London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 29th JULY 2014 AT 09.30 – 13.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.30	1.	**Welcome and apologies for absence** Apologies received from: Karen Broughton Jessica Cecil			
	2.	**Patient Story** To hear an account of a patient story			
09.45	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	4.	**Minutes of previous meetings** To approve the minutes of the meeting held on 24th June 2014	Approval	RH	TAB 1
	5.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.55	6.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	Oral
PERFORMANCE REPORTING					
10.05	7.	**Integrated Performance Dashboard** To receive the integrated performance dashboard	Discussion and direction	PW	TAB 3
10.30	8.	**Board Assurance Framework and Corporate Risk Register** To receive the quarter 2 documents	Assurance	SA	TAB 4
10.45	**BREAK**				
QUALITY GOVERNANCE					
11.00	9.	**Clinical Directors' Joint Report** To note the report from the Joint Clinical Directors	Assurance	SL/FM/ MW	TAB 5
11.10	10.	**Quality Governance Committee Assurance Report** To receive the report from the Quality Governance Committee meeting on 18th June 2014	Assurance	BMc	TAB 6
11.20	11.	**Annual Patient Experience Report 2013/14** To approve the annual patient experience report for 2013/14	Approval	SL	TAB 7

11.30	12.	**Annual Safeguarding Report 2013/14 and Savile Update** 12.1 To approve the annual safeguarding report for 2013/14 12.2 To provide the Trust Board with assurance in relation to the recommendations from recent NHS reports published in respect of the Savile allegations	Approval/ Assurance	SL	TAB 8
11.45	13.	**Annual Revalidation Report** To approve the annual revalidation report	Approval	FM	TAB 9
FINANCE					
11.55	14.	**Finance Report** 14.1 To note the finance report for month 3 14.2 To note the report from the Finance and Investment Committee meeting on 17th July 2014	Discussion and direction	AG NM	TAB 10
STRATEGIC AND BUSINESS PLANNING					
12.05	15.	**Modernisation Programme** To receive an update on the Modernisation Programme	Discussion and direction	PW	TAB 11
12.15	16.	**Recruitment Update** To receive an update on recruitment	Discussion and direction	DP	Presentation
12.30	17.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 12
BUSINESS ITEMS					
12.40	18.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for June and July 2014	Approval	SA	TAB 13
	19.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Compliance with Standing Orders	SA	TAB 14
	20.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 15
	21.	**Questions from members of the public**		RH	
	22.	**Any other business**			
	23.	**Date of next meeting** The date of the next Trust Board meeting is on Tuesday 30th September 2014			
The public meeting will close at 13.00					

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 24th June 2014 at 09:30 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Chairman
Ann Radmore	Chief Executive
Fergus Cass	Non-Executive Director
Jessica Cecil	Non-Executive Director
Theo de Pencier	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
John Jones	Non-Executive Director
Jason Killens	Director of Operations
Steve Lennox	Director of Nursing and Quality
Nick Martin	Non-Executive Director
Bob McFarland	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation and Strategy
Francesca Guy	Committee Secretary
David Prince	Director of Support Services
Mark Whitbread	Director of Paramedic Education and Development
Paul Woodrow	Director of Performance (minute 70 only)
Members of the Public:	
Kathy West	Patients' Forum
Mark Docherty	LAS Lead Commissioner
Members of Staff:	
Anna McArthur	Communications Manager
William Broughton	Paramedic
Michael Richman	Paramedic
Richard Webb-Stevens	Paramedic (minute 65 only)
Katy Millard	Head of Control Services (minute 75 only)
John Goldie	SEL NHS 111 (minute 75 only)

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64. Welcome and Apologies

64.1 No apologies had been received.

65. Staff Story

65.1 Richard Webb-Stevens joined the meeting to give an account of his experience of being deaf and working at the LAS. Richard had initially wanted to join the army, but his hearing loss meant that this had not been possible. Instead Richard had joined the LAS 16 years ago and had worked in the cycle response unit for the past 6 and half years. Richard spoke about his work raising deaf awareness throughout the LAS and introducing initiatives such as emergency SMS for the deaf. Richard also did regular outreach work in the deaf community to help improve access to emergency

services. Richard commented that he would like to develop an access package for new people joining the service or for people who had become deaf whilst in service.

65.2 The Chair noted that this was an inspiring story and was an example of the innovation that the NHS was trying to pursue.

65.3 Ann Radmore asked whether there was anything that could be done to make it easier for people who were deaf or hard of hearing to apply for jobs at the LAS. Richard responded that frontline staff required a minimum level of hearing ability to ensure that they were sufficiently able to communicate with and listen to patients. However, the Trust should be prepared to make reasonable adjustment to enable people with disabilities to work on the frontline.

65.4 The Chair thanked Richard for attending the Trust Board meeting and for giving an account of his experience of working at the LAS.

66. Declarations of Interest

66.1 None declared.

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

67.1 The minutes of the part I meeting held on 3rd June 2014 were approved, subject to some amendments.

68. Matters Arising

68.1 The following matters arising were discussed:

68.2 **26.12:** Bob McFarland noted that the mental health action plan had been presented to the Quality Committee on 18th June 2014 but that it had been tabled at the meeting and therefore the committee had not been able to discuss it in depth.

68.3 **50.5:** Andrew Grimshaw noted that no further changes had been made to the 2013/14 accounts following their presentation to the Trust Board on 3rd June 2014.

Update on recruitment

68.4 David Prince gave an update on recruitment activity.

68.5 Ann Radmore stated that she believed that the current rate of staff turnover would be a continuing trend, which reflected a significant change in the behaviour of paramedics and the demand for their skills in the wider healthcare sector. The Executive Management Team (EMT) had worked through what the LAS could offer paramedics to attract them to work in London. David Prince added that he was also exploring options for recruiting from the military and was looking to understand whether there was an alternative route to becoming a paramedic, other than going to university.

68.6 In response to a question from Bob McFarland about whether the Trust had turned a corner with regards to recruitment, Ann Radmore stated that it was not likely that the LAS would see an improvement until the early part of 2015. Increasingly, paramedics left the Trust after 5 to 6 years and this trend had been experienced across other ambulance services. This was a reflection of the development of the paramedic profession and necessitated a significant shift in the Trust's approach to recruitment and retention.

68.7 Nick Martin asked whether the recruitment campaign should focus on other countries such as China and Philippines. David responded that this had been considered but that the training was variable and therefore conversion to UK requirements was more difficult. Australia and New Zealand had been targeted as they had an oversupply of paramedics and the baseline training was very similar to that of the UK.

68.8 Theo de Pencier suggested that the 2015 Rugby World Cup might also attract people to work in London.

68.9 The Chair suggested that the Trust Board should have a regular update on recruitment.

69. Report from the Trust Chairman

69.1 The Chair gave an update on the Shockingly Easy campaign and noted that there had been 115 defibrillator accreditations in May and June.

69.2 The Chair noted that he had asked the NHS Trust Development Authority to identify any Trust Boards which they considered to set an example of best practice, with a view to observing their meetings.

70. Integrated Board Performance Report

70.1 Paul Woodrow joined the meeting for this agenda item and provided an update on current performance:

- Performance was challenged in month 2 for both red 1 and red 2;
- Overall activity in May was 1% above contract, however there had been a significant increase in Category A activity. Demand varied across CCGs and high utilisation rates meant that it had been difficult to meet the peaks in demand which had been experienced in some areas;
- Resourcing had been challenged, with difficulties filling overtime shifts;
- The A19 target had been achieved and was the best A19 performance in the country. The call-answering target had also been achieved;
- The 75th percentile had been achieved in 8 minutes and 20 seconds for red 1 and 8 minutes and 55 seconds for red 2;
- The surge plan had been escalated above amber for a considerable period in June.

70.2 Paul noted that a performance improvement plan had been developed and the Category A trajectory was being reviewed. The Category C determinants had also been reviewed, which would aid productivity in the Clinical Hub. Staffing in the Clinical Hub had also been increased, which ensured that held calls received regular ringbacks.

70.3 With regards to financial performance, Paul noted that the delivery of the target surplus was at risk given the current performance position and the risk of the imposition of the penalties. The current level of spend would need to be reviewed as it could not be sustained within the current financial plan.

70.4 With regards to workforce, Paul noted that 13 paramedics had left last month, however the recruitment campaign was underway and graduate paramedics would be joining the service in September 2014. Consideration would need to be given to how the service was managed over the next few months until the benefits of the new recruits were realised.

70.5 The Chair asked how well the Trust understood the reasons for people leaving. David Prince

responded that an external company had been employed to undertake exit interviews and the retention group met on a fortnightly basis to review the intelligence. Ann Radmore added that there were three broad reasons why people were leaving: training and the options for study that were available; how people were managed and the fact that the high cost area supplement did not reflect the true cost of working in London.

70.6 The Chair asked to what extent operational staff, including the control room, felt under significant pressure during times of high demand. Jason responded that operational staff did feel under pressure, particularly people in the control room as they were required to manage the relationship with patients whose calls were being held. Frontline staff were also under significant pressure given that utilisation rates were the highest in the country, which meant that surges in activity could not be absorbed.

70.7 Jessica Cecil asked whether the evidence from serious incidents and complaints indicated that welfare checks mitigated the risk of holding Category C calls. Paul Woodrow responded that the triage system was very risk adverse and therefore holding calls did not necessarily represent a safety risk, however there was a concern around the quality of patients' experience. The review of the Category C determinants would help to improve the productivity of the Clinical Hub and ensure that hear and treat was delivered where it was appropriate to do so.

70.8 The Chair noted that the Trust Board recognised that current performance levels were not acceptable and that actions had been considered to address this. The Trust Board would need to assure itself that the right actions were being taken and to understand when the impact of these actions would be seen. Ann Radmore responded that resourcing would continue to be challenged over the summer as members of staff would increasingly be taking annual leave. Management was meeting with CCGs to review the action plans and also to agree what actions CCGs could take to support the Trust.

70.9 The Chair asked Fionna Moore whether she was satisfied that all actions were being taken to maintain safety. Fionna responded that she was satisfied and that the clinical directors were part of a conference call on a daily basis. Staffing in the Clinical Hub had been increased and a process was in place for ringing back higher priority Category C calls.

70.10 The Chair asked whether the high utilisation rate was at the root of the challenged performance position. Jason responded that an independent benchmarking of utilisation rates in UK ambulance services indicated that the LAS was at the highest end of the range with over 80% utilisation compared with the lowest at 44%. High utilisation meant that the Trust was unable to meet the surges in demand experienced over the last months.

70.11 Bob McFarland asked what impact high demand had had on the delivery of training and the ability of Team Leaders to provide support to crews. Jason responded that the Trust had maintained the delivery of 2000 hours of Core Skills Refresher training per week. Team Leaders had protected time from Monday to Thursday to undertake operational workplace reviews, personal development reviews and clinical performance indicator completion, and were deployed to frontline duties Friday to Sunday.

70.12 Theo de Pencier noted the impact that poor air quality had on health and suggested that there might be some assistance that could be accessed to deal with the consequences of poor air quality.

70.13 William Broughton asked whether it was possible to use elements of the surge plan during periods of normal demand in order to keep resources back to manage the surges in demand. Jason responded that the Trust was currently proactively operating at surge amber. Karen added that discussions were underway with CCGs about whether there was a different response that the Trust

could routinely give to certain groups of patients.

71. Quality Account 2013/14

71.1 Steve Lennox reported that the Quality Committee had reviewed the Quality Account for 2013/14 and had recommended Trust Board approval. There were a number of small changes that would be made to the report prior to its submission. Steve would work through the Patients' Forum recommendations with Malcolm Alexander to agree how these would be taken forward.

71.2 Ann Radmore noted that the patient engagement strategy made a recommendation to set up a patient reference group and the LAS would engage with this group in the future.

71.3 The Trust Board approved the Quality Account for 2013/14.

72. Clinical Directors' Joint Report

72.1 Fionna Moore noted the following:

- The increasing use of surge red had continued into June, with surge red being enacted almost every day in June;
- Yesterday (23rd June) the surge plan had been escalated to purple and a major internal incident had been declared. Approximately 350 calls had been received per hour and at certain times of the day over 200 calls were being held;
- Clinical Performance Indicator completion rates were below target and this would be an area of focus for the Team Leaders. Team Leader training was currently underway;
- There had been an increase in complaints, however this was relative to the number of calls received;
- The work undertaken by the Clinical Audit and Research Unit gave assurance that risks were being managed and mitigated appropriately;
- The results of the National Ambulance Service Clinical Performance Indicator audit for single limb fractures indicated that LAS performance was the worst in the country. An action plan had been developed to improve this position and Team Leaders had been asked to disseminate learning.

72.2 The Chair noted that the mental health Clinical Performance Indicator remained the lowest scoring audit. Bob McFarland commented that performance against this indicator had been discussed at the Quality Committee and that the majority of the individual elements of the CPI were performing well, with the exception of two: recording the patient's appearance as an indication of their ability to cope, and consideration of safeguarding for the patient. Actions to improve this position had been identified and had been included in the mental health action plan for this year.

72.3 Ann Radmore noted that the Mental Health Committee was meeting this week and would review the mental health component of the Core Skills Refresher training, which should lead to an increase of knowledge in this area. Compliance against this CPI would continue to be reported to the Trust Board.

