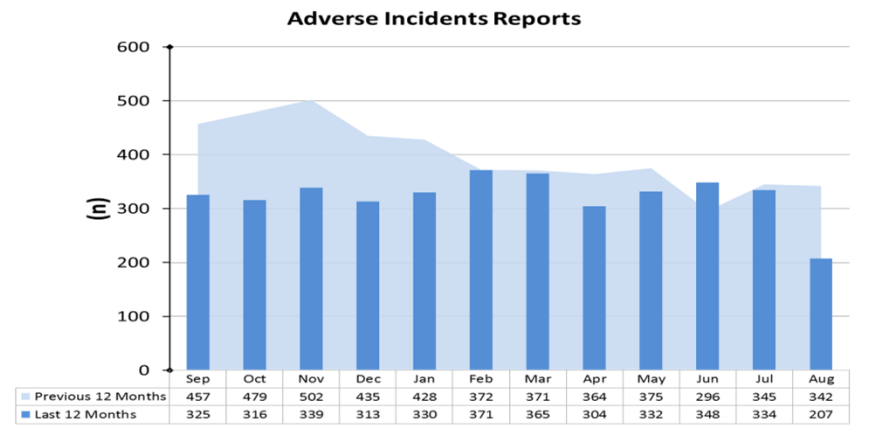
- 104 staff have undertaken training (non CSR) during August.

Clinical Training

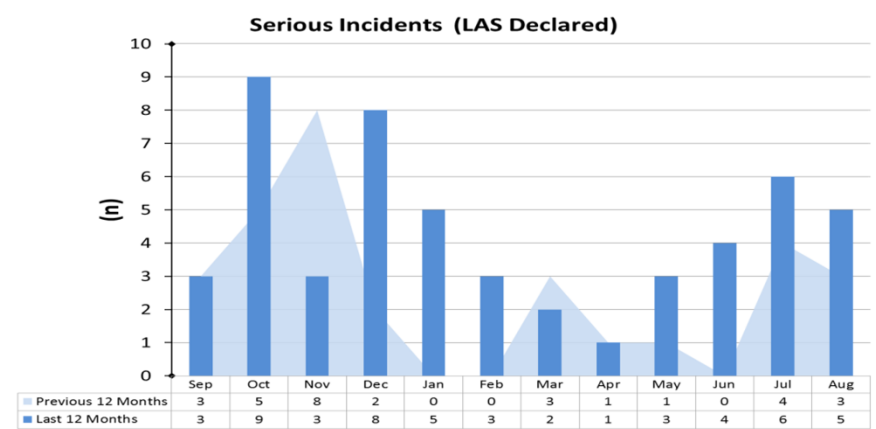
- There are three CSRs per year, CSR 2015.1, 2015.2 and 2015.3
- CSR 2015.1 is now complete and 84% attendance was achieved.
- CSR 2015.2 started in August:
 - 576 places were available, and 310 staff completed CSR 2015.2 during August.
 - Of the above figure, 219 were registered clinicians
 - 13 CSR courses were cancelled due to low subscription during August – 4 at Bromley, 4 at Kenton and 5 at New Malden. This is being managed by the operational teams.



Serious & Adverse Incidents



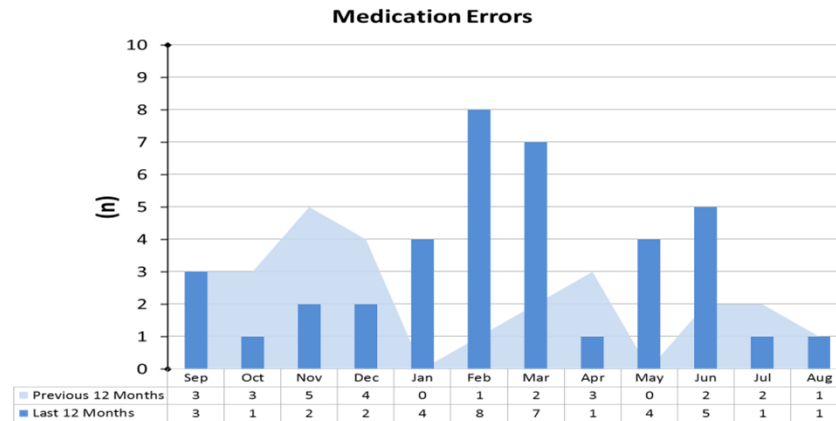
- The number of adverse incidents reported for August is 207 which remains low as there are on-going although reducing issues with data entry. The backlog of LA52 and LA277 awaiting entry onto the system has been reduced and now totals 55 forms. These are being entered in date order to ensure issues are identified as quickly as possible despite the backlog.
- The top 5 patient safety incident themes are: Issues with patient treatment, Issues with clinical assessment, Issues with resource dispatch, Issues with removal of patient from scene, Issues with conveyance.
- The top 5 staff safety incident themes are: Abusive Behaviour, Physical Violence, Manual Handling Incidents, Exposure to harmful substances, Sharp Objects.
- These incidents and themes are reviewed in more detail via the Clinical Safety and Standards Committee.



- 5 new SIs were declared during August. 14 SIs are outstanding. 2 are overdue with commissioners; 1 being dependant on an end to end review with 111 and the other awaiting comment with the SMT lead. 12 are within timescale and are at varying stages; 1 with EMT for review with an FLO meeting arranged, 1 a de-escalation has been requested and 10 are in the report preparation stage and on track.
- The first SI/FLO/Duty of Candour training session has been booked. This will initially focus on the Quality Governance and Assurance Managers.
- The SI policy is being reviewed to reflect the SI framework 2015 and to make the investigation process more explicit following feedback from HM Coroner.



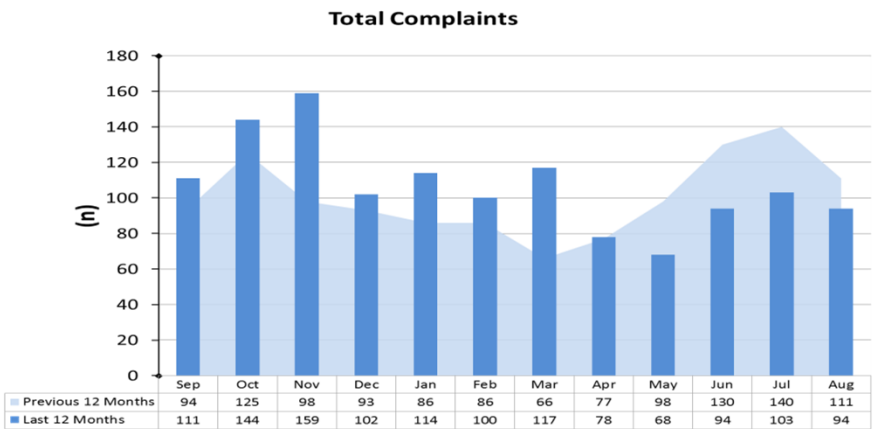
Medicines Management



- There have not been any controlled drug incidents during August 2015.
- There have been two drug incidents for reporting, neither of which had a patient safety implication and both are being managed according to policy.
- The number of medication errors differs between the number reported via LA52, and the number known to the medicines management group. This could be due to the LA52 backlog but could be due to the differing ways of reporting incidents. The medicines management group are reviewing this.
- The Tranexamic Acid patient group direction must be signed by all paramedics using the drug. This was communicated to all station admin groups, but there is a significant variation in the number of staff in each area who have signed the PGD. A reminder has been sent out to each area. The PGD has remained the same meaning the risk is minimal, however the Trust is not compliant with this requirement under PGD use.
- The medicines management group were alerted to and have investigated an incident involving the administration of diazemuls to a patient where the indications for administration were unclear. There was no evidence of an adverse outcome. Formal feedback has been given to the Paramedic, and a formal practice review has been arranged.
- The final draft of the audit of ketamine and midazolam use by the Advanced Paramedic Practitioners has been written and is awaiting approval. The audit demonstrates that the use of these drugs is safe and effective.
- A Medication Safety Officer has been appointed to work within the Trust.



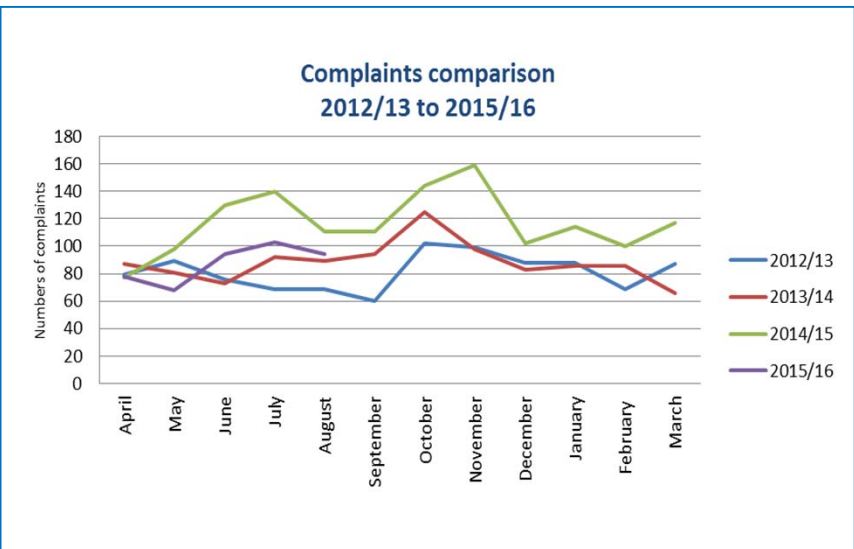
Complaints (1) – Volume & Response time



94 complaints were received in August compared to 103 in July, 94 in June and 28% more than during May (68). This reflects the general trend of complaints at this time of the year, complaints are invariably affected by the weather and as August was unseasonably poor, call rates were in general slightly lower.

The monthly average for 2014/15 was 117 complaints (compared with 90 in 2013/14, 81 in 2012/13 and 50 in 2011/12). The current monthly average for 2015/16 = 88.

Trust	Complaints received 2014/15	Percentage of national total (rounded)
North West Ambulance Service	2133	25%
London Ambulance Service	1403	17%
East of England Ambulance Service	974	11%
South West Ambulance Service	882	10%
North East Ambulance Service	658	8%
Yorkshire Ambulance Service	611	7%
South Central Ambulance Service	599	9%
South East Coast Ambulance Service	535	6%
West Midlands Ambulance Service	522	6%
East Midlands Ambulance Service	117	1%
Total all	8434	100%





Complaints (2) – by Area and Subject of complaint & PALS

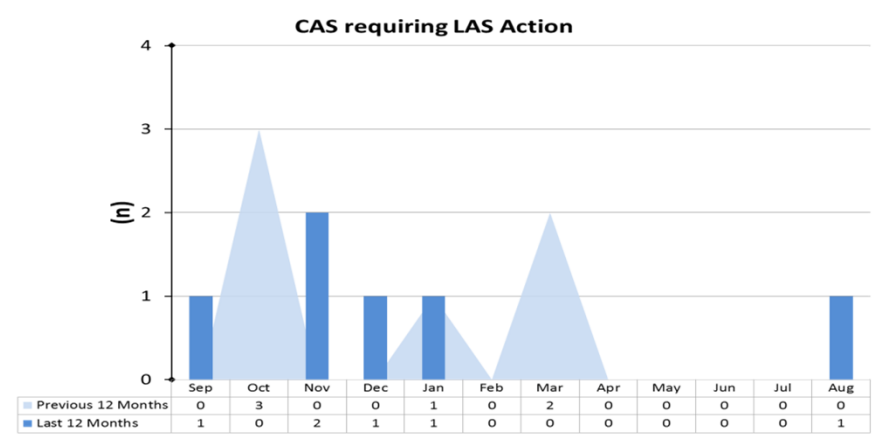
Complaints by subject 2014 -2015	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	August	Totals
Delay	65	87	95	71	70	50	55	33	22	47	40	44	679
Conduct	23	33	37	19	32	25	34	21	29	25	28	24	330
Road handling	7	7	10	4	5	8	8	7	5	8	8	10	87
Non-conveyance	8	6	5	3	2	5	2	9	4	3	10	3	60
Not our service	0	3	1	0	2	3	1	1	0	4	1	5	21
Treatment	4	1	5	1	3	5	10	4	5	5	7	3	53
Patient Injury or Damage to Property	2	3	1	0	0	3	3	0	1	1	1	1	16
Location Alert referral	0	2	1	1	0	1	0	0	1	1	2	2	11
Conveyance	1	1	2	3	0	0	2	2	1	0	2	1	15
Clinical Incident/Equipment	0	0	0	0	0	0	1	1	0	0	4	1	7
Assisting with external agency	0	0	1	0	0	0	0	0	0	0	0	0	1
Disputes safeguarding referral	0	1	1	0	0	0	1	0	0	0	0	0	3
Aggravating factors	1	0	0	0	0	0	0	0	0	0	0	0	1
Totals	111	144	159	102	114	100	117	78	68	94	103	94	1284

- Complaints about delays are attributed to Control Services when the problem may actually represent less than optimum operational resourcing
- Complaints relating to delay (44) and staff conduct (24) continue to be the main themes
- The complaints review by the Transformation team is underway and will be reported on in October.

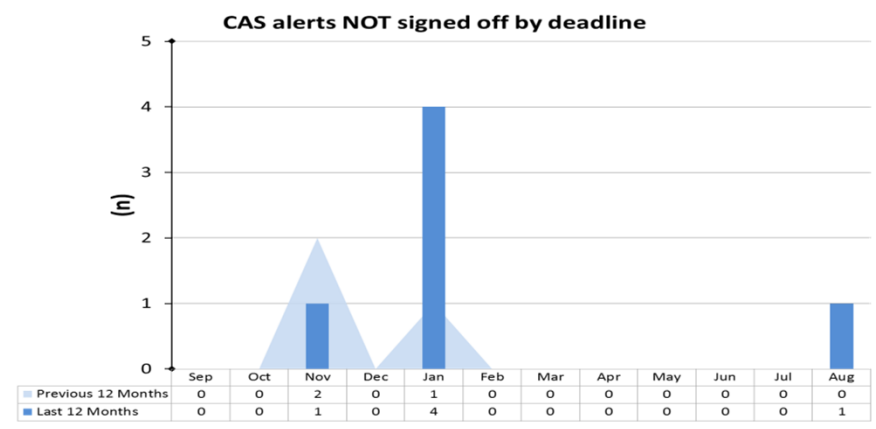
- PALS specific enquiries = 275.
- Average monthly PALS for 2013/14 = 287.
- Current average for 2014/15 = 298.
- Current average for 2015/16 = 305
- At the time of writing there are 99 x PALS cases remaining open; this includes 36 requests for medical records awaiting consent from the patient, 63 cases awaiting QA reports/further supporting information and cases under liaison with the Consultant Midwife.



NHS CAS Alerts



- 13 Estates Field Notices, 1 Patient Safety Alert and 5 Medical Device Alerts received during August. None of these have any relevance to the Trust.



- MDA/2015/028 relates to automatically retracting safety syringes, manufactured by Medicine Ltd. This was reported in July to EMT. These syringes were in place within the Trust and a plan put in place to re-call the syringes. However, the replacement syringes have been delayed due to non-availability. This means that the deadline has been breached. It is unclear if there are any penalties relating to missed deadlines.
- There is no patient safety consequence but a low risk to staff. However, universal precautions of handling sharps mitigate this risk.
- The risk is further mitigated as the new syringes are now in stock and being delivered to LAS sites.



Prevention of Future Deaths

- Since the last report, 2 preventing futures deaths reports have been received by the Trust.
- One is being jointly reviewed by the LAS and MPS, with a reply due by 15th September 2015.
- One references a concern which has recently been addressed through another preventing future deaths report. The reply for this is due by 19th October 2015.



Locality Alert Register

- The number of addresses flagged as a 'location alert' have remained the same as the previous month (277). The number of addresses flagged by the Metropolitan Police Service have risen slightly (495 July 2015, 523 August 2015)
- The Deputy Director of Operations and the Deputy Director of Nursing are working together to ensure all category four patients have a care plan in place.

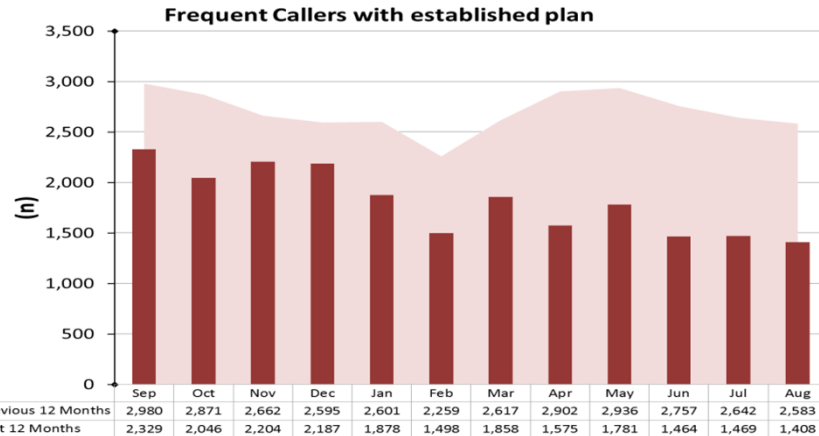
EFFECTIVENESS



Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
Frequent Callers	<ul style="list-style-type: none"> Significant progress with data sharing agreements has been made. A DARZI fellow has now started with the Trust, whose portfolio will be frequent callers. 			
STEMI Performance	<ul style="list-style-type: none"> STEMI to PPCI within 150 minutes has decreased to 87.4% although this figure is dependant on correct MINAP data. Compliance to the STEMI care bundle has increased by 4.5% 			
ROSC at Hospital (including UTSTEIN)	<ul style="list-style-type: none"> ROSC sustained to hospital has increased to 31.6% ROSC sustained to hospital in the Utstein group has fallen slightly, to 62.5%) 			
Survival to Discharge (including UTSTEIN)	<ul style="list-style-type: none"> Survival to discharge has improved to 8.9% Survival to discharge in the Utstein group has increased to 37.7% 			
CARU Reports	<ul style="list-style-type: none"> The monthly stroke and cardiac arrest and STEMI reports for July 2015 have been released. 			



Frequent Callers



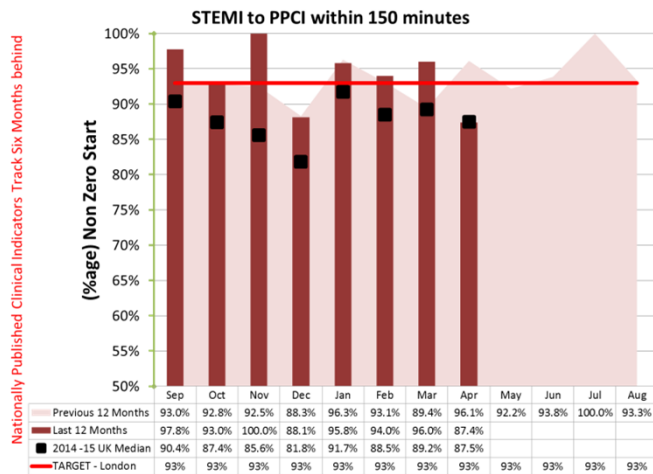
- Significant progress has been made in relation to data sharing agreements with other health and social care providers
- Standard operating procedures and related policies have been updated
- A workshop with all of the new Stakeholder Engagement Managers (SEMs) has been held to introduce them to the process for identifying and managing frequent callers
- Monthly meetings with the MPS continue and have resulted in the successful management of 5 high intensity users of both emergency services

High volume intensity users										
As of 01/09/15										
		10 or more calls	15%	FC plans	MH issues	Open/actual cases	Closed during month	5 or more calls	15%	12 or more calls over 3 months
2014	Dec	142	22	24	9	36	0	889	133	973
2015	Jan	142	22	40	13	46	3	998	150	890
	Feb	144	22	41	18	51	40	1095	164	831
	Mar	177	27	52	16	59	9	1234	185	719
	Apr	152	23	70	25	64	5	998	150	746
	May	150	22	44	19	69	19	945	142	689
	Jun	170	25	52	26	78	6	1088	163	696
	Jul	192	29	60	30	86	3	1217	183	756
	Aug	194	29	55	29	92	25	1150	172	806
	Sep									
	Oct									
	Nov									
	Dec									

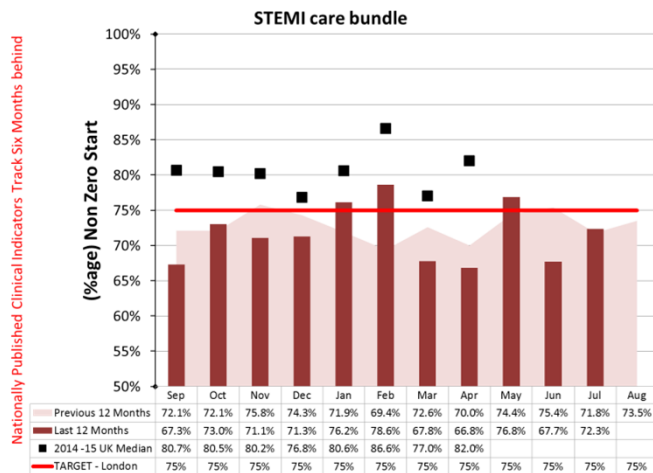
- A DARZI fellow has now started with the LAS. The DARZI fellow portfolio relates to frequent callers.



STEMI



- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- April's data (most recent data available) shows a decrease in compliance to STEMI to PPCI within 150 minutes from 96% to 87.4%. This figure is reliant on the MINAP data being accurate.

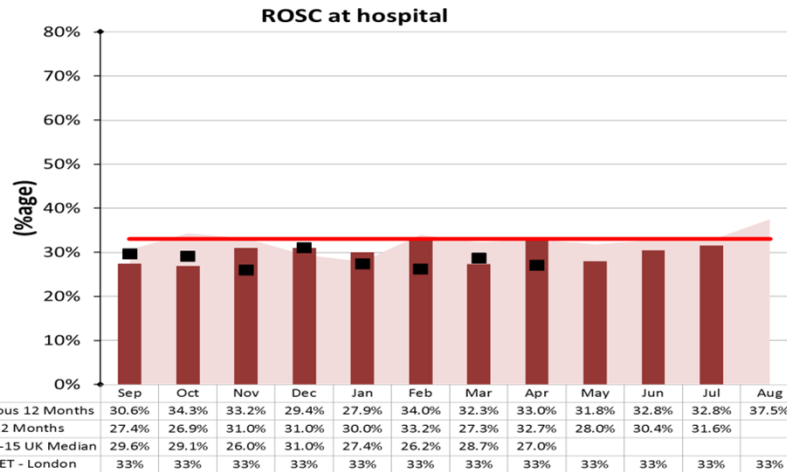


- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- The compliance to the STEMI care bundle has increased when compared to last month, an increase of 4.5%
- The figure from the graph opposite differs from that in the cardiac monthly CARU report (72.3% v's 74%). This is because the data for the dashboard uses the same definitions as for the AQI bundle which is different to the local reporting.



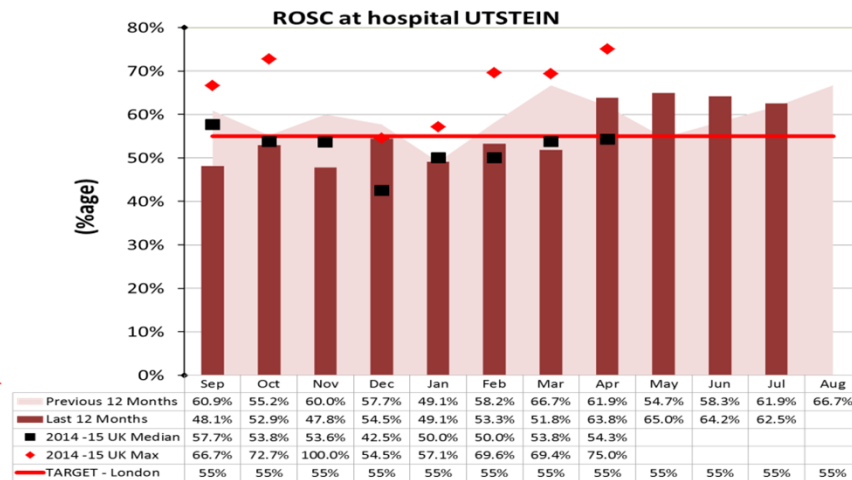
ROSC

Nationally Published Clinical Indicators Track Six Months behind



- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- ROSC sustained until hospital has increased to 31.6% in July (the most recent data available)
- The Cardiac Arrest Annual Report has been released and shows the excellent care provided to these patients.
- The annual report also demonstrates the benefits seen with public access defibrillators.

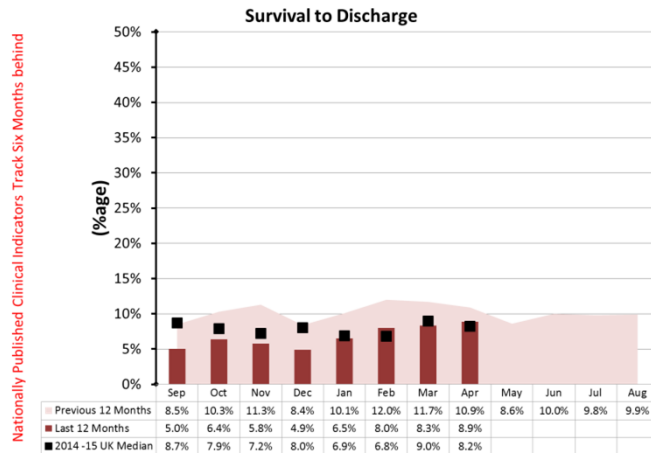
Nationally Published Clinical Indicators Track Six Months behind



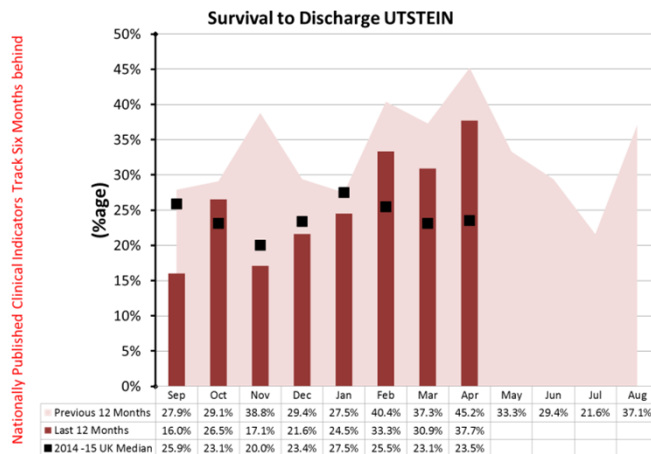
- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- ROSC sustained until hospital for the UTSTEIN group has decreased slightly on the previous month (62.5% July, 64.2% June)
- There will always be month on month variability within this group due to the small numbers represented. This is not clinically significant.



Survival to Discharge



- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- Survival to discharge figures have increased in April (most recent available data), from 8.3% (March) to 8.9% (April)



- Clinical quality monitoring data is reported using time frames different to other aspects of this report as it requires in-depth clinical review and is dependent on a number of other processes (e.g. PRF availability/data from external sources)
- Survival to discharge figures for the UTSTEIN group show an increase from 30.9% in March, to 37.7% in April.



CARU Reports (Cardiac, Stroke, Trauma), Airway Management/ETC02

CARDIAC (July 2015)

- Resuscitation efforts were commenced on 41% of cardiac arrest patients attended
- Approximately 10% of the cases had a defibrillator download submitted – the highest figure to date
- The average time from 999 call to arrival on scene for STEMI patients has increased by 2 minutes to 13 minutes. It is important to note that a number of STEMIs present as C1 priority calls not R2 calls at the call taking stage.
- The average on-scene time for STEMI patients has increased by 1 minute to 44 minutes. This is being addressed through Clinical Team Leader feedback, and via the job cycle time project.

AIRWAY MANAGEMENT

- An advanced airway was placed successfully in 87% of cardiac arrest patients where resuscitation was attempted.
- 99% of these patients had end-tidal CO₂ measured and documented
- 3 patients had no end-tidal CO₂ level documented on their PRF, nor an accompanying capnography printout.
- Cases with no end-tidal CO₂ monitoring undertaken are sent for review by the area governance lead, and reported back to the Safety and Standards Committee.
- The Medical Directorate will produce a flowchart to ensure feedback on each case is undertaken, and to close the loop.

STROKE (July 2015)

- 98% of stroke patients were provided with the full pre-hospital care bundle
- 99.6% of FAST positive patients had the time of onset recorded or a reason why this could not be documented
- 99.5% of FAST positive patients were conveyed to a HASU. 5 patients were taken to an ED instead of a HASU
- Average response from call to arrive on scene time was 14 minutes, a reduction of 1 minute.
- Average on scene time is 35 minutes.
- 62.7% of patient eligible for thrombolysis arrived at a HASU within 60 minutes. One issue impacting on this figure is the lack of access to a HASU from some areas of London.