72.4 The Trust Board considered the following question from the Patients' Forum:

72.5 *Can the Board confirm that the London Ambulance Service will have the technical and workforce capacity to match all of its front line responses to the clinical needs of Category A and Category C patients from 8th September 2014?*

72.6 The Chair noted that this had been discussed earlier and the expectation was that the LAS would

not see a significant improvement in staffing until the early part of 2015. However the recruitment campaign was underway and graduate paramedics would be joining the service in September 2014.

72.7 The Trust Board considered the following question from the Patients' Forum:

72.8 *The Patients' Forum welcomes the excellent Patient Experiences/Complaints Report (Clinical Directors Report) and the Board's commitment to implementing the 14 recommendations of the Francis Report on complaints. Will the Board in addition ensure that sufficient resources are available to meet the Health Service Commissioners aspiration, that all Trusts should be 'visibly learning from mistakes and consequently improving services for others'? How will NEDS make sure that such learning from complaints has taken place across the London Ambulance Service?*

72.9 Steve Lennox responded that learning from experience was a key part of the quality strategy. Bob McFarland responded that this had been discussed at the last Quality Committee meeting and whilst there were already mechanisms in place for learning from experience, it was recognised that this was an area for further improvement.

72.10 Kathy West commented that often minor changes could improve the patient experience. King's College Hospital gave handouts to patients to encourage them to give feedback.

73. Finance Report

73.1 Andrew Grimshaw noted that the financial position was in line with the plan until the end of month 2, however the delivery of the target surplus was at risk given the current performance position and high use of overtime and private ambulances. There was also a risk that financial penalties would be imposed at the end of the year if the performance position did not improve.

73.2 In response to a question from Theo de Pencier about the level of cash, Andrew stated that he would seek to maximise the cash position whilst meeting liabilities as they fell due. This did not affect the capital expenditure.

73.3 Fergus Cass asked how much confidence there was that the Cost Improvement Programme would be delivered. Andrew responded that the Cost Improvement Programme was currently on plan and each division was developing detailed delivery plans to cover the year.

73.4 Mark Whitbread joined the meeting.

74. LAS Business Plan 2014/15

74.1 Karen Broughton commented that the 2014/15 business plan set out the detail of how the first year of the strategy would be delivered and how the objectives would be delivered across the year.

74.2 The Chair commented that commitment to the deadlines as set out in the business plan would be required. Karen agreed that this would be key to the achievement of the strategy, however it also needed to be recognised that there might be reasons for changing a deadline, but that these changes and the rationale behind them would always be communicated to the Trust Board.

74.3 Theo de Pencier noted that it was a very well-written plan and asked whether management had sufficient capacity to deliver the plan given the other priorities. Ann Radmore responded that the management team had already reprioritised a number of the objectives with this in mind, in order to finalise the plan. However it should be recognised that a lot needed to be achieved this year in order to make the required step change.

74.4 The Trust Board approved the 2014/15 business plan.

75. NHS 111 post step in progress report

75.1 Katy Millard and Jon Goldie joined the Trust Board meeting to give a presentation on the LAS running of South East London NHS 111 following 6 months' of operation. In the presentation, Katy and Jon noted that the LAS had absorbed significantly more activity than planned, whilst achieving the key performance indicators and operating within the financial envelope. 8% of calls were passed to 999, of which 81% of calls were conveyed. By comparison, the LAS's predecessor had passed 15% of calls to 999 and other providers also exceeded the target of 10%.

75.2 Jon Goldie commented that SEL NHS 111 was currently taking part in a national GP trial with 2 GPs working in the 111 environment across peak hours of operation.

75.3 Theo de Pencier noted that this had been a success story and asked how the LAS compared with other ambulance services that provided 111 services. Jon Goldie responded that the LAS was a smaller provider and therefore received a small volume of calls. The management of the call queue was therefore different.

75.4 Will Broughton asked whether the GP trial had had an impact on the number of calls passed to 999. Jon responded that the 8% rate had been seen consistently prior to the GP trial.

75.5 The Chair thanked Katy and Jon for giving their presentation to the Trust Board.

76. Christmas IT incidents

76.1 Ann Radmore gave an overview of the key findings of the investigation and the actions taken to mitigate the risks. The majority of the actions had been completed and a number were ongoing. The Information Management and Technology action plan would address the longer-term control room resilience issues. The aspiration was to have two completely separate control rooms, however this would require investment and a submission would be made to NHS England in this context. There had been no recurrence of the problem since Boxing Day 2013.

76.2 Fionna Moore and David Prince confirmed that they were content with the investigation and for the serious incident report to be approved.

76.3 It was agreed that the report should be formally shared with the NHS Trust Development Authority and NHS England.

ACTION: JC to formally share the Christmas IT incidents report with the NHS Trust Development Authority and NHS England.

DATE OF COMPLETION: 29th July 2014

77. Modernisation Programme

77.1 Paul Woodrow gave an update on progress with the modernisation programme:

- Of the 9 separate workstreams, 3 had been completed and had transferred to business as usual;
- The consultation on the proposed skill mix had commenced on 12th June and involved 460 members of staff. The arrangements for transitioning members of staff into the new model would need to be worked through;

- The roster review was nearly complete and the new rosters would be implemented in September. The new rosters reflected the pattern of activity and would therefore make best use of current staffing levels;
- The extension of active area cover would go live from 1st July 2014;
- Some elements of the response model had been brought forward to 8th September to align with the implementation of the new rosters. This meant that all frontline vehicles would be able to respond to any type of incident from September;
- Agreement on rest break arrangements was required before the new annual leave arrangements could be implemented. It was anticipated that this would be resolved in quarter 2.

78. Report from Chief Executive

78.1 The Trust Board noted the report from the Chief Executive.

79. Report from Trust Secretary

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

80. Forward Planner

80.1 The Trust Board noted the forward planner and noted the need to add a 6 monthly update on the 2014/15 business plan.

ACTION: FG to add a 6 monthly update on the 2014/15 business plan to the Trust Board forward planner.

DATE OF COMPLETION: 29th July 2014

81. Questions from members of the Public

81.1 The Trust Board considered the following question from the Patients' Forum:

81.2 *Will the Board ensure and demonstrate that the 2014/5 Business Plan and the Trust's 5 year strategy are subject to an Equalities Impact Assessment and continuous public involvement in their development and implementation?*

81.3 Karen confirmed that the business plan and strategy would be subject to an equalities impact assessment. The communications and engagement strategy set out the mechanisms for engaging with the public.

81.4 The Trust Board considered the following question from the Patients' Forum:

81.5 *When will the workforce be enhanced by the London Ambulance Service's key objective of ensuring that all responses include an HCPC registered paramedic?*

81.6 Ann Radmore responded that, as set out in the LAS strategy, this would not be achieved until 2017/18. Further work was required in order to work through what this would look like in detail.

81.7 Will Broughton asked a question about paramedic education. Mark Whitbread responded that the universities would now only run BSC courses. The number of university places had been increased and a further university would be delivering BSC courses from January 2015. Ann Radmore added

that it had been a conscious decision to ensure that paramedic training at universities was delivered at BSC level.

81.8 Will Broughton asked whether there were plans to provide frontline staff with more time for career progression. Ann Radmore responded that this had been part of the discussion about the clinical career structure. Paramedics were the only degree-educated healthcare professional who did not have access to bursaries for their first degree and this imbalance needed to be addressed nationally. The Trust also needed to establish clearer development time in partnership with staff. The first step was to transition to the new rosters and to introduce individual learning accounts and protected learning time. The Chair noted that the inclusion of Mark Whitbread on the Trust Board reflected the overall importance of paramedic education going forward.

82. Any other business

82.1 There were no items of other business.

82.2 The public meeting was closed.

83. Date of next meeting

83.1 The next meeting of the Trust Board is on Tuesday 29th July 2014 at 09.30.

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Signed by the Chair

ACTIONS

from the Meeting of the Trust Board held on 24th June 2014

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/01/14	**06.4**	SA to arrange for the Trust Board to have a briefing on the governance structure and the role of the committees.	**SA**	Document to be updated to reflect revised quality governance structure. Work in progress as the terms of reference for the quality reporting committees have only recently been drafted.

CLOSED ACTIONS

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
25/03/13	**32.4**	RH to meet with SL to discuss the NHS Constitution and its application.	**RH**	Action complete.
24/06/14	**76.3**	JC to formally share the Christmas IT incidents report with the NHS Trust Development Authority and NHS England.	**JC**	Action complete.
24/06/14	**80.1**	FG to add a 6 monthly update on the 2014/15 business plan to the Trust Board forward planner.	**FG**	Added to forward planner for 25th November. Action complete.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JULY 2014

PAPER FOR INFORMATION

Document Title:	**Integrated performance dashboard**
Report Author(s):	**Paul Woodrow, Director of Performance**
Lead Director:	**Paul Woodrow, Director of Performance**
Contact Details:	
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

- The response time targets for Red 1, Red 2 and A19 were not achieved in the month of June
- Red 2 is significantly off the year to date trajectory
- Activity is 0.8% year to date above contracted levels
- Category C patients continue to see response times which are lower than planned
- Complaints rose again last month, mainly attributable to response delays
- The delivery of the target surplus is at risk given our performance position, and high use of overtime and private ambulance support
- Current performance on Category A activity makes the Trust potentially liable for penalties on the R1, R2 and A19 performance targets. LAS Commissioners are discussing the reinvestment of penalties, as such they have not been reflected in the reported position
- Workforce metrics continue to be a primary focus for EMT with recruitment and retention being the main priorities

Executive Summary

- The three core response time targets for Red 1, Red 2 and A 19 transport target were not met in June
- Red 1 75% was reached in eight minutes thirty seconds and Red 2 75% was reached in nine minutes forty seconds.
- Category C patients are still receiving longer response times than planned

- 999 call answering performance was above target for the third consecutive month
- NHS 111 in South East London run by the LAS continues to perform above all national KPIs
- Deep cleaning of vehicles is on target after being below target for the two preceding months
- Turnover and vacancies both increased in month 3
- 20 Paramedics left the LAS in June
- 55 EACs have received job offers and offers have been made to 145 graduate Paramedics who will begin to join us in the end of September, early October
- EMT have formed a retention sub-group and have undertaken a number of actions to improve retention

Attachments

Integrated performance dashboard – June Data

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☒ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Av. Daily Vol.

London Ambulance Service NHS
NHS Trust

Av. Daily Vol.

Trust Board Integrated Performance report

June Data
18-Jul-14

LONDON AMBULANCE SERVICE NHS TRUST

INTEGRATED PERFORMANCE REPORT 2014/15: June 2014 (MONTH 3)

Quality Exceptions		**There was an overall rise in June mainly attributable to response to response delays. Cat C response times still remain a challenge**
Performance Exceptions		**Red 1, red2 and A19 response time standards were not met in the month of June. The year to date trajectory for Red 2 remains off track**
Workforce Exceptions		**Workforce exceptions continue to be the priority. Turnover and vacancy rates continue to rise. Sickness levels also increased in month**
Value for Money Exceptions		**The current performance position puts the planned surplus at risk. Response time penalties will expose us to further financial risk**

QUALITY

	Quality measures	Target	Current month	Previous month	Year end forecast
1	Serious Incidents declared	1	1	3	RED
2	Complaints received	69	130	98	RED
3	999 Call Answering - 5 secs	95.0%	95.3%	95.1%	GREEN
4	NHS111 Call Answering- 60secs	95.0%	97.4%	97.0%	GREEN
5	NHS 111 Transfer rate to 999	10.0%	8.2%	8.0%	GREEN
6	Aspects of care compliance (MH)	95.0%	93.0%	89.0%	GREEN
7	Deep Clean of vehicles % completed	90.0%	90.0%	89.1%	GREEN
8	Category C1 (20 mins)	75.0%	53.1%	60.7%	RED
9	Category C2 (30 mins)	75.0%	51.6%	57.3%	RED
10	CSR 2014 Delivery - % of Frontline	60.0%	14.0%	11.0%	GREEN
11	Red 1 - 75% reached in mins/secs	8 minutes	08:30	08:20	GREEN
12	Red 1 number of responses >10 mins		141	159	
13	Red 1 95th Percentile Time to respond		13.88	13.38	
14	Red 2 -75% reached in mins/secs	8 minutes	09:40	08:55	AMBER
15	Red 2 number of responses >10 mins		6102	5310	
16	Red 2 95th Percentile Time to respond		17.01	15.31	
17	Surge plan escalation > Amber (Hours)		196	113	

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

PERFORMANCE / ACTIVITY

	Performance / activity measures	Target	Current month	Previous month	Year end forecast
1	Red 1 Performance	75.0%	69.9%	72.9%	RED
2	Red 2 Performance	75.0%	63.8%	69.1%	RED
3	Trust A19 Performance	95.0%	94.2%	95.8%	AMBER
4	FRU A8 Performance	80.0%	64.7%	69.5%	RED
5	Cat A Red 1 Incidents	1,264	1,194	1,381	GREEN
6	Cat A Red 2 Incidents	37,727	39,157	39,836	AMBER
7	Cat A Total Incidents	38,992	40,351	41,217	GREEN
8	Total incidents	92,986	88,431	91,237	AMBER
9	Total Activity against Plan	98,225	101,050	97,611	GREEN
10	Clinical Hub Discharges	5,412	9,911	9,156	GREEN

VALUE FOR MONEY

		Target	Current month	Previous month	Year end forecast
1	EBITDA (£000)	879	397	1,323	AMBER
2	Net surplus (£000) (negative - deficit)	- 539	- 778	117	AMBER
3	Cost Improvement Programme (£000)	799	787	674	GREEN
4	Capital expenditure (£000)	5,936	148	115	AMBER
5	Monitor FRR	4	4	3	AMBER
6	Cash balance (£000)	14,253	23,163	23,964	GREEN