TRAUMA (Q1 2015/16)

- 1372 patients were treated as major trauma patients
- On scene times for blunt and penetrating trauma are 36 minutes and 17 minutes respectively. Blunt trauma shows a reduction of 4 minutes. Penetrating trauma shows an increase of 2 minutes.
- 124 patients were conveyed to a MTC despite not being indicated. This may impact on patient experience due to protracted journey times.
- Feedback is provided to crews regarding inappropriate conveyance to MTCs and on scene times.

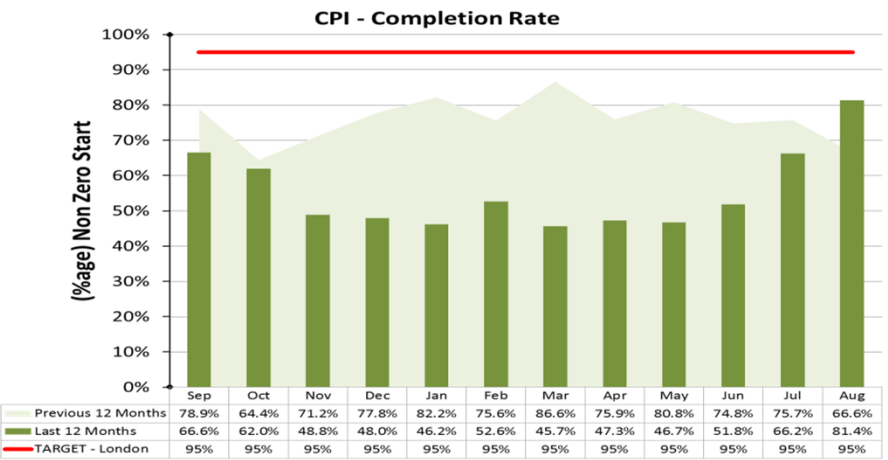
CARING



Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
CPI Compliance	<ul style="list-style-type: none"> All CPI audits achieved in excess of the 95% requirement, except mental health which remains below the required level, at 90% as Trust average. 			
CPI completion	<ul style="list-style-type: none"> 14 complex areas achieved 100% completion. 3 complexes completed less than 50% of the expected CPIs. 			
CPI Feedback	<ul style="list-style-type: none"> 75% of frontline staff have not received any CPI feedback during this financial year. 4 complexes achieved 100% of their expected feedback sessions. 			
Friends & Family Test	<ul style="list-style-type: none"> 6 FFT responses have been received, from a possible 22,510 see and treat cases. 			
Patient & Public Education	<ul style="list-style-type: none"> 25 events were attended during August. 			



CPI Completion, Feedback Sessions and Compliance (JULY 2015)



- The new 50:50 role for team leaders should begin to improve the completion rates LAS wide
- Completion rates at Brent, Camden and New Malden remain below 50%
- The change in complex areas and teams has created an issue with the CPI system, as the CPI system was not updated at the same time. Therefore although some areas had completed all CPI audits required on the system, there were still audits required under the new structure.
- 14 (old structure) complex areas achieved 100% completion.

CPI Compliance

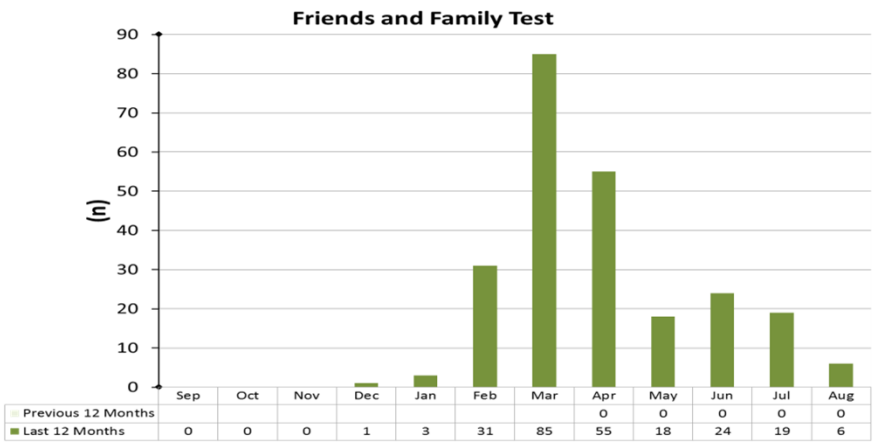
- Compliance to the Non-convey, Acute Coronary Syndrome, Cardiac Arrest, Glycaemic Emergencies, Stroke and General documentation remain high, with LAS wide average scores in excess of 96%
- The Mental Health CPI remains a concern, with the LAS wide average compliance currently at 90%. Areas for improvement are:
 - Safeguarding concerns
 - Appearance
- Mental Health appeared on CSR last year, and some improvements have been seen. However, the CPI remains the lowest in compliance.

CPI Feedback Sessions

- 4 (old structure) complexes achieved 100% of their expected feedback sessions
- 75% of frontline operational staff are yet to receive their first face to face feedback session for this financial year.
- Friern Barnet, Isleworth, New Malden and the Volunteer Responders provided <10% of the expected feedback sessions.



Friends and Family



- Total number of FFT responses received = 6
- Extremely likely = 4
 - Likely = 1
 - Don't know = 1
 - PTS responses = 3
 - Number of PTS journeys = 4084
 - See & treat responses = 3
 - Number of see & treat patients = 22,510
 - It is important to note that PTS undertake a number of repeat journeys, with the same patients.



Patient Experience

Events on database = 39

Events attended = 25

- X3 Brownie/cub visits
- X2 Mental health focus groups (one patient and one staff)
- X3 Knife crime talks
- X2 People who help us (4-5yr olds)
- X3 BLS
- X1 Older people talk
- X11 Other

Tzivos Hashem Summer Scheme (Jewish summer scheme), 4th August – x60 3-5yr olds Paramedic Karen Treagust - x60 3-5yr olds

'Karen interacted beautifully with the kids and held their attention the whole time. The children loved her presentation'

Elderly Citizen Workshop, 20th August - Grace O'Shaughnessy (Control Services Tutor)

Hi Ruth

Thanks so much for providing us with Grace, she was excellent. The residents really enjoyed it. Was great to have a rep from the LAS for them so thank you again

•Twickenham Police Station Open Day, 9th August – Team Leader Andrew Windsor & Paramedic Ellis Gingell

'Good afternoon,

I would like to thank you for your help for a very successful open day at Twickenham Police Station. Your help, willingness to support us and efforts help make nearly 1,400 people happy for the day. Please pass my thanks on to anyone else in your team for their kind efforts.'

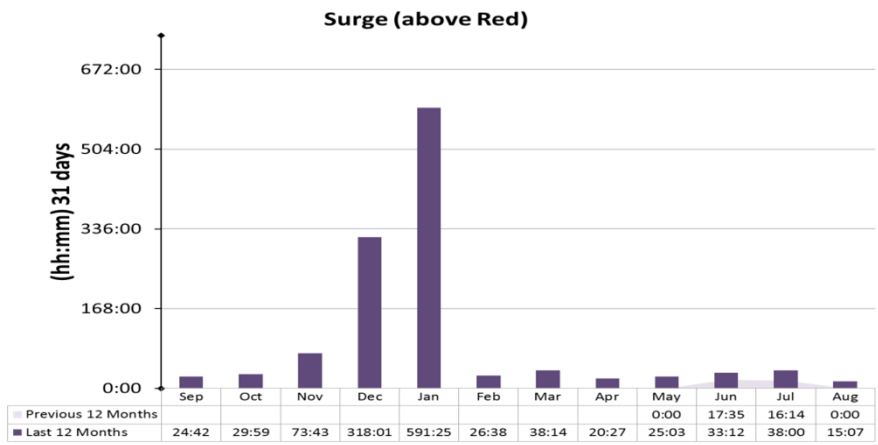
RESPONSIVENESS



Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
EOC Surge Plans	15 hours were spent at Surge Purple or above during August.			



EOC Surge Status



- 15 hours were spent at Surge Purple or above during August. This is a decrease from the previous month.
- The implementation of Surge Red operating 24/7 has enabled the Trust to respond to the highest priority calls within the required timeframe. The lowest acuity 999 calls receive an enhanced clinical assessment through NHS111 or the Clinical Hub. However, there is significant risk associated with increasing Surge level, and the Trust has seen some extended delays for lower priority calls, as well as delays for some of the higher priority calls. This risk is mitigated by the Clinical Hub and senior clinical and operational oversight.

WELL LED



Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides	Current RAG	Historic RAG	RAG
Workforce (Nursing)	<ul style="list-style-type: none">• The Director of Nursing and Quality has responded to the paper from Monitor, requesting the Trusts views on nursing agency rules.• Further information relating to the Well Led domain is evidenced in the integrated performance report.			



Workforce (Nursing)

- The Director of Nursing and Quality has responded to Monitors paper requesting the Trusts views on nursing agency rules: initial engagement setting out new agency control proposals.
- NHSE have establishment a London Nursing Workforce Board and supporting structures to Address the London Nursing Workforce Issues
- The LAS is engaged in the 'Securing a sustainable nursing workforce for London Programme' which aims to get employers, HEIs and commissioners to work together to build a compelling vision of the CapitalNurse.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Cardiac Arrest Annual Report
Report Author(s):	Clinical Audit and Research Unit
Presented by:	Fenella Wrigley
Contact Details:	Fenella.wrigley@lond-amb.nhs.uk
History:	EMT
Status:	For approval
Background/Purpose	
<p>The Cardiac Arrest Annual Report (2014-15) has been published and is ready for release to external stakeholders following approval from the Trust Board.</p> <p>Key Findings:</p> <ul style="list-style-type: none">• In 2014-15, the LAS attended 10,211 cardiac arrests, and attempted resuscitation on 4,665 of these patients.• Figures from the National Ambulance Quality Indicators demonstrate very good performance against other English ambulance services, despite seeing slight decreases in some clinical outcomes.• The LAS performed above average for all cardiac arrest clinical outcome indicators.• The LAS was ranked 2nd in the country for achieving ROSC on arrival at hospital, and for survival to hospital discharge for the Utstein group.• Survival to hospital discharge rates dropped from 10.3% to 9.0% for all patients where resuscitation was attempted.• 63.1% of patients received by-stander CPR prior to LAS arrival, a significant increase from 55.8% in 2013/14.• 58.6% of patients where a public access defibrillator was used survived to hospital discharge.	
Action required	
<p>To approve the content of the Annual Report, and support the release of the report externally.</p>	
Assurance	
<ul style="list-style-type: none">• Although slight decreases are noted for some of the quality indicators, the number of patients remains small, and fluctuations are expected. These are therefore not clinically significant.	

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



London Ambulance Service
NHS Trust



Cardiac Arrest Annual Report: 2014/15

September 2015

Produced by:

Gurkamal Viridi, Scott Picton and Rachael Fothergill

✉ CARU.Enquiries@lond-amb.nhs.uk

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

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Key findings

- In 2014/15, the LAS attended 10,211 cardiac arrests and attempted to resuscitate 4,665 of these patients.
- Figures from the national Ambulance Quality Indicators (2014/15) ^[1] demonstrate that the LAS performed very well in comparison to the other English ambulance services (despite seeing slight decreases in some clinical outcomes, see below). We ranked 2nd in the country for achieving ROSC on arrival to hospital (for all patients and the Utstein comparator group) and also ranked 2nd for survival to hospital discharge amongst the Utstein group. We performed above average for all cardiac arrest clinical outcome indicators (see Appendix 1 for comparisons against other Trusts and mean values).
- The proportion of patients achieving a pulse on arrival at hospital (return of spontaneous circulation - ROSC) remained relatively stable at around 31%. For the Utstein comparator group there was a small decrease in ROSC to 55.1% (from 58.5% in 2013/14).
- Survival to hospital discharge rates dropped from 10.3% to 9.0% for all patients where resuscitation was attempted, and by 0.9% to 31.5% for those meeting the Utstein inclusion criteria (from 32.4% in 2013/14).
- Considerably more patients received bystander cardiopulmonary resuscitation (CPR) than ever before with 63.1% of patients receiving CPR prior to LAS arrival (from 55.8% in 2013/14).
- When a public access defibrillator was used (n=116), 76.7% of patients were reported to have sustained ROSC to hospital and the overall survival to discharge rate was 58.6%. This high survival rate demonstrates the importance of public access defibrillators.
- The percentage of patients whose arrest was bystander witnessed has remained stable with almost half having a witnessed arrest (49.2%).
- The presence of an initial shockable rhythm decreased slightly to 18.7% (from 21.5% in 2013/14).
- The majority of calls (94%) were identified as requiring a high priority response and were triaged as Category A ensuring ambulance staff were dispatched to the patient promptly.
- The median response time of 8 minutes was within target; although almost a minute longer than last year.
- A greater number of patients who achieved ROSC with evidence of myocardial infarction were taken to a Heart Attack Centre (HAC) compared with the previous year (362 vs. 297). The survival rate of these patients was 49.6%; considerably higher than the survival rate of presumed cardiac aetiology patients in general.
- Advanced Paramedic Practitioners (APP) are dispatched to cardiac arrests (either automatically or via enhanced triage by an APP) to manage resuscitation efforts. When an APP was present with primacy of care, ROSC sustained to hospital and survival to discharge rates were 33.8% and 10.3% respectively.

1. Introduction

The London Ambulance Service NHS Trust (LAS) provided an emergency response to 10,211 patients who suffered an out-of-hospital cardiac arrest in London between 1st April 2014 and 31st March 2015. Our staff delivered to these patients basic and/or advanced life support techniques in an attempt to resuscitate patients and, where possible, transported them to hospital for definitive care.

This report presents information regarding the response and treatment that our patients received, explores the factors present that may affect survival, and the outcomes of patients. Data have been sourced from the LAS cardiac arrest registry, which captures information from a range of clinical and operational sources including: Patient Report Forms (PRFs), vehicle Mobile Data Terminals (MDTs), 999 call logs and defibrillator data. Survival to hospital discharge information is collected using national databases and individual hospital patient records.

A breakdown of figures by LAS Complex and receiving hospital can be found in Appendices 1 and 2. Appendix 4 is dedicated to a specific group of cardiac arrest patients that are conveyed to a Heart Attack Centre (HAC) following successful resuscitation as part of a specialist care pathway. Appendix 5 displays information according to the Clinical Commissioning Group (CCG) area in which the cardiac arrest occurred. Finally, Appendix 6 focuses on cardiac arrest patients under the age of 35.

A glossary of abbreviations and terms are included on page 14 for readers unfamiliar with the medical or Emergency Medical Service (EMS) terminology used.

2. Overview

Of the 10,211 out-of-hospital cardiac arrest patients attended, a resuscitation effort was not undertaken for 54.3% (n= 5,546) of cases. The vast majority of these patients were recognised as deceased on arrival (91.9%; n=5,098) and 8.1% (n=448) had a Do Not Attempt CPR (DNA-CPR) order - or similar equivalent - in place, or the patient's death was expected.

Resuscitation was attempted by LAS staff for 45.7% (n=4,665) of all cardiac arrest patients. The remainder of this report focuses on these patients and Table 1 (overleaf) provides an overview of the patient demographics and clinical presentation, call and response information, and interventions provided by the LAS.

Gender	
Male	62.9%; n=2,933
Female	37.1%; n=1,731
Unknown	0%; n=1

Age (years)	
Overall average	66
Male average	64
Female average	69

Race ^{□^}	
White	61.6%; n=2,873
Asian	7.5%; n=348
Black	6.6%; n=306
Mixed	0.2%; n=7
Other	3.6%; n=166
Unable to obtain	17.5%; n=818
Not documented	3.2%; n=147

Peak occurrence	
Time of day (hours)	08:00-11:59 23.2%; n=1,081
Day	Sunday 14.8%; n=691
Month	December 11.1%; n=516

Chief Complaint	
Cardiac arrest	52.1%; n=2,430
Other	47.9%; n=2,235

Response category [□]	
R1	64.3%; n=3,001
R2	29.7%; n=1,385
C1	1.4%; n=66
C2	3.1%; n=146
C3	0.8%; n=39
C4	0.6%; n=28

Response times (median in minutes)	
999 call - scene	07:38
999 call - CPR [#]	09:11
999 call - defibrillation [◇]	12:39

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

^ This data should be viewed with caution as definitive information is not routinely obtainable.

Figures exclude arrests witnessed by LAS staff.

◇ Figures are based on patients with an initial rhythm of VF/VT and exclude arrests witnessed by LAS staff.

Location	
Private	77.7%; n=3,626
Public	22.3%; n=1,039

Witnessed [□]	
Bystander	49.2%; n=2,293
LAS	17.6%; n=819
Unwitnessed	33.2%; n=1,548
Not documented	0.1%; n=5

Bystander CPR [#]	
Yes	63.1%; n=2,427/3,846
No	36.9%; n=1,419/3,846

Initial rhythm	
Asystole	53.3%; n=2,486
PEA	26.4%; n=1,230
VF/pulseless VT	18.7%; n=873
Not documented	1.6%; n=76

Aetiology [®]	
Presumed cardiac	85.9%; n=4,006
Other medical	3.4%; n=159
Trauma	4.5%; n=209
Asphyxiation	3.2%; n=150
Overdose	2.6%; n=123
Drowning	0.3%; n=15
Electrocution	0.1% n=3

Airway management [*]	
Airway placed	87.8%; n=4,096/4,665
ETT success rate	82.8%; n=1,469/1,775
SGA success rate	90.1%; n=3,149/3,494
ETCO ₂ measured	96.3%; n=3,946/4,096

Resuscitation terminated on scene	
Yes, by LAS	33.1%; n=1,544
Yes, by other Healthcare Professional	3.8%; n=177
No	63.1%; n=2,944

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

* Airway management refers to the application of an advanced airway intervention, including endotracheal tube (ETT) and supraglottic airway device (SGA). End tidal carbon dioxide (ETCO₂) is measured to assess the accurate placement of these devices.

Table 1 – Overview of all cases where resuscitation was attempted (n=4,665).

3. ROSC sustained to hospital and survival to hospital discharge

3.1. All patients for whom resuscitation was attempted

1,465 of the 4,665 patients (31.4%) for whom resuscitation attempted maintained ROSC to hospital, which is a slight increase from last year's rate of 31.2%. The rate of survival to discharge for this group was 9.0% (n=414/4,595); a decrease of 1.3% from 2013/14.

ROSC sustained to hospital	
Yes	31.4%; n=1,465
No	68.4%; n=3,193
Not Documented	0.2%; n=7

Survived to discharge ⁺	
Yes	9.0%; n=414/4,593
No	91.0%; n=4,181/4,595

⁺ Denominator excludes patients with unknown survival outcomes (n=70).

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

3.2. All patients for whom resuscitation was attempted – subgroup analyses

The Utstein template is an internationally recognised system enabling comparisons of patient outcomes amongst EMS providers. In 2014, the Utstein template^[2] was updated to allow analysis of outcomes for comparator sub-groups irrespective of aetiology: bystander witnessed arrests with a shockable (VF/pulseless VT) initial heart rhythm, bystander witnessed arrests with non-shockable rhythms, and arrests where bystander CPR was undertaken and a shockable rhythm was present.

Comparator groups	ROSC sustained to hospital	Survival to discharge ⁺
Bystander witnessed arrests with shockable rhythms*	54.2%; n=301/555	31.1%; n=166/534
Bystander witnessed (other rhythms)*	31.8%; n=553/1,738	3.5%; n=60/1,718
Bystander CPR with VF/VT*	53.3%; n=279/523	31.0%; n=157/506

⁺ Denominators exclude patients with unknown survival outcomes.

* Figures exclude arrests witnessed by LAS staff.

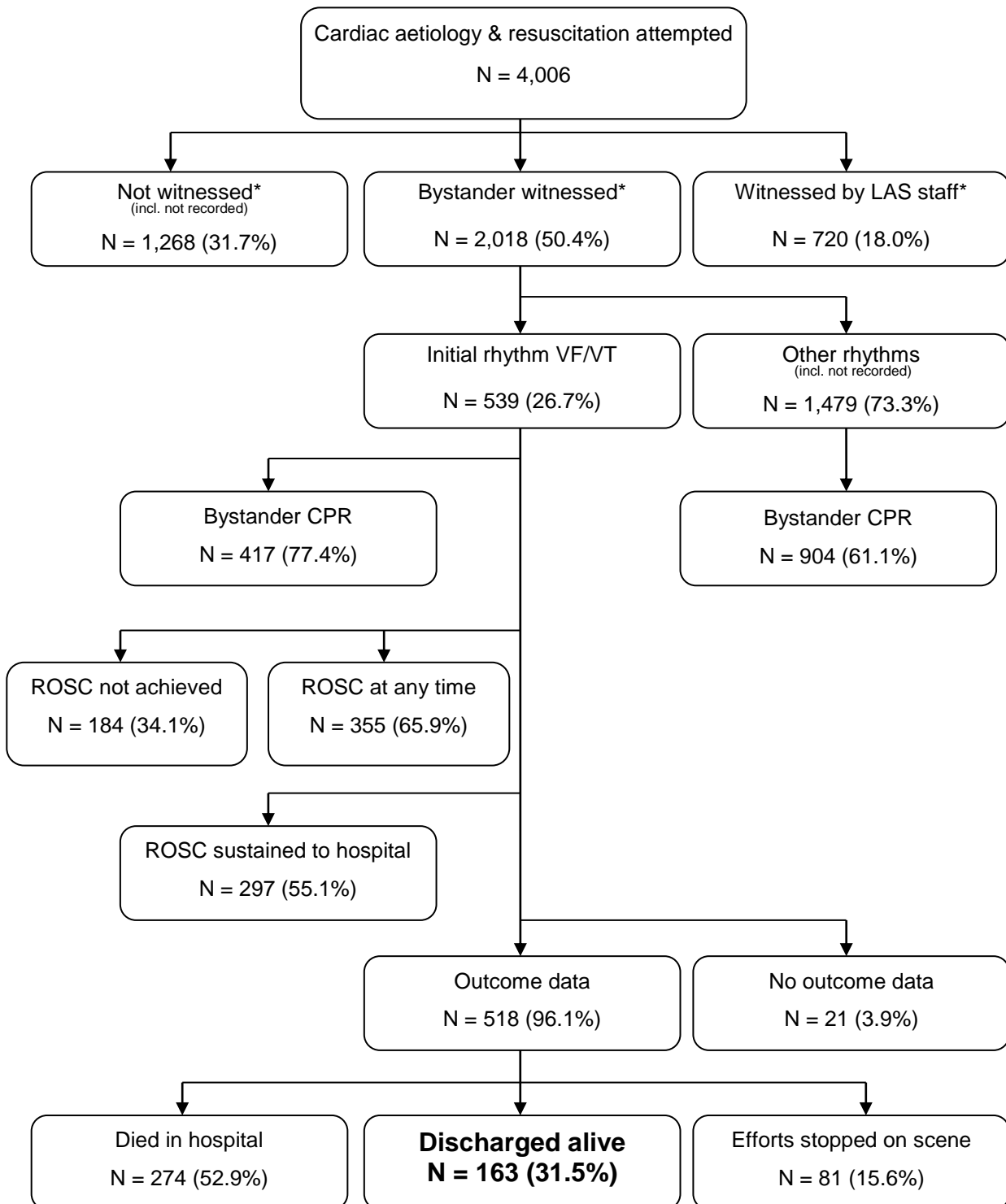
Table 3 – ROSC sustained to hospital and survival to discharge for all resuscitation attempted cases.

3.3. Utstein survival

The Utstein survival calculation^[3] used in this report examines patients where resuscitation was attempted and focuses on those where: the arrest was of a presumed cardiac aetiology, bystander witnessed, and in a shockable rhythm (VF/pulseless VT) on arrival of the EMS.

Figure 1 shows that ROSC was sustained to hospital for 55.1% (n=297/539) of patients; a decrease of 3.4% from 2013/14. Survival to discharge was achieved for 31.5% (n=163/518); a marginal decrease of 0.9% from the previous year.

Figures 2 and 3 show the ROSC sustained to hospital and survival to discharge rates over time; showing both the improvements and fluctuations observed in rates.



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

Figure 1 – Outcome for the Utstein comparator group

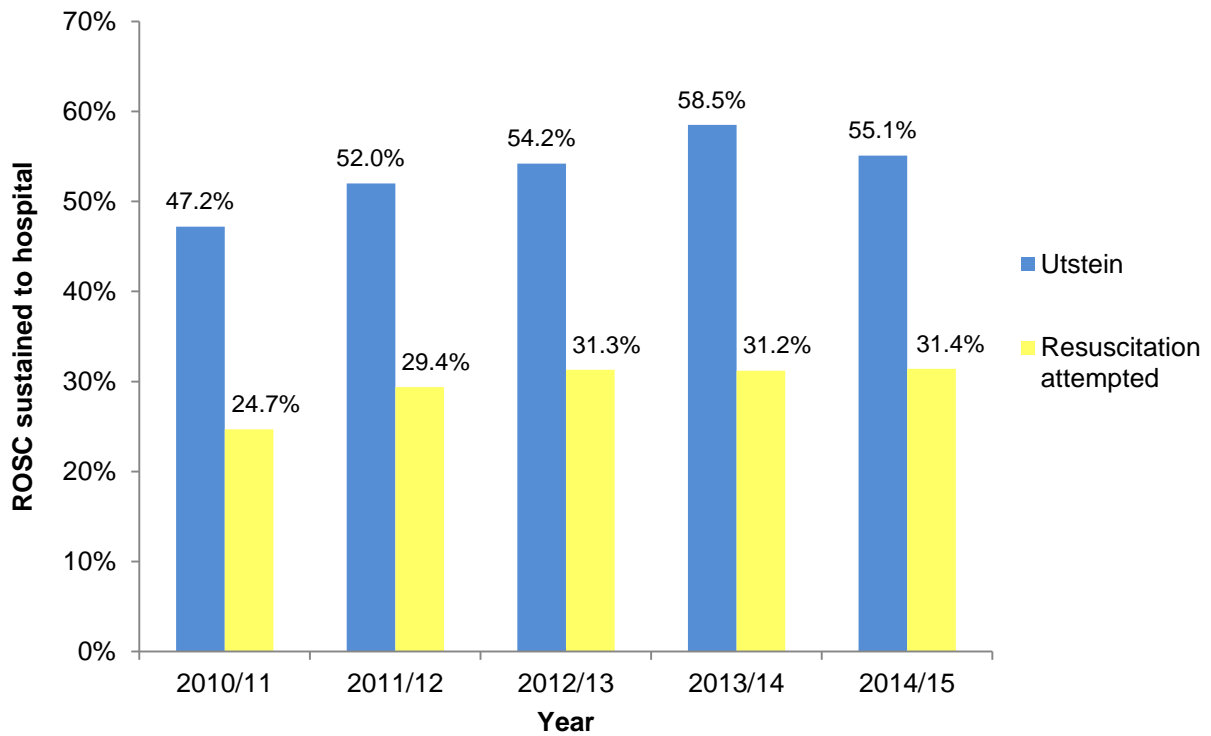


Figure 2 – ROSC sustained to hospital for the Utstein comparator group and all resuscitation attempted patients by year.

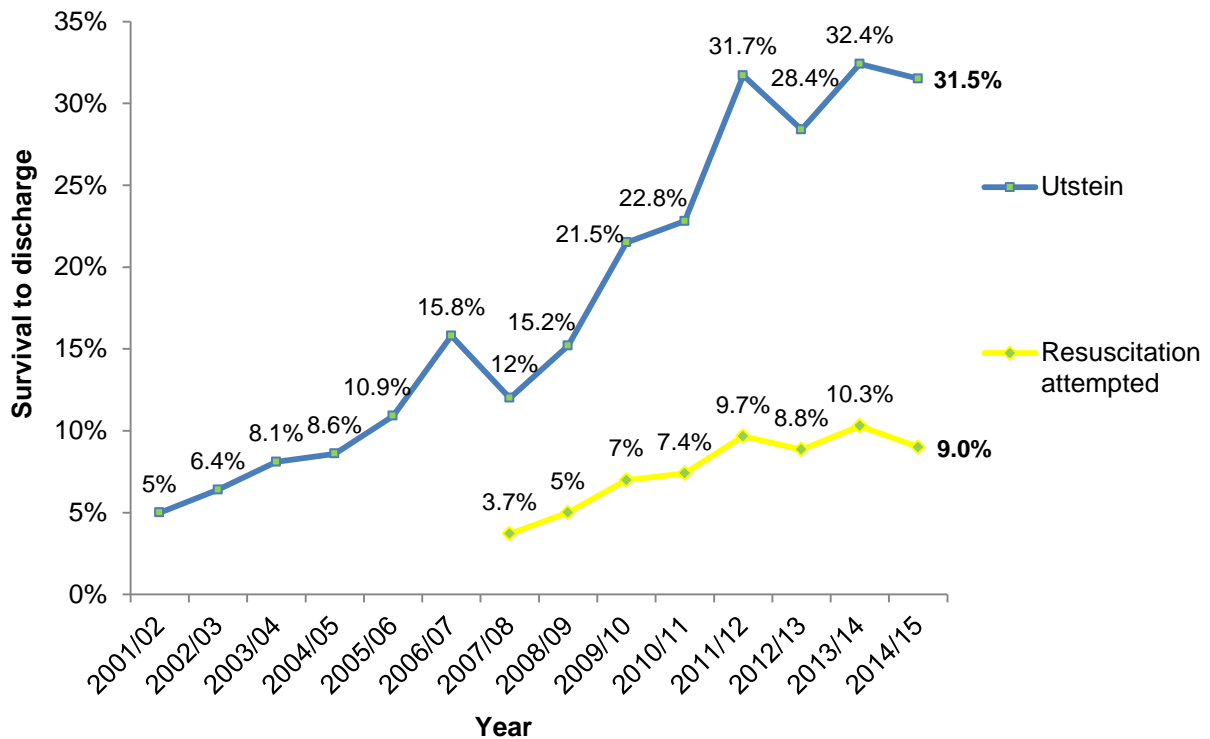


Figure 3 – Survival to discharge for the Utstein comparator group and all resuscitation attempted patients by year.

3.4. EMS only witnessed arrests

The table below shows the outcomes of the 819 cardiac arrest patients whose arrest was witnessed by LAS staff.

EMS witnessed arrest outcomes	
ROSC sustained to hospital	36.5%; n=299/819
Survived to discharge	16.8%; n=134/800

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

Table 4 – ROSC sustained to hospital and survival to discharge where resuscitation was attempted.

The majority of patients where the arrest was EMS witnessed had an initial rhythm of PEA (47.1%; n=386). Of these, ROSC was sustained to hospital in 26.2% (n=101) of patients and 5.8% (n=22/380) survived to discharge from hospital. Where the patient was in an initial rhythm of VF/pulseless VT (22.8%; n=187), patients were considerably more likely to sustain ROSC to hospital (65.2%; n=122) and survive to hospital discharge (53.8%; n=98/182). Asystolic patients (27.5%; n=225) had a ROSC sustained to hospital rate of 28.9% (n=65) and survival to discharge rate of 5.5% (n=12/220).

4. Factors influencing outcomes

The factors that influence the chances of positive outcomes for patients who suffer a cardiac arrest are complex. This section presents some of the key factors that affect patient outcomes.

4.1. Bystander intervention

Bystanders have a crucial role in the chain of survival. Our Emergency Medical Dispatchers will provide CPR instructions at the point of the 999 call to bystanders prior to the arrival of the LAS. Furthermore, during 2014/15, over 1000 public access defibrillators were established at locations across London as part of the 'Shockingly Easy' campaign and we continued to teach life-saving skills to members of the public.

4.1.1. Bystander CPR and bystander witnessed arrests

Figure 4 below shows the increases in rates of bystander CPR and witnessed rates over the last 5 years, including this years' record high rates of 63.1% and 49.2% respectively.

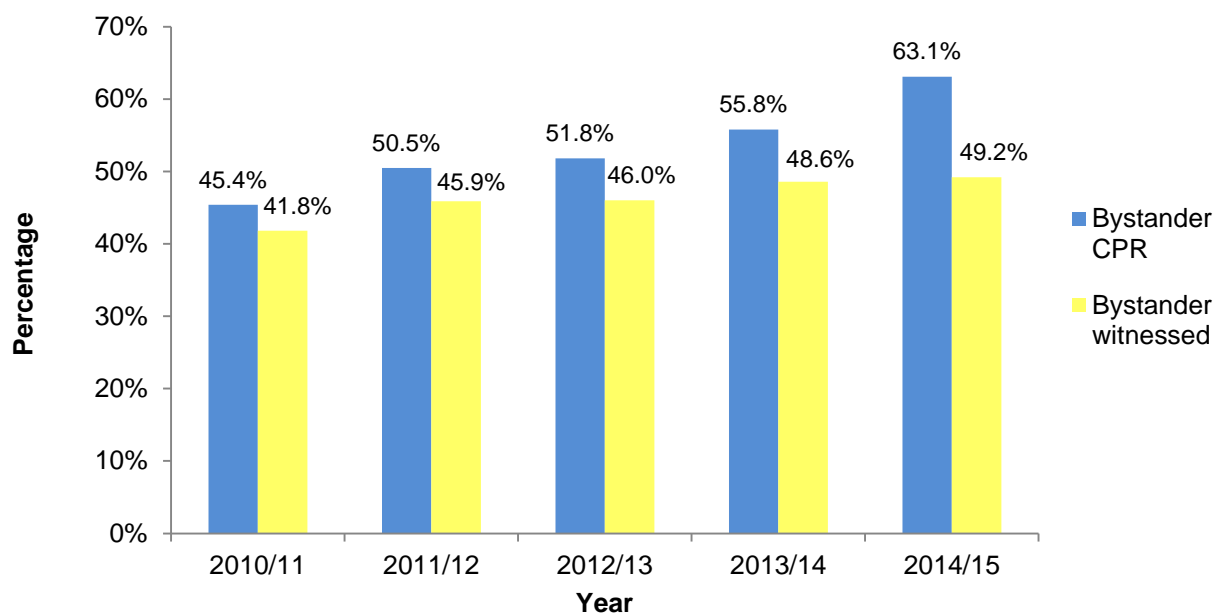


Figure 4 – Rates of bystander CPR and witnessed arrests for all resuscitation attempted patients.

4.1.2. Public Access Defibrillator use

In 2014/15, a public access defibrillator was deployed by members of the public in 116 of cardiac arrest incidents. In 43 cases the defibrillator was not used as it was either not indicated or ambulance staff arrived on scene prior to its use. For the remaining 73 cases the defibrillator was applied and at least one shock given. Further event information for these patients is given below:

Public Access Defibrillator Use	
Bystander witnessed:	67.1%; n=49
Bystander CPR:	71.2%; n=52
ROSC sustained to hospital:	76.7%; n=56
Survival to discharge ⁺ :	58.6%; n=41/70

+ Denominator excludes patients with unknown survival outcomes (n=3)

Table 5 – Public Access Defibrillator use event information and patient outcomes.

4.2. Location of cardiac arrest

The majority of arrests where resuscitation was attempted occurred at home (n=3,198). Survival was more likely from arrests that occurred in public locations, with leisure centres/ sports clubs (29.7%), work (28.7%) and public transport (26.5%) having the highest survival rates.

Private (n=3,626)	No.	Witnessed	Bystander CPR	Survival to Discharge ⁺
Home	3,198	56.7% (1,476/2,603)	57.9% (1,506/2,603)	6.8% (215/3,155)
Care home	428	58.7% (209/356)	76.1% (271/356)	1.6% (7/427)

Public (n=961)	No.	Witnessed	Bystander CPR [#]	Survival to Discharge ^{+#}
Street	501	68.9% (297/431)	67.7% (292/431)	15.3% (74/485)
Work	98	64.9% (50/77)	77.9% (60/77)	28.7% (27/94)
Healthcare facility (e.g. GP surgery, walk in centre)	85	62.3% (43/69)	94.2% (65/69)	17.9% (15/84)
Public transport	68	73.3% (44/60)	61.7% (37/60)	25.0% (17/68)
Social Venue (e.g. Pub, Restaurant, Cinema)	66	87.7% (50/57)	80.7% (46/57)	25.0% (16/64)
Shop/ Bank	44	80.0% (28/35)	68.6% (24/35)	20.9% (9/43)
Hotel/ Hostel	38	60.6% (20/33)	69.7% (23/33)	13.5% (5/37)
Leisure Centre/Sports Club	37	90.6% (29/32)	90.6% (29/32)	29.7% (11/37)
Parkland/Woodland/River	31	41.4% (12/29)	75.9% (22/29)	9.7% (3/31)
Airport	22	78.9% (15/19)	78.9% (15/19)	22.7% (5/22)
Other (e.g. School, Prison, Place of Worship)	49	44.4% (20/45)	82.2% (37/45)	20.8% (10/48)

+ Denominators exclude patients with unknown survival outcomes.

Please view with caution due to small numbers.

Table 6 – Location of cardiac arrests where resuscitation was attempted.

4.3. Initial rhythm

Patients who present in a shockable rhythm (VF/pulseless VT) have the best chance of surviving their arrest. Figure 5 below shows the changing presentation of initial arrest rhythms over the last five years with VF/VT rates decreasing this year to 18.7% (from 21.5% in 2013/14). This will have an impact on patient outcomes as patients with an initial rhythm of VF/VT have considerably higher rates of ROSC sustained to hospital and survival to discharge (55.6% and 32.4% respectively).

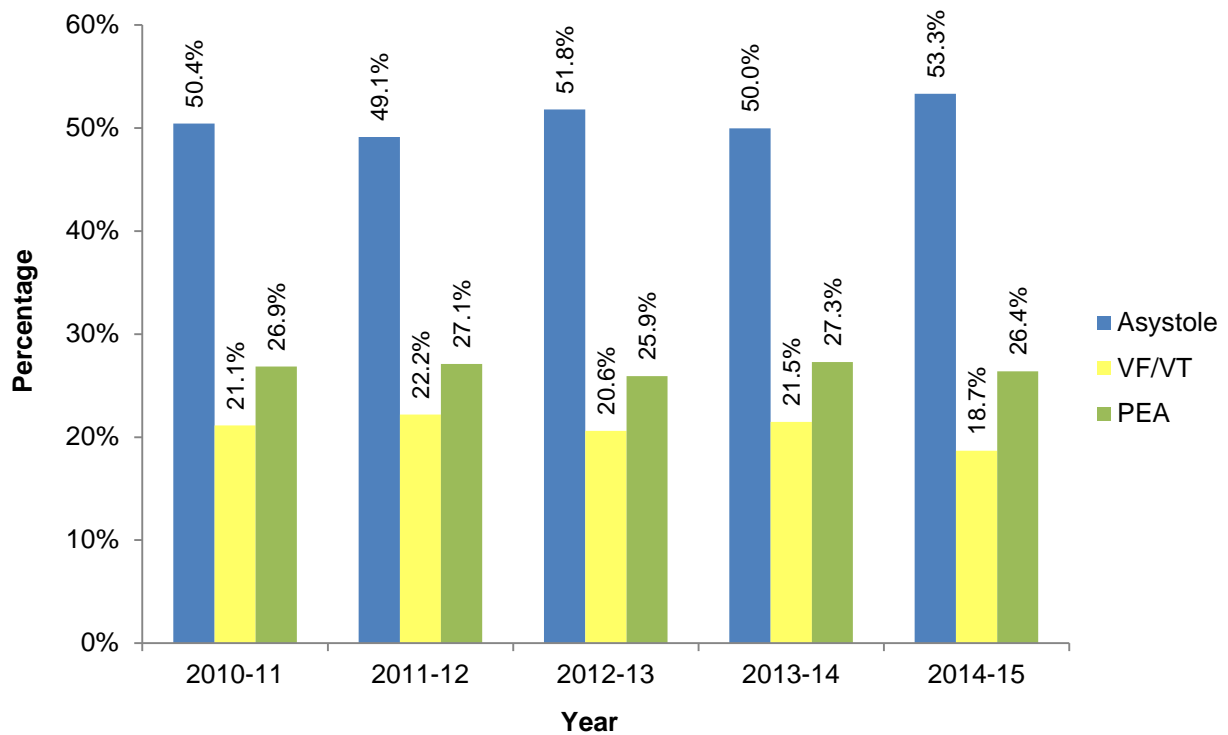


Figure 5 – Rates of initial rhythm for all resuscitation attempted patients.

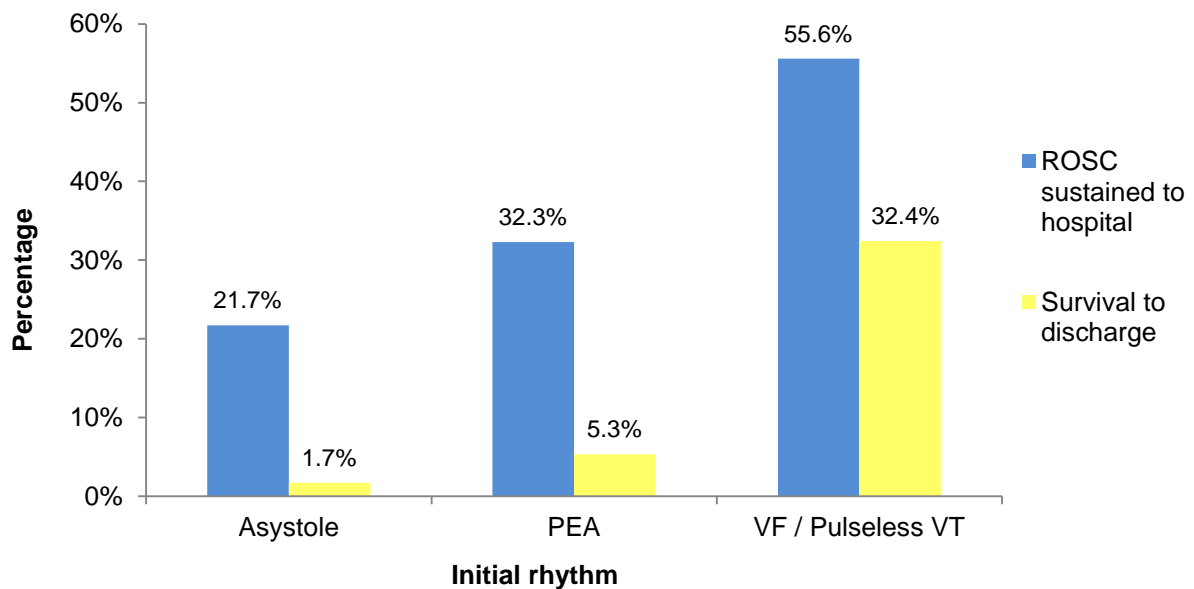


Figure 6 – Initial rhythm compared with ROSC sustained to hospital and survival to discharge for all resuscitation attempted patients.

4.4. Aetiology

The cause of a cardiac arrest affects the outcome and is an important factor in determining the recognition of reversible causes. The most frequent aetiology of arrest was presumed cardiac (85.9%; n=4,006). The remaining aetiologies include other medical causes, trauma from external causes (such as penetrating and blunt injuries), asphyxia (such as respiratory obstruction and asphyxiation from hangings or suffocation), drowning, electrocution and overdose.

Cause	No.	Initial Rhythm [^]			ROSC sustained to hospital [#]	Survived to discharge ^{#+}	
		Asystole	PEA	VF/VT			
Presumed cardiac	4,006	51.6% (2,066)	26.0% (1,043)	21.2% (851)	32.5% (1,302)	9.4% (371/3,951)	
Other Medical[®]	Terminal illness	121	70.2% (85)	24.0% (29)	5.0% (6)	9.1% (11)	0% (0/121)
	Neonatal	13	38.5% (5)	-	-	15.4% (2)	0% (0/10)
	Asthma/COPD	10	40.0% (4)	50.0% (5)	10.0% (1)	70.0% (7)	50.0% (5/10)
	Pulmonary embolism	5	40.0% (2)	40.0% (2)	20.0% (1)	20.0% (1)	0% (0/5)
	Internal bleeding	3	33.3% (1)	66.7% (2)	-	0% (0)	0% (0/3)
	Hypothermia	2	-	100.0% (2)	-	0% (0)	0% (0/2)
	Anaphylaxis	2	50.0% (1)	50.0% (1)	-	100.0% (2)	0% (0/2)
	Infection	1	-	100.0% (1)	-	0% (0)	0% (0/1)
	Epilepsy	1	-	-	-	100.0% (1)	100% (1/1)
	Stroke	1	-	100.0% (1)	-	0% (0)	0% (0/1)
	<i>Total</i>	159	61.6% (98)	27.0% (43)	5.0% (8)	15.1% (24)	3.9% (6/156)
Trauma[®]	Road Traffic Collision	85	50.6% (43)	41.2% (35)	2.4% (2)	12.9% (11)	4.8% (4/84)
	Fall from height	39	56.4% (22)	38.5% (15)	-	2.6% (1)	0% (0/39)
	Stabbing	36	63.9% (23)	36.1% (13)	-	11.1% (4)	0% (0/36)
	Blunt trauma	10	40.0% (4)	50.0% (5)	-	0% (0)	0% (0/10)
	Haemorrhage	12	50.0% (6)	50.0% (6)	-	8.3% (1)	0% (0/11)
	Fall down stairs	8	75.0% (6)	12.5% (1)	-	50.0% (4)	0% (0/7)
	Blunt assault	7	71.4% (5)	14.3% (1)	14.3% (1)	14.3% (1)	0% (0/7)
	Hit by train	3	33.3% (1)	33.3% (1)	-	33.3% (1)	0% (0/3)
	Head injuries	5	40.0% (2)	20.0% (1)	40.0% (2)	40.0% (2)	20.0% (1/5)
	Shooting	3	100.0% (3)	-	-	0% (0)	0% (0/3)
	Burns	1	100.0% (1)	-	-	0% (0)	0% (0/1)
	<i>Total</i>	209	55.5% (116)	37.3% (78)	2.4% (5)	12.0% (25)	2.4% (5/206)
Asphyxial[®]	Asphyxiation	82	82.9% (68)	14.6% (12)	-	34.1% (28)	5.1% (4/79)
	Obstruction	62	50.0% (31)	43.5% (27)	1.6% (1)	50.0% (31)	11.5% (7/61)
	Smoke inhalation	6	66.7% (4)	33.3% (2)	-	50.0% (3)	0% (0/5)
	<i>Total</i>	150	68.7% (103)	27.3% (41)	0.7% (1)	41.3% (62)	7.6% (11/145)
Overdose	123	74.0% (91)	17.9% (22)	4.9% (6)	36.6% (45)	14.7% (18/122)	
Drowning	15	73.3% (11)	13.3% (2)	6.7% (1)	33.3% (5)	7.1% (1/14)	
Electrocution	3	33.3% (1)	33.3% (1)	33.3% (1)	66.7% (2)	66.7% (2/3)	

[^] Not documented values (n=76) are not presented.

[#] Please view with caution due to small numbers.

⁺ Denominators exclude patients with unknown survival outcomes.

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

Table 7 – Aetiology of all cases where resuscitation was attempted.

4.5. Advanced Paramedic Practitioners (APPs)

In May 2014, the LAS launched the role of Advanced Paramedic Practitioners (APPs). APPs are trained in a greater range of assessments and skills, and carry mechanical CPR devices, ultrasound equipment for assessment of reversible causes and ventilator devices for use post ROSC. APPs are dispatched to cardiac arrests (either automatically or via comprehensive triage by an APP based in the Emergency Operations Centre) to manage resuscitation efforts and provide enhanced care to patients.

When an APP was present with primacy of care (n=853), the ROSC sustained to hospital rate was 33.8% (n=288) and survival to discharge was 10.3% (n=87/843).

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

During 2014/15, 362 patients who achieved a stable ROSC following an arrest of presumed cardiac origin presented with a STEMI on a 12-lead ECG and were conveyed directly to a HAC as part of a specialist care pathway. Survival to discharge for these patients was higher than other groups at 49.6% (n=174/351). A breakdown of survival and initial rhythm for these patients by all eight London HACs can be found in Appendix 4.

5. Discussion

This year, we have seen a decrease in survival (by 1.3% for all patients where resuscitation was attempted, and 0.9% for the Utstein comparator group). ROSC sustained to hospital increased slightly (by 0.2%) for all patients who had resuscitation commenced and decreased (by 3.4%) for the Utstein group. Given that there have been fluctuations in rates in previous years (see Figures 2 and 3), and these changes in ROSC sustained to hospital and survival to discharge are minimal, the LAS can be reassured that the quality of care delivered to patients continues to be of a high standard. Furthermore, we compare favourably against other English ambulance services, ranking 2nd for three of the four cardiac arrest clinical outcome measures (see Appendix 1).

The profile of patient characteristics and clinical presentations reported have remained relatively stable (i.e. gender, age, location of arrest, whether or not the arrest was bystander witnessed and aetiology). Changes have been observed in initial rhythms where shockable VF/pulseless VT rhythms have decreased by 2.8% to 18.7% (from 21.5% in 2013/14) and this may have impacted on patient outcomes given that this group of patients have a higher survival rate than patients in other rhythms. Decreases in VF/pulseless VT have been observed world-wide in recent years and are reflective of ageing populations and co-morbidities.^[2]

Our response to patients has been within the NHS England target of 8 minutes^[1], with a median time of 7 minutes and 38 seconds. However, it is important to note that this is nearly a minute longer than last year. It is recognised that response times will have an impact on survival.^[4]

Bystander CPR rates have increased by 7.3% to 63.1% (from 55.8% in 2013/14), and the numbers of patients where a public access defibrillator has been used have increased dramatically from 18 in 2013/14 to 73 in 2014/15. The outcome of patients where a public access defibrillator has been used remain high at 58.6%.

We have also introduced the role of APP and can demonstrate that where an APP is dispatched to support resuscitation efforts patient outcomes are robust, with a ROSC sustained to hospital rate of 33.8% and survival to discharge rate of 10.3%.

Patients conveyed to a HAC under the specialist care pathway for post ROSC patients with clear evidence of a STEMI on their ECG have continued to demonstrate higher survival rates than all other groups (49.6%).

In addition to the placement of public access defibrillators, introduction of APPs and use of the specialist HAC pathway, the LAS has introduced mechanical CPR to our experienced clinicians. To ensure that cardiac arrest patients receive the highest standards of clinical care, we have reviewed and updated our cardiac care guidelines for basic and advanced life support practices and trauma care. We maintained the delivery of full energy defibrillation shocks of 360 joules to patients in shockable rhythms, and have also enabled our APPs to provide double sequential defibrillation in patients in refractory VF. We have also updated our guidelines on the use of adrenaline and placed an upper threshold of 10 doses, based on evidence of poor outcome of patients with a greater number of doses.

The LAS has continued to provide education to staff via Clinical Skills Refresher courses and to Team Leaders through clinical update sessions. The concept of Crew Resource Management has continued to be embedded and the APPs have supported this through the provision of both on-scene and virtual leadership of cardiac arrest incidents (alongside Medical Directorate colleagues) as well as staff support through post resuscitation debriefs.

We successfully commenced the pilot of the Paramedic 2 research project – a randomised double blind controlled trial examining adrenaline use in cardiac arrest patient outcomes. We also have completed a small pilot of the Immediate Coronary Angiography After Ventricular Fibrillation Out-Of-Hospital Cardiac Arrest (ARREST) randomised control trial – where a small group of cardiac arrest patients have been taken directly to a HAC to receive angiography with a view to undertaking primary angioplasty as necessary. In 2015/16 both projects will extend beyond the pilot stage to fully active research projects. Finally, we are also exploring new resuscitation technologies and continuing to enhance the APP role by augmenting their clinical skills and introducing greater numbers of APPs pan-London.

It is hoped that the initiatives we have planned and our continued investment in our staff will ensure improvements in future years.

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Glossary for abbreviations and terms

Advanced Life Support – Includes skills such as advanced airway management, manual defibrillation, cannulation and drug administration.

Angiography – A procedure performed at a Heart Attack Centre to check the blood flow in the coronary arteries.

Automated External Defibrillator (AED) – A portable defibrillator that automatically diagnoses if the heart is in a rhythm that can be shocked and if so delivers a shock.

Basic Life Support – Includes skills such as CPR, manual airway positioning and AED use.

Bystander – A lay person or non-Emergency Medical Service personnel.

Category A – Red 1 and Red 2 form part of a Category A - an immediately life threatening - response. In line with national definitions, 999 call is defined as the time at which the chief complaint is established or one minute elapses, whichever comes first.

Chain of survival – A concept that refers to the elements that are associated with survival; early recognition of cardiac arrest and access to EMS systems, CPR, defibrillation and advanced care.

Chief Complaint – The primary medical reason that the caller has called 999 as defined by the call triage system.

Complex – Each of the LAS Clusters are subdivided into several smaller operational areas known as Complexes. Please note that these do not necessarily align with Clinical Commissioning Group areas.

Defibrillators – The LAS use portable defibrillators to help diagnose the heart's rhythm and deliver a pre-set charged shock of 360J. LAS staff use both AEDs and manual defibrillators, and are able to use an override to enable CPR to be continued whilst the AED is charging.

Double sequential defibrillation – uses two defibrillators to provide multiple high energy shocks in refractory VF to help terminate the rhythm.

Electrocardiogram (ECG) – The LAS use 12-lead ECGs to diagnose STEMIs.

Emergency Medical Dispatchers (EMDs) – Staff based in the LAS Emergency Operations Centre that answer 999 calls and dispatch resources to patients.

Emergency Medical Technician (EMT) – A clinical grade below that of a paramedic with 4 different levels (1-4). EMT Level 4s are able to place the SGA advanced airway in cardiac arrest patients.

Endotracheal Tube (ETT) – Type of advanced airway that some paramedic staff are able to place.

End-Tidal Carbon Dioxide (ETCO₂) – Measurement of gas exchange in lungs which enables a clinician to accurately tell whether an airway device has been placed correctly, and allows other information such as effectiveness of compressions and ventilations to be ascertained. ETCO₂ measurement is compulsory for patients where an advanced airway has been placed.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for angiography and primary Percutaneous Coronary Intervention (pPCI).

Initial rhythm – The rhythm that the heart is in on initial presentation to LAS staff.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Paramedic – A majority of clinical staff are paramedics and are able to perform advanced airway management, cannulation and administration of drugs to cardiac arrest patients.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Primary Percutaneous Coronary Intervention (pPCI) – A surgical procedure performed at a Heart Attack Centre which seeks to unblock arteries by means of insertion of a catheter into the affected artery and inflating a small balloon to re-open it. The opened artery is then held in place with a small stent.

Recognition of Life Extinct (ROLE) – The LAS will recognise if life is extinct if there are signs unequivocal with life present or there is evidence of a prolonged period of cardiac arrest with no attempt at basic life support (BLS) prior to the arrival of the LAS. ROLE can be used upon arrival of a clearly deceased patient, or after resuscitation has been attempted.

Response Category: R1 – Red 1 is used for calls where the patient is not breathing and are classed as the most time critical.

Response Category: R2 – Red 2 is used for calls where the complaint is serious but slightly less immediately time critical.

Response Category: C1 to C4 – All other calls are given a Category C response based on the information provided by the caller regarding the patient's condition. The 999 call time definition is the same as Category A calls.

Return of Spontaneous Circulation (ROSC) – Refers to a return of cardiac output by the heart after a period of cardiac arrest. ROSC sustained to hospital is the most widely used measure for out-of-hospital cardiac arrests and indicates the patient had ROSC at handover to hospital staff.

Supraglottic Airway Device (SGA) – Type of advanced airway that all clinical staff from EMT4 upwards have the skill to place.

Survival to Discharge – The patient was successfully discharged from a hospital to a non-hospital environment (therefore excluding transfers from one hospital to another).

Utstein – Refers to the internationally recognised criteria for outcomes. The patients in this group are all witnessed having a cardiac arrest by a bystander, all present with an initially shockable rhythm of VF or pulseless VT and have a presumed cardiac aetiology.

Witnessed – Either seen or heard by a bystander or seen by LAS staff.