WORKFORCE

	Workforce measures	Target	Current month	Previous month	Year end forecast
1	Staff Turnover % All Trust	8.5%	11.1%	10.5%	RED
2	Vacancies (%) All Trust	5.0%	10.4%	9.3%	RED
3	Paramedic Vacancies against EST		- 250.80	- 240.29	RED
4	Vacancies as number for All Trust		- 498.00	- 449.95	RED
5	Paramedic Leavers	6	20	13	RED
6	Sickness (%) All Trust	5.0%	6.2%	5.39%	RED
7	Sickness (%) Frontline	5.0%	7.0%	5.96%	RED

Supporting Commentary for exceptions against specific quadrants

QUALITY

Commentary:

- Serious incidents declared for the month were down on the previous month
- Complaints up on previous month and up 40% from April 2014, this rise is mainly attributable to response time delays
- Category C patients continue to see response times which are lower than our planned
- NHS 111 in South East London continues to perform well against the national KPIs
- We continue to monitor the time to treatment at the 95th percentile for Red 1 & 2 patients and last month saw an improvement in Red 2 and static for Red 1
- Deep cleaning of vehicles for infection control is now back on target

WORKFORCE

Commentary:

- Staff turnover for the whole Trust rose last month as did the overall vacancy rate
- Paramedic vacancies increased again last month with 20 new Paramedic leavers recorded in month
- Sickness levels within the Trust have increased with sickness in frontline operations now standing at 7%

PERFORMANCE / ACTIVITY

Commentary:

- The Trust failed to meet all three operational response time standards in the month of June (Red 1 and Red 2 and A19 Transport target)
- FRU performance continues to be below optimum levels which is contributing to the overall poor performance outturn
- Activity for the month of June is above contracted levels and the year to date position is now 0.8% above plan
- 999 call answering remains above the 95% threshold
- Clinical Hub continues to over perform against the “hear and treat” trajectory

VALUE FOR MONEY

Commentary:

- In month the Trust is reporting £0.2m adverse to plan. Year to date the Trust is adverse to plan £0.2m. The main drivers for this position are lower than planned income from LETBs (£0.1m) and higher than planned Frontline staffing costs (£0.1m). The delivery of the target surplus is at risk given the current performance position, and high use of overtime and private ambulances.
- The Trust has been spending in excess of plan on Frontline staffing across Q1 in order to support performance. This level of spend cannot be maintained within the current financial plan.
- Current performance on Category A activity makes the Trust potentially liable for penalties on the R1, R2 and A19 performance targets. LAS Commissioners are discussing the reinvestment of penalties; as such they have not been reflected in the reported position.

Supporting Action for exceptions against specific quadrants

QUALITY

Actions:

- Dedicated staff to provide call backs to patients waiting our attendance
- New reporting tool developed and implemented to monitor the compliance to the timeliness of welfare call backs
- Daily monitoring of time to treatment times for all Red category calls based on the 95th percentile
- Re-alignment of Category C determinants will see a proportion of C calls that currently go to the clinical hub for further assessment without getting resolved being directly transferred to dispatch groups for ambulance response
- Surge plan levels continue to be reviewed on a weekly basis by the executive team

WORKFORCE

Actions:

- Executive sub-group for retention set up led by Director of Support Services
- Re-design of the exit interview process completed
- External specialist company commissioned to do some retrospective analysis with 200 staff who have left the organisation in the last 12 months
- National recruitment campaigns are now underway for Paramedic and Emergency Ambulance Crew (EAC)
- 55 offers made for EACs
- 145 offers made to graduate Paramedics who will graduate this Autumn
- Print media campaign for Paramedics in Northern Ireland commenced in July
- International recruitment campaign in Australia and New Zealand underway with team travelling to Australia and New Zealand in September. Capacity to take 245 applicants through recruitment process to offer placed

PERFORMANCE / ACTIVITY

Actions:

- Deep dive analysis being carried out within EOC in relation to FRU performance
- Re-alignment of Category C cohorts to go live on 1 August to optimise hear and treat performance through the clinical hub (c90,000 additional calls passed to the hub for review per year)
- Continued use of surge plan to manage peaks in demand
- Review of HCP activity and responding differently to a proportion of journeys contained within this activity
- New “Emergency Ambulance Crew” role goes live on 21 July. More A&E Support transitioning to the new role creating more operational capacity to respond to a full range of calls
- Reduce multiple attendance ration in line with our operating efficiency plans
- Review of all elements of the job cycle time as part of our national benchmarking review

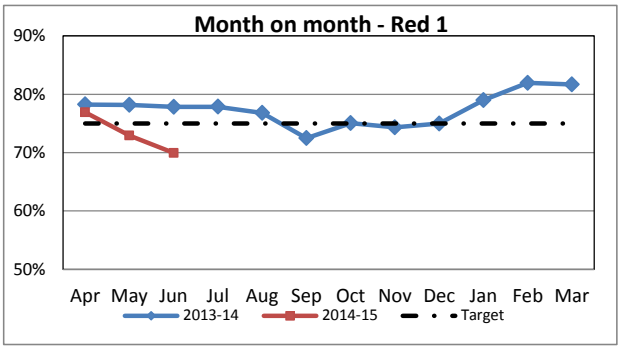
VALUE FOR MONEY

Actions:

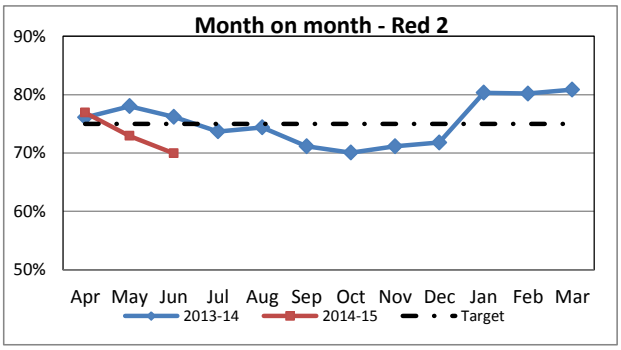
- Agree the reinvestment of penalties with commissioners.
- Seek confirmation of planned funding from LETBs.
- Ensure the forecast is complete and accurate to support the maximisation of resourcing to the Frontline.
- Ensure actions in support of CQUINs are delivered.
- Ensure all CIPs are delivered in line with plan.
- Ensure action plans are in place to deliver the capital investment programme.
- Finalise actions in respect of working capital management.