Appendix 1: National comparisons

Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall)

		Incidents	Performance (%)
South Central Ambulance Service NHS Trust	38.5	1,486	38.5
London Ambulance Service NHS Trust	31.4	4,665	31.4
North West Ambulance Service NHS Trust	29.6	3,786	29.6
South East Coast Ambulance Service NHS Foundation Trust	29.6	2,867	29.6
West Midlands Ambulance Service NHS Trust	28.7	4,100	28.7
North East Ambulance Service NHS Trust	26.7	1,638	26.7
South Western Ambulance Service NHS Foundation Trust	25.0	3,739	25.0
East of England Ambulance Service NHS Trust	24.1	3,441	24.1
Isle of Wight NHS PCT	22.8	127	22.8
Yorkshire Ambulance Service NHS Trust	22.6	2,973	22.6
East Midlands Ambulance Service NHS Trust	19.2	2,770	19.2
		Mean	27.3

Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein Comparator Group)

		Incidents	Performance (%)
North East Ambulance Service NHS Trust	59.6	198	59.6
London Ambulance Service NHS Trust	55.1	539	55.1
South East Coast Ambulance Service NHS Foundation Trust	54.5	402	54.5
Yorkshire Ambulance Service NHS Trust	52.0	333	52.0
East of England Ambulance Service NHS Trust	50.0	332	50.0
South Central Ambulance Service NHS Trust	50.0	412	50.0
North West Ambulance Service NHS Trust	47.7	461	47.7
West Midlands Ambulance Service NHS Trust	45.6	485	45.6
South Western Ambulance Service NHS Foundation Trust	45.1	572	45.1
Isle of Wight NHS PCT	37.0	27	37.0
East Midlands Ambulance Service NHS Trust	35.8	316	35.8
		Mean	49.1

Survival to discharge (Overall)

		Incidents	Performance (%)
South Central Ambulance Service NHS Trust	16.7	1,433	16.7
Yorkshire Ambulance Service NHS Trust	10.6	2,742	10.6
South Western Ambulance Service NHS Foundation Trust	9.7	3,722	9.7
North West Ambulance Service NHS Trust	9.3	3,453	9.3
London Ambulance Service NHS Trust	9.0	4,597	9.0
South East Coast Ambulance Service NHS Foundation Trust	8.5	2,728	8.5
West Midlands Ambulance Service NHS Trust	8.3	4,100	8.3
East of England Ambulance Service NHS Trust	6.5	3,346	6.5
Isle of Wight NHS PCT	5.5	127	5.5
East Midlands Ambulance Service NHS Trust	4.9	2,608	4.9
North East Ambulance Service NHS Trust	4.8	1,550	4.8
		Mean	8.6

Survival to discharge (Utstein Comparator Group)

		Incidents	Performance (%)
Yorkshire Ambulance Service NHS Trust	40.9	301	40.9
London Ambulance Service NHS Trust	31.5	518	31.5
South Central Ambulance Service NHS Trust	29.6	399	29.6
South Western Ambulance Service NHS Foundation Trust	27.7	567	27.7
North East Ambulance Service NHS Trust	26.5	166	26.5
South East Coast Ambulance Service NHS Foundation Trust	26.1	376	26.1
North West Ambulance Service NHS Trust	22.8	395	22.8
Isle of Wight NHS PCT	22.2	27	22.2
East of England Ambulance Service NHS Trust	20.6	310	20.6
West Midlands Ambulance Service NHS Trust	20.6	485	20.6
East Midlands Ambulance Service NHS Trust	15.5	277	15.5
		Mean	26.3

Appendix 2: Response times and patient outcomes per Complex

Cluster	Complex	Number of patients	Median times (mins)			ROSC sustained to hospital	Resuscitation attempted survival ⁺	Utstein survival ^{##}
			999 call - scene	999 call - CPR [^]	999 call - Defibrillation [#]			
North West	Hillingdon	197	07:53	08:57	12:04	34.0% (67)	12.2% (24/196)	37.9% (11/29)
	Kenton	212	07:29	09:08	13:15	35.8% (76)	8.1% (17/211)	33.3% (7/21)
	Brent	239	08:08	09:51	12:53	29.3% (70)	8.4% (20/238)	43.3% (13/30)
West	Hanwell	172	07:11	09:01	12:06	33.1% (57)	10.5% (18/171)	22.2% (6/27)
	Isleworth	162	07:28	08:33	12:54	27.2% (44)	9.0% (14/156)	36.8% (7/19)
	Fulham	176	07:44	09:48	12:52	32.4% (57)	10.3% (18/175)	45.5% (10/22)
North Central	Friern Barnet	157	07:46	09:58	12:52	33.8% (53)	8.3% (13/157)	28.6% (6/21)
	Chase Farm	99	07:35	09:27	13:07	35.4% (35)	9.2% (9/98)	33.3% (5/15)
	Edmonton	257	07:58	10:04	13:57	29.6% (76)	7.5% (19/254)	22.7% (5/22)
	Camden	212	07:10	08:56	11:58	27.4% (58)	11.5% (24/209)	48.0% (12/25)
East Central	City & Hackney	195	07:40	08:32	10:41	39.0% (76)	12.5% (24/192)	47.8% (11/23)
	Newham	153	07:32	09:05	13:00	32.7% (50)	7.3% (11/150)	16.7% (2/12)
	Tower Hamlets	120	08:12	09:36	14:06	22.5% (27)	5.1% (6/118)	14.3% (2/14)
	Whipps Cross	331	07:46	09:05	12:06	33.5% (111)	9.6% (31/324)	29.0% (9/31)
North East	Romford	237	07:05	08:21	11:08	32.1% (76)	5.3% (12/225)	4.2% (1/24)
South East	Greenwich	231	07:58	09:23	15:28	29.4% (68)	5.7% (13/227)	26.3% (5/19)
	Bromley	202	08:02	09:04	12:27	32.3% (65)	10.5% (21/200)	46.7% (7/15)
	Barnehurst	192	07:16	08:52	14:22	29.2% (56)	5.8% (11/191)	10.0% (2/20)
	Deptford	266	07:03	08:51	13:03	32.0% (85)	13.8% (36/261)	45.0% (18/40)
South West	New Malden	150	07:23	08:58	11:22	43.3% (65)	11.6% (17/147)	30.0% (6/20)
	St Helier	217	07:48	09:03	12:46	24.9% (54)	5.6% (12/215)	27.3% (6/22)
	Wimbledon	168	07:36	09:02	12:52	35.9% (60)	12.7% (21/166)	47.1% (8/17)
	Croydon	207	07:58	09:11	12:11	24.6% (51)	7.4% (15/203)	16.7% (3/18)

[^] Figures exclude arrests witnessed by LAS staff.

[#] Figures are based on patients with an initial rhythm of VF/VT and exclude arrests witnessed by LAS staff.

⁺ Denominators exclude patients with unknown survival outcomes.

[#] Please view with caution due to small numbers.

Appendix 3: Survival per Hospital

Hospital	2012/13			2013/14			2014/15		
	Number of Patients	Survival with ROSC sustained to hospital ⁺		Number of Patients	Survival with ROSC sustained to hospital ⁺		Number of Patients	Survival with ROSC sustained to hospital ⁺	
Barnet	60	10.0%	(2/20)	58	24.2%	(8/33)	77	21.4%	(6/28)
Central Middlesex	20	0.0%	(0/6)	21	0.0%	(0/1)	4	0.0%	(0/1)
Charing Cross	46	33.3%	(9/27)	43	47.1%	(8/17)	31	7.7%	(1/13)
Chelsea & Westminster	24	17.6%	(3/17)	40	25.0%	(4/16)	35	25.0%	(4/16)
Croydon	117	14.3%	(7/49)	104	6.1%	(2/33)	106	5.6%	(2/36)
Darent Valley	17	33.3%	(2/6)	15	16.7%	(1/6)	12	14.3%	(1/7)
Ealing	63	3.8%	(1/26)	76	18.5%	(5/27)	66	9.7%	(3/31)
Hammersmith	113	40.5%	(32/79)	119	49.4%	(40/81)	94	38.7%	(29/75)
Harefield	41	40.5%	(15/37)	36	40.0%	(12/30)	61	58.8%	(30/51)
Hillingdon	84	33.3%	(14/42)	82	29.7%	(11/37)	100	25.0%	(10/40)
Homerton	59	23.1%	(6/26)	35	10.0%	(1/10)	48	13.6%	(3/22)
King's College	180	32.0%	(32/100)	181	51.1%	(46/90)	192	40.7%	(44/108)
King George	61	6.5%	(2/31)	69	16.7%	(5/30)	75	16.2%	(6/37)
Kingston	63	9.5%	(4/42)	63	4.0%	(1/25)	58	16.7%	(3/18)
London Chest	87	45.8%	(33/72)	107	47.3%	(43/91)	124	56.5%	(61/108)
Newham	88	14.8%	(4/27)	81	11.1%	(2/18)	114	16.7%	(6/36)
North Middlesex	89	18.9%	(10/53)	107	14.3%	(6/42)	149	9.8%	(6/61)
Northwick Park	152	7.7%	(5/65)	127	9.3%	(4/43)	120	9.8%	(5/51)
Princess Royal	64	19.4%	(6/31)	87	31.4%	(11/35)	87	9.8%	(4/41)
Queen Elizabeth	121	34.5%	(20/58)	133	29.6%	(16/54)	150	12.5%	(7/56)
Queen's	166	14.9%	(7/47)	146	12.3%	(7/57)	150	6.0%	(3/50)
Royal Free	115	45.2%	(33/73)	129	38.8%	(31/80)	110	41.2%	(28/68)
Royal London	98	30.8%	(12/39)	100	20.0%	(8/40)	122	20.0%	(12/60)
St George's	171	37.9%	(36/95)	188	42.6%	(46/108)	200	38.7%	(46/119)
St Helier	59	4.3%	(1/23)	59	9.1%	(2/22)	78	17.2%	(5/29)
St Mary's	68	11.1%	(3/27)	73	32.0%	(8/25)	81	30.0%	(9/30)
St Thomas'	89	40.0%	(16/40)	97	42.0%	(21/50)	114	39.0%	(23/59)
The Heart	21	72.2%	(13/18)	24	70.0%	(14/20)	17	66.7%	(10/15)
University College Hospital	62	28.6%	(6/21)	51	42.1%	(8/19)	44	27.3%	(6/22)
Lewisham	100	26.7%	(8/30)	79	20.8%	(5/24)	80	19.0%	(4/21)
West Middlesex	91	25.0%	(9/36)	85	29.0%	(9/31)	79	23.5%	(8/34)
Whipps Cross	98	7.3%	(3/41)	106	21.2%	(11/52)	112	13.2%	(5/38)
Whittington	70	31.0%	(9/29)	51	19.2%	(5/26)	45	24.0%	(6/25)
Other Hospitals	3	-	-	9	50.0%	(2/4)	10	33.3%	(1/3)

⁺ Denominators exclude patients with unknown survival outcomes.

Appendix 4: Rhythm and survival per Heart Attack Centre for resuscitated patients with a STEMI

Heart Attack Centre	Number of Patients	Initial Rhythm			Survival to discharge ⁺
		Asystole	VF/VT	PEA	
Hammersmith*	52	7.7% (4)	71.2% (37)	17.3% (9)	46.01% (23/50)
Harefield	53	18.9% (10)	67.9% (36)	13.2% (7)	49.1% (26/53)
King's College*	50	20.0% (10)	66.0% (33)	12.0% (6)	48.9% (23/47)
London Chest	91	19.8% (18)	70.3% (64)	9.9% (9)	57.1% (52/91)
Royal Free	40	20.0% (8)	62.5% (25)	17.5% (7)	34.2% (13/38)
St George's	48	20.8% (10)	70.8% (34)	8.3% (4)	45.7% (21/46)
St Thomas'	12	8.3% (1)	75.0% (9)	16.7% (2)	60.0% (6/10)
The Heart	16	25.0% (4)	62.5% (10)	12.5% (2)	62.5% (10/16)

* 3 patients had no initial rhythm documented; 2 taken to Hammersmith and 1 to King's College.

+ Denominators exclude patients with unknown survival outcomes.

Appendix 5: Patient characteristics, response times, and outcomes per Clinical Commissioning Group

Incident CCG	Number of Patients	Age	Male %	Median 999 Call – Scene	Bystander CPR*	Presumed cardiac	Shockable Initial Rhythm	ROSC sustained to hospital	Survived to discharge ⁺
Barking & Dagenham	128	64	54.7% (70)	07:46	56.9% (58/102)	90.6% (116)	20.3% (26)	34.4% (44)	3.3% (4/122)
Barnet	204	69	60.8% (124)	08:17	66.3% (116/175)	87.3% (178)	18.6% (38)	27.0% (55)	5.4% (11/204)
Bexley	149	72	61.7% (92)	07:03	59.7% (71/119)	88.6% (132)	18.8% (28)	27.5% (41)	5.4% (8/149)
Brent	173	66	61.3% (106)	07:13	53.1% (76/143)	89.0% (154)	16.8% (29)	28.3% (49)	7.0% (12/172)
Bromley	202	70	63.4% (128)	08:18	62.6% (102/163)	88.6% (179)	18.3% (37)	33.2% (67)	9.0% (18/200)
Camden	101	65	66.3% (67)	07:00	60.9% (53/87)	88.1% (89)	25.7% (26)	35.6% (36)	13.0% (13/100)
Central London	113	64	74.3% (84)	06:57	72.6% (69/95)	84.1% (95)	23.0% (26)	31.0% (35)	13.4% (15/112)
City & Hackney	155	64	61.3% (95)	07:31	68.5% (85/124)	81.9% (127)	17.4% (27)	33.5% (52)	9.9% (15/152)
Croydon	206	68	58.7% (121)	08:00	65.0% (104/160)	90.3% (186)	18.9% (39)	27.7% (57)	7.0% (14/200)
Ealing	188	68	67.0% (126)	08:06	64.7% (97/150)	89.9% (169)	19.7% (37)	33.0% (62)	10.2% (19/186)
Enfield	190	64	63.7% (121)	07:50	69.0% (109/158)	82.1% (156)	15.3% (29)	33.7% (64)	9.5% (18/190)
Greenwich	154	63	63.0% (97)	07:27	62.3% (76/122)	84.4% (130)	18.8% (29)	29.2% (45)	6.0% (9/151)
Hammersmith & Fulham	85	68	69.4% (59)	07:29	67.6% (48/71)	85.9% (73)	18.8% (16)	34.1% (29)	8.3% (7/84)
Haringey	139	61	62.6% (87)	08:03	58.5% (69/118)	77.7% (108)	19.4% (27)	31.7% (44)	8.0% (11/137)
Harrow	129	72	61.2% (79)	08:12	59.8% (67/112)	95.3% (123)	14.7% (19)	33.3% (43)	8.6% (11/128)
Havering	163	71	63.2% (103)	07:24	60.8% (79/130)	92.0% (150)	12.9% (21)	32.5% (53)	4.7% (7/150)
Hillingdon	216	67	62.5% (135)	07:50	70.9% (129/182)	90.3% (195)	25.5% (55)	35.6% (77)	12.1% (26/214)
Hounslow	137	69	64.2% (88)	07:41	58.4% (66/113)	86.1% (118)	19.0% (26)	29.9% (41)	10.3% (14/136)
Islington	106	59	63.2% (67)	07:29	62.9% (56/89)	73.6% (78)	17.9% (19)	37.7% (40)	14.3% (15/105)
Kingston	76	65	67.1% (51)	06:42	67.2% (45/67)	85.5% (65)	26.3% (20)	38.2% (29)	12.2% (9/74)
Lambeth	165	63	63.6% (105)	07:06	60.3% (79/131)	77.6% (128)	17.6% (29)	38.2% (63)	10.4% (17/164)
Lewisham	146	64	60.3% (88)	08:05	58.8% (70/119)	79.5% (116)	14.4% (21)	23.2% (34)	7.6% (11/145)
Merton	100	67	61.0% (61)	07:24	66.7% (52/78)	90.0% (90)	21.0% (21)	31.0% (31)	13.1% (13/99)
Newham	186	63	60.8% (113)	07:19	65.4% (100/153)	89.8% (167)	18.3% (34)	30.6% (57)	9.8% (18/183)
Redbridge	180	69	60.0% (108)	07:26	65.2% (103/158)	84.4% (152)	17.8% (32)	35.6% (64)	11.9% (21/177)
Richmond	84	72	75.0% (63)	08:04	69.8% (44/63)	88.1% (74)	25.0% (21)	32.1% (27)	8.9% (7/79)
Southwark	136	60	61.0% (83)	07:08	59.1% (68/115)	81.6% (111)	16.2% (22)	27.2% (37)	12.6% (17/135)
Sutton	126	67	62.7% (79)	07:31	59.4% (57/96)	87.3% (110)	15.9% (20)	30.2% (38)	6.3% (8/126)
Tower Hamlets	116	62	69.8% (81)	07:46	62.3% (66/106)	75.9% (88)	17.2% (20)	25.0% (29)	6.9% (8/116)
Waltham Forest	167	65	59.9% (100)	08:09	60.7% (85/140)	87.4% (146)	16.2% (27)	28.1% (47)	7.4% (12/163)
Wandsworth	129	66	61.2% (79)	07:17	61.8% (68/110)	85.3% (110)	19.4% (25)	28.7% (37)	11.7% (15/128)
West London	105	63	61.0% (64)	07:14	60.9% (53/87)	81.0% (85)	21.0% (22)	33.3% (35)	10.5% (11/105)
Out of London	6	69	83.3% (5)	12:57	80.0% (4/5)	83.3% (5)	50.0% (3)	16.7% (1)	0.0% (0/6)

* Figures exclude arrests witnessed by LAS staff.

+ Denominators exclude patients with unknown survival outcomes.

Appendix 6: Cardiac arrest patients under 35 years old

	Under 1	1-8	9-18	19-35
Number of patients:	64	42	41	251
Gender:				
Male	53.1% (34)	54.8% (23)	73.2% (30)	70.5% (177)
Female	45.3% (29)	45.2% (19)	26.8% (11)	29.5% (74)
Unknown	1.6% (1)	-	-	-
Arrest location:				
Private	89.1% (57)	78.6% (33)	58.5% (24)	56.6% (142)
Public	10.9% (7)	21.4% (9)	41.5% (17)	43.4% (109)
Witnessed[◇]:				
Bystander	28.1% (18)	31.0% (13)	43.9% (18)	39.0% (98)
LAS staff	10.9% (7)	11.9% (5)	17.1% (7)	14.7% (37)
Unwitnessed	60.9% (39)	54.8% (23)	39.0% (16)	45.8% (115)
Not Documented	-	2.3% (1)	-	0.4% (1)
Bystander CPR*:				
Yes	63.2% (36/57)	59.5% (22/37)	70.6% (24/34)	70.1% (150/214)
No	36.8% (21/57)	40.5% (15/37)	29.4% (10/34)	29.9% (64/214)
Rhythm:				
Asystole	64.1% (41)	69.0% (29)	61.0% (25)	59.8% (150)
PEA	10.9% (7)	23.8% (10)	17.1% (7)	19.1% (48)
VF/ Pulseless VT	1.6% (1)	2.4% (1)	14.6% (6)	19.9% (50)
Not Documented	23.4% (15)	4.8% (2)	7.3% (3)	1.2% (3)
ROSC sustained to hospital:				
Yes	14.1% (9)	19.0% (8)	19.5% (8)	30.7% (77)
No	85.9% (55)	81.0% (34)	80.5% (33)	69.3% (174)
Survived to discharge⁺:				
Yes	6.8% (4/59)	12.5% (5/40)	10.0% (4/40)	15.0% (37/247)
No	93.2% (55/59)	87.5% (35/40)	90.0% (36/40)	85.0% (210/247)

◇ Totals for Under 1 and 19-35 year olds do not equal 100% due to rounding.

* Figures exclude arrests witnessed by LAS staff.

+ Denominators exclude patients with unknown survival outcomes.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29 September 2015
Document Title:	Finance Report Month 05 - Part 1 & 2
Report Author(s):	Director of Finance and Performance
Presented by:	Andrew Grimshaw
Contact Details:	02077832041
History:	<i>EMT, Finance & Investment Committee</i>
Status:	<i>To note the paper</i>
Background/Purpose	
Statement of Comprehensive Income	
<p>In Month the position is on plan while year to date the Trust is reporting a £1m adverse variance from plan. Based on this performance achieving the year end forecast deficit of £9.5m is challenged.</p> <p>The adverse position is driven by:</p> <ul style="list-style-type: none">• Income reduction provision of £0.7m related to a >2% reduction in Cat C activity as per the CCG contract• Additional Frontline Pay spend related to higher than expected incentive rates to maintain capacity and extended periods of unproductive time for new starters (e.g. supervision for international paramedics)• £0.5m additional pressure due to unidentified CIP not delivered.	
Statement of Position	
<p>Capital Expenditure is as planned.</p>	
Statement of Cashflow	
<p>Cash is £3.1m below plan. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July resulting in lower than expected cash being received in this period. Payment is expected in September. CBRN funding is still being negotiated. The £18m transformation funding is contracted to be paid quarterly in arrears, this will place additional stress on our cash flow throughout the year.</p>	
Action required	
<p>Note the financial position reported as at Month 5 (August) 2015</p>	

Assurance

The reporting of the financial position is as follows:

Timely: the report relates to the latest financial period (Month 5 – August)

Accurate: The report covers all core financial statements and key issues and conforms to all accounting rules and regulations.

All reports have been submitted to respective internal and external stakeholders within agreed timescales.

Key implications and risks arising from this paper

Clinical and Quality	
Performance	
Financial	x
Governance and Legal	x
Equality and Diversity	
Reputation	
Other	

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

**London Ambulance Service NHS Trust
Finance Report - Part 1 – 2015/16
Month 5: August**

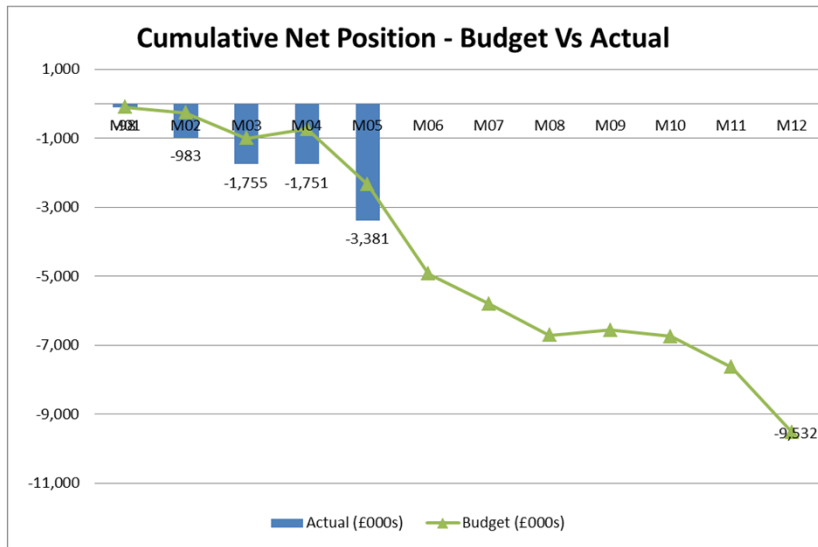
**EMT Meeting – 22 September 2015
Trust Board – 29th September 2015**

Andrew Grimshaw
Finance Director

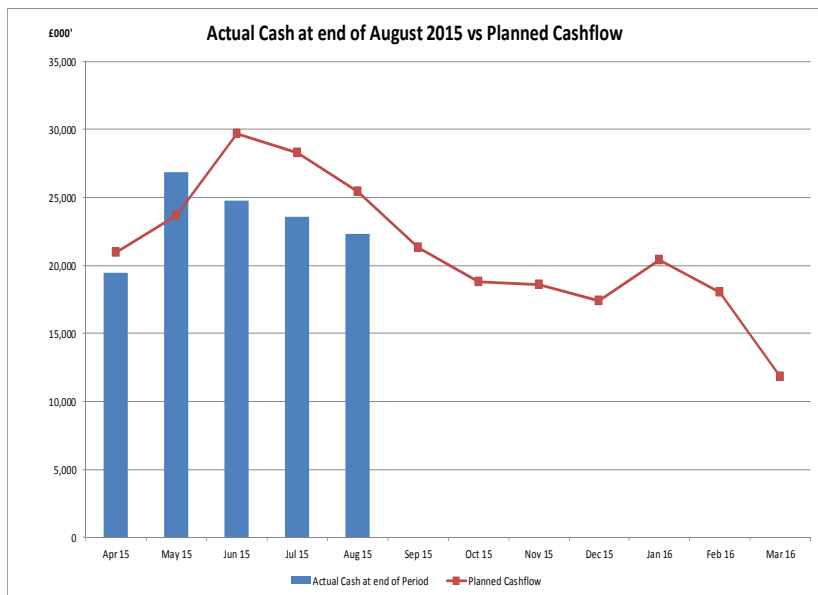
Finance Summary: M5 (2015/16)

Financial Indicator	Summary Performance	Current Month	Previous month
Surplus	In month the position is on plan while year to date the Trust is reporting a £1m adverse variance from plan. Based on this performance achieving the year end forecast deficit of £9.5m is challenged. The Trust has revised its plan in line with NTDA guidance and committed to additional savings of £0.5m. This will be reflected in future reports.	RED	RED
	The adverse position is driven by: <ul style="list-style-type: none"> Income reduction provision of £0.7m related to a >2% reduction in Cat C activity as per the CCG contract Additional Frontline Pay spend related to higher than expected incentive rates to maintain capacity and extended periods of unproductive time for new starters (e.g. supervision for international paramedics) £0.5m additional pressure due to unidentified CIP not delivered. 		
Income	Income is £0.2m adverse in Month and £0.7m adverse year to date. The key drivers for this position are: <ul style="list-style-type: none"> Income reduction provision of £0.75m related to a >2% reduction in Cat C activity as per the CCG contract Adjustments to projected 111 and PTS income. These are partially offset by reduced expenditure. 	AMBER	AMBER
Expenditure (incl. Financial Charges)	In Month expenditure is £0.2m favourable to plan, and year to date £0.3m adverse. The key drivers for this position are: <ul style="list-style-type: none"> Additional Frontline Resourcing costs (Primarily Overtime in Frontline and EOC Rosters, Incentives and PAS) £0.5m additional pressure due to unidentified CIP not delivered. Partially offset by £1.75m of planned creditors released to support the position. 	AMBER	AMBER
	The Trust's main cost pressures arise from additional frontline resourcing costs. There are 2 key drivers for the additional expenditure: <ul style="list-style-type: none"> Additional incentive rates being offered to maintain capacity to deliver required performance trajectories. Higher than expected rates of unproductive time relating to the Training and supervision of EACs and international paramedics. This has required the use of further flexible resource to maintain capacity (Incentives, Overtime and PAS). 		
CIPs	CIP is £0.5m adverse to plan due to unidentified savings programmes required due to the reduction in CBRN funding (£3.0m). This represents a £0.4m additional contribution towards the unidentified CIP of £0.9m YTD. The full year plan of £8.4m is still expected to be achieved once additional schemes are implemented. Further, efficiencies and cost control are being developed to close the remaining gap. As part of the revised plan the CIP target will increase by £0.5m in month 6 reports.	RED	RED
Balance Sheet	Capital Expenditure is as planned. The Capital position has been reviewed as regards the taking up of a £6.0m Capital loan. The Trust has decided not to obtain the loan and manage within its internally generated resources.	AMBER	AMBER
Cashflow	Cash is £3.1m below plan. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July resulting in lower than expected cash being received in this period. Payment is expected in September. CBRN funding is still being negotiated. The £18m transformation funding is contracted to be paid quarterly in arrears, this will place additional stress on our cash flow throughout the year.	AMBER	AMBER

Executive Summary - Key Financial Metrics



Description	2015/16 - Month 5			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000	£000	£000	£000	£000
			fav (adv)			fav (adv)	
Dept Health							
Surplus / (Deficits)	(1,608)	(1,629)	(21)	(2,345)	(3,378)	(1,033)	(9,531)
EFL				(10,747)	(7,612)	(3,135)	8,648
CRL				4,482	4,480	2	20,664
Suppliers paid within 30 days - NHS	95%	84%	(11.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	91%	(4.0%)	95%	88%	(7.0%)	95%
Monitor							
EBITDA %	-0.5%	-0.8%	(0.4%)	3.8%	2.7%	(1.0%)	6.3%
EBITDA on plan	(123)	(212)	(88)	4,921	3,581	(1,340)	8,356
Net Surplus	(1,608)	(1,629)	(21)	(2,345)	(3,378)	(1,033)	(9,531)
NRAF (net return after financing)				-1.69%	-2.44%	(0.8%)	-6.90%
Liquidity Days				0.80	(0.53)	(1.33)	(10.86)
CSRR (Continuity of Service Risk Rating)				4.0	3.0	1.0	3.0



- In Month the position is on plan while year to date the Trust is reporting a £1m adverse variance from plan. Based on this performance achieving the year end forecast deficit of £9.5m is challenged.
- On-going pressures are:
 - Additional spend in support of performance.
 - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
 - Identification and delivery of CIPs.
 - Reduced income recovery due to Cat C under-performance.
- Cash is £3.1m below plan. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July resulting in lower than expected cash being received in this period. Payment is expected in September. CBRN funding is still being negotiated.
- The EFL variance is due to lower than planned cash balances.
- The Trust would expect to score a Continuity of Service Risk Rating (CSRR) of 3 for the YTD results based on the current Monitor metrics (maximum rating). The cause of the variance from plan is that the current asset (excluding inventories) to current liabilities ratio has become negative in August.
- CRL position – The capital plan is on target.
- The Trust has revised its plan in line with NTDA guidance and committed to additional savings of £0.5m. This will be reflected in future reports.

Statement of Comprehensive Income

Statement of Comprehensive Inc. 2015/16 - Month 5

2015/16 - Month 5			Description	Year to Date			FY 2015/16
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000		£000	£000	£000	£000
		fav/(adv)				fav/(adv)	
Income							
22,718	22,538	(180)	Income from Activities	117,889	116,993	(896)	282,370
2,553	2,536	(17)	Other Operating Income	13,330	13,534	204	30,944
25,271	25,074	(197)	Subtotal	131,219	130,527	(692)	313,315
Operating Expense							
19,122	19,829	(707)	Pay	95,517	96,183	(666)	234,564
6,272	5,457	816	Non Pay	30,781	30,763	18	70,395
25,394	25,286	108	Subtotal	126,298	126,946	(648)	304,959
(123)	(212)	(88)	EBITDA	4,921	3,581	(1,340)	8,356
-0.5%	-0.8%	-0.4%	EBITDA margin	3.8%	2.7%	(1.0%)	2.7%
Depreciation & Financing							
1,136	1,074	63	Depreciation	5,522	5,240	282	13,657
304	297	7	PDC Dividend	1,519	1,486	33	3,646
45	47	(2)	Interest	226	233	(7)	581
1,485	1,418	67	Subtotal	7,267	6,960	307	17,885
(1,608)	(1,629)	(21)	Net Surplus/(Deficit)	(2,345)	(3,378)	(1,033)	(9,529)
(6.4%)	-6.5%	-0.1%	Net margin	-1.8%	-2.6%	-0.8%	-3.0%

Income

- Income is £0.2m adverse in Month and £0.7m adverse YTD. This relates to:
- £0.75m income reduction provision related to a >2% reduction in Category C income as per the CCG core contract.
- The Trust is currently expecting £4.3m related to CBRN income in its position. However, this has not been confirmed. Consideration will need to be made around continuing to accrue for this income in month 6.

Operating Expenditure (excl. Depreciation and Financing)

- Overall £0.1m favourable in Month and £0.6m adverse YTD primarily due to:
 - Additional Frontline Resourcing costs of £1.6m. This is driven by 2 main factors – additional incentive rates to maintain capacity to deliver required performance levels and higher than expected unproductive hours related to the Training and supervision of new recruits (EACs and International Paramedics)
 - There is currently some variability in the reporting of Overtime and Incentives due to the complex nature of the arrangements, timing of claims and redesign of rostering systems. Finance are continually reviewing and monitoring these areas to mitigate this.
- £0.5m additional pressure due to unidentified CIP not delivered. This is related to the reduction in CBRN Income of £3.0m per annum
- Partially offset by £1.75m of planned reserve releases to support the position.

Depreciation and Financing

- Overall Financial Charges are £0.1m favourable in Month and £0.3m favourable YTD due to minor delays in the Capital Programmes

Divisional Expenditure (excludes Income)

Divisional Expenditure 2015/16 - Month 5							
2015/16 - Month 5			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000	£000	£000	£000	£000	
fav/(adv)			fav/(adv)				
Operational Divisions							
12,445	13,595	(1,150)	Core Frontline (Rostered)	61,720	65,704	(3,983)	149,298
1,381	1,457	(75)	Core Frontline (Non Rostered)	6,414	7,317	(903)	15,394
0	0	0	Other Frontline	0	0	0	0
1,868	1,935	(67)	EPRR	9,332	8,214	1,118	22,421
0	0	0	Resource Centre	0	0	0	0
2,188	2,055	133	EOC	10,939	10,825	114	26,254
182	285	(103)	PTS	1,284	1,513	(230)	2,340
383	297	86	NETS	1,721	1,098	623	5,700
566	450	116	111 Project	2,792	2,467	325	6,885
19,014	20,075	(1,061)	Subtotal	94,202	97,139	(2,936)	228,291
Support Services							
2,229	2,062	168	Fleet & Logistics	11,021	10,685	336	26,500
953	937	16	IM&T	4,765	4,747	18	11,384
349	361	(12)	HR	1,744	1,909	(164)	4,187
0	0	0	Education & Development	0	0	0	0
794	689	105	Estates	3,941	3,850	90	9,683
19	1	18	Support Services Management	94	111	(17)	226
4,343	4,050	294	Subtotal	21,565	21,302	263	51,979
Corporate							
234	285	(51)	Chief Executive & Chair	1,173	1,133	40	2,810
297	321	(24)	Corporate Services	1,487	1,630	(143)	3,568
0	0	0	Business Development	0	0	0	0
82	85	(3)	Strategic Communication	409	391	19	982
254	188	66	Finance	1,272	1,650	(377)	3,051
14	0	14	Project Management	71	43	28	170
24	45	(20)	Nursing & Quality	615	612	3	1,477
213	334	(121)	Transformation & Strategy	1,066	1,450	(384)	2,559
869	854	15	Clinical Education & Standards	4,347	3,904	444	10,434
108	130	(21)	Medical	538	530	8	1,296
2,097	2,243	(145)	Subtotal	10,979	11,342	(362)	26,348
Central							
1,418	336	1,082	Central Corporate	6,783	4,087	2,696	16,142
7	1	6	Other Central Costs	35	40	(5)	84
1,425	338	1,088	Subtotal	6,818	4,127	2,691	16,226
26,880	26,705	175	TOTAL	133,565	133,909	(344)	322,843
25,271	25,074	(197)	Income Memorandum	131,219	130,527	(692)	313,315
(1,608)	(1,630)	(22)	NET POSITION MEMORANDUM	(2,345)	(3,381)	(1,036)	(9,529)

Operational Divisions

- Expenditure is currently £2.9m adverse YTD
- Frontline Spend is Currently £4m adverse due to ongoing performance pressures (and additional use of overtime and PAS) and the requirements for additional incentive rates.
- The Non-Rostered Frontline is £0.9m adverse to plan due to the pending allocation of staff in the Operational Management restructure. This is offset by favourable positions in other operational areas notable EOC and EPRR.
- This is currently offset by underspends in EPRR (£1.1m) and NETS (Non Emergency Transport Service) (£0.6m). Spend is expected to increase in these areas as Transformation programmes are fully implemented.
- PTS is currently making a small loss (£0.2). The management team are reviewing current operations to minimise this impact.
- The NETs service is still being developed and Capacity pressure will be seen in Core frontline until this has been fully implemented.

Support Services

- Support Services is favourable to plan £0.3m
- Fleet is underspent £0.3m YTD mainly due to variation in maintenance spending.
- HR are overspent £0.2m due to additional double running costs associated with the new Occupational Health arrangements. This ceased at month 4 and costs have now been returned to normal rates.

Corporate

- Overall Corporate divisions are £0.4m adverse to plan
- Corporate Services is £0.1m overspent due partly to the CQC related costs in Q1.
- Finance is £0.4m overspent due to Planned consultancy costs in Performance as part of the Transformation programme. The current overspend is driven by timing differences in the budget phasing.
- Transformation and Strategy is overspent (£0.4m) due to additional agency costs in the contracting team which will continue subject to an imminent restructure.
- Clinical education is underspent by £0.4m due to timing differences between Transformation programme roll out and budget phasing

Central

- Central Corporate is favourable mainly due to the allocation of central budgets to divisional positions
- Planned Creditors of £1.75m have been released YTD in order to support the operational position.
- In addition £0.9m of other reserves have been released

Income

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

Cost Improvement Programme

Description	Year to Date			FY 2015/16		
	Budg	Act	Var	Budg	Fcast	Var
	£000	£000	£000	£000	£000	£000
Core CIP						
			fav/(adv)			fav/(adv)
Fleet - Winter tyres	125	276	151	250	276	26
Fleet - Fuel	100	207	107	240	240	0
Fleet - Accident damage	35	153	118	153	153	0
Estate - Rev to Cap	75	75	0	180	180	0
Estate - New Sites	50	0	(50)	120	120	0
Estate - Energy	25	0	(25)	60	60	0
Estate - Site Disposal	10	0	(10)	24	24	0
Estate - Various	50	50	0	180	180	0
IMT - Contracts	75	250	175	180	315	135
IMT - Phones	85	10	(75)	204	204	0
IMT - Staffing	25	0	(25)	78	0	(78)
IMT - MFD	0	0	0	35	35	0
Corporate - HR	50	0	(50)	120	120	0
Corporate - EMT	90	187	97	216	216	0
Procurement - Supplier Management	85	342	257	260	341	81
Procurement - Substitution	10	10	0	105	105	0
Procurement - Stores	70	70	0	315	315	0
Frontline - Action 1	70	0	(70)	620	620	0
Frontline - Action 2	875	923	48	2,100	2,100	0
Support - Action 3	44	0	(44)	198	198	0
Support - Action 4	185	0	(185)	561	561	0
Other CIP Programmes	935	31	(904)	2,250	2,085	(165)
Total Core CIP	3,069	2,584	(485)	8,449	8,450	1

- CIPs are currently adverse to plan by £0.5m
- A detailed review of CIP was undertaken in Month 4 against existing programmes and identifying any new opportunities.
- Overall the review shows an improved position for Month 5 as the gap related to Other unidentified CIP programmes (£0.9m) has been reduced by £0.4m due to other areas of delivery.
- Fleet delivery is currently exceeding expectations as tyre budgets are managed and contracts are reviewed. In addition, fuel prices continue to stay low and newer vehicles have improved fuel efficiency.
- Estate delivery is broadly on track except for the sale of an existing site which is being developed and a decision will be made later in the year.
- IM&T are delivering overall mainly due to the renegotiation and tighter management of new and existing contracts.
- Corporate – HR is currently in the process of a restructure in which savings are being explored but are not yet developed. EMT and Senior management posts have been restricted and removed.
- Procurement – Price, Volume and Stock Management initiatives continue to deliver as planned
- Frontline – the Trust continues to deliver productivity in its Team Leader cohort. All frontline staffing issues remain under review as part of the Transformation programme and Operational Management restructure.

Statement of Financial Position: YTD

	Mar-15						Aug-15		
	Act	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Plan	Var	%
	£000	£000	£000	£000	£000	£000			
Non Current Assets									
Property, Plant & Equip	134,668	134,833	134,839	134,967	135,439	134,933	134,572	361	0.27%
Intangible Assets	10,634	10,371	10,159	9,894	9,828	9,607	9,695	(88)	-0.91%
Trade & Other Receivables	0	0	0	0	0	0	0	0	
Subtotal	145,302	145,204	144,998	144,861	145,267	144,540	144,267	273	0.19%
Current Assets									
Inventories	3,026	3,047	3,056	3,042	3,041	3,045	3,028	17	0.56%
Trade & Other Receivables	33,813	27,718	20,714	20,430	21,170	21,200	15,284	5,916	38.71%
Cash & cash equivalents	14,699	19,452	26,814	24,757	23,556	22,311	25,446	(3,135)	-12.32%
Non-Current Assets Held for Sale	101	101	101	101	101	101	101	0	
Total Current Assets	51,639	50,318	50,685	48,330	47,868	46,657	43,859	2,798	6.38%
Total Assets	196,941	195,522	195,683	193,191	193,135	191,197	188,126	3,071	1.63%
Current Liabilities									
Trade and Other Payables	(39,303)	(38,131)	(39,058)	(37,265)	(37,142)	(37,564)	(35,660)	(1,904)	5.34%
Provisions	(7,357)	(7,260)	(7,281)	(7,281)	(7,281)	(6,399)	(4,388)	(2,011)	45.83%
Borrowings	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	
Net Current Liabilities	(46,660)	(45,391)	(46,339)	(44,546)	(44,423)	(43,963)	(40,048)	(3,915)	9.78%
Non Current Assets plus/less net current assets/Liabilities	150,281	150,131	149,344	148,645	148,712	147,234	148,078	(844)	-0.57%
Non Current Liabilities									
Trade and Other Payables	0	0	0	0	0	0	0	0	
Provisions	(9,963)	(9,911)	(10,010)	(10,082)	(10,145)	(10,297)	(10,116)	(181)	1.79%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	
Total Non Current Liabilities	(10,070)	(10,018)	(10,117)	(10,189)	(10,252)	(10,404)	(10,223)	(181)	1.77%
Total Assets Employed	140,211	140,113	139,227	138,456	138,460	136,830	137,855	(1,025)	-0.74%
Financed by Taxpayers Equity									
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	0	0.00%
Retained Earnings	30,746	30,648	29,762	28,991	28,995	27,365	28,390	(1,025)	-3.61%
Revaluation Reserve	47,368	47,368	47,368	47,368	47,368	47,368	47,368	0	0.00%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	140,211	140,113	139,227	138,456	138,460	136,830	137,855	(1,025)	-0.74%

Non Current Assets

- Non current assets stand at £144.5m, a £0.3m above plan.

Current Assets

- Current assets stand at £46.7m, a £2.8m above plan.
- Cash position as at August is £22.3m, a £3.1m below plan. This is due to a higher than planned trade & other receivables, provision balances and trade & other payables. Delays in agreeing the service level agreement for the accident and emergency services contracts means that the transformation and CQUIN funding for the 1st quarter of the year was invoiced in July. Payment is expected in September. CBRN funding is still being negotiated.
- Within Trade & Other Receivables, Receivables (debtors) at £5.4m are £0.3m below plan, accrued income at £11.3m is £6.3m above plan and prepayments at £4.4m are £0.1m below plan. The reason for the higher than planned accrued income is the delays in agreeing the service level agreement (SLA) for the accident and emergency service. Under the new SLA invoicing arrangements invoices are raised quarterly in arrears. Also we are accruing for the CBRN income as the contract is still being negotiated.

Current Liabilities

- Current liabilities stand at £44.0m, a £3.9m increase on plan.
- Payables and accruals at £37.6m are £1.9m above plan.
- The Trust has a high volume of unapproved trade payables at £4.1m.
- Current provisions at £6.4m are £2.0m higher than plan. The Trust is waiting for the final bills from the police and army for their support during the strike. Also the Trust has not incurred any redundancy costs associated with the first stages of the management restructure.

Non Current Liabilities

- Non current provisions and borrowings are £0.2m above plan.

Taxpayers Equity

- Taxpayers Equity stands at £136.8m, a £1.0m lower than plan.
- Retained Earnings at £27.4m, a £1.0m lower than plan. The Trust has a higher than planned year to-date deficit.

Cashflow Statement YTD

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD Move	YTD Plan	Var
	Actual	Actual	Actual	Actual	Actual	Aug-15	Aug-15	Aug-15
	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	14,699	19,452	26,814	24,757	23,556	14,699	14,699	0
Operating Surplus	1,240	449	559	1,356	(258)	3,346	4,700	(1,354)
(Increase)/decrease in current assets	6,074	6,995	298	(739)	(34)	12,594	18,525	(5,931)
Increase/(decrease) in current liabilities	193	178	52	(430)	1,229	1,222	278	944
Increase/(decrease) in provisions	(160)	109	60	51	(741)	(681)	(2,872)	2,191
Net cash inflow/(outflow) from operating activities	7,347	7,731	969	238	196	16,481	20,631	(4,150)
Cashflow inflow/outflow from operating activities	7,347	7,731	969	238	196	16,481	20,631	(4,150)
Returns on investments and servicing finance	6	9	15	18	10	58	40	18
Capital Expenditure	(2,600)	(378)	(3,041)	(1,457)	(1,451)	(8,927)	(9,924)	997
Dividend paid	0	0	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0	0	0
Cashflow inflow/outflow from financing	(2,594)	(369)	(3,026)	(1,439)	(1,441)	(8,869)	(9,884)	1,015
Movement	4,753	7,362	(2,057)	(1,201)	(1,245)	7,612	10,747	(3,135)
Closing Cash Balance	19,452	26,814	24,757	23,556	22,311	22,311	25,446	(3,135)

Cash funds at 31 August stand at £22.3m, which is £3.1m below plan.

Operating Surplus

- The operating surplus is £1.4m lower than planned due to higher than planned deficit.

Current Assets

- The ytd movement on current assets is £12.6m, a £5.9m decrease on plan.
- Current assets movement was lower than planned due to an increase in accrued income £6.3m, decrease in receivables £0.3m and prepayments £0.1m.
- Accrued income includes CBRN funding that is still being negotiated but has not been guaranteed. The Trust will review the recognition of this income if assurances are not received.

Current Liabilities

- The ytd movement on current liabilities is £1.2m, a £0.9m increase on plan.
- Current liabilities movement was higher than planned due to increases in accruals £2.9m and decreases to trade and other payables £2.0m.

Provisions

- The ytd movement on provisions is £0.7m, a £2.2m increase on plan. The Trust is waiting for the final bills from the police and army for their support during the strike. Also the Trust has not incurred any redundancy costs associated with the first stages of the management restructure.

Capital Expenditure

- The ytd movement on Capital Expenditure payments is £8.9m, £1.0m lower than plan.
- The Trust was holding payment on some capital invoices due to issues on the quality of the goods delivered. As most of the issues have now been resolved payment will resume in September.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29 September 2015
Document Title:	Report from the Finance and Investment Committee (FIC)
Report Author(s):	Director of Finance
Presented by:	Chair of the FIC
Contact Details:	
History:	<i>This paper summarises the agenda for the FIC meeting of the 24 Sept for the Trust Board.</i>
Status:	<i>Assurance</i>
Background/Purpose	
This paper details the agenda for the FIC meeting of the 24 th Sept. It is not possible to prepare a detailed paper between this date on the Trust Board papers being issued. The Chairman of the FIC will update the Trust Board on key items discussed at the meeting and any items requiring approval.	
Action required	
To note the agenda for the FIC of 24 th Sept.	
Assurance	
This paper details the published agenda for the FIC.	

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

Trust Board 29th September 2015.**Report from the Finance and Investment Committee (24th Sept 2015).**

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

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

The Chairman of the FIC will provide a verbal update to the Trust Board at the meeting on the 29th September.

ITEM	SUBJECT	Purpose	Potential Action for Trust Board
FINANCIAL PERFORMANCE			
3.	3.1 Finance Report Month 05 15/16 3.2 Rolling 05 Months Cash Flow 3.3 Forecast 2014/15	Note Note Note	Note paper to Trust Board
FINANCIAL PLANNING			
4.	4.1 DCA Business Case Update 4.2 TDA request to Review 2015/16 Plan 4.3 Performance Improvement Plan Update	Note Note Note	Note issue of revised plan
FINANCIAL GOVERNANCE			
5.	5.1 Terms of Reference (ToR) 5.2 Review of Financial Policies	Approve Note	Note if FIC approved
OTHER FINANCIAL REPORTS FOR INFORMATION			
6.	6.1 Review of the Tax Strategy	Note	
PERFORMANCE			
7.	7.1 Performance Management Update	Note	
REPORTS FROM SUB-GROUPS			
8.	8.1 Procurement Update 8.2 Fleet Delivery Board 8.3 IM&T Strategy Update	Note Note Note	
ANY OTHER BUSINESS			
9.	9.1 Agenda Planner 2015/16	Note	



Report to:	London Ambulance Trust Board
Date of meeting:	29th September 2015
Document Title:	Board Assurance Framework and Trust Risk Register (Strategic Risks)
Report Author(s):	Frances Field, Risk and Audit Manager Mick Salami, Interim Risk and Audit Manager
Presented by:	Sandra Adams, Director of Corporate Affairs/Trust Secretary
Contact Details:	Sandra.adams@lond-amb.nhs.uk
This paper has been previously presented to:	Executive Management Team
Recommendation:	To review key risks to the Trust and to take assurance from the actions in place to mitigate the risks to achievement of the strategic objectives

Background/Purpose

The Board Assurance Framework (BAF) comprises the principal risks facing the Trust now and looking ahead to the potential risk and impact to the achievement of the strategic goals. These risks are regularly reviewed by the risk leads and additional mitigating actions identified where to reduce the level of risk further. The current risk register includes a number of longstanding risks and the Board will need to consider whether to accept/tolerate this level of risk for the foreseeable future. A risk awareness session planned for Autumn 2015 for board members will include this discussion. The key risks identified at present that would warrant such discussion are:

BAF risk number & concise description:

3 – front line turnover (April 14)

4 - resources vs demand (July 06)

7 – performance at shift changeover (Dec 06).

The EMT considered the risk register and BAF at the meeting on 16th September and agreed further review of these risks and to identify additional mitigating actions. The EMT also considered the following to represent the key risk areas currently facing the Trust and its strategic business objectives:

- Performance
- Maintaining the balance between safety & quality of service
- Staff morale
- Financial position.

Further consideration is being given to identifying the key emerging risks and any gaps in articulated risks from this.

The BAF format has been reviewed and is now presented in a more concise way mapped back to a heat map and to a risk trajectory. Over time, the Board should see a downward trajectory for each of the BAF principal risks.

Action required

To review key risks to the Trust and to take assurance from the actions in place to mitigate the risks

to achievement of the strategic objectives.

Implications

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

- Quality and patient engagement (Director of Nursing and Quality)
- Safety (Medical Director)
- Clinical Education (Director of Paramedic Education)
- Operations (Director of Operations)
- Financial (Director of Finance and Performance)
- Strategic (Director of Transformation and Strategy)
- Fleet and Logistics (Director of Finance and Performance)
- IM&T (Director of Finance and Performance)
- Human Resources (Director of Transformation and Strategy)
- Estates (Director of Director of Corporate Affairs/Trust Secretary)
- Governance (Director of Corporate Affairs/Trust Secretary)

Quality Framework

This paper supports the following domains of the quality framework:

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

LAS Objectives

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

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

Equality Analysis

Has an Equality Analysis been carried out?

- Yes
- No

Key issues from the assessment:

Board Assurance Framework and Corporate Risk Register

September 2015

The Board Assurance Framework (BAF) comprises the principal risks facing the Trust now and looking ahead to the potential risk and impact to the achievement of the strategic goals. Principal risks here are described as having a gross rating of >16 and each is mapped to at least one of the 4 strategic business objectives. Risks on the corporate risk register are reviewed regularly and updated at least quarterly which then informs the BAF which is presented to the Executive Management Team (EMT) each month and to each Trust Board meeting in public.

The BAF format has been reviewed and updated to make it more concise and simpler to view. Each principal BAF risk has a control sheet and these are brought together on a heat map and risk trajectory. Over time, the Board should expect to see a downward trajectory for each risk as controls are enhanced and further actions taken to mitigate the level of risk being presented. Where a risk is still high despite the level of controls in place, advice will be given to the Board as to whether to accept and tolerate the current level of risk and how this will be monitored. The Board is due to undertake another strategic risk session in the Autumn 2015 and risk acceptance and tolerance will be included within this as there are a number of longstanding risks on the BAF that are likely to remain in place for the foreseeable future:

BAF risk number & concise description:

3 – front line turnover (April 14)

4 - resources vs demand (July 06)

7 – performance at shift changeover (Dec 06).

Key risk areas:

The EMT considered the risk register and BAF at the meeting on 16th September and agreed further review of these risks and to identify additional mitigating actions. The EMT also considered the following to represent the key risk areas currently facing the Trust and its strategic business objectives:

- Performance
- Maintaining the balance between safety & quality of service
- Staff morale
- Financial position.

The EMT is also considering the key emerging risks for further discussion and to review against the corporate risk register in order to identify and address any gaps in articulated risks.

The attached report summarises the key BAF and corporate risk activity since July 2015.

Sandra Adams
Director of Corporate Affairs/Trust Secretary

Changes to the Board Assurance Framework (BAF) since June 2015

The new format of the BAF was considered and approved by both the EMT and the Audit Committee in September 2015. Each BAF risk is now shown on a one-page control sheet.

A risk trajectory sheet has been introduced to show risk movement of the 'net risk' score for all BAF risk items. The risk trajectory sheet supports the Heat map and demonstrates the efficacy of actions applied by each directorate to mitigate their risks.

Trust Risk Register and Board Assurance Framework

A risk review was carried out by the Risk and Audit Manager in conjunction with risk owners during August – September 2015. There have been some additions and amendments to the Board Assurance Framework since the last Trust Board meeting in July 2015. The Executive Management Team reviewed the BAF risks on 16th September and will be undertaking a full review of the register within the next month. The top risks identified as currently facing the Trust were:

- Performance
- Managing the balance between maintaining safety and quality of service
- Staff morale
- Financial position.

These are reflected in the top scoring risks on the risk register and will inform the full review being undertaken by the EMT. Further work is being undertaken on emerging risks and identifying any gaps in articulated risks.

The attached extract from the risk register includes clinical risks incorporated within the Board Assurance Framework and risks with a net scoring of 15 and higher.

Current risk activity

The following risks were approved for addition to the Trust Risk Register by the Senior Management Team:

ID	Title	Initial			Target			Current			
		Impact	Likelihood	Risk Rating	Impact	Likelihood	Risk Rating	Impact	Likelihood	Risk Rating	
451	There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.	4	4	16	4	3	12	4	4	16	BAF risk 29
445	Risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence, resulting in potential	5	4	20	5	2	10	5	3	15	BAF risk 30 Since reviewed and due to be downgraded

	adverse consequence to the health of LAS staff and that of the general public to whom they are responding. reputational damage.											
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.	5	3	15		5	1	5		5	3	15
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	5	3	15		5	1	5		5	3	15
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.	5	3	15		5	1	5		5	3	15

The following risks were approved for re-grading between July and September 2015:

ID	Title	Initial			Target			Current			Change to rating since last review
		Impact	Likelihood	Risk Rating	Impact	Likelihood	Risk Rating	Impact	Likelihood	Risk Rating	
433	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	4	4	16	4	3	12	4	3	12	BAF risk 18 ↓
C. Gawne (Director of Strategic communication) proposed to regrade net rating from major x likely = 16 to major x possible = 12											
434	There is a risk that that new sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch). This could result in a lack of support by stakeholders: at best this would mean no support for change or growth programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage.	4	4	16	4	2	8	4	3	12	BAF risk 19 ↓
C. Gawne (Director of Strategic communication) proposed to regrade net rating from major x likely = 16 to major x possible = 12											
429	There is a risk that there are currently no arrangements in place for routine quality assurance of dispatch functions which may affect	4	5	20	4	2	8	4	5	20	BAF risk 28 ↑

<p>the quality of call management and the service provided to patients. Lack of QA for dispatch resulting in an unquantifiable level of risk from poor compliance with dispatch protocols.</p>												
<p>New Update – Proposed re-grading net rating from major x likely = 16 to major x almost certain = 20 in line with the gross rating</p>												

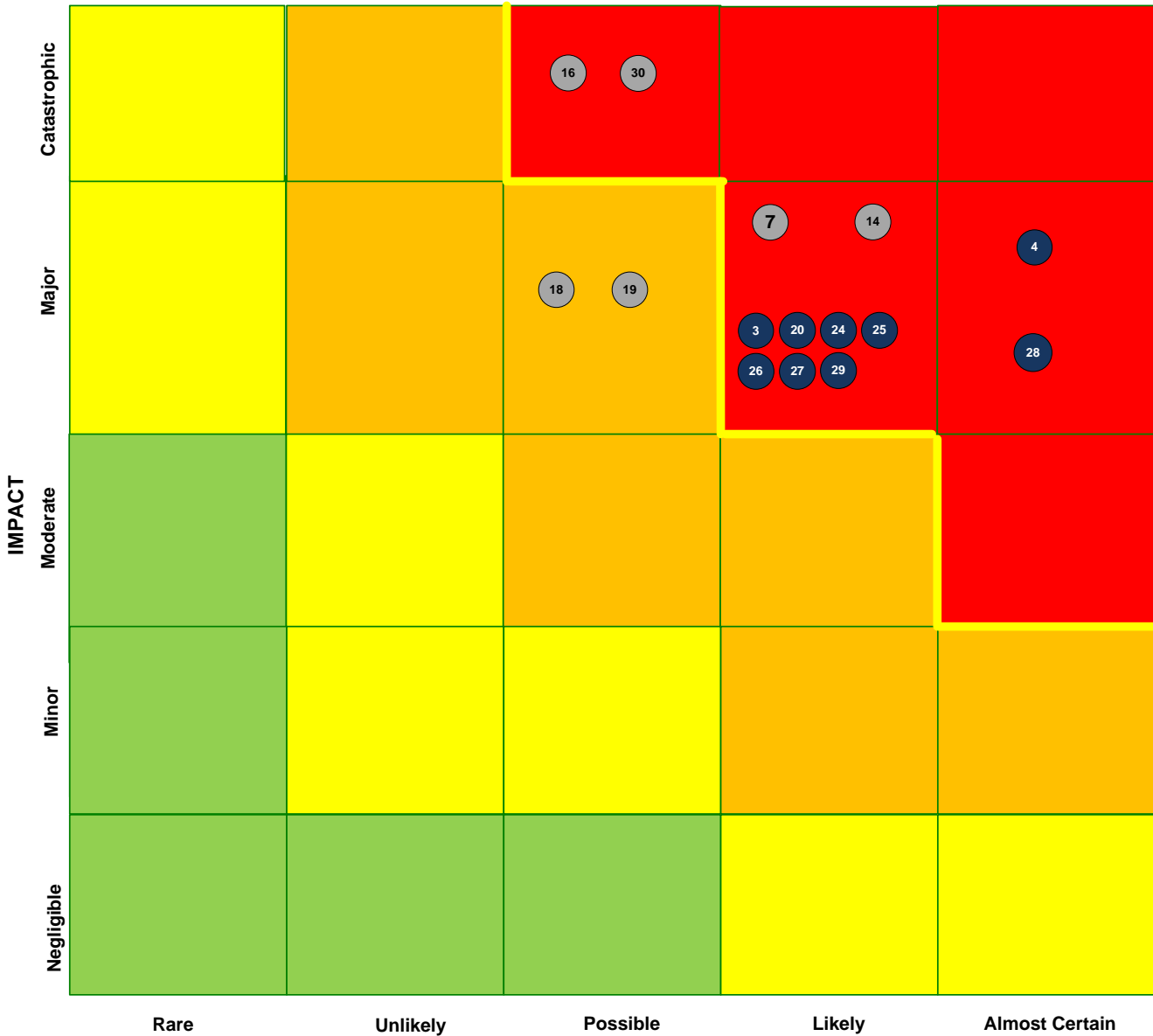
Sandra Adams
Director of Corporate Affairs/Trust Secretary

Mick Salami
Interim Risk and Assurance Manager

Frances Field
Risk and Assurance Manager

21st September 2015

Board Assurance Framework – September 2015



Key:

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

Risk Severity

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

- 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 7 - RR 269 Performance falls at staff changeover time
- BAF Risk 14 - RR 394 Developing and delivering cost improvements
- BAF Risk 16 - RR 410 Patient safety for category C patients
- BAF Risk 18 - RR 433 Staff engagement
- BAF Risk 19 - RR 434 Stakeholder engagement
- BAF Risk 20 - RR 440 Acquiring new 111 contracts as stated in the 5 year strategy
- BAF Risk 24 - RR 441 There may be insufficient vehicle numbers to meet demands
- BAF Risk 25 - RR 442 There may be insufficient range and volume of equipment on vehicles
- BAF Risk 26 - RR 443 Availability of equipment for frontline vehicles
- BAF Risk 27 - RR 444 Condition of equipment for frontline vehicles
- BAF Risk 28 - RR 429 No routine arrangements for quality assurance of dispatch in place
- New risk** BAF Risk 29 - RR 451 Lack of ring backs on delayed response calls
- BAF Risk 30 - RR 445 Exposure to category 4 infectious disease organisms

Risk trajectory since June 2015



Board Assurance Framework – Risk Trajectory

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

	*	CRR Ref	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	
PRINCIPAL RISK 3 Staff turnover	1	388	16		16	16	16		16	16		
PRINCIPAL RISK 4 Resources vs. demand	1	265	20		20	20	20		20	20		
PRINCIPAL RISK 7 Performance at changeover	1	269	16		16	16	16		16	16		
PRINCIPAL RISK 14 Delivery of cost improvement	3	394	16		16	16	16		16	16		
PRINCIPAL RISK 16 Category C patients	1	410			15	15	15		15	15		
PRINCIPAL RISK 18 Staff engagement	2, 4	433							16	12		
PRINCIPAL RISK 19 Stakeholder engagement	1	434	16		16	16	16		16	12		
PRINCIPAL RISK 20 Potential inability to win new NHS 111 contracts	1, 3	440	20			16	16		16	16		
PRINCIPAL RISK 24 Insufficient vehicle	1	441	-		-	-	16		16	16		
PRINCIPAL RISK 25 Insufficient volume of equipment	1	442	-		-	-	16		16	16		
PRINCIPAL RISK 26 Availability of equipment	1	443	-		-	-	16		16	16		
PRINCIPAL RISK 27 Effective equipment	1	444	-		-	-	16		16	16		
PRINCIPAL RISK 28 QA for dispatch functions	1	429	-		-	-	-		20	20		
PRINCIPAL RISK 29 Lack of ring back on delayed response calls	1	451	-		-	-	-		-	16		
PRINCIPAL RISK 30 Staff exposure to Cat C disease organism	2	445	-		-	-	-		-	15		

* Business Objective reference number.