PERFORMANCE / ACTIVITY

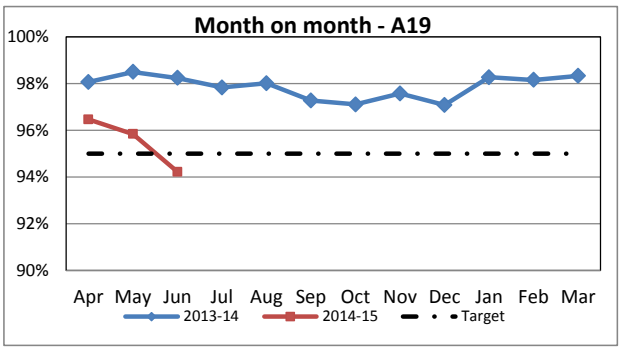
1. Cat A - Red 1 Performance



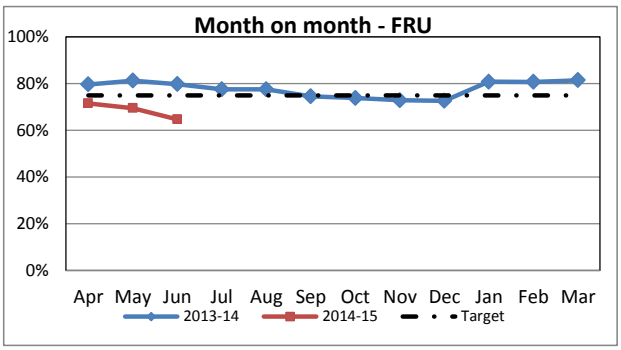
2. Cat A - Red 2 Performance



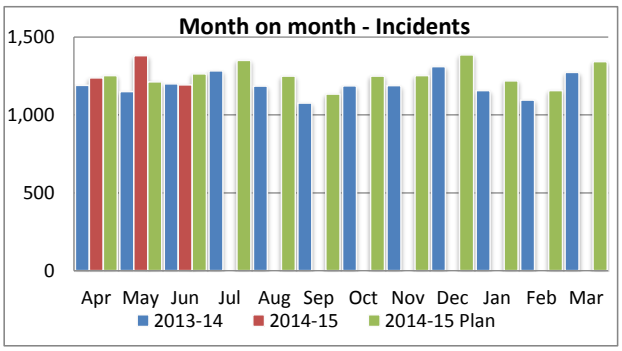
3. Trust A19- Performance



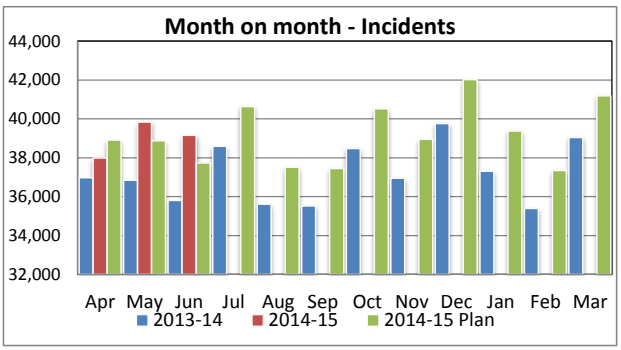
4. FRU A8 - Performance



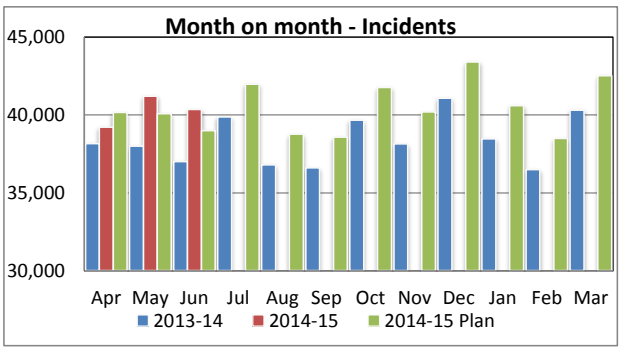
5. Cat A - (Red 1) Incidents



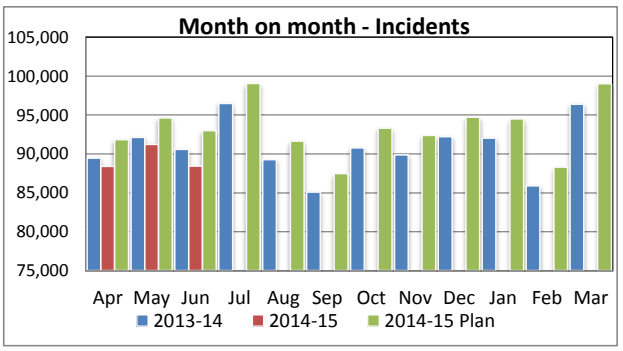
6. Cat A (Red 2) Incidents



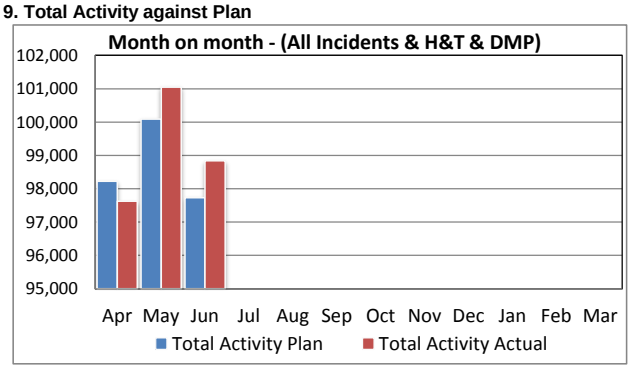
7. Cat A - Total Incidents



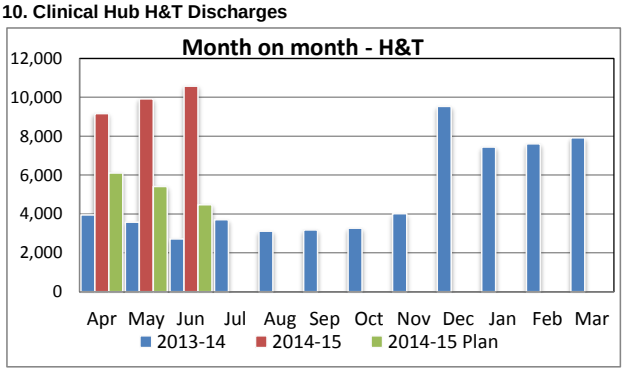
8. Total Incidents



9. Total Activity against Plan

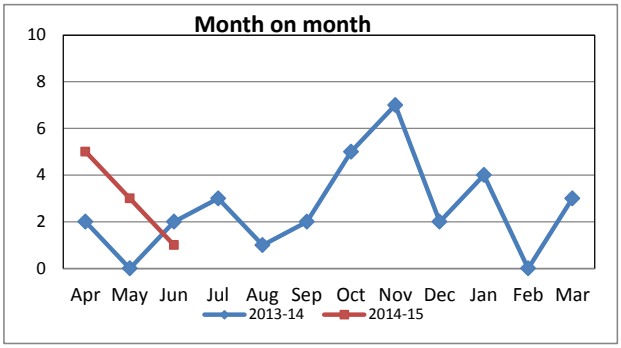


10. Clinical Hub H&T Discharges

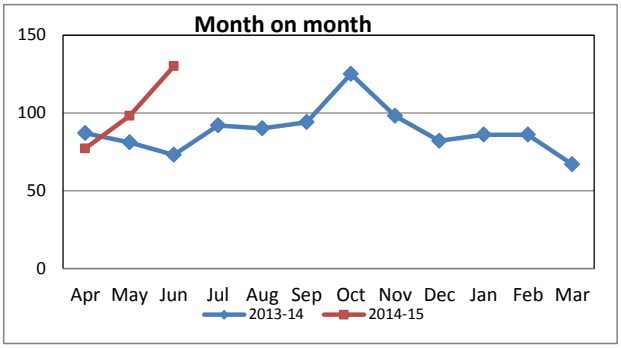


QUALITY

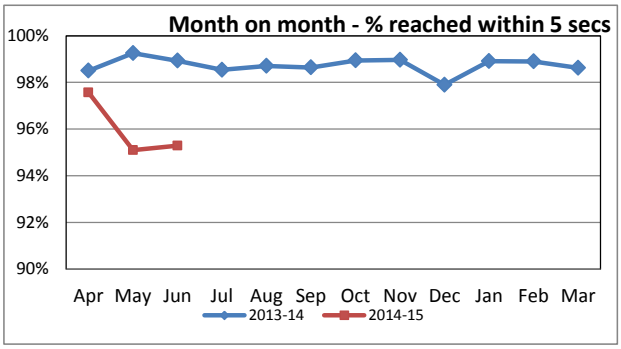
1. Serious Incidents declared



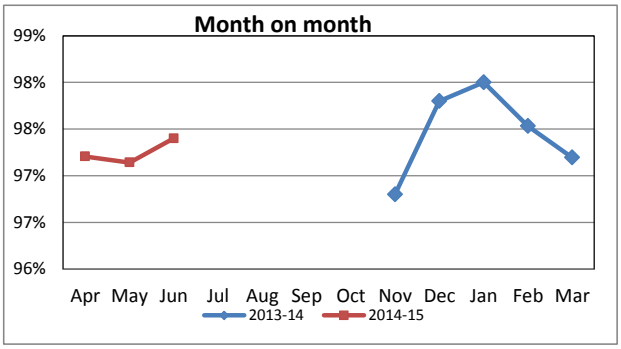
2. Complaints received



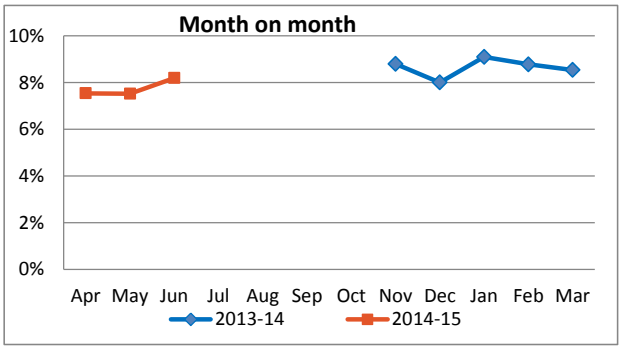
3. 999 Call Answering - 5 secs



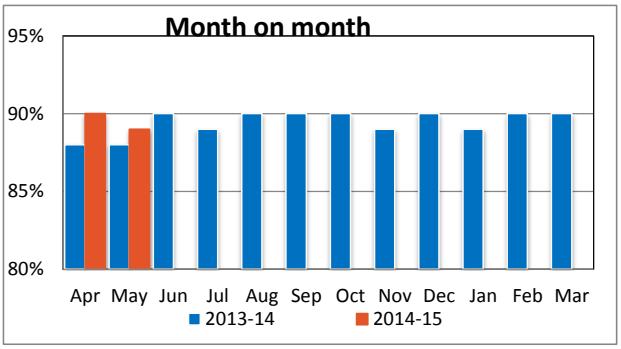
4. NHS111 Call Answering- 60secs



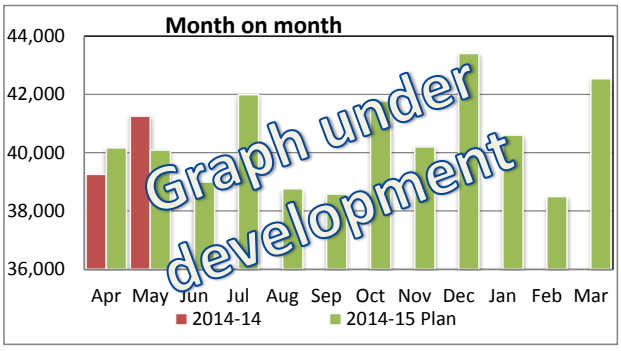
5. NHS 111 Transfer rate to 999



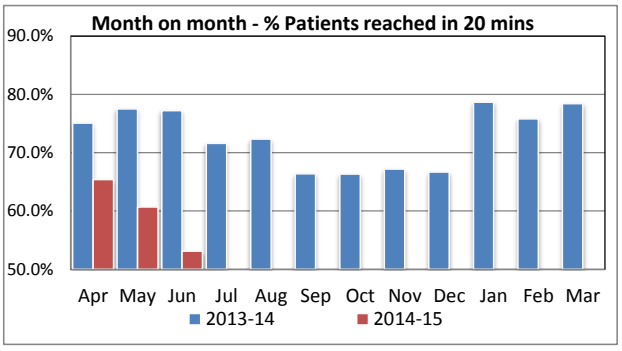
6. Aspects of care compliance (MH)



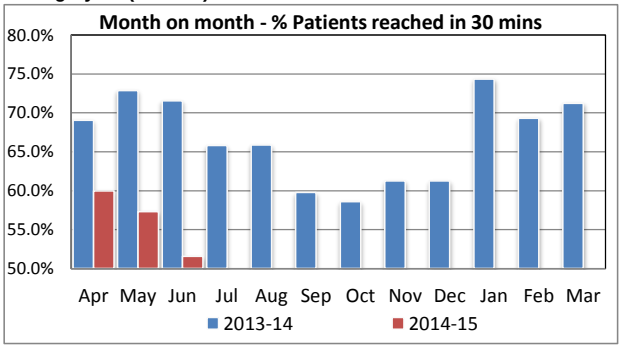
7. Deep Clean of vehicles % completed



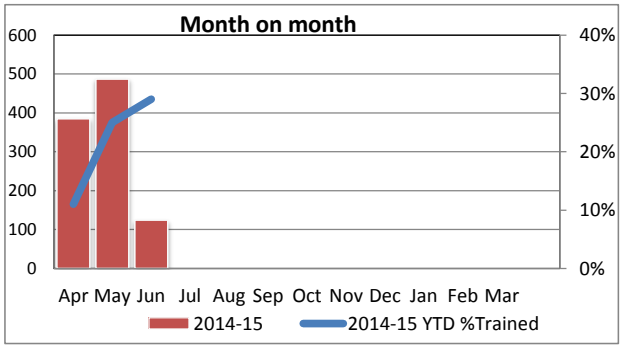
8. Category C1 (20 mins)



9. Category C2 (30 mins)

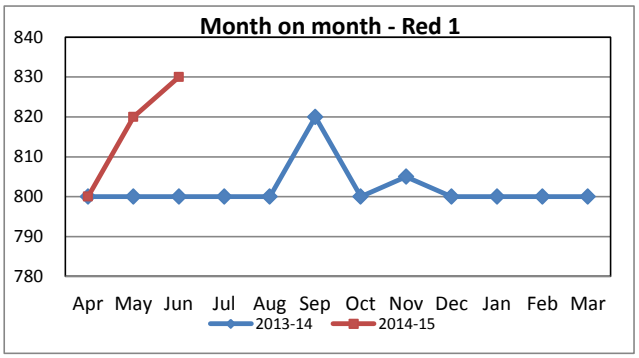


10. CSR 2014 Delivery - % of Frontline

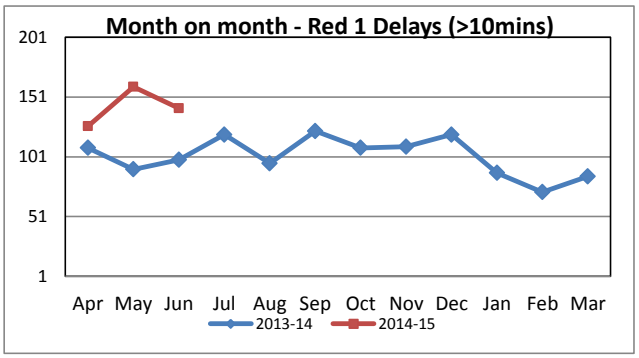


SAFETY

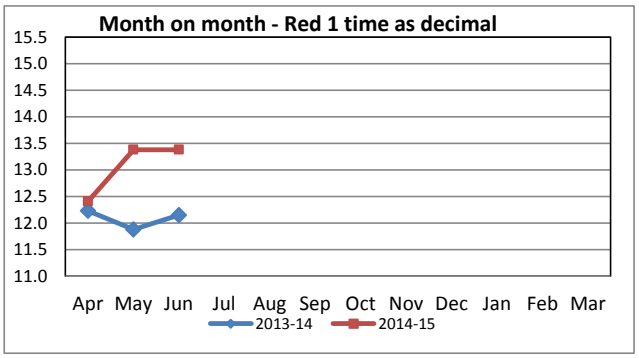
1. Red 1 - 75% reached in Mins/secs



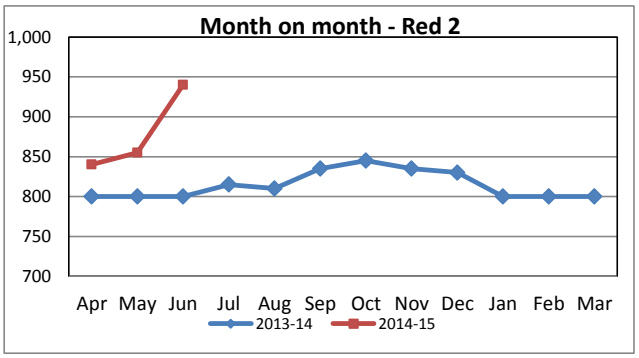
2. Red 1 - number of responses>10mins



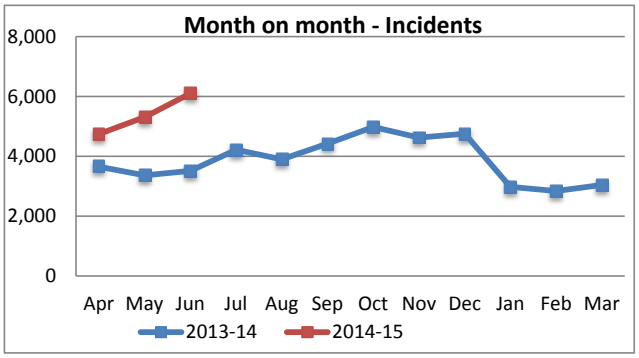
3. Red 1 - Time to get to 95th Percentile



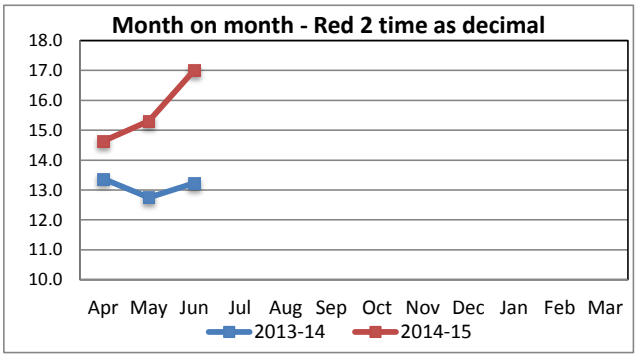
4. Red 2 - 75% reached in Mins/secs



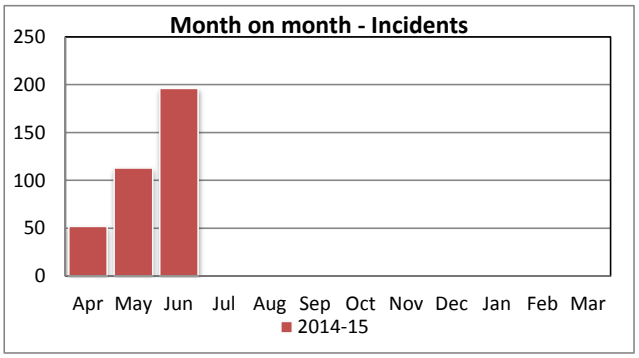
5. Red 2 - number of responses>10mins



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

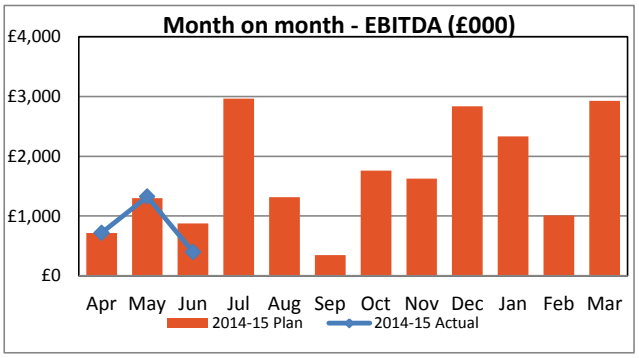


7. Surge plan escalation > Amber (Hours)

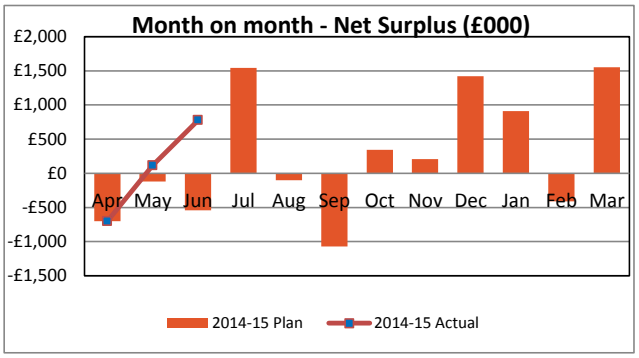


VALUE FOR MONEY

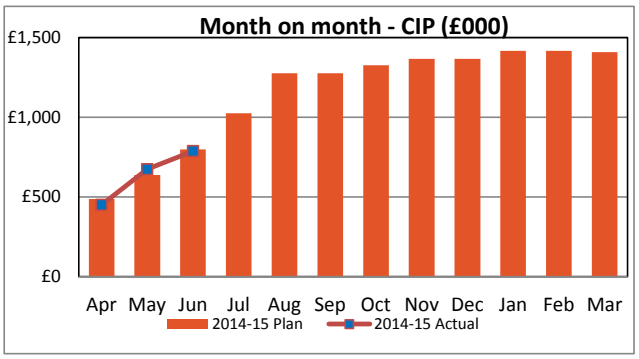
1. EBITDA (£000)