Board Assurance Framework – September 2015

BAF Risk 3: Front line turnover increases by significant numbers

Risk Classification: Performance	Monitoring Committee:	Audit Committee		Gross Risk	Current or Net Risk	Target
Principal Risk Description: 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.	Last reviewed by committee on:	7 th Sept. 2015	Linked to Corporate Risk CRR No. 388	Impact	4	4
	Last reviewed by Director on:	21 st August 2015		Likelihood	4	4
	Date of next review	September 2015		Total Score	16	16
Risk Consequences: Staff - additional pressure on staff health and wellbeing, manifesting itself as increased sickness absence, increased stress and pressure, an increase in patient complaints, a reduction in patient and staff satisfaction and potentially increasing turnover further. Patients - reduction in the response times	Underlying Cause/Source(s) of Risk 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; 11. Dissatisfaction with relief rotas and working pattern.					
Existing Key Controls 1. NHS staff benefits (e.g. pensions, T&Cs, etc.) 2. LAS staff benefits (e.g. cycle scheme) 3. LAS retention staff benefits (EMT suggestions) 4. Listening into Action - to understand staff improvements. 5. Actively recruiting university and registered paramedics and emergency ambulance crew 6. The use of overtime, private and voluntary ambulance services to increase available resources. Impact on utilisation rate, i.e. to reduce it. 7. Clinical support provides career progression opportunities, with on-going training development. 8. Revision of the Staff Exit Surveys to provide accurate information leavers. 9. Retention data of resignations, projected leavers, projected joiners to identify reasons for resignation and opportunity to take intervention action.	Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> 1. Workforce Committee to report to EMT as part of retention strategy 2. Reports and progress reviewed at EMT, Workforce Committee & monitored weekly at the Forecast & Planning Group.					
How controls are monitored/measured 1. Recruitment activity reviewed monthly at EMT and weekly at Performance Improvement Board 2. Reports and progress reviewed at EMT & Workforce Committee. 3. Workforce committee to report to EMT and Finance and Improvement Committee.	Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i> None identified as at 21 st August 2015					
Further actions - plans to reduce gaps in control/Improve Assurance					Due Date	
1	Review exit interview process and data capture.				On-going	
2	Review and update rewards and retention strategy.				On-going	
3	Promote learning and development opportunities.				On-going	
4	Recruitment drive to fill vacant established posts.				On-going	
5	Develop a Health and Wellbeing Strategy				Summer 2015	
Risk owner: Director of Workforce, Strategy & transformation		Signed:		Date: 21 st August 2015		

Board Assurance Framework – September 2015

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

<p>Risk Classification: Performance</p> <p>Principal Risk Description: There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.</p>	<p>Monitoring Committee:</p>	Audit Committee		Gross Risk	Current or Net Risk	Target																											
	<p>Last reviewed by committee on:</p>	7 th Sept. 2015	<p>Linked to Corporate Risk No. 265</p>	Impact	5	5																											
	<p>Last reviewed by Director on:</p>	26 th August 2015		Likelihood	4	4																											
	<p>Date of next review</p>	September 2015		Total Score	20	16	12																										
<p>Risk Consequences: Patient Safety and Financial Penalties</p>	<p>Underlying Cause/Source(s) of Risk Recruitment; Attrition; Growing vacancy factor; Increased demand; Patient Safety and Financial Penalties</p>																																
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. On-going recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. Increased as of September 2014. 3. New rosters implemented successfully. 4. Targeted use of overtime and increased disruption payments. 5. Surge plan was reviewed again in January 2015. 6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories 7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls. 8. An extension in the operating hours for active area cover was implemented on the 21st July 2014. <p>How are controls measured On-going recruitment to vacancies (Weekly) Use of agency Paramedics to enhance bank scheme. (On-going)</p>	<p>Positive Assurance 1) Recruitment activity reviewed fortnightly at EMT 2) Weekly forecast & planning meetings 3) ADO's review surge plan as required, and plan to do again imminently 4) Plans for non-auto dispatch back-up have been developed and will run from 7/09/15 for 3 weeks and this should reduce MAR 5) Skill mix: the skill mix model has been updated in Sept 2015 to include international recruits and is currently under review. 6) NETS now in place with 108 staff in post.</p> <p>Gaps in Control/Assurance (1.) <i>Where we are failing to put controls/ systems in place or make them effective?</i> (2) <i>Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective. Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>Agreed plan in place until end of December 2015 for private provision. Surge plan will be reviewed again in October 2015.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #4a4a8a; color: white;"> <th style="width: 5%;"></th> <th style="width: 85%;">Further actions - plans to reduce gaps in control/Improve Assurance</th> <th style="width: 10%;">Due Date</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Sickness management.</td> <td style="text-align: center;">30 Sept. 2015</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Skill mix: the skill mix model has been updated in January 2015 to include international recruits and is currently under review. To be reviewed again in August 2015</td> <td style="text-align: center;">31st Aug. 2015</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Annual leave review: a revised annual leave policy is in its final draft stage.</td> <td style="text-align: center;">30 Sept. 2015</td> </tr> <tr> <td style="text-align: center;">4</td> <td>Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role</td> <td style="text-align: center;">On-going</td> </tr> <tr> <td style="text-align: center;">5</td> <td>Improve provisioning and reduce calls through the use of PTS and taxi service. Targets now set for 2015/16.</td> <td style="text-align: center;">On-going</td> </tr> <tr> <td style="text-align: center;">6</td> <td>Clinical triage of Red 2 calls.</td> <td style="text-align: center;">On-going</td> </tr> <tr> <td style="text-align: center;">7</td> <td>Despatch on disposition pilot.</td> <td style="text-align: center;">On-going</td> </tr> <tr> <td style="text-align: center;">8</td> <td>IMD incident management desk – to manage incidents.</td> <td style="text-align: center;">On-going</td> </tr> </tbody> </table>							Further actions - plans to reduce gaps in control/Improve Assurance	Due Date	1	Sickness management.	30 Sept. 2015	2	Skill mix: the skill mix model has been updated in January 2015 to include international recruits and is currently under review. To be reviewed again in August 2015	31 st Aug. 2015	3	Annual leave review: a revised annual leave policy is in its final draft stage.	30 Sept. 2015	4	Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role	On-going	5	Improve provisioning and reduce calls through the use of PTS and taxi service. Targets now set for 2015/16.	On-going	6	Clinical triage of Red 2 calls.	On-going	7	Despatch on disposition pilot.	On-going	8	IMD incident management desk – to manage incidents.	On-going
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<p>Risk owner's update:</p>																																	
<p>Risk owner: Director of Operations</p>	<p>Signed:</p>	<p>Date: 26th August 2015</p>																															

Board Assurance Framework – September 2015

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

Risk Classification: Performance Principal Risk Description: There is a risk that at staff changeover times, LAS performance falls.	Monitoring Committee: Audit Committee			Gross Risk	Current or Net Risk	Target
	Last reviewed by committee on: 7 th Sept. 2015	Linked to Corporate Risk No. 269.	Impact	4	4	4
	Last reviewed by Director on: 26th August 2015		Likelihood	5	4	2
	Date of next review September 2015		Total Score	20	16	8
Risk Consequences:	Underlying Cause/Source(s) of Risk Current rest break agreement permits staff to conclude shift by up to 30 minutes early where no break given by EOC					
Existing Key Controls 1. Daily monitoring of rest break allocation to resolve end of shift losses. 2. Use of bridging shifts for VAS/PAS. 3. Roster reviews/changes include staggered shifts. 4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies of sufficient EOC resourcing (ORH review). How are controls measured & monitored <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i> 1. By Sector delivery Manager reporting to on-call Assistant Director of Operations. 2. Performance Project Meeting PA Consulting 3. New Rotas in place since Q2 14/15 4. Modernisation Programme Board minutes 5. Weekly tracking report.	Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> New Rotas in place since Q2 14/15; Modernisation Programme Board minutes; and Weekly tracking report. Skill mix: the skill mix model has been updated in Sept 2015 to include international recruits and is currently under review. Rota changes to be implemented as result of ORH review Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective?</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i> None identified as at 26 th August 2015					
Further actions - plans to reduce gaps in control/Improve Assurance						
						Due Date
		1	Agree and implement changes to rest break arrangements.			2015/16
		2	Recruitment			
		3	Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015			August 2015
		4	On-going vigorous management of out of service. P. Woodrow to set improvement trajectory to get out of service levels back within target.			On-going
		5	Proactive use of the surge plan			continuous
		6	Out of service being HUB implemented			
Risk owner's update:						
Risk owner: Director of Operations		Signed:		Date: 26 th August 2015		

Board Assurance Framework – September 2015

BAF Risk 14: Developing and delivering Cost Improvements

<p>Risk Classification: Finance</p> <p>Principal Risk Description: It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the on-going viability and solvency of the Trust.</p>	<p>Monitoring Committee: Audit Committee</p>	<p>Last reviewed by committee on: 7th Sept. 2015</p>	<p>Linked to Corporate Risk No. 394</p>	<p>Impact</p>	5	4	3
		<p>Last reviewed by Director on: August 2015</p>		<p>Likelihood</p>	4	4	2
		<p>Date of next review September 2015</p>		<p>Total Score</p>	20	16	6
<p>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.</p>	<p>Underlying Cause/Source(s) of Risk</p> <ul style="list-style-type: none"> CIP governance not clearly defined and in place. 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 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. 						
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments. 	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i></p> <p>On-going reporting to CIP Programme Board and Quality Committee.</p> <p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective?</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>None identified as at 26th August 2015</p>						
<p>How are controls measured</p> <p>Report to CIP Programme Board (Monthly) Reporting to FIC (On-going) Reports to Quality Committee (on-going)</p>	<p>Further actions - plans to reduce gaps in control/Improve Assurance</p>					<p>Due Date</p>	
	1	Review support to drive the CIP Programme.					30 Sept. 2015
	2	Ensure all schemes have clear project plans.					30 Sept. 2015
	3	Embed all CIPs in budgets. Ensure managers sign off.					30 Sept. 2015
	4	Review current benchmarking information.					On-going
<p>Risk owner's update:</p>							
<p>Risk owner: Director of Finance</p>		<p>Signed:</p>		<p>Date: 26th August 2015</p>			

Board Assurance Framework – September 2015

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

Risk Classification: Performance Principal Risk Description: There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	Monitoring Committee: Audit Committee			Gross Risk	Current or Net Risk	Target	
	Last reviewed by committee on: 7 th Sept. 2015	Linked to Corporate Risk No. 410	Impact	5	5	5	
	Last reviewed by Director on: August 2015		Likelihood	4	3	2	
	Date of next review September 2015		Total Score	20	15	10	
Risk Consequences: 50% total volume of calls is Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.	Underlying Cause/Source(s) of Risk 50% total volumes of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.						
Existing Key Controls <ol style="list-style-type: none"> Undertaking ring backs within set time frames for held calls Fully trained workforce with 20 minute education breaks throughout shift. LAS overtime (targeted incentives towards peak times. Additional focus on safety reporting. QA – MPDS (999); QA – CHUB MTS (H&T;) – Report safeguarding incident concerns. Falls care is being introduced. Flag elderly fallers on vulnerable person monitor (VP). Clear process of escalation of response process implemented. Implementation of VP (mental health / elderly fallers) and CP (sickle cell / septic patients) screen to monitor higher risk patients. Managing patients through use of non-emergency transport options where clinically appropriate. NETS desk and HCP lines starting 1st July Recruitment well underway and number of leavers significantly less than number of new starters. FRU performance improvement plan in place. How are controls measured Performance dashboard; Operations; SI group, governance group; Monitoring SI and complaint themes.	Positive Assurance Recruitment activity reviewed fortnightly at EMT Weekly forecast & planning meetings Medical Director and DDO (Control Services) to review surge plan as required, and plan to do again imminently Plans for non-auto dispatch back-up have been developed and will run from 7/09/15 for 3 weeks and this should reduce MAR Overtime disruption payments are in place until end October 2015 Gaps in Control/Assurance (1.) Where we are failing to put controls/ systems in place or make them effective? (2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective. Include any procedure/policy to be developed to augment the control or provide assurance. None identified as at 25 th August 2015						
	Further actions - plans to reduce gaps in control/Improve Assurance					Due Date	
	1	Recruit to Establishment minus agreed vacancy factor of 5%.				Q4 2015/16	
	2	Deliver efficiencies in full from Capacity Review and complete Roster Implementation.					
	3	Recruit to establishment in the clinical hub.					
	4	Allocate EMDs to clinical hub to assist with ring backs –					
	5	Increasing taxi use. Use of an SOP with taxi booking makes the process safer.					
	6	Discussion with NHS111 regarding the green calls and outcomes					
	7	More accurate reporting of category C delays and monitoring of safety incidents.					
	8	Update surge plan and make appropriate revisions				October 2015	
Risk owner's update:							
Risk owner: Director of Operations		Signed:		Date: 26 th August 2015			

Board Assurance Framework – September 2015

BAF Risk 18: Directors and line managers do not fully commit to staff engagement in terms of time and focus							
Risk Classification: Governance Principal Risk Description: There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff.	Monitoring Committee:	Audit Committee			Gross Risk	Current or Net Risk	Target
	Last reviewed by committee on:	7 th Sept. 2015	Linked to Corporate Risk No.433	Impact	4	4	4
	Last reviewed by Director on:	26 th August 2015		Likelihood	4	3	2
	Date of next review	September 2015		Total Score	16	12	6
Risk Consequences: This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	Underlying Cause/Source(s) of Risk All staff need time with their line manager to support them to deliver what the organisation needs them to in terms of performance improvement, better care for patients and looking after and retaining our staff.						
Existing Key Controls 1. Corporate communications channels reviewed and refreshed as part of communications strategy approved by the Board in June 2014. Team Talk introduced in September 2014 and now the operational management restructure is now in place – it is believed delivery and feedback will be improved. 2. Set up Workforce Committee to monitor delivery of staff engagement plan 3. Operational restructure will improve engagement with line managers.	Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> Clinical Team Leaders have completed their training and are now active in their role since August 2015.						
How are controls measured Team Talk feedback report to EMT Staff Survey, Team talk feedback	Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i> None identified as at 28 th August 2015						
Further actions - plans to reduce gaps in control/Improve Assurance						Due Date	
	1	Performance management and appraisal of engagement objectives for line managers.					
	2	Training and support for senior managers.					
	3	Evaluation with front line staff					
Risk owner's update:							
Risk owner: Director of Strategic Communications		Signed:			Date: 28 August 2015		

Board Assurance Framework – September 2015

BAF Risk 19: New Assistant Directors of Operations (ADOs) are focused on internal performance improvement and do not give time or focus to external stakeholder engagement							
Risk Classification: Reputation Principal Risk Description: There is a risk that that new sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch)	Monitoring Committee:	Audit Committee			Gross Risk	Current or Net Risk	Target
	Last reviewed by committee on:	7 th Sept. 2015	Linked to Corporate Risk No. 434	Impact	4	4	4
	Last reviewed by Director on:	26 th August 2015		Likelihood	4	3	2
	Date of next review	September 2015		Total Score	16	12	8
Risk Consequences: This could result in a lack of support by stakeholders: at best this would mean no support for change or growth programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	Underlying Cause/Source(s) of Risk ADO's are essential for strong local stakeholder management, it cannot be done effectively centrally						
Existing Key Controls 1. New ADOs are developing strong relationships with key stakeholders. 2. New communication public affairs manager starting September 2015 to support them	Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> Stakeholder Engagement Managers are now active in their roles since August 2015.						
How are controls measured/monitored? <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i>	Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i> GP survey (planned for autumn/winter 2015)						
	Further actions - plans to reduce gaps in control/Improve Assurance					Due Date	
1. Regular updates and feedback between Communications and ADOs	1	Provide support and training and regular stakeholder perception testing				December 2015	
2. GP survey (planned for autumn/winter 2015)	2	Work with new operations directorate stakeholder managers to develop their role.				On-going	
	3	Support for new ADO's from communications team around stakeholder management and briefing on local politicians and stakeholders				On-going	
Risk owner's update:							
Risk owner: Director of Strategic Communications		Signed:			Date: 26 th August 2015		

Board Assurance Framework – September 2015

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

Risk Classification: Infrastructure/Finance	Monitoring Committee:	Audit Committee		Gross Risk	Current or Net Risk	Target
Principal Risk Description: There is a risk that the LAS will not be in a position to win new NHS 111 contracts as stated in the 5 year strategy.	Last reviewed by committee on:	7 th Sept. 2015	Linked to Corporate Risk No. 440	Impact	4	4
	Last reviewed by Director on:	26 th August 2015		Likelihood	4	4
	Date of next review	September 2015		Total Score	16	16
Risk Consequences: Successful 111 bidders and their service can adversely affect demand for 999 service. Negative impact on the financial position of the organisation through potential loss of existing business or failure to establish competitive pricing models based on efficiencies of scale for new bids	Underlying Cause/Source(s) of Risk <ol style="list-style-type: none"> There is no consistent 111 tender process or service across London. 111 contracts across London are going out to tender at different times and are constructed differently across London e.g. from single 111 services to major partnership arrangements for multiple urgent care services. 111 growth may not be given adequate resource/attention due to current 999 performance pressures diverting attention away, particularly at a senior level. LAS costs may not be competitive. Detailed modelling to accurately assess what areas of London we will bid for, informing the impact on services such as, estates, IM&T, clinical support, resourcing, legal services, governance arrangements etc. has not been possible due to the tendering process 					
Existing Key Controls <ol style="list-style-type: none"> Contract team in place, gathering information of service requirements / KPIs / costing of service. Improve interactions between 999 and 111 services and grow our 111 business 	Positive Assurance (<i>Evidence that shows we are reasonably managing our risks and objectives are being delivered</i>) <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> Business Plan Actions 21.8.2015 in respect of work with CCG and the Bid for 111					
How are controls measured/monitored? <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i> <ol style="list-style-type: none"> Regular updates and feedback between Communications and ADOs GP survey (planned for autumn/winter 2015). 	Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2.) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective. Include any procedure/policy to be developed to augment the control or provide assurance.</i> None identified as at 26 th August 2015					
				Further actions - plans to reduce gaps in control/Improve Assurance		Due Date
				1	Understanding developed, through conversations with 111 commissioners across London, of their timeframes for tendering.	
				2	Work with CCGs to influence 111 system development across London	
				3	Bid for new 111 services as contracts become available	
Risk owner's update:						
Risk owner: Director of Strategy & Transformation		Signed:		Date: 26 th August 2015		

Board Assurance Framework – September 2015

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

<p>Risk Classification: Infrastructure</p> <p>Principal Risk Description: There is a risk that there may be insufficient vehicle numbers to meet demands.</p>	Monitoring Committee:	Audit Committee		Gross Risk	Current or Net Risk	Target	
<p>Last reviewed by committee on:</p> <p>Last reviewed by Director on:</p> <p>Date of next review</p>		7 th Sept. 2015	Linked to Corporate Risk No. 441	Impact	4	4	3
		26 th August 2015		Likelihood	4	4	3
		September 2015		Total Score	16	16	9
<p>Risk Consequences: The Trust fails to provide adequate vehicle numbers to support The risk above will impact on the Trust's ability to provide adequate vehicle numbers to support operational demand leading to further impact on operational performance for the Trust</p>	<p>Underlying Cause/Source(s) of Risk</p>						
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Forward view of fleet requirement for next 5 years 2. Asset management plan to ensure no frontline vehicle exceeds 7 years old and that Unplanned Maintenance levels do not adversely affect Fleet Capacity and the provision of a safe environment to Operational Staff 3. Ensure capital investment is committed to support fleet volume and replacement 4. External/stakeholder support in place as required 5. Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan 6. Have an agreed vehicle specification 7. Agree and maintain adequate headroom in fleet numbers to manage variation 	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i></p> <p>Monthly statement of Fleet requirement Annual specifications to Fleet board On-going capacity plan</p> <p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>None identified as at 26th August 2015</p>						
<p>How are controls measured/monitored? Fleet Strategy Annual Plan Business Case Approval Fleet Management Team Meetings Fleet Delivery Board (the frequency for these is variable)</p>	<p>Further actions - plans to reduce gaps in control/Improve Assurance</p>					<p>Due Date</p>	
<p>Risk owner's update:</p>	1	Complete capacity plan and ensure it is reviewed and updated regularly, ensure this is aligned with the operational plans evolving				30 th Sept 2015/ On-going	
	2	Complete business plan for next 2 years				OBC Completed FBC 30 th Sept	
	3	Agree & sign off DCA & FRU specification				30 th Sept 2015	
	4	Calculate and agree the headroom required along with operations and finance and adapt procurement appropriately				30 th Sept 2015	
	5	Complete Medium term Fleet Strategy 2017-18 and 5 years				31 st March 2016	
<p>Risk owner: Director of Finance</p>	<p>Signed:</p>		<p>Date: 26th August 2015</p>				

Board Assurance Framework – September 2015

BAF Risk 25: Insufficient range and volume of equipment to meet demands								
Risk Classification: Infrastructure Principal Risk Description: There is a risk that there may be insufficient range and volume of equipment to meet demands.	Monitoring Committee:	Audit Committee			Gross Risk	Current or Net Risk	Target	
	Last reviewed by committee on:	7 th Sept. 2015		Linked to Corporate Risk No..442	Impact	4	4	3
	Last reviewed by Director on:	26 th August 2015			Likelihood	4	4	2
	Date of next review	September 2015			Total Score	16	16	6
Risk Consequences: Staff will not have equipment required to provide appropriate patient care	Underlying Cause/Source(s) of Risk							
Existing Key Controls 1. Agreed vehicle equipment lists including re-usable v disposable in place 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit How are controls measured/monitored? 1. Vehicle Equipment Procedure 2. Fleet management information 3. Budget reports 4. Equipment Inventory 5. Fleet management information 6. Fleet reports/Equipment group 7. Report to recommend	Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i>							
	Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i>							
	None identified as at 26 th August 2015							
	Further actions - plans to reduce gaps in control/Improve Assurance						Due Date	
	1	Define and agree a “core” equipment list for DCA & FRU.					10 th Sept. 2015	
	2	Logistics to take responsibility for supplying core equipment					Immediate	
	3	Undertake an Audit of available equipment/ Continue to purchase equipment					10 th Sept. 2015	
	4	Undertake an equipment amnesty and physically review all stations and complexes for “retained” equipment.					On-going	
	5	Introduce monitoring process for tracking equipment					November 2015	
	6	Develop system to reintroduce equipment that gets decontaminated and Agree equipment to be tracked / scanned each day and accountabilities for each item					31 st October 2015	
7	Review contents, responsibility and issue of “bags”. Agree terms of reference, and timeline					30 th Sept. 2015		
8	Implement working group to review personal issue kit					30 th Sept. 2015		
Risk owner’s update:								
Risk owner: Director of Finance		Signed:		Date: 26 th August 2015				

Board Assurance Framework – September 2015

BAF Risk 26: The equipment for frontline vehicles may not be available when required

<p>Risk Classification: Infrastructure</p> <p>Principal Risk Description: There is a risk that the equipment for frontline vehicles may not be available when required.</p>	<p>Monitoring Committee: Audit Committee</p>	<p>Last reviewed by committee on: 7th Sept. 2015</p>	Linked to Corporate Risk No. 443	<p>Impact</p>	4	4	3
		<p>Last reviewed by Director on: 27th August 2015</p>		<p>Likelihood</p>	4	4	2
		<p>Date of next review September 2015</p>		<p>Total Score</p>	16	16	6
<p>Risk Consequences: Staff will not have equipment required to provide appropriate patient care</p>	<p>Underlying Cause/Source of Risk:</p>						
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Serial numbers on all re-usable equipment for accurate tracking. 2. Agree & set requirements for stock levels on vehicles and monitor regularly. 3. Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays. 4. Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5. Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles <p>How are controls measured/monitored Partial via VP reporting OOS policy & reports Measured on one-off/periodic basis</p>	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered). List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> Clinical Equipment Group; Asset tracking report; VP reports; VP Contract; Equipment Process; Project completion</p> <p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective? (2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective? Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>None identified as at 27th August 2015</p>						
	Further actions - plans to reduce gaps in control/Improve Assurance						Due Date
	1	Agree equipment to be tracked / scanned each day and accountabilities for each item					10 th Sept 2015
	2	Ensure Intersperse provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports.					10 th Sept 2015
	3	Ensure adequate stocks of consumables and equipment are available to VP staff					On-going
	4	Review current VP contract and agree any immediate changes					25 th Sept 2015
	5	Agree essential equipment, plan and implement a process to make key items available centrally to restock					10 th Sept 2015
	6	Plan rollout of and implement complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided					31 st October 2015
	7						
<p>Risk owner's update:</p>							
<p>Risk owner: Director of Finance</p>		<p>Signed:</p>			<p>Date: 27th August 2015</p>		

Board Assurance Framework – September 2015

BAF Risk 27: The equipment for frontline vehicles may not be in an effective condition

<p>Risk Classification: Infrastructure</p> <p>Principal Risk Description: There is a risk that the equipment for frontline vehicles may not be in an effective condition.</p>	<p>Monitoring Committee: Audit Committee</p>	<p>Last reviewed by committee on: 7th Sept. 2015</p>	<p>Last reviewed by Director on: 27th August 2015</p>	<p>Date of next review September 2015</p>	<p style="background-color: #4b4b9b; color: white; padding: 5px;">Linked to Corporate Risk No.444</p>	<p>Impact 4</p>	<p>Likelihood 4</p>	<p>Total Score 16</p>	<p>Gross Risk 4</p>	<p>Current or Net Risk 4</p>	<p>Target 3</p>	
<p>Risk Consequences: Staff will not have equipment required to provide appropriate patient care</p>		<p>Underlying Cause/Source(s) of Risk</p>										
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Agreed VP cleaning, deep cleaning and stocking service levels are set, maintained and monitored 2. Decontamination of equipment during VP, including monitoring 3. Decontamination of items left at hospital, including monitoring 4. Replacement equipment budgets in place. Process agreed and adhered to 5. Maintenance/Replacement of Kit undertaken when required 		<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i> Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet reports; and OOS reports.</p>										
<p>How are controls measured/monitored <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i></p> <p>Partial via VP reports Decontamination reports Partially monitored within Fleet & Logistics Monitored within Fleet & Logistics</p>		<p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>None identified as at 25th August 2015</p>										
		<p>Further actions - plans to reduce gaps in control/Improve Assurance</p>								<p>Due Date</p>		
		1	Complex based fleet to increase vehicle availability for VP								31 st October 2015	
		2	Monitor Decontamination of equipment trial								December 2015	
		3	Implement contract for decontamination								January 2016	
		4	Develop system to reintroduce equipment that gets decontaminated								18 th Sept 2015	
		5	Establish revised process for collection of equipment left at hospital for decontamination & subsequent redistribution								30 th Sept 2015	
		6	Review process for maintenance of equipment								31st August 2015	
		7	Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports.								10 th Sept 2015	
		8	Ensure current performance against 95% deep clean within 6 weeks maintained.								On going	
<p>Risk owner's update:</p>												
<p>Risk owner: Director of Finance</p>			<p>Signed:</p>			<p>Date: 27th August 2015</p>						

Board Assurance Framework – September 2015

BAF Risk 28: There are currently no arrangements for routine quality assurance (QA) of dispatch functions.

<p>Risk Classification: Clinical & Quality</p> <p>Principal Risk Description: There is a risk that there are currently no arrangements in place for routine quality assurance of dispatch functions which may affect the quality of call management and the service provided to patients.</p>	<p>Monitoring Committee: Audit Committee</p>	<p>Last reviewed by committee on: 7th Sept. 2015</p>	<p>Last reviewed by Director on: 27th August 2015</p>	<p>Date of next review September 2015</p>	<p style="background-color: #4b4b9b; color: white; padding: 5px;">Linked to Corporate Risk No.429</p>		<p>Impact 4</p>	<p>Likelihood 5</p>	<p>Total Score 20</p>	<p>Gross Risk 4</p>	<p>Current or Net Risk 5</p>	<p>Target 2</p>	<p>Total Score 8</p>
<p>Risk Consequences: Lack of QA for dispatch resulting in an unquantifiable level of risk from poor compliance with dispatch protocols.</p>	<p>Underlying Cause/Source(s) of Risk No real time proactive checking of dispatch regimes. Routine QA is undertaken for call handling, but the only detailed examination of the dispatch process is done arising from complaints and incidents. Although there are metrics available relating to performance we have limited information on the quality of the allocation decisions and call management within EOC. Instances of sub-optimal dispatch have been identified within Serious Incident and complaint investigations.</p>												
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Training for CP Dispatch and Allocation 2. Updated Operational procedures 3. Increased breach analysis 	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i></p>												
<p>How are controls measured/monitored <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i> SMT Five-weekly watch reviews</p>	<p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective? (2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective. Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p>None identified as at 27th August 2015</p>												
<p>Further actions - plans to reduce gaps in control/Improve Assurance</p>										<p>Due Date</p>			
1	Introduce a QA process within dispatch									October 2015			
2	KPI within dispatch									November 2015			
3	Training opportunities for staff in order for them to progress further.									November 2015			
<p>Risk owner's update:</p>													
<p>Risk owner: Director of Operations / Deputy Director of Operations – Control Services</p>					<p>Signed:</p>				<p>Date: 27th August 2015</p>				

Board Assurance Framework – September 2015

BAF Risk 29: There is a lack of ring-backs on delayed response calls within EOC

<p>Risk Classification: Clinical & Quality</p> <p>Principal Risk Description: There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.</p>	<p>Monitoring Committee: Audit Committee</p> <p>Last reviewed by committee on: 7th Sept. 2015</p> <p>Last reviewed by Director on: 27th August 2015</p> <p>Date of next review: September 2015</p>	<div style="background-color: #4a4a8a; color: white; padding: 5px; font-weight: bold;">Linked to Corporate Risk No. 451</div>		<p>Gross Risk</p> <p>Impact</p> <p>Likelihood</p> <p>Total Score</p>	<p>Current or Net Risk</p> <p>4</p> <p>4</p> <p>16</p>	<p>Target</p> <p>4</p> <p>3</p> <p>12</p>
<p>Risk Consequences: Patients are not contacted meaning their condition can deteriorate without the EOC being aware and being able to re-triage</p>	<p>Underlying Cause/Source(s) of Risk 1. Inability of the Service to provide resources to dispatch on calls in a timely manner. 2. Insufficient resources in EOC to carry out the ring backs. 3. Instances of serious incidents and inquests where patients have deteriorated when there has been no contact by the service for a significant period of time. 4. Increased demand vs. resource.</p>					
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs. 2. Additional technical support to prompt re-categorisation and contact. 3. New ring back status monitors. 4. New information within EOC to be able to properly inform patients of the likely wait time for a response. 5. Staff removed from call handling to undertake ring backs when capacity allows. 	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i></p> <p>Gaps in Control/Assurance <i>(1.) Where we are failing to put controls/ systems in place or make them effective?</i> <i>(2) Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective?</i> <i>Include any procedure/policy to be developed to augment the control or provide assurance.</i></p> <p style="text-align: center;"><i>None identified as at 27th August 2015</i></p>					
<p>How are controls measured <i>List documents e.g. progress reports fed into committees or groups, newly developed procedure, audits, process reviews etc. (include frequency).</i> Measured daily, monthly or as required</p>	Further actions - plans to reduce gaps in control/Improve Assurance					Due Date
	1	Additional resources to undertake call backs and manage held call stacks.				On-going
	2	Additional front line resource				On-going
	3					
	4					
	5					
<p>Risk owner's update:</p>						
<p>Risk owner: Director of Operations / Deputy Director of Operations – Control Services</p>			<p>Signed:</p>		<p>Date: 27th August 2015</p>	

Board Assurance Framework – September 2015

BAF Risk 30:

Risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence

<p>Risk Classification: Clinical & Quality</p> <p>Principal Risk Description: There is a risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence, resulting in potential adverse consequence to the health</p>	<p>Monitoring Committee:</p>	<p>Audit Committee</p>		<p>Gross Risk</p>	<p>Current or Net Risk</p>	<p>Target</p>	
<p>Risk Consequences: Resulting in potential adverse consequence to the health of LAS staff and general public to whom they are responding. This will have impact on core business due to potential increase in staff sickness levels. Risk to health of staff and the public. Staff's risk of infection.</p>	<p>Last reviewed by committee on:</p>	<p>N/a</p>	<p>Linked to Corporate Risk No.445</p>	<p>Impact</p>	<p>5</p>	<p>5</p>	<p>5</p>
	<p>Last reviewed by Director on:</p>	<p>21st August 2015</p>		<p>Likelihood</p>	<p>4</p>	<p>3</p>	<p>2</p>
	<p>Date of next review</p>	<p>September 2015</p>		<p>Total Score</p>	<p>20</p>	<p>15</p>	<p>10</p>
	<p>Underlying Cause/Source(s) of Risk 1) Staff lack of equipment because they haven't been fitted with the (PPE) FFP3 respirator mask. 2) Lack of knowledge and training regarding infectious disease processes, use of regular and enhance IPC PPE, to prevent self-contamination 3) A potential increase in staff sickness levels as a result of staff exposures to VHF and the need for quarantine/treatment. 4) Lack of clarity regarding HR processes to manage staff exposure.</p>						
<p>Existing Key Controls</p> <ol style="list-style-type: none"> 1. Infection Control Workbook; standard infection prevention control training programme in place. 2. Task and finish group for Category 4/VHF (Ebola) assurance (chaired by EPRR). Plus regular EPRR Ebola management bulletins, including algorithms for early identification of possible cases of VHF 3. Support from the Clinical Hub and Health Protection Unit for enhanced risk assessment on suspected cases. 4. Waste contract in place – includes Cat A waste for incineration 5. IPC at Clinical Basic Training and CSR 6. Ebola assurance monitoring by VHF Group and at IPCC 7. National Transfer procedures agreed 8. On-going engagement with PHE 9. Develop VHF Plan – Action cards, transfer process, VHF bulletins 10. Process for Cat 4 patients works effectively. 11. Review the requirements of involvement of individuals. 12. VHF Group set up for compliance and assurance. 	<p>Positive Assurance <i>(Evidence that shows we are reasonably managing our risks and objectives are being delivered)</i> <i>List any report, e.g. to the board or other committees including update on the risk, reviews, reports of surveys, etc.</i></p> <ul style="list-style-type: none"> Clear process for confirmed Ebola case between LAS and the Royal Free and working arrangement with Health Protection Units. FFP3 Fit testing and provision of personal issued respirators, basic clinical training for existing staff – captured at FITFLU Programme commenced 15/10/14. 			<p>Gaps in Control/Assurance</p> <ul style="list-style-type: none"> Current OHS contract does not include contract tracing– new contract from 1st April 2015 for new provider has enhanced specification Infection Control Specialist and OHD service (not 24 hrs.) 			
<p>How are controls measured/monitored</p>			<p>Further actions - plans to reduce gaps in control/Improve Assurance</p>			<p>Due Date</p>	
<p>Risk owner's update:</p>			<p>1</p>	<p>LAS Ebola VHF processes (e.g. policy and procedures) internally and externally aligned</p>	<p>Completed as part of 1 above</p>		
<p>Risk owner: Director of Nursing & Quality</p>			<p>2</p>	<p>Share HART training package with the education and development department to ensure a consistent standard of infection control training including the use of enhanced PPE – awaiting funding for PPE.</p>	<p>On-going</p>		
<p>Signed:</p>			<p>3</p>	<p>Enhance the decontamination process for vehicles as per national and expert guidance, to include for example hypochlorite / Bioquell, for use by all crews.</p>	<p>31/05/15</p>		
<p>Date: 21st August 2015</p>			<p>4</p>	<p>Ensure availability of a secure information exchange portal between OHD & LAS</p>	<p>On-going</p>		

Board Assurance Framework – September 2015

**London Ambulance Service NHS Trust
Trust Risk Register September 2015 (15+)**

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Like- lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like- lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like- lihood	Target Rating	Comments
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	Recruitment Attrition Growing vacancy factor Increased demand Patient Safety and Financial Penalties	31-Jul-06	4		Safe	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 January-October 2015. 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. 8. A percentage of these circa 35% will be discharged through Hear and Treat 9. 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. 10. An extension in the operating hours for active area cover was implemented on the 21st July 2014. 11. METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.32/1.33	Paul Woodrow	26-Aug-15	Major	Almost Certain	20	1. Sickness management—A performance management dashboard is being developed. The occupational health contract is being reviewed. (21/09/15: Completed) 2. Roster review: Rosters for all complexes have been agreed and implemented and are currently under review. (21/09/15: Completed, due for review) 3. Skill mix: the skill mix model has been updated in January-September 2015 to include international recruits and is currently under review. (21/09/15: Completed) 4. 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 consulting with trade unions with a view to implementing a revised annual leave arrangement as defined in the policy. This work remains pending. 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. Delay caused by capita and now implementation planned mid May. Work in progress on single site working due to be completed 27th May 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 paramedics	1. P. Woodrow 2. S. Kime 3. P. Woodrow / M. Whitbread 4. S. Sale 5. P. Woodrow 6. K. Broughton / T. Crabtree 7. J. Goldie / K. Millard 8. K. Millard 9. K. Millard 10. K. Millard	1. Completed 2. Completed 3. Completed, Updated Sept 2015 4. Sep 2015 5. Completed 6. On-going 7. On-going 8. On-going 9. On-going 10. On-going	1. Recruitment activity reviewed fortnightly at EMT 2. Weekly forecast & planning meetings 6. ADO's review surge plan as required, and plan to do again imminently 8. Plans for non-auto dispatch back-up have been developed and will run from 7/09/15 for 3 weeks and this should reduce MAR	Major	Possible	12	26/08/15: Updated on BAF Reviewed by ADO's 03/06/15. 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
429	There is a risk that there are currently no arrangements in place for routine quality assurance of dispatch functions which may affect the quality of call management and the service provided to patients. Lack of QA for dispatch resulting in an unquantifiable level of risk from poor compliance with dispatch protocols.	No real time proactive checking of dispatch regimes. Routine QA is undertaken for call handling, but the only detailed examination of the dispatch process is done arising from complaints and incidents. Although there are metrics available relating to performance we have limited information on the quality of the allocation decisions and call management within EOC. Instances of sub-optimal dispatch have been identified within Serious Incident and complaint investigations.	14-Jan-15	28		Safe Effective Responsive	Operational	Major	Almost Certain	20	1. Training for CP Dispatch and Allocation 2. Updated Operational procedures 3. Increased breach analysis	Paul Woodrow (Katy Millard)	27-Aug-15	Major	Almost Certain	20	1. Introduce a QA process within dispatch 2. KPI within dispatch 3. Training opportunities for staff in order for them to progress further.	1. A. Buckler 2. K. Canavan 3. J. Lockett	1. 31/10/15 2. 30/11/15 3. 30/11/15	1. SMT 2. SMT 3. Five-weekly watch reviews	Major	Unlikely	8	27/08/15: BAF updates provided by B. Jordan Net rating was proposed for revision from major x possible = 12 to major x almost certain = 20 by control services on the 04/06/15.
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		Safe	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts. 4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies of sufficient EOC resourcing (ORH review).	Paul Woodrow	26-Aug-15	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 January 2015 to include international recruits. This was reviewed in August 2015 (Completed Sept 2015) 5. Ongoing vigorous management of out of service. P. Woodrow 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 / P. Woodrow 2. P. Woodrow 3. K. Broughton 4. P. Woodrow 5. K. Brown / C. Vale 6. ADO's 7. TBC	1. 2015/16 2. Completed 3. On-going 4. Completed 5. On-going 6. On-going 7. On-going	1. By Sector delivery Manager reporting to on call Assistant Director of Operations 4. Performance Project Meeting PA Consulting	Major	Unlikely	8	26/08/15: BAF Updated K.Millard reviewed 13/04/15. December 2014 Risk reviewed by ADO group. Updated provided by P.Woodrow and J.Killens August 2014

**London Ambulance Service NHS Trust
Trust Risk Register September 2015 (15+)**

Risk ID	Risk Description	Underlying Cause/Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
394	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPs will threaten the ongoing viability and solvency of the Trust. 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.	<ul style="list-style-type: none"> 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		Well Led	Finance	Catastrophic	Likely	20	<ol style="list-style-type: none"> Appropriate supporting evidence available for CIP. All CIPs supported by detailed milestone plan. All CIPs embedded in budgets. All CIPs owned by relevant manager. Benchmarking of CIP opportunity. CIP governance clearly defined and in place. Board/FIC scrutiny of CIP planning and delivery in place. CIPs delivering in line with expectations. Capacity and capability available to support delivery. All CIPs supported by Quality Inputs Assessments. 	Andrew Grimshaw	26-Aug-15	Major	Likely	16	<ol style="list-style-type: none"> Review support to drive the CIP Programme. Ensure all schemes have clear project plans. Embed all CIPs in budgets. Ensure managers sign off. Review current benchmarking information. 	<ol style="list-style-type: none"> A. Grimshaw A. Grimshaw K. Hervey / A. Bell A. Grimshaw 	<ol style="list-style-type: none"> 30/09/15 30/09/15 30/09/15 On-going 	<ol style="list-style-type: none"> Report to CIP Programme Board Reporting to FIC Report to CIP Programme Board Reports to CIP Programme Board & Quality Committee 	Moderate	Unlikely	6	<p>26/08/15: D.Harker on behalf of A.Grimshaw - advises that all dates of action can be changed to 30/09/15.</p> <p>14/08/15 A.Bell advised reviewed by FIC 23/07/15, no change in grading.</p> <p>Reviewed by FIC 21/05/15</p> <p>Reviewed by A. Bell 11/03/15.</p> <p>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 = 6. K.</p> <p>Approved by SMT 09/04/14 for inclusion on the risk register.</p>
451	There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.	Inability of the Service to provide resources to dispatch on calls in a timely manner. Insufficient resources in EOC to carry out the ring backs. Instances of Serious Incidents and Inquests where patients have deteriorated when there has been no contact by the service for a significant period of time. Increased demand vs resource.	10-Jun-15	29			Operational	Major	Likely	16	<ol style="list-style-type: none"> More involvement by the Clinical Hub and EMDs who monitor the calls and identifying priorities for ring backs. They are reviewing any calls which have been held for over 1hr and being challenged on whether they are appropriate for NETS/taxis. Additional technical support to prompt re-categorisation and contact. New ring back status monitors. New information within EOC to be able to properly inform patients of the likely wait time for a response. Staff removed from call handling to undertake ring backs when capacity allows. 	Paul Woodrow (Katy Millard)	26-Aug-15	Major	Likely	16	<ol style="list-style-type: none"> Additional resources to undertake call backs and manage held call stacks. Additional front line resource 	<ol style="list-style-type: none"> K. Millard P. Woodrow 	<ol style="list-style-type: none"> ORH Review recruitment ongoing Continual recruitment process in place 		Major	Possible	12	<p>27/08/15: BAF Updates provided by B. Jordan</p> <p>Approved by the SMT 10/06/15</p>
441	There is a risk that there may be insufficient vehicle numbers to meet demands. Impacting on the Trust's ability to provide adequate vehicle numbers to support operational demand impacting on operational performance for the Trust		21-May-15	24			Fleet and Logistics	Major	Likely	16	<ol style="list-style-type: none"> Forward view of fleet requirement for next 5 years 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 Ensure capital investment is committed to support fleet volume and replacement External/stakeholder support in place as required Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan Have an agreed vehicle specification Agree and maintain adequate headroom in fleet numbers to manage variation 	Andrew Grimshaw	26-Aug-15	Major	Likely	16	<ol style="list-style-type: none"> Complete capacity plan and ensure it is reviewed and updated regularly, ensure this is aligned with the operational plans evolving Complete business plan for next 2 years Agree & sign off DCA & FRU specification Calculate and agree the headroom required along with operations and finance and adapt procurement appropriately Complete Medium term Fleet Strategy 2017-18 and 5 years 	<ol style="list-style-type: none"> Hd of Fleet & Logistics / Dir of Operations DoF Hd of Fleet & Logistics Hd of Fleet & Logistics DoF Hd of Fleet & Logistics 	<ol style="list-style-type: none"> 30/09/15 / On-going OBC Completed FBC 30/09/15 30/09/15 30/09/15 31/03/16 	<ol style="list-style-type: none"> Fleet Strategy Annual Plan (Head of F&L/Dir of Finance) Business Case Approval (Head of F&L) Fleet Management Team Meetings Fleet Delivery Board Fleet Strategy 	Moderate	Possible	9	<p>26/08/15: BAF Updated</p> <p>Agreed at FIC 21/05/15.</p>
433	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	All staff need time with their line manager to support them to deliver what the organisation needs them to in terms of performance improvement, better care for patients and looking after and retaining our staff.	11-Feb-15	18		Effective Well Led	Corporate	Major	Likely	16	<ol style="list-style-type: none"> Corporate communications channels reviewed and refreshed as part of communications strategy approved by the Board in June 2014. Team Talk introduced in September 2014 and now the operational management restructure is now in place – it is believed delivery and feedback will be improved. Set up Workforce Committee to monitor delivery of staff engagement plan. Operational restructure will improve engagement with line managers. 	C. Gawne	21-Aug-15	Major	Likely	16	<ol style="list-style-type: none"> Performance management and appraisal of engagement objectives for line managers. Training and support for senior managers Evaluation with front line staff 	<ol style="list-style-type: none"> Directors CTLs 50% Clinical 50% Management Director of Communications 	<ol style="list-style-type: none"> On completion of operational structure Ongoing conferences Internal communication mechanism. Audit by Dec 2015 	<ol style="list-style-type: none"> Team Talk feedback report to EMT. Staff Survey, Team Talk feedback 	Major	Unlikely	8	<p>21/08/15 C. Gawne proposed to regrade net rating from major x likely = 16 to major x possible = 12.</p> <p>Approved by C. Gawne and noted by SMT 11.02.15</p>

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434	There is a risk that that new sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch). This could result in a lack of support by stakeholders: at best this would mean no support for change or growth programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	ADO's are essential for strong local stakeholder management, it cannot be done effectively centrally	11-Feb-15	19		Responsive Well Led	Corporate	Major	Likely	16	1. New ADOs are developing strong relationships with key stakeholders from Aug 2015 2. New Communication Public Affairs Manager starting September 2015 to support them from Aug 2015	C. Gawne	26-Aug-15	Major	Likely	16	1. Provide support and training and regular stakeholder perception testing 2. EMT to support ADO's in their involvement with Operations Directorate stakeholder engagement 3. Support for new ADO's from Communications around stakeholder management and briefing on local politicians and stakeholders.	1-2. Director of Communications and Director of Operations 3. Communications Team	1. December 2015 2. Ongoing 3. Ongoing	1-2. Regular updates and feedback between Communications and ADOs	Major	Unlikely	8	Approved by C. Gawne and noted by SMT 11.02.15
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		Safe	Clinical	Major	Likely	16	1. NHS staff benefits (e.g. pensions, T&Cs, etc.) 2. LAS staff benefits (e.g. cycle scheme) 3. LAS retention staff benefits (EMT suggestions) 4. Listening into Action - to understand staff improvements. 5. Actively recruiting university and registered paramedics and emergency ambulance crew 6. 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. 7. Clinical support structure provides career progression opportunities, with on-going training development 8. Revision of the Exit Surveys to provide accurate information on staff who leave, i.e. 9. NHS, competitors, etc. and reason for leaving 9. Retention data of resignations, projected leavers, projected joiners to identify reasons for resignation and opportunity to take intervention action.	Karen Broughton	24-Aug-15	Major	Likely	16	1. Review exit interview process and data capture. 2. The comprehensive Retention Strategy is being monitored by the Workforce Committee 3. Promote learning and development opportunities. 4. Recruitment drive to fill vacant established posts. 5. Develop a Health and Wellbeing Strategy	1. Karen Broughton 2. Karen Broughton 3. Mark Whitbread 4. Karen Broughton 5. Tony Crabtree	1. On-going 2. On-going 3. On-going 4. On-going 5. Summer 2015	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for ongoing cohorts of A&E support and Paramedic staff. 5. Development of reward strategy. 6. Development of clear clinical career structure.	Major	Unlikely	8	24/08/15 JJ: The comprehensive Retention Strategy is being monitored by the Workforce Committee – no other update Reviewed by K.Broughton May 2015. It is possible that the changes and difficulties with the Senior Paramedic programme could impact on this. however, the improvement plan should also impact in the other direction. EMT reviewed the rating based on current assurance on 20/1/15 and agreed net rating to graded at major x likely = 16. R. Faisey updated risk 7th January 2015. Proposed regrading of net rating from major x almost certain = 20 to major x likely = 16 back in line with the gross rating. SMT discussed risk rating on 14/1/15 and suggested risk remained at 20.
443	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care		21-May-15	26			Fleet and Logistics	Major	Likely	16	1. Serial numbers on all re-usable equipment that can be accurately tracked. 2. Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3. Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4. Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5. Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles	Andrew Grimshaw	26-Aug-15	Major	Likely	16	1. Agree equipment to be tracked / scanned each day and accountabilities for each item 2. Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 3. Ensure adequate stocks of consumables and equipment are available to VP staff 4. Review current VP contract and agree any immediate changes 5. Agree essential equipment, plan and implement a process to make key items available centrally to restock 6. Plan rollout of and implement complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided	1-3. Logistics manager 4. Head of Fleet & logistics 5. Logistics manager 6. Head of Fleet & logistics	1. 10/09/15 2. 10/09/15 3. On-going 4. 25/09/15 5. 10/09/15 6. 31/10/15	1. Partial via VP reporting 2. Partial via VP reporting 3. OOS policy & reports 4. OOS policy & reports 5. OOS policy & reports	Moderate	Unlikely	6	Agreed at FIC 21/05/15.
440	There is a risk that the LAS will not be in a position to win new NHS 111 contracts as stated in the 5 year strategy.	Cause There is no consistent 111 tender process or service across London. 111 contracts across London are going out to tender at different times and are constructed differently across London e.g. from single 111 services to major partnership arrangements for multiple urgent care services. 111 growth may not be given adequate	08-Apr-15	20		Well Led	Corporate	Major	Likely	16	1. Contract team in place ...gathering information of service requirements / KPIs / costing of service. 2. Improve interactions between 999 and 111 services and grow our 111 business	Karen Broughton	26-Aug-15	Major	Likely	16	1. Understanding developed, through conversations with 111 commissioners across London, of their timeframes for tendering. 2. Work with CCGs to influence 111 system development across London by: a) Continue to provide high standard 111 service in SE London with good governance b) Prepare clinically focussed bids for future 111 tenders c) Maintain interface between 111 and 999 pan-London through monthly London 111 Group and share lessons learnt d) Look at innovative ways to link 111, 999 and Urgent Care in SE London. 3. Bid for new 111 services as contracts become available	1. J. Nightingale 2. J. Nightingale 3. P. Woodrow & F. Wrigley 4. P. Woodrow & F. Wrigley	1. End Feb 2015 2. March 2015 3. 31/03/2016 4. 31/03/2016	2. Monthly Review	Moderate	Unlikely	6	26/08/15: BAF Updated 13/05/15 Karen Broughton proposed to re-grade net rating to impact 3 x likelihood 3 = 9

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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	Safe	Corporate	Major	Likely	16	1. Line manager instructed to use the incident reporting E-Mail address when completing a RIDDOR F2508 form. This is located within HS 011 This will result in a copy being received by the department from the HSE. 2. RIDDOR F2508 forms are completed electronically, allowing reporters to save a copy as a PDF file 3. Absences due to industrial injury are recorded on GRS, allowing potential RIDDOR reportable injuries (due to absence) to be tracked and cross referenced 4. HS011 requires all incidents to be reported within 7 days. RIDDOR reportable incidents are reported directly by line manager to HSE. 5. The Datix Web pilot incident reporting system is currently being used in 3 complexes. This system has inbuilt guidance regarding RIDDOR reporting, and a direct hyperlink to the RIDDOR form. This process is to be incorporated within the Incident Reporting Project Datix Web role out that is currently being reviewed. 6. LA52 packs to be kept on vehicles.	Sandra Adams Tony Crabtree	09-Jun-15	Major	Likely	16	1. All incidents received by the Safety and Risk Department are to be reviewed by a Safety and Risk Advisor to follow up RIDDOR reporting, updating the DATIX record with the reference number. Reviewed at corporate level. 2. Absences of more than 7 days resulting from industrial injury is to be tracked on a spreadsheet to allow Safety and Risk Advisors to chase RIDDOR references, updating the DATIX record with this reference number 3. Incidents from January 2013 are to be reviewed for data quality on DATIX by Governance and Safety and Risk. As part of this, the incident will be reviewed to establish if it is RIDDOR reportable to gather more accurate numbers. (to be picked up at the Integrated Governance Meeting and discussed) 4. HS011 requires all incidents to be reported within 7 days, allowing a Safety and Risk Advisor to request a RIDDOR form to be completed. It is the line managers responsibility to ensure RIDDOR is completed as required.	1. Safety and Risk 2. Safety and Risk 3. Safety and Risk and Governance 4. Safety and Risk	1. Completed and on-going 2. Ongoing action 3-04/04/15 4. On-going action	HS011 requiring all incidents to be reported within 7 days. HS011 requires all RIDDOR reportable incidents to be reported, giving instructions on doing so.	Moderate	Unlikely	6	Risk reviewed by P. Nicholson and F. Field 13/08/15. Amended to reflect focus on staff safety. Further risk identified with a focus on patient safety. 9/06/15 SA proposed this risk is closed and replaced with 2 risks focussing on patient safety and staff safety. Managers have been reminded in H&S bulletin about RIDDOR reporting. This highlights their responsibility to inform the HSE directly, together with forwarding a copy direct to the H&S dept. This will increase the level of reporting prior to the roll out of Datix Web. The new system is a real time reporting system that will include a direct link to the HSE and the H&S dept. HS 011 also has a direct link to HSE. J. Selby, 16/10/14 - Item 1 - This action is addressed Item 2 - This item is addressed	
442	There is a risk that there may be insufficient range and volume of equipment to meet demands. Staff will not have equipment required to provide appropriate patient care		21-May-15	25		Fleet and Logistics	Major	Likely	16	1. Agreed vehicle equipment lists including re-usable v disposable in place 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit	Andrew Grimshaw	26-Aug-15	Major	Likely	16	1. Define and agree a "core" equipment list for DCA and FRU 2. Logistics to take responsibility for supplying core equipment 3. Undertake an audit of available equipment 4. Continue to purchase equipment 5. Undertake an equipment amnesty and physically review all stations and complexes for "retained" equipment 6. Introduce monitoring process for tracking equipment 7. Develop system to reintroduce equipment that gets decontaminated 8. Agree equipment to be tracked/scanned each day and accountabilities for each item 9. Review contents, responsibility and issue of "bags". Agree terms of reference and timeline. 10. Implement working group to review personal issue kit	1-3. Head of F&L 4-5. Logistics Manager 6. Head of F&L 7-8. Logistics Manager 9-10. Head of F&L	1. 10/09/15 2. Immediate 3. 30/06/15 4. On-going 5. 30/09/15 6. 30/11/15 7. 18/09/15 8. 31/10/15 9. 30/09/15 10. 30/09/15	1-3. Monitored within Fleet & Logistics 4. Budgets (Dir of Finance) 5. Some items agreed (Head of F&L/Dep Dir Operations)	Moderate	Unlikely	6	26/08/15: BAF Updated Agreed at FIC 21/05/15.	
444	There is a risk that the equipment for frontline vehicles may not be in an effective condition. Staff will not have equipment required to provide appropriate patient care		21-May-15	27		Fleet and Logistics	Major	Likely	16	1. Agreed VP cleaning, deep cleaning and stocking service levels are set, maintained and monitored 2. Decontamination of equipment during VP, including monitoring 3. Decontamination of items left at hospital, including monitoring 4. Replacement equipment budgets in place. Process agreed and adhered to 5. Maintenance/Replacement of Kit undertaken when required	Andrew Grimshaw	26-Aug-15	Major	Likely	16	1. Complex based fleet to increase vehicle availability for VP 2. Monitor Decontamination of equipment trial 3. Implement contract for decontamination 4. Develop system to reintroduce equipment that gets decontaminated 5. Establish revised process for collection of equipment left at hospital for decontamination & subsequent redistribution 6. Review process for maintenance of equipment 7. Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 8. Ensure current performance against 95% deep clean within 6 weeks maintained.	1. Head of Fleet & Logistics 2-5. Corporate Logistics Manager 6. Head of Fleet & Logistics 7. Corporate Logistics Manager 8. VP Manager	1. 31st October 2015 2. 30th June 2015 3. 30th June 2015 4. 31st August 2015 5. 30th June 2015	1-2. Partial via VP reports 3. Decontamination reports 4. Partially monitored within Fleet & Logistics 5. Monitored within Fleet & Logistics	Moderate	Unlikely	6	Agreed at FIC 21/05/15.	