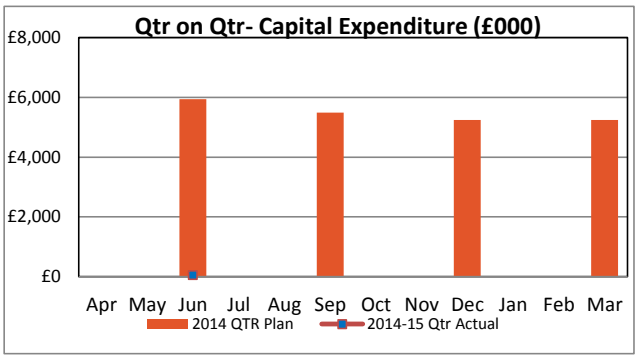
2. Net Surplus (£000)



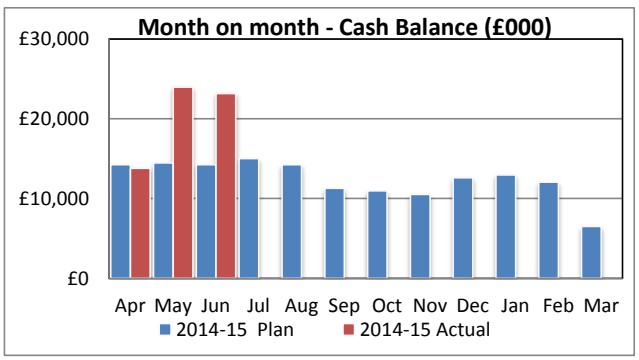
3. Cost Improvement Programme (£000)



4. Capital Expenditure (£000)

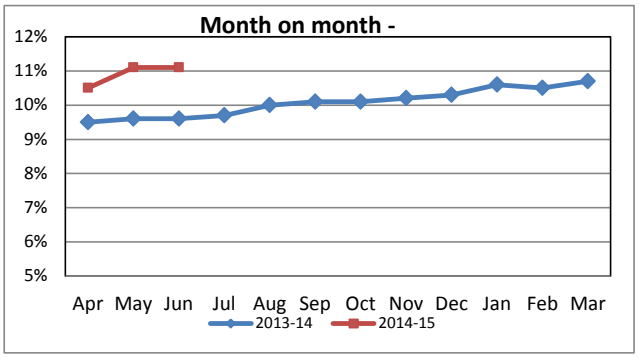


5. Cash Balance

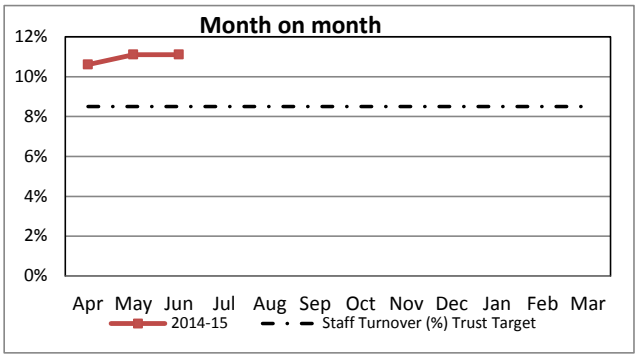


WORKFORCE

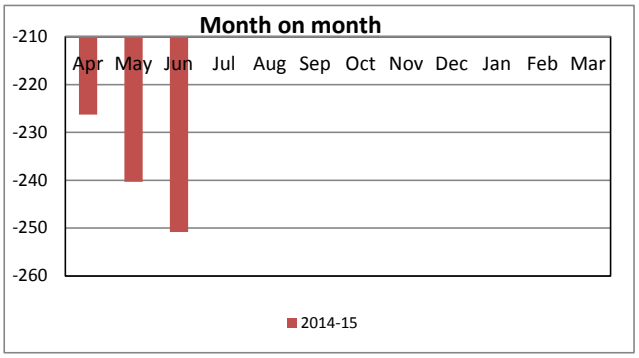
1. Staff Turnover



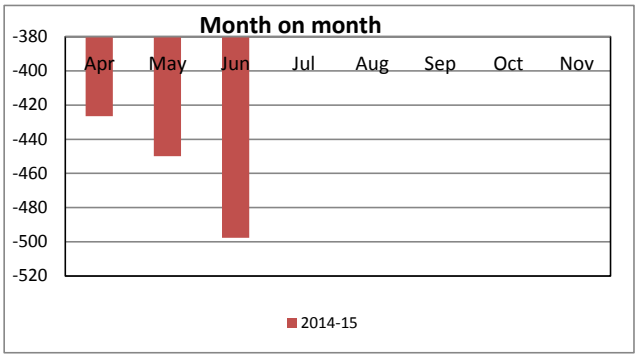
2. Vacancies (%)



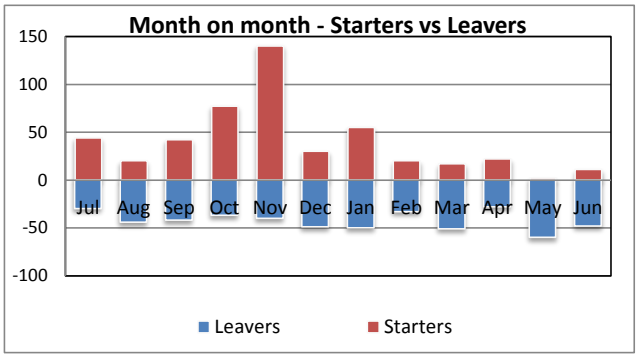
3. Vacancies (WTE) - Paramedic



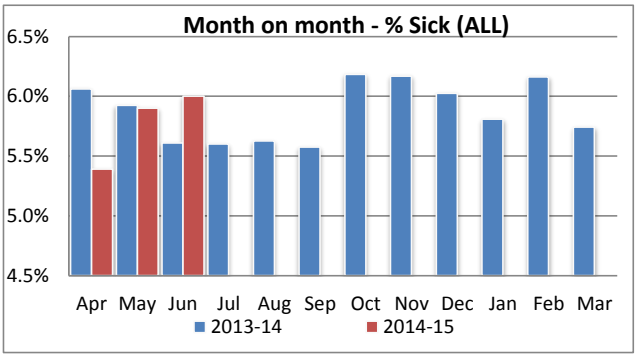
4. Vacancies (WTE) - All Trust



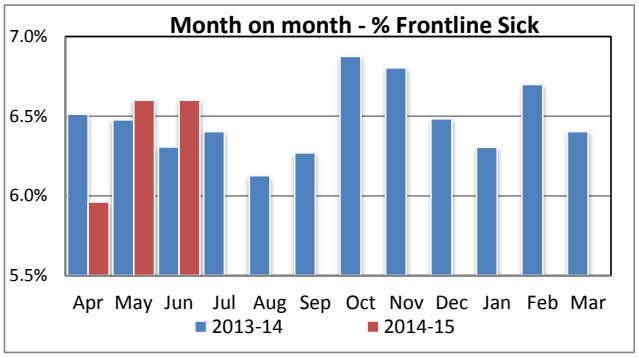
5. Starters vs Leavers



6. Sickness - All Staff (%)



7. Frontline Sickness (%)



Definitions relating to Summary Page

Quadrant	Name	Description / Measure Used
Quality measures	Serious Incidents declared	
	Complaints received	
	999 Call Answering - 5 secs	The % of 999 calls answered within 5 seconds of the call connect time. This measure is only available for the LAS as a whole.
	NHS111 Call Answering- 60secs	
	NHS 111 Transfer rate to 999	
	Aspects of care compliance (MH)	
	Deep Clean of vehicles % completed	
	Category C1 (20 mins)	The % of Category C C1 incidents where any responder arrived on scene within 20 minutes, measured from the call connect time. If no call connect time is available, the time the call was answered is used.
	Category C2 (30 mins)	The % of Category C C2 incidents where any responder arrived on scene within 30 minutes, measured from the call connect time. If no call connect time is available, the time the call was answered is used.
	CSR 2014 Delivery - % of Frontline	
Performance	Red 1 Performance	The % of Category A Red 1 incidents where any responder arrived on scene within 8 minutes, measured from the call connect time. If no
	Red 2 Performance	The % of Category A Red 2 incidents where any responder arrived on scene within 8 minutes, measured from either first dispatch, chief
	Trust A19 Performance	The percentage of Category A incidents where a vehicle capable of conveying a patient arrived on scene within 19 minutes, measured from the call connect time. If a motorcycle or cycle is the only responder (and arrives within 19 mins) this will be counted
	FRU A8 Performance	The % of Category A Incidents where an FRU (Single responder) arrived on scene within 8 minutes. The time to start the clock will depend on if it is a Red 1 or Red 2 incident.
	Cat A Red1 Incidents	Incidents are all calls where at least one responder/resource capable of stopping the clock arrived on scene on a Red1 incident. It does not matter how many vehicles arrive on scene, it is still only counted as one incident.
	Cat A Red2 Incidents	Incidents are all calls where at least one responder/resource capable of stopping the clock arrived on scene on a Red2 incident. It does not matter how many vehicles arrive on scene, it is still only counted as one incident.
	Cat A Total Incidents	Incidents are all calls where at least one responder/resource capable of stopping the clock arrived on scene on Cat A incident. It does not matter how many vehicles arrive on scene, it is still only counted as one incident.
	Total incidents	Incidents are all calls where at least one responder/resource capable of stopping the clock arrived on scene. These include both Category
	Total Activity against Plan	This is the result of combining Cat A, C, Other, H&T (Hear and Treat) and DMP related incidents together and comparing this against the agreed plan with commisioners for that period.
	Clinical Hub Discharges	These are calls which have been triagged without the need for transports by EOC clinicians within the HUB.
Workforce Measures	Staff Turnover % All Trust	
	Vacancies (%) All Trust	
	Paramedic Vacancies against EST	
	Vacancies as number for All Trust	
	Paramedic Leavers	No of Paramedic leaving frontline operations.
	Sickness (%) All Trust	
	Sickness (%) Frontline	
Value for Money	EBITDA (£000)	
	Net surplus (£000)	
	Cost Improvement Programme (£000)	
	Capital expenditure (£000)	
	Monitor FRR	
	Cash balance (£000)	
SAFETY	Red 1 - 75% reached in mins/secs	This is a measure which shows the exact time taken to reach 75% of Red 1 patients (shown in minutes & seconds)
	Red 1 number of responses >10 mins	How many of the total number of Red 1 incidents we attended, did we take more then 10 minutes to get to scene from call connect
	Red 1 number of responses>15 min	How many of the total number of Red 1 incidents we attended, did we take more then 15 minutes to get to scene from call connect
	Red 2 -75% reached in mins/secs	This is a measure which shows the exact time taken to reach 75% of Red 2 patients (shown in minutes & seconds)
	Red 2 number of responses >10 mins	How many of the total number of Red 2 incidents we attended, did we take more then 10 minutes to get to scene from call connect
	Red 2 number of responses>15 min	How many of the total number of Red 2 incidents we attended, did we take more then 15 minutes to get to scene from call connect
	Surge plan escalation > Amber (Hours)	Measure used to record how long over the month, we have had to bring in surge plan because one or a number of the triggers have been hit.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR ASSURANACE

Document Title:	**Board Assurance Framework and Trust Risk Register (Key Risks)**
Report Author(s):	**Frances Field, Risk and Audit Manager**
Lead Director:	**Sandra Adams, Director of Corporate Affairs**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To keep the Trust Board appraised of the key risks raising the organisation**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To take assurance from the management of the key risks currently facing the organisation and to highlight any potential gaps that need to be addressed.**

Key issues and risks arising from this paper

The key risks to the organisation achieving its strategic objectives are described in the Board Assurance Framework. These will need to be closely managed and monitored and timely action taken to mitigate and this needs to become part of business as usual.

Executive Summary

Board Assurance Framework

The attached Board Assurance Framework (BAF) was updated in June 2014 to include the 2014/15 business objectives approved by the Trust Board in May 2014. The Trust's key risks have been mapped to the business objectives on page one of the document and the heat map on page 2 depicts the movement of the risks since January 2014. Changes to the BAF since January 2014 are set out in the tables below:

a) The following new key risks have been added to the Trust Risk Register since January 2014 and now appear on the BAF.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	Change to rating since last review
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.	3	5	15		3	2	6		3	5	15	⇧ 3 3 12
399	There is a risk that a lack of critical equipment on an Ambulance may impact on the crew's ability to respond to all category A calls and /or any calls requiring specialist equipment to be deployed at the scene.	4	4	16		4	2	8		4	4	16	
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.	4	4	16		4	1	4		4	4	16	
401	There is a risk that the current age profile of the LAS Vehicle Fleet will result in increased downtime impacting on operational performance and implementation of the modernisation process.	4	5	20		4	2	8		4	5	20	
402	There is a risk that the current age profile of Fleet Workshop Managers and Technicians will impact on the future resilience of the Fleet Operation.	4	5	20		4	2	8		4	5	20	
403	There is a risk that a number of Ambulance and Fast Response Units will not be road worthy as their average service intervals have extended beyond 16 weeks, the average time taken for brake pads to wear.	4	4	16		4	1	4		4	4	16	
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).	4	4	16		3	2	6		4	4	16	

b) The following key risk has been downgraded since January 2014 and will not appear on the next iteration of the BAF.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	rating prior to last review
387	There is a risk that the LAS could be in a position where its call handling system is unsupported by Priority Dispatch Systems (the suppliers) from late 2014 onwards. this will involve both our call taking system (ProQA) and the MPDS version we are using (12.2). This will significantly impact our ability to maintain and use both systems and compromise efficient working and patient safety.	4	5	20		4	1	4		4	3	12	⇩ 4 5 20
Rationale for downgrade - -confirmation now provided by Northrop Grumman that they will produce an interface to the new version of ProQA (Paramount) at nominal cost, the risk to the Trust is reduced. The need for a confirmed Trust strategic (Paramount vs Pathways) direction is therefore not currently critical.													

c) The following key risks have been downgraded since January 2014 and are no longer included on the BAF.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	rating prior to last review
368	here is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death.	5	5	25		5	1	5		5	1	5	⇩ 5 2 10
Rationale - as a result of the completed deployment of latest MDT software which works in conjunction with the enhanced CommandPoint™ software the risk has reached its target rating with a likelihood reduced to Rare with impact Major													

22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	4	5	20		3	3	9		3	4	12	⇩ 3 5 15
Rationale – a reduction in the current was approved by the Senior Management Team in April 2014 due to the number of controls in place which are further mitigating the risk.													
398	There is a risk that the Trust will have difficulty acquiring timely supplies of printed material namely PRFs, controlled drugs registers, controlled drugs daily check sheet books, LA3 and LA5. This would be Trust wide and impact on all crew and staff and patients. Crews would be unable to document any patient for each of the calls they attended and would be unable to complete legal document such as recognition of life extinct.	5	3	15		5	1	5		5	3	5	
This risk was identified and mitigated In May 2014 and therefore does not appear on the BAF.													

c) The following draft risks were assessed by directors with responsibility for the 2014/15 business objectives (in June 2014) and have been included on page one of the BAF. These risks will be subject to discussion and formal approval by the Executive Management Team at a strategic risk review meeting scheduled for August 2014.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	Link to 2014/15 Business Objective
	There is a risk that the organisation will not achieve the level of success required with the implementation of the Shockingly Easy Defibrillator Campaign across London, resulting in lack of sales of defibrillators and training packages and therefore lack of revenue to maintain the costs of providing the service.	4	3	12		4	1	4		4	2	8	1. Improve Patient Care
	There is a risk that we don't deliver an improved service for mental health patients which may result in no improvement in patient outcomes and may affect our reputation with commissioners and stakeholders	3	4	12		3	2	6		3	4	12	1. Improve Patient Care

	There is a risk that the patient voice does not influence how we improve the patient experience or how we change and grow the service. This may result in failure to provide a high quality service thereby decreasing the patient experience and failing to evidence we have implemented lessons from the Francis report	3	4	12		2	2	4		2	4	12	1. Improve Patient Care
	There is a risk that the Trust is unable to maintain an adequate supply of uniform, potentially impacting on new staff not being able to commence duties	3	3	9		3	1	3		3	3	9	1. Improve Patient Care
	There is a risk that the patient and crew could come into contact with a source of infection if a vehicle is not cleaned to the required standard and/or procedures followed by all relevant personnel.	4	4	16		4	2	8		4	2	8	1. Improve Patient Care
	There is a risk that the review of HR processes and structure will not happen or not happen effectively resulting in the HR service not being fit for purpose.	2	4	8		1	2	2		2	4	8	2. Improve recruitment and retention
	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. This would result in staff becoming more disengaged which would prevent the organisation growing, developing and improving in the future: staff need to play their part or this won't happen.	4	4	16		4	3	12		4	4	16	2. Improve recruitment and retention
	There is a risk that that the Cluster Assistant Directors of Operations (ADO's) are not supported or given time to focus on stakeholder engagement, 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.	4	4	16		4	3	12		4	4	16	2. Improve recruitment and retention
	There is a risk that the review of HR processes and structure will not happen or not happen effectively.	2	4	8		1	2	2		2	4	8	5. Simplify our business processes
	There is a risk that we will not be able to recruit the calibre of staff required to establish a robust governance framework and which delivers value for money within the organisation.	3	4	12		3	2	6		3	3	9	5. Simplify our business processes

	There is a risk that as a result of proposed changes to the way the CQC inspects organisations and changes within the organisation, the Trust may not be fully prepared for an inspection which could result in an unfavourable report.	4	4	16		4	2	8		4	3	12	5. Simplify our business processes
	There is a risk that the Trust will not be successful in generating potential revenue from the provision of Patient Transport Services to make the service a viable business unit for the Trust.	3	5	15		3	2	6		3	4	12	7. Increase organisational effectiveness and development

Trust Risk Register (key Risks)

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

Attachments: Board Assurance Framework – July 2014
Trust Risk Register – Key Risks July 2014

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Quality Strategy
This paper supports the following domains of the quality strategy:

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

LAS Objectives
This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☒ Improve recruitment and retention
☒ Implement the modernisation programme
☒ Achieve sustainable performance
☒ Develop our 111 service
☒ Simplify our business processes
☒ Increase organisational effectiveness and development

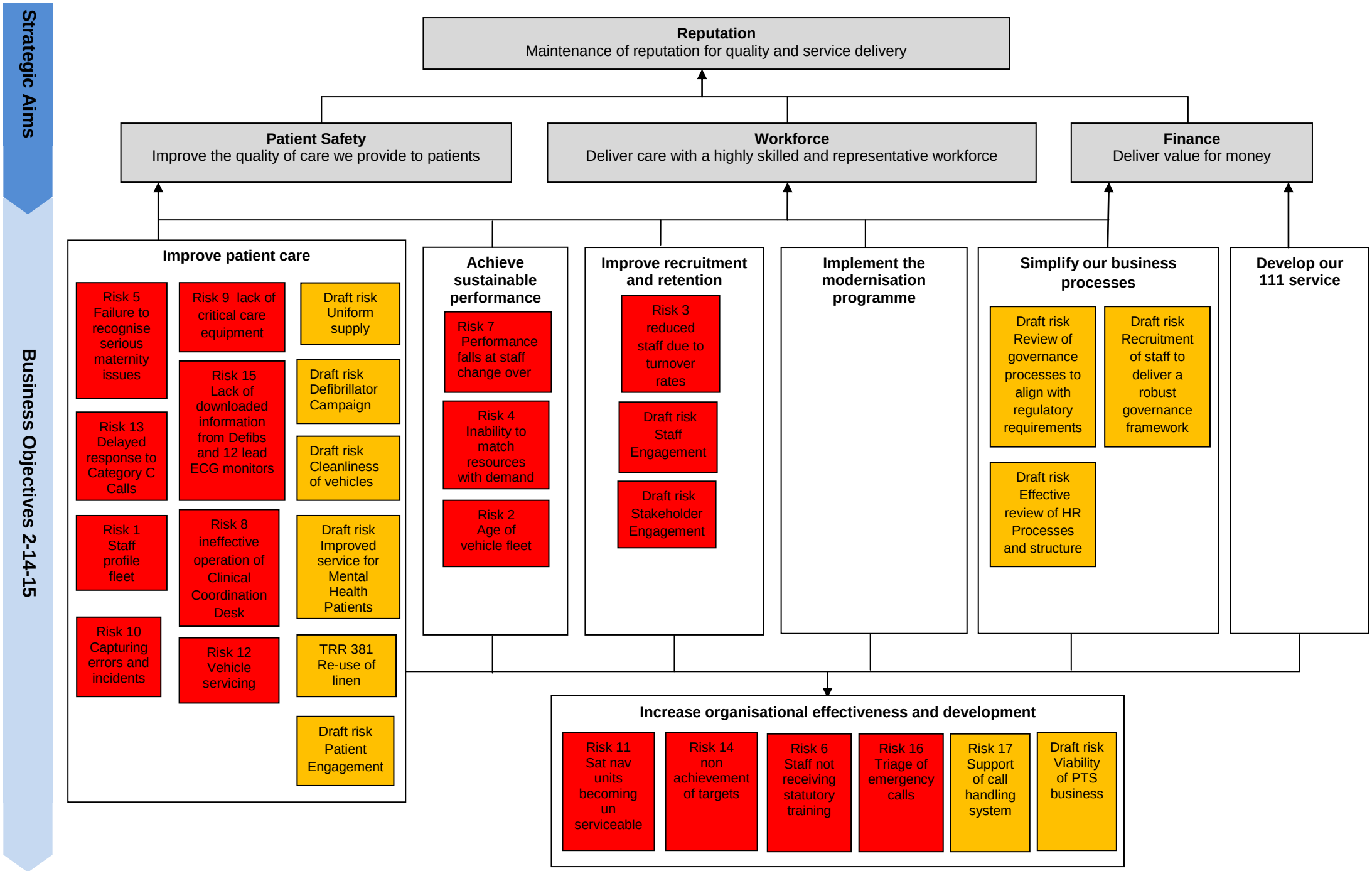
Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

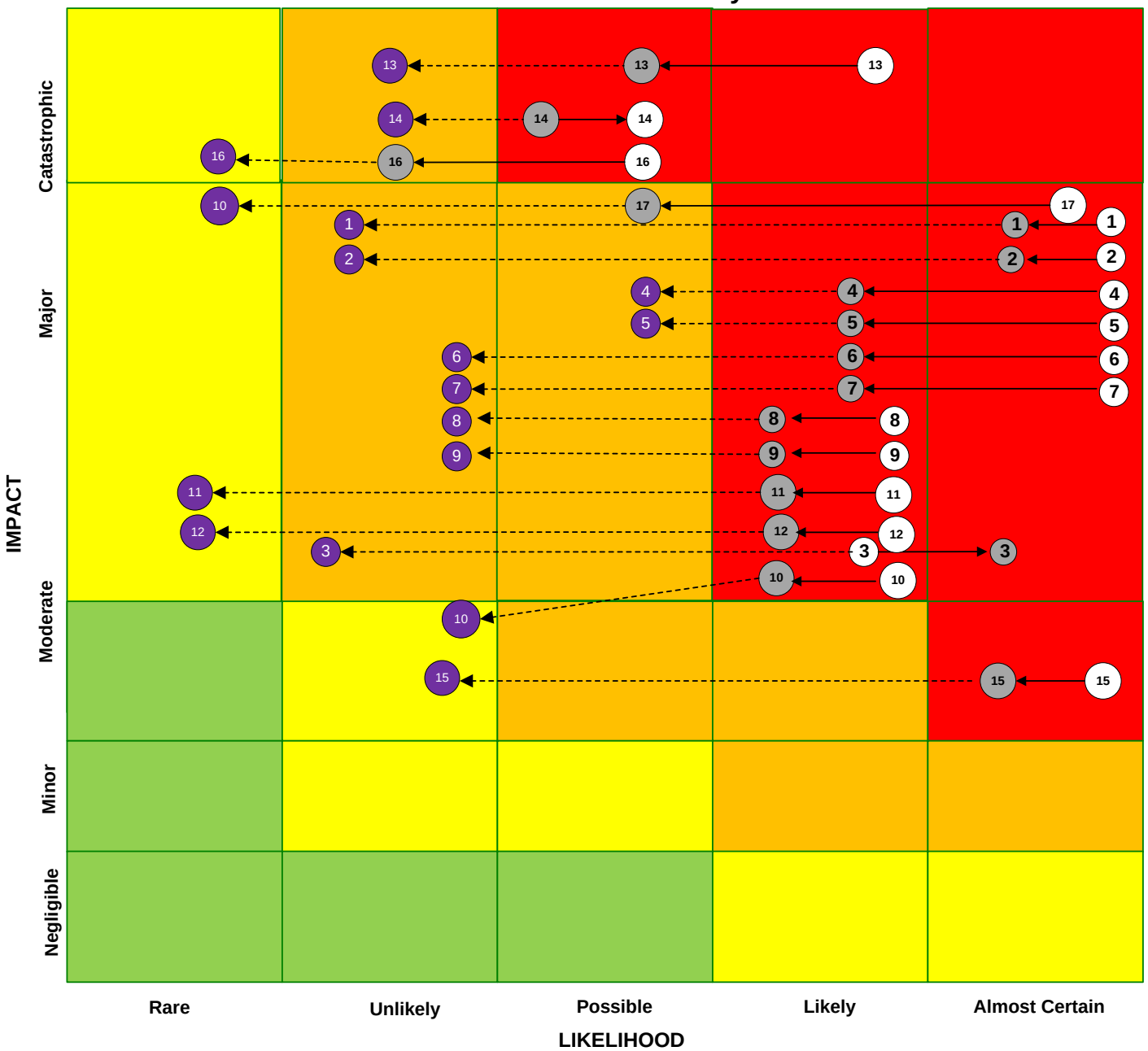
Key issues from the assessment:

Board Assurance Framework July 2014

Key Risks to the Strategic Plan



Board Assurance Framework July 2014



Key:

- Gross risk assessment
- Net risk rating
- Target risk rating
- High Risk
- Significant Risk
- Moderate Risk
- Low Risk

Risk trajectory since May 2014

New Risk	BAF Risk 1	RR 402	Current age profile of fleet Workshop Managers and Technicians
New Risk	BAF Risk 2	RR 401	Current age profile of the LAS Vehicle Fleet will result in increased downtime
↕	BAF Risk 3	RR 388	Reduced staff due to turnover
↕	BAF Risk 4	RR 265	Service Performance affected by the inability to match resources to demand (proposed for escalation to 20)
↕	BAF Risk 5	RR 31	Failure to recognise serious maternity issues
↕	BAF Risk 6	RR 355	Staff not receiving statutory training
↕	BAF Risk 7	RR 269	Performance falls at staff changeover times
↕	BAF Risk 8	RR 349	Ineffective operation of Clinical Co-ordination Desk
New Risk	BAF Risk 9	RR 399	A lack of critical equipment on ambulances
New Risk	BAF Risk 10	RR 404	Accurately and effectively capturing errors and incidents in accordance with national guidelines
New Risk	BAF Risk 11	RR 400	Satellite navigation units becoming unserviceable
New Risk	BAF Risk 12	RR 403	Service intervals of Ambulance and Fast Response Units
↕	BAF Risk 13	RR 379	Delay to Category C calls
↕	BAF Risk 14	RR 329	Non achievement of contractually agreed targets
↑	BAF Risk 15	RR 207	Staff not being able to download information from Defibrillators and 12 lead ECG monitors
↕	BAF Risk 16	RR 382	MPS calls are incorrectly triaged
↓	BAF Risk 17	RR 387	Call handling system may be unsupported by Priority Dispatch System (downgraded to 12)

London Ambulance Service NHS Trust
Risk Register - Strategic Risks July 2014

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
402	There is a risk that the current age profile of Fleet Workshop Managers and Technicians will impact on the future resilience of the Fleet Operation	Age profile of Fleet Workshop Managers and Technicians	09-Jul-14			Business Continuity	Major	Almost Certain	20	Regular recruitment of Vehicle Technicians. Recruitment aimed at long term temporary staff.	Sean Westrope		Major	Almost Certain	20	1. Establishment of apprenticeship scheme.	1. S. Westrope	1. October 2014		Major	Unlikely	8	Risk Approved by SMT at meeting on 9th July 2014
401	There is a risk that the current age profile of the LAS Vehicle Fleet will result in increased downtime impacting on operational performance and implementation of the modernisation process.	Age profile of the LAS Vehicle Fleet	09-Jul-14			Operational	Major	Almost Certain	20	Capital programme for 2014/15 includes replacements	Sean Westrope		Major	Almost Certain	20	1. Agree comprehensive 5 year replacement plan. 2. Agree funding for additional vehicle technicians.	1. S. Westrope 2. S. Westrope	1. October 2014 2. August 2014	5 year plan to be managed by Fleet Procurement Board and monitored by Vehicle Working Group	Major	Unlikely	8	Risk Approved by SMT at meeting on 9th July 2014
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	31-Jul-06	3	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Use of agency Paramedics to enhance bank scheme. Modernisation programme. Targeted use of overtime. Surge plan	Jason Killens	15-Apr-14	Major	Likely	16	Modernisation programme to implement efficiencies from capacity review. 1. Sickness management 2. Attendance management 3. Roster review 4. Skill mix 5. Annual leave review 6. New response model 7. Workforce plan operations / recruitment and retention	1 - 2 J. Killens 3 - 6 M. Kennedy / J. Chalmers 7. T.Crabtree / D. Prince	3. Complete 4. May 2014 5. May 2014 6. Sep/Oct 2014 7. Q4 2014/15		Major	Possible	12	
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	4	4	Clinical	Major	Almost Certain	20	1. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 2. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee (CQSEC). 3. Review incidents reported through LA52's, 4. Patient Experiences and legal Claims relating to problematic obstetric incidents. 5. Maternity care update articles in the Clinical Update. 6. Monitoring the delivery of the CPD obstetrics module. 7. The maternity pathway for use by Clinical Hub has been redesigned after audit findings. This has been implemented and reviewed. A planned reaudit will occur in 2014. 8. Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife. 9. Pan-London Maternity Divert Policy (Updated Sept. 2013): Robust framework to limit temporary closures of maternity units and to organise redirection.	Fionna Moore	14-Apr-14	Major	Likely	16	1. Director of Paramedic Development & Education to directly oversee delivery of CSR 2013/2014. CSR to be delivered to >85% clinical staff. 2. Appointment of Consultant Midwife (post vacant) to provide professional advice and education. Update post from 0.2 WTE to 0.4 WTE to increase availability and impact through obstetric education.	1. End 2014 2. May 2014	1. Review during each quarter and any serious or recurrent themes highlighted through updates to operational and/or control staff and CQSEC. 2. End of 2013/14 financial year 3. End of 2014/15 financial year	1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services. 2. Incident reporting. 3. Reports to CQSEC, SI group, Learning from Experiences	Major	Possible	12	SMT 14/05/14 agreed rating to remain at major x likely = 16. FM 14/04/14 suggested that net rating remains at 16 until the consultant midwife is in post and will review in 6 months time. the recruitment process is underway with expressions of interest for the post being made. SMT 09/04/14 approved regrading but requested the risk remain visible on the register (not archived). Proposal to reduce current rating to possible x major = 12
355	There is a risk of staff not receiving clinical and non-clinical statutory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills	23-Nov-11	11	5	Corporate	Major	Almost Certain	20	1. Agreement with operations that there will be an agreed abstraction of up to 90 staff per week to attend CSR during agreed periods. 2. Paramedic registration.	Mark Whitbread	01-Apr-14	Major	Likely	16	1. The TNA which applies to April 2014 to be reviewed and agreed by TSG. 2.A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commence from October 2012. 4. Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.	1. J. Chalmers 2. J.Thomas 3. P. Billups 4. P. Cook	1. May 2014 2. Complete 3. Complete 4. Ongoing	1. TSG review and agree TNA on an annual basis. 2. TNA used as basis for agreeing service training plan. 3. TSG review reulgar reports of uptake on training.	Major	Unlikely	8	SMT 09/04/14 suggested that current risk rating remains until the risk is reviewed for splitting between clinical and non clinical. Update control sheet. Propose risk owners made up of Directors within TSG / or its successor for principal risk. Action plans underpin headline risk made up of clinical and non clinical training action plans. discuss with Karen B / Jane Chalmers and Mark W. Split risk between clinical (MW) and non clinical (B'ON) 8/1/14- BO'N proposes change of net rating to Major x
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	5	17	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.	Jason Killens	15-Apr-14	Major	Likely	16	1. 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 which is intended to be implemented under Modernisation is under discussion between trust management and trades unions. The target date for completion of the discussions and agreement of the skill mix is May 2014. Skill mix has been included in the modernisation programme's implementation planning and subsequent implementation into BAU 5. Ongoing vigorous management of out of service. J. Killens to set improvement trajectory to get out of service levels back within target.	1. T. Crabtree 2. J. Killens 3. D. Prince 4. M.Kennedy / J. Chalmers 5. K. Brown / Sean Westrope	1. Q2 14/15 2. Q2 14/15 3. Q2 14/15 4. May 2014 5. Q2 14/15		Major	Unlikely	8	

London Ambulance Service NHS Trust
Risk Register - Strategic Risks July 2014

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	13	4	Operational	Major	Likely	16	1. CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12	Jason Killens	15-Apr-14	Major	Likely	16	1. Increase the number of staff trained to undertake the Clinical Coordination Role 2. Ensure that, if there is no option but to split the desk between Waterloo and Bow, the CCD is co-located with the Clinical Hub at both sites				Major	Unlikely	8	SMT - 11/06/14 did not approve archiving of risk. K. Millard to review. SA - recommend for archiving JK - 15/04/14 recommend to SMT for archiving due to the clinical hub now being in place.
399	There is a risk that a lack of critical equipment on an Ambulance may impact on the crew's ability to respond to all category A calls and /or any calls requiring specialist equipment to be deployed at the scene.	Underlying causes are varied and emanate from various functions of the Trust. This potentially affects the ability of a crew to provide the appropriate response at a scene which may delay treatment to the patient. Due to the equipment either being: Defective Contaminated Impounded Missing Replaces Risk 303 & 362	11-Jun-14			Fleet and Logistics	Major	Likely	16	1. Vehicle Daily Inspection completed, as part of the Vehicle Preparation process, by the Vehicle Preparation complex Team indicating which items are missing. 2. The crew will also check for critical equipment and try to source. (OP/026) 3. Crews should advise EOC/DSO which equipment they are missing, this should also be reflected in their LA1 (OP/026).	Sean Westrope		Major	Likely	16	1. Improved equipment exchange by the LSU team. Equipment will be carried on their vehicles enabling a swifter exchange. This is dependant upon time of visit by LSU team. 2. Joint site visits by Logistics/Estates advising relevant process involving equipment 3. Joint education on equipment issues and continuous declaration of spare equipment. A process will be put in practice advising how equipment can be relocated to a frontline vehicle. A group needs to be set up including a lead DSO from each area. 4. Logistics Support Unit now hold a central budget to replace broken equipment which is processed through Deptford Stores. This will provide an improved and speedier replacement/exchange process.	1. Karen Merritt 2. Fleet & Logistics / Estates 3. Fleet & Logistics / Estates 4. Karen Merritt	1. June 2014 2. Ongoing 3. Ongoing 4. Ongoing	Continuous review of the actions	Major	Unlikely	8	Approved by SMT 11/06/14
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			Corporate	Major	Likely	16	All incidents are reviewed weekly, with triggers in place within Datix to ensure incidents received of moderate risk grading are automatically forwarded to the Serious Incident Group. Weekly Serious Incident Group meetings to review outstanding and pending cases. Standing agenda item at bi-weekly Senior Management Team meetings. Monthly reports to the Executive Management Team.	Sandra Adams		Major	Likely	16	1. Review of the Serious Incident Policy. 2. Review of the governance arrangements to support the incident management process. (Serious or all moderate / severe). 3. Implement quarterly / 6 monthly of non-escalated incidents for a quality review. 4. Complete the Incident Reporting Project (Phase 2) leading to the roll-out of Datix Web.	1. S. Adams / D.Hallilley 2. S. Adams / D. Prince 3. S. Adams / D. Prince 4. C. McMahon / P. McKenna	1. 2. 3. Q3 2014/15 4. On hold	Serious Incident Policy reviewed annually. Internal Goverance audits, and external audits by accredited providers highlighting gaps in our procesess Incident reporting procedure being developed	Moderate	Unlikely	6	Risk Approved by SMT at meeting on 9th July 2014
400	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	SatNav's were originally specified and procured in 2001. The selected manufacturer was Siemens VDO, distributed in the UK by MixTelematics Ltd. Over time the unit design has evolved (CD to DVD to SDcard) but fundamentally they have remained backward	11-Jun-14			Operational	Major	Likely	16	1. Telent Ltd, who carry out the frontline MDT/SatNav maintenance visits, are investigating alternative break/fix arrangements with a 3rd party. 2. Replacement of SatNavs is within scope of the eAmbulance project.	Jason Killens		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. 2. With information on alternative SatNav devices, an assement of the work to reengineer the MDT interface (rewrite software) will be undertaken. 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.	1. John Downard 2. John Downard 3. John Downard	1. TBC 2. TBC 3. TBC		Major	Rare	4	Approved by SMT 11/06/14
403	There is a risk that a number of Ambulance and Fast Response Units will not be road worthy as their average service intervals have extended beyond 16 weeks, the average time taken for brake pads to wear.	The risk potential affects the safety of Operational Staff and members of the Public. If the risk is not addressed this may result in criminal prosecution against members of the Trusts Executive. The underlying cause of the Risk is a lack of scheduling of the Planned Maintenance activity and monitoring of	09-Jul-14			Health & Safety	Major	Likely	16	The Trust utilises the scheduling facility in the asset management software TRANMAN for planning the routine maintenance of the vehicles. There is a dedicated management resource to ensure implementation of the plan.	David Prince		Major	Likely	16	1. A recovery plan has been produced and provided to Corporate Fleet Manager for instigation and delivery. 2. The data and application of TRANMAN will be reviewed to ensure that it acts as an effective control against the risk. 3. Review management controls and performance monitoring to ensure a safety environment. 4. Develop a safety management system for the department. 5. Resolve the fleet capacity issues within the Trust (as per action plan for the provision of a safe environment 14/15).	1. P. Mann 2. S. Westrope 3. S. Westrope 4. S. Westrope 5. S. Westrope	1. 20-08-2013 2. 31-08-2013 3. 31-10-2013 4. 31-10-2013 4. End of 15/16 Fiscal Year	Daily Monitoring of progress against plan and priority of scheduling in the Workshops for the vehicles concerned. Re-organisation of the department to provide clear lines of responsibility and accountability.	Major	Rare	4	Risk Approved by SMT at meeting on 9th July 2014