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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	11-Jun-14	10	Safe	Operational	Major	Likely	16	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies.	Paul Woodrow	17-Mar-15	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. eAmbulance project to refine current requirements and procure viable commercial (h/w & s/w) solution, which is likely to require in-house bespoke 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	21/09/15 Query J. Killens as risk owner Risk reviewed by IM&T March 2015. 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. 27/7/15 - Whilst LAS Sat Navs are known to be End of Life we have to complete a re-engineering of Command Point to allow newer models of Sat Nav to be used. This work is progressing and should be ready to test in Q3. The risk we are carrying (covered in IM&T Risk ref 400) is the manual use of Sat Navs when Command Point is not available. This is mitigated through Map Books and will only be fully resolved once up to date devices can be utilized.	
445	Risk of exposure to Category 4 infectious disease organisms as well as other infectious diseases of high consequence, resulting in potential adverse consequence to the health of LAS staff and that of the general public to whom they are responding.	Personal Protective Equipment (PPE) Some operational staff are at risk of infection due to: • Staff not having the equipment because they haven't been fitted with the FFP3 respirator mask. • Staff coming completing basic training having been fit tested but not having the equipment issued. • Assurance of the PAS/VAS/Community Responders status for category 4 preparedness. Patient facing staff knowledge, understanding and training Operational staff are at risk of infection due to: • Lack of knowledge and specific training regarding infectious disease processes, the use of regular and	27-May-15	30		Health & Safety	Catastrophic	Likely	20	1. Infection Control Workbook; standard infection prevention control training programme in place. 2. Infection Control Specialist and OH&D service (not 24 hrs) 3. Task and finish group for Category 4/VHF(Ebola) assurance (chaired by EPRR) 4. Clear process for confirmed Ebola case between LAS and the Royal Free and working arrangement with Health Protection Units. 5. Regular EPRR Ebola management bulletins, including algorithms for early identification of possible cases of VHF at the call taking stage and CHUB 6. Support from the Clinical Hub and Health Protection Unit for enhanced risk assessment on suspected cases. 7. Current OHS contract does not include contract tracing- new contract from 1st April 2015 for new provider has enhanced specification 8. Waste contract in place - includes Cat A waste for incineration 9. IPC at Clinical Basic Training and CSR - requires enhancement for Ebola PPE 10. FFP3 Fit testing and provision of personal issued respirators, basic clinical training for existing staff - captured at FITFLU Programme commenced 15/10/14 11. Ebola assurance monitoring by VHF Group and at IPCC 12. National Transfer procedures agreed 13. Ongoing engagement with PHE	Zoe Packman	10-Sep-15	Catastrophic	Possible	15	1. Develop VHF Plan - Action cards, transfer process, VHF bulletins, 2. Identify, risk assess, procure, distribute enhanced PPE: HART LAS operational staff 3. LAS Ebola VHF processes (e.g. policy and procedures) internally and externally aligned 4. Develop a set of FAQ's for all staff 5. Develop monthly compliance data and reporting for FFP3 fit testing to the IPC team for assurance 6. Share HART training package with the education and development department to ensure a consistent standard of infection control training including the use of enhanced PPE 7. Review the requirements of involvement of individuals to take part in the form working group with terms of reference for actions identified and monitoring arrangements to be put in place. 8. Enhance the decontamination process for vehicles as per national and expert guidance, to include for example hypochlorite / Bioquell, for use by all crews. 9. Procure an enhanced Category A waste disposal service Additional control measures to reduce existing level of risk: (PATIENTS & STAFF) 10. Review Incident Outbreak Policy 11. Enhance Occupational Health Service contract requirements to incorporate immediate access, contact tracing and follow up or alternative internal arrangement. New contract in place from the 1st April. 12. Identify an Incident Control Group in the event of a	1. LL VHF Group 2. L.L. / ECH / HF R. Deakins A. Fulcher K. Merritt 3. S Woodmore Chris Reeves 4. Comms assisted by VHF group 5. P. Williams 6. S Woodmore I Bullamore E Hitchcock 7. L. Lehane 8. Trust Decon Lead 9. N. Smith ECH 10. E. Hitchcock 11. Fatima Fernandes 12. S. Lennox 13. J Downard 14. C Gawne 15. L. Lehane P Williams	1. Completed 17/03/15 2. Complete 3. Completed as part of 1 above 4. Completed in line with national guidance 17/03/15 5. Complete 6. Ongoing 7. Completed 17/03/15 8. 31/05/15 9. Complete 10. May 2015 11. Completed 12. Complete 13. Ongoing 14. Completed 17.03/15 15. Ongoing	6. M Rainey advised crews are using Clinell wipes (Green then Activated Red then Green) which is effective, however testing is due to take place for Bioquell - liaison with E Hitchcock. Hypochlorite was found to damage the metal in the ambulances. 8. Awaiting Enhanced PPE to prepare and share training package - liaison with L. Lehane.	Catastrophic	Unlikely	10	10/09/15 NC/MS met with M Rainey to discuss and update 19/08/15 IPC taskforce - review risk EH/LL Simon Woodmore / Mark Rainey / FF	
410	There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	50% total volume of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.	01-Oct-14	16	Safe Effectiveness	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 - if a concern is flagged during welfare ring-back. 4. LAS Surge Management Plan. 5. Targeted additional resource at times of peak pressure using PAS/VAS/taxis. 6. LAS overtime 7. C1-C4 buckets have been redefined based on clinical outcomes. 8. Removal of exit message and clarity to patients regarding time delays. 9. Additional focus on safety reporting. QA - MPDS (999); QA - CHUB MTS (H&T); - Report safeguarding incident concerns 10. Falls care is being introduced. Flag elderly fallers on vulnerable person monitor (VP). Clear process of escalation of response process implemented 11. METDG is in place 24/7. 12. The CHUB now have a Clinical Manager overseeing each shift 13. Implementation of VP (mental health / elderly fallers) and CP (sickle cell / septic patients) screen to monitor higher risk patients. 14. Managing patients through use of non emergency transport options where clinically appropriate. NETS desk and HCP lines to be	Paul Woodrow	26-Aug-15	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 5%. 2. Reviewing the determinants to best maximise resource availability, to assist with reduction in 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. 9. Use of lower acuity ambulances. Non emergency transport service in place partially from July 2015 and fully from September 2015. DX018 (low acuity calls) passed to CHUB resulting in greater use of taxis. 10. Increasing taxi use. Use of an SOP with taxi booking makes the process safer. 11. Discussion with NHS 111 regarding the green calls and outcomes.	1. K. Broughton 2. P. Woodrow 3. P. Woodrow 4. K. Millard 5. K. Millard 6. K. Millard 7. K. Millard 8. 9. K. Millard / F. Wrigley 10. K. Millard / F. Wrigley 11. K. Millard / F. Wrigley	1. Ongoing 2. Complete 3. Q4 14/15 4. Q3 14/15 5. Q2 14/15 6. 2014/15 7. Oct 2015 8. On-going 9. Completed 10. On-going 11. On-going	1. Reported on dashboard 2. Performance dashboard 3. Business as usual 4. IDM reports 5. IDM reports 6. Operations 7. QA 8. Implemented - monitor complaint themes 9. SI Group - Governance Group 10. Implemented - Monitor SI and complaint themes 11. Resourcing reports 12. Implemented 13. Although is fully implemented. For reviewed in Nov. 2015 to check effectiveness and decide if now effective 14. Bi-weekly HCP nets meeting	Catastrophic	Unlikely	10	21/09/15: 1) Have APPs in the control room. 2) Clinical Team Leaders are available 50% of their time to address any clinical problems. 26/08/15 - A.Blakely: Reviewed by medical Directorate - August 2015. Risk should remain as the staffing in the CHUB remains at risk, although the QGM roles are recruited to. Reviewed at Control Services meeting 4/06/15 Reviewed by Medical Directorate - May 2015. CHUB Staffing currently at risk although there is a plan in place, so should currently stay as it is. ADO's reviewed 12/03/15. F. Wrigley reviewed 18/03/15. F. Moore reviewed risk on 5/01/15 FW / DSW 03/12/14 Additional measures to	

**London Ambulance Service NHS Trust
Trust Risk Register September 2015 (15+)**

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	12	1,2,4,5	Effective	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from data cards. 5. LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units. 6. New Malden pilot has trialled the transmission of data from the LP15	Mark Whitbread	26-Aug-15	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 out of it. The evaluation of this exercise will be reviewed in February 2015. This practice is in place all of the time now 6. Put a suggestion forward for it to be included as a CQUIN in the next financial year to the CQRG. Team leaders now in place 50/50 will influence the output.determine the impact of this risk review 3 months	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread	1. Complete 2. Complete 3. Complete 4. Ongoing post N/Malden pilot evaluation 5. Commence Mid Dec 14	EOC briefings undertaken	Moderate	Unlikely	6	26/08/15 - A.Blakely: Reviewed by Medical Directorate August 2015. Downloads remain at similar levels. Any update re: comment below? June 2015 - M. Whitbread to review with F. Moore for next course of action. Reviewed by Medical Directorate May 2015 - should remain.We are at 8% for defib downloads for April (compared to 1% for the whole of 14/15). March 2015 - Risk reviewed by M. Whitbread. 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.
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	08-Oct-14			Safe Effective	Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks. 2. Enterprise antivirus monitoring LAS infrastructure.	Steve Bass / Vic Wynn	19-Jun-15	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. De0pl	1. R. Clifford	1. August 2015	1. Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	RC:19/06/2015 System Procured and deployment phase has begun RC:06/05/2015 System Procured and deployment phase has begun RC:25/03/15: Intrusion System has been purchased - Install date is for April 2015 22/01/2015 Funding approved and procurement completed. Implementation to be completed by 28/02/2015 (subject to detailed planning of implementation) 18/12/2014 IM&T approved the purchasing/deployment of an Intrusion Detection System (IDS) to monitor LAS networks
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 2013)	08-Oct-14			Safe Effective	Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks 2. Enterprise antivirus monitoring LAS infrastructure	Steve Bass / Vic Wynn	19-Jun-15	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. 31/08/15 2. 31/08/15	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	RC: 19/06/2015 Firewalls have been placed in situ. A traffic review is in progress to ascertain the valid traffic between sites. a "hardening" process will begin once all traffic has been validated (July 2015) RC: 06/05/2015 Firewalls have been placed in situ. A traffic review is in progress to ascertain the valid traffic between sites. a "hardening" process will begin once all traffic has been validated (July 2015) RC 25/03/15: Firewalls have been purchased and are in situ - On target for full implementation and go live by agreed date 22/01/2015 .The network audit is needed to determine valid network traffic paths which will be incorporated into the new security rules / controls . This will continue until the next planned Control Services exercise/operation "on paper"

**London Ambulance Service NHS Trust
Trust Risk Register September 2015 (15+)**

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	CQC Domain	Risk Category	Gross Impact	Gross Like- lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like- lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like- lihood	Target Rating	Comments
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			Safe Effective	Information Governance	Catastrophic	Possible	15	1. Enterprise antivirus monitoring CAC desktops 2. Desktop ports disabled (i.e. USB, DVD) 3. No access to internet /email for CAC desktops	Steve Bass / Vic Wynn	19-Jun-15	Catastrophic	Possible	15	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 Bquiri	1. 31/08/15	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	19/06/2015 Implementation reliant on CAD upgrade (within a planned EOC outage)- Centralised system to distribute updates (patches) being implemented and will be available by June 2015 20/05/2015 Implementation reliant on CAD upgrade planned on 15th May (within a planned EOC outage)- still ongoing 25/03/2015 Third party (NG) still testing CommandPoint software on Windows 7 22/01/2015 The new (required) CommandPoint software is still in testing, due to defects identified. The observed defects have been rectified and are being retested.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Report from the Audit Committee on 7th September 2015
Report Author(s):	John Jones, Chair of the Audit Committee
Presented by:	John Jones, Chair of the Audit Committee
Contact Details:	sandra.adams@lond-amb.nhs.uk
History:	Assurance report from the most recent Audit Committee
Status:	For information
Background/Purpose	
The purpose of this report is to update the Trust Board on the key items of discussion at the Audit Committee meeting on 7 th September 2015.	
Action required	
The Trust Board is asked to note the report from the Audit Committee meeting on 7 th September 2015.	
Assurance	
It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control.	

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

GOVERNANCE AND RISK MANAGEMENT

Board Assurance Framework and Corporate Risk Register & the Risk Management Strategy and Policy

The Audit Committee reviewed the updated risk register and board assurance framework (BAF), which is aligned to the 2015/16 business objectives. The BAF is a dynamic document and reflects the key issues facing the Trust. The committee heard that the Executive Management Team review and update the risks and controls prior to each meeting of the Trust Board and that each risk had been reviewed and updated during August 2015. Particular emphasis needed to be given to reducing the level of risk and removing the risk from the BAF and to explain why any long standing BAF risk was not being sufficiently mitigated to reduce the severity level and this led to a discussion about risk acceptance and tolerance. It was noted that the Trust Board would be undertaking a risk review session in the Autumn and this would incorporate discussion about risk tolerance and acceptance.

The Audit Committee discussed specific risks relating to staff turnover, vehicle preparation and equipment, and 111 contracts.

In summary, the Audit Committee is assured that the risk management process is working well, and that there will be more focus going forward on understanding the true risks facing the Trust, identifying any gaps and taking action to address these. Greater links would also be made between the integrated performance report and the BAF.

Risk Focus Areas

Steve Bass, interim Chief Information Officer, attended the meeting to present a further deep dive on IM&T risks. The purpose of the deep dive was to update the Committee on the findings and recommendations of the IM&T review undertaken between March and July 2015. The paper presented an overview of the review activities and the key findings. The Executive Management Team had received the same presentation in August and had made a number of key decisions in order to progress the findings.

The committee took assurance on the work underway and noted that a key consideration with this would be to balance what was required/needed with affordability.

Single Tender Waiver Register

The Audit Committee queried why certain contracts were not planned in advance, for example for private ambulance provision, and asked for assurance that contracts were not just being rolled forward. Andrew Grimshaw confirmed that there was proactive and rigorous contract management in place with robust discussion and negotiation and the Trust worked within the procurement framework.

Terms of Reference

The Terms of Reference had been reviewed at the June meeting as part of the annual effectiveness review and Audit Committee annual report. Further scrutiny was given to these and a number of changes recommended for approval at the November meeting.

FINANCIAL REPORTING

Losses and Special Payments Report

The Committee considered the report and asked for more information about the actions being taken to improve the area of accident damage.

INTERNAL AUDIT

Internal Audit Progress Report

The Committee noted the progress against the 2015/16 Internal Audit plan: management were due to comment on the draft Business Continuity Management report and findings which had received a rating of partial assurance with improvements identified; the review of risk management was underway; both reports would be brought to the November meeting. The Audit Committee received the report on safeguarding and took assurance from the rating of significant assurance with minor improvement potential, and noted that due dates and responsible officers had been added since the previous draft. The Committee felt this reflected well on Alan Taylor, Head of Safeguarding.

The Committee heard that the 2015/16 work programme had been updated following review by the Executive Management Team.

Review of progress against Internal Audit recommendations

The Committee received an update on progress against recommendations and actions. It was noted that 18 outstanding recommendations remained of which 8 were overdue, comprising 2 high priority, 5 medium priority and 1 of low priority. The Audit Committee was assured of progress and the focus being given by management to taking action and felt this was going in the right direction. Concern was expressed where there was no comment against priority recommendations.

Local Counter Fraud Specialist Progress Report

The Committee noted the progress report since 1st June 2015 and received an update on cases.

EXTERNAL AUDIT

Formal appointment of the new External Auditors

The Committee welcomed David Riglar from Ernst and Young LLP and noted the apologies from the Director, Mick West, who was unable to attend. The contract was for 2 years with an option to extend, and the Committee would receive the audit plan at the meeting in February 2016.

REPORTS FROM COMMITTEES

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

INTERNAL AND COUNTER FRAUD CONTRACTS

The Audit Committee discussed the options for the above contracts which currently run until March 2016.

Date of next meeting: The next meeting of the Audit Committee is on Monday 9th November 2015.



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Annual report - revalidation
Report Author(s):	Fionna Moore / Fenella Wrigley
Presented by:	Fenella Wrigley, Interim Medical Director
Contact Details:	fenella.wrigley@lond-amb.nhs.uk
History:	Executive Management Team
Status:	To provide assurance on the revalidation of doctors within the London Ambulance Service NHS Trust
Background/Purpose	
<p>The London Ambulance Service (LAS) is the Designated Body for a small number of doctors who either only work for the LAS or have their principle connection with the Service.</p> <p>Currently five doctors have a registered connection with the LAS. All have undergone appraisal in the past year and have agreed Personal Development Plans. None of the doctors have yet reached the dates when submission of their revalidation recommendations is required.</p> <p>Three of the doctors that this document relates to may have significant difficulties in providing evidence for revalidation and fitness to practice, given their limited scope of work with the Emergency Bed Service. They have also been retired from active clinical practice for a number of years.</p> <p>One doctor currently has a restriction to his practice from the GMC.</p> <p>The LAS is working to actively support the efforts of each individual to provide evidence to support revalidation. Both the interim Medical Director and one of the Assistant Medical Directors are trained appraisers and have oversight of this process.</p> <p>Risks: There is a risk that one of the five doctors with a prescribed connection to the LAS will be unable to provide sufficient evidence to justify a positive recommendation for revalidation.</p>	
Action required	
<p>Once the Trust Board has taken assurance from the report the Chief Executive will sign a Statement of Compliance.</p>	

Assurance

- The LAS Medical Director has been the Responsible Officer (RO) for the organisation, supported by the Deputy Medical Director who is a trained Appraiser. The Medical Director has now been appointed to the position of Chief Executive and the role of RO is now undertaken by the interim Medical Director.
- The LAS is working to actively support the efforts of each individual to provide evidence to support revalidation.
- Both the interim Medical Director and one of the Assistant Medical Directors are trainer appraisers and oversee the annual revalidation process.

Key implications and risks arising from this paper

Clinical and Quality	X
Performance	
Financial	
Governance and Legal	X
Equality and Diversity	
Reputation	
Other	

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

Improve the quality and delivery of urgent and emergency response	X
To make LAS a great place to work	X
To improve the organisation and infrastructure	X
To develop leadership and management capabilities	



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Board Statements and Declarations
Report Author(s):	Sandra Adams, Director of Corporate Affairs/Trust Secretary
Presented by:	Sandra Adams
Contact Details:	sandra.adams@lond-amb.nhs.uk
History:	N/A
Status:	Approval
Background/Purpose	
<p>The Trust makes two monthly governance compliance submissions to the TDA: Board Statements and Monitor Compliance. These statements are brought to the Trust Board with an exception report where there is a risk of, or actual, non-compliance. The Trust Board can confirm compliance with each statement and requirement with the exception of the following where there is a risk of non-compliance:</p> <p>Board statement 5 – NHS Constitution – the 2014 staff survey was reported to the Strategy Review and Planning Committee as ‘failing against all 4 staff pledges’. The Trust meets the pledges for patients.</p> <p>The Retention strategy was implemented in early 2015 and includes an action plan to address key areas.</p> <p>Board statement 10 - The Board is unable to declare compliance with this statement this month having re-run the forecasting model for activity and planned capacity in the coming months. We delivered in Q1 and have plans in place to recruit more staff and improve productivity, we will not achieve the national target until we are at full establishment (Q3 15/16) and all new staff in training are released to the front line operations (Q4 15/16).</p> <p>The above statement will be declared as one of non-compliance.</p>	
Action required	
To approve submission of a full compliance statement with the exception of Board Statements 5 & 10.	
Assurance	
EMT reviewed the full set of statements in April 2015 and identified the Board Statement 5 as a risk to compliance. Evidence was available against each of the other statements to support compliance.	

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



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 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	
<p>This report is intended to inform the Trust Board about key transactions thereby ensuring compliance with Standing Orders and Standing Financial Instructions.</p> <p>Tenders received One new tender was received on 10th August 2015:</p> <ol style="list-style-type: none">1. Provision of security services Tenders received from: CIS Security Limited Mercury Security t/a SGCFM Octavian Continental Limited Profile Security Services Limited Unipart Security Solutions. <p>Use of the Trust Seal There have been no new entries to the Register for the use of the Trust Seal since 28th July 2015.</p>	
Action required	
<p>To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 28th July 2015 and to be assured of compliance with Standing Orders and Standing Financial Instructions.</p>	
Assurance	
<p>Compliance with Standing Orders and Standing Financial Instructions.</p>	

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



TRUST BOARD FORWARD PLANNER 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 Quality 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 24 th September 2015 Audit Committee on 7 th September 2015	

24th November 2014

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

2016

Community First Responders – presentation – date to be confirmed

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 Governance Committee	Bob McFarland	13			14			14		22		17		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	



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	2016 Trust Board calendar
Report Author(s):	Sandra Adams, Director of Corporate Affairs/Trust Secretary
Presented by:	Sandra Adams, Director of Corporate Affairs/Trust Secretary
Contact Details:	sandra.adams@lond-amb.nhs.uk
History:	N/A
Status:	For approval
Background/Purpose	
<p>The Trust Board meets formally in public six times a year and holds 5 strategy, review and planning meetings in private five times a year. Dates for reporting committees are scheduled to facilitate timely reporting of key assurance information to the Trust Board.</p> <p>The Trust Board is asked to approve the dates for 2016 with one caveat: approval of the annual accounts, annual report and annual governance statement is undertaken by the Audit Committee in late May/early June for recommendation to the Trust Board for approval and submission. Dates for both the Audit Committee and Trust Board fall in week commencing 30th May 2016 which is also the Spring Bank Holiday. As it is likely that the annual reporting submission date will fall at the end of that week or early week commencing 6th June 2016 it is proposed that the Audit Committee is held in the morning of Tuesday 31st May and the Trust Board follows that afternoon. If the submission date for the annual report and accounts is extended then it may be possible to hold the Trust Board on Tuesday 7th June 2016 instead.</p>	
Action required	
To approve the calendar for 2016 with the caveat on the date for the annual reporting submissions.	
Assurance	
Dates for reporting committees are scheduled to facilitate timely reporting of key assurance information to the Trust Board.	

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

2016 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	26		29		31		26		27		29		9.00 - 14.00
Strategy Review and Planning	Trust Chair		23		26		28				25		13	9.00 - 16.00
Annual General Meeting	Trust Chair									27				14.00 - 15.30
Charitable Funds Committee	Trust Chair													
Nominations and Remuneration Committee	Trust Chair													
Audit Committee	John Jones		15		18	30				5		7		14.00 - 17.00
Finance and Investment Committee	Nick Martin	21		24		19		21		22		24		
Quality Governance Committee	Bob McFarland	12		15		17		12		13		15		14.00 - 17.00
Improving Patient Experience Committee	Director of Nursing and Quality													14.00 - 16.00
Clinical Safety and Standards Committee	Medical Director													14.00 - 16.00
Clinical Development & Professional Standards	Director of Paramedic Education & Development													14.00 - 16.00
Executive Management Team (EMT)	Chief Executive Officer	Every Wednesday 9.00 - 12.00											9.00 - 12.00	

Denotes formal sub-committee of the TB

Awaydays

Annual Reports



Report to:	London Ambulance Service Trust Board
Date of meeting:	29th September 2015
Document Title:	Register of Interests – September 2015
Report Author(s):	Sandra Adams
Presented by:	Sandra Adams
Contact Details:	sandra.adams@lond-amb.nhs.uk
History:	N/A
Status:	For information and assurance
Background/Purpose	
<p>Register of Interests – Section 15 of the Standing Orders, Reservation and Delegation of Powers of the Trust Board Directors; supported by Appendix VII, Section 7, Standards of Business Conduct.</p> <p>Section 15 of the Standing Orders refers specifically to Board Directors and the Trust Board can take assurance that:</p> <ul style="list-style-type: none">- 15.2: Board directors and officers are invited to declare any new or undeclared interests at the commencement of all meetings of the Trust Board. This has been extended to Trust Board committees and the Executive Management Team;- 15.3: Board directors have registered on appointment, and provided an annual update as a minimum, any significant pecuniary or other interest material and relevant to the business of the Trust. <p>All directors have submitted declaration forms in 2015. There are no changes to declared interests since May 2015.</p>	
Action required	
To review the Register of Interests for information and assurance purposes.	
Assurance	
In accordance with Standing Orders the Register of Interests has been refreshed an updated and all managers, senior managers and directors have subsequently been advised of the additional requirement to incorporate ‘familiar relationships’.	

Key implications and risks arising from this paper	
Clinical and Quality	N/A
Performance	N/A
Financial	Potential risk if not declared
Legal	Potential risk if not declared
Equality and Diversity	N/A
Reputation	Potential risk if not declared
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve the quality and delivery of urgent and emergency response	N/A
To make LAS a great place to work	N/A
To improve the organisation and infrastructure	N/A
To develop leadership and management capabilities	N/A

Trust Board Register of Interest - May 2015

Name	Date	Nil declaration	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Richard Hunt	04/03/2015		✓	Director of Maven Executive Coaching and Mentoring	Director of Attan Partners Ltd				
Jessica Cecil	25/02/2015		✓				On the advisory board of IntoUniversity, a charity aimed at getting disadvantaged young people to university	One sister is an NHS physiotherapist who also sees patients privately; another sister is a public health researcher at Imperial College.	
John Jones	04/02/2015	✓							
Fergus Cass	04/03/2015		✓	Book Aid International - Charity - Trustee; Hospices of Hope - Charity - Trustee; Hospices of Hope Trading Limited - Charity related chain of shops - Chair Melton Court Parking Limited: company managing parking spaces at block where I live: Director			As noted above, I am a trustee of Hospices of Hope, a charity supporting hospice care in Romania and neighbouring countries		
Nicholas Martin	24/02/2015		✓	Cambridge Guarantee Holdings (Director); A2Dominion Housing Association (Director)			Chair, City of Westminster College		
Robert McFarland	05/02/2015	✓					Trustee and Chair of the European Doctor's Orchestra.		
Theo de Pencier	04/03/2015		✓	Freight Transport Association (FTA) - Chief Executive	LAS are members of FTA and from time to time purchase services/goods. I am not an owner or partner in FTA.			Other NHS Trusts are also members of FTA and from time to time purchase services/goods.	
Sandra Adams	04/02/2015	✓							
Karen Broughton	05/02/2015	✓							
Andrew Grimshaw	05/02/2015		✓	Director of LSO Consulting Ltd.					
Charlotte Gawne	17/03/2015		✓	Director – Vannin Consulting (currently a dormant IT consultancy)					
Jason Killens	10/02/2015	✓							
Fionna Moore	05/03/2015		✓	Medical Director, Location Medical Services.			Member Executive Committee, Resuscitation Council (UK)		
Paul Woodrow	10/02/2015	✓							
Mark Whitbread	09/03/2015	✓							
Zoe Packman	09/03/2015		✓					Honorary senior clinical fellow, Kingston University and St George's University of London	
Fenella Wigley	14/02/2015		✓				Regional Professional Lead for Doctors - St John Ambulance London Region		Expert Clinical Advisor to UKBA; Consultant in Emergency Medicine, Barts Health NHS Trust