London Ambulance Service NHS Trust
Risk Register - Strategic Risks July 2014

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	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
379	There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.	40% of total volume of calls are Category A. Inability to match resource to demand as the responding priority is focussed on more seriously ill patients.	11-Mar-13	7		Clinical	Catastrophic	Likely	20	1. Undertaking ring backs within set time frames for held calls. 2. Fully trained workforce with 20 minute education breaks throughout shift. 3. C3 calls passed to hub for enhanced assessment C1 and C2 held calls are reviewed by hub 4. LAS Surge Management Plan. 5. Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime.	Jason Killens	15-Apr-14	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 4% 2. Deliver efficiencies in full from CapacityReview and complete Roster Implementation. 3. Review the determinants to best maximise resource availability, to assist with reduction multiple attendance ratio for single incidents. 4. Recruit to establishment in the clinical hub. 5. Allocate EMDs to clinical hub to assist with ring backs – Service Development put in for additional staff to undertake this work 6. Offer near misses for APP and CTL to spend 6 months in the clinical Hub in preparation for next tranche of recruitment 7. Introduce surge plan and make appropriate revisions 8. More accurate reporting of category C delays and monitoring of safety incidents	**1. D.Prince** **2. J.Killens** 3. J. Killens 4. K. Millard 5. K. Millard 6. K. Millard 7. K. Millard 8.	1. 2015/16 2. Q3 14/15 3. Q1 14/15 4. Q3 14/15 5. Q2 14/15 6. 2014/15 7. Ongoing 8.	1. Operational Demand and Capacity Review Group 2. Senior Management Team 3. Medical Directorate senior clinical advice; Clinical risk and Patient safety 3. The weekly SI group reviews patient safety incidents	Catastrophic	Unlikely	10	
382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	In 2001 CAD link was developed, which enabled the MPS and LAS to exchange emergency calls and other messages directly via each organisation's CAD system. This process bypasses the standard triage system that all other 999 calls are subject to. To request the LAS, the MPS complete a basic triage of the call, known as the SEND protocol (Secondary Notification of Dispatch). SEND requires the MPS to answer five key questions to determine the medical priority of the call. Requests for the LAS from the MPS may be incorrectly triaged as a result of the limitations of the medical triage system used by the MPS Central Communications Command (SEND protocol). Erroneous	07-May-13	12		Clinical	Catastrophic	Likely	20	1. LAS METDG in in place 7 days a week. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated. 3. EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately. 4. The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning.	Jason Killens	15-Apr-14	Catastrophic	Possible	15	1. ~~A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.~~ ~~2. Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS~~	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. Completed 2. Completed		Catastrophic	Rare	5	JK to state what residual risk rating is prior to archiving All mitigating actions have been put in place and the risk. JK 15/04/14 residual risk to be tolerated. .
329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10	9	3,4,8	Finance	Catastrophic	Possible	15	1. 2013/14 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and EMT. 3. Regular communication with commissioners. 4. The contract of the Director of Modernisation and OD has been extended to end of June 2014 to maintain focus on the Modernisation Programme.	Karen Broughton	01-Apr-14	Catastrophic	Possible	15	1. Review by Finance Investment Committee 2. Review capacity vs demand 3. Develop a programme of sustainable performance and performance management 4. Develop clear escalation procedures when measuring performance . 5. Establish relationship with Commissioners 6. Negotiate suitable operating contract with Commissioners. 7. Recruitment	1. K.Hervey 2. J. Killens 3. P. Woodrow 4. P. Woodrow 5. K. Broughton 6. K. Broughton 7. D. Prince		1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board. Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed	Catastrophic	Unlikely	10	This risk is under review for re-assessment and proposal of new risk to replace it. K. Broughton - May 2014.
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	***	1,2,4, 5	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**	10-Apr-14	Moderate	Almost Certain	15	1. To highlight the importance of clinical incident reporting in the Team Leader Clinical Update Course. 2. Audit of FR2 data cards and card readers. 3. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 4. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 5. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area. 6. Consider roll out of transmittable data from LP15 once vehicle on station	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread 6. M.Whitbread	1. Complete 2. Ongoing 3. Ongoing 4. Ongoing 5. Ongoing 6. Ongoing post N/Malden pilot evaluation	2. EOC briefings undertaken	Moderate	Unlikely	6	SMT 14.05.14 approved regrading to moderate x almost certain = 15 M.Whitbread to raise with EMT regarding mitigating actions. Proposed increasing current rating to moderate x almost certain = 15 APPs will be conducting a feasibility study using laptops to download data at two sites - Brent and Westminster with the intention of reviewing the outcomes with the attending crew in order to establish any learning from the event

London Ambulance Service NHS Trust
Risk Register - Strategic Risks July 2014

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398	There is a risk that the Trust will have difficulty acquiring timely supplies of printed material namely PRFs, controlled drugs registers, controlled drugs daily check sheet books, LA3 and LA5. This would be Trust wide and impact on all crew and staff and patients. Crews would be unable to document any patient for each of the calls they attended and would be unable to complete legal document such as recognition of life extinct.	The company who currently print these forms is having financial difficulties. The parent company has gone into liquidation and the branch we deal with is being sold. There is a risk that that if it is sold the printing may not be continued.	01-May-14			Corporate	Catastrophic	Possible	15	1. The company already hold 200 boxes (2 months of PRFs) in stock for the LAS , as well as stocks of the other forms / material. 2. Logistics hold PRFs, CD Registers, LA3s/5s etc… prior to them being sent out to complexes so there is stock available in-house too	Mark Whitbread		Catastrophic	Possible	15	1. Requested the printers to print and hold double the normal amount which will provide us with 4 months stock aside from the PRFs on LAS sites Consideration needs to be given to asking for similar "buffer" stocks of other documents. 2. To meet with ServicePoint to discuss the future. 3. To set up meetings with other providers as a backup plan.	1. M. Whitbread / R. Deakins 2. M. Whitbread / R. Deakins 3. M. Whitbread / R. Deakins	1. May 2014 2. May 2014 3. May 2014	Procurement to draw up a contract with the printing company and which is annualy reviewed. Regular review of stocks held by printing company. Regular review of stocks held by LAS logistics. Regular review of stocks held by LAS logistics. Ensure there is a business continuity plan for the loss of printing either through liquidation / fire etc	Catastrophic	Rare	5	16/07/14 DW propose to archive as arrangements have made to liaise directly with printers instead of via printing agency. Procurement to draw up a contract with the printing company and which is annualy reviewed. Regular review of stocks held by printing company. Regular review of stocks held by LAS logistics. Regular review of stocks held by LAS logistics. Ensure there is a business continuity plan for the loss of printing either through liquidation / fire etc
387	There is a risk that the LAS could be in a position where its call handling system is unsupported by Priority Dispatch Systems (the suppliers) from late 2014 onwards. this will involve both our call taking system (ProQA) and the MPDS version we are using (12.2). This will significantly impact our ability to maintain and use both systems and compromise efficient working and patient safety.	Priority Dispatch have developed an updated and improved operating system for MPDS. This system, ProQA Paramount, repleaces the existing ProQA, Paramount is currently available for UK users and is compatible with the current version of MPDS, 12.2.. In Q3/4 2013/14 a new verison of MPDS, version 13, will be released. It is not possible to use use Version 13 without Paramount. It is likely that, following	23-Oct-13	2		Business Continuity	Major	Almost Certain	20	1. Work has been undertaken by IM&T to scope the work required to integrate Paramount to facilitate identifying the costs involved. 2. Task and finish group prepared a detailed paper of the options which went to the Executive Management and Senior Management Teams on the 18th December 2013.	David Prince (Vic Wynn)	01-Apr-14	Major	Possible	12	1. A workshop has been planned for January 2014 involving the Executive and Senior Management Teams based on the recommendations made in the report.	1. EMT/SMT	1. Jan 2014		Major	Rare	4	SMT 14/05/14 approved regrade. Latest update on timing is that the development may not meet the timescale required, propose net rating is regraded to Possible x Major = 12 Rationale for downgrade - - confirmation now provided by Northrop Grumman that they will produce an interface to the new version of ProQA (Paramount) at nominal cost, the risk to the Trust is reduced. The need for a confirmed Trust strategic (Paramount vs Pathways) direction is therefore not currently critical.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR INFORMATION

Document Title:	**Clinical Directors' Joint Report**
Report Author(s):	**Fionna Moore / Steve Lennox / Mark Whitbread**
Lead Director:	**Fionna Moore / Steve Lennox / Mark Whitbread**
Contact Details:	
Why is this coming to the Trust Board?	**Information only**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☒ Other: Parts of this report have been presented elsewhere
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

- Still increasing use of Surge Red, and for the first time Surge Purple
- A steep rise in the number of complaints received into the Patient Experiences Department

Executive Summary

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

Demand Management Plan / Surge Plan: There has been a further rise in the use of Surge Red, and also for the first time, Surge Purple since the last report to Trust Board. Surge Purple has now been implemented on a number of occasions.
Clinical Performance Indicators: There has been a rise in the completion levels of CPI audits in May. The Mental Health CPI remains the lowest scoring, but has improved since the last report to Trust Board.
Prevention of Future Deaths Reports: The Trust has not received any prevention of future deaths reports.
Medicines Management: There has been one reportable controlled drugs incident since the last report to Trust Board
Locality Alert Register: The number of addresses held on the locality alert register remains on a par since the last report to Trust Board.

Attachments:
Clinical Directors' Joint Report

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☐ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Directors' Joint Report - 29th July 2014

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

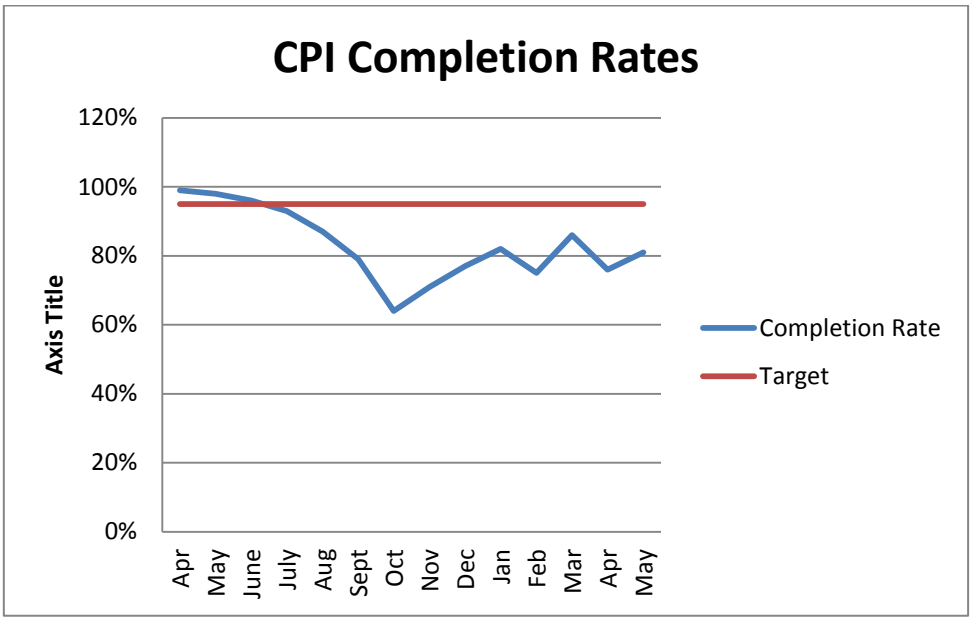
In particular, the Clinical and Quality Directorate would like the Board to focus on the following areas:

- **Increasing use of Surge Red, and during June the first uses of Surge Purple. This puts the Trust's reputation at risk, and impacts on the quality of the service we provide. There is also an increasing risk associated with each level of Surge which is implemented, with more calls being referred elsewhere at point of contact.**
- **A continuing rise in the number of complaints received into the Patient Experiences department.**
- **Poor performance against the national CPI (cycle 12) for the management of febrile convulsions in children.**

Domain 1 - Safety

Clinical Performance Indicator completion and compliance

The CPI completion rate dropped significantly in April, when compared to March, but has increased this month (May) by 5%. The South had the biggest increase in completion rate since the last report, an increase of 12%.



CPI Completion June 2013 to May 2014

Area	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
East	97%	95%	91%	71%	30%	62%	64%	85%	81%	91%	71%	71%
South	95%	93%	89%	88%	79%	65%	89%	94%	77%	81%	79%	91%
West	97%	90%	83%	76%	76%	82%	77%	68%	69%	88%	76%	77%
LAS	**96%**	**93%**	**87%**	**79%**	**64%**	**71%**	**77%**	**82%**	**75%**	**86%**	**76%**	**81%**

CPI Compliance May 2014

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	96%	98%	96%	98%	92%	98%	98%
South	98%	97%	96%	97%	93%	97%	98%
West	98%	97%	97%	97%	93%	97%	98%
LAS Total	**98%**	**97%**	**96%**	**97%**	**93%**	**97%**	**98%**

CPI Compliance April 2014

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	95%	97%	97%	88%	98%	97%
South	99%	95%	97%	97%	89%	98%	97%
West	98%	96%	97%	97%	90%	97%	98%
LAS Total	**98%**	**95%**	**97%**	**97%**	**89%**	**97%**	**97%**

CPI compliance remains >95% against all clinical care standards, except mental health which has now been on-going for a number of months. However, May has seen the highest ever compliance to the Mental Health CPI audit since its introduction. It is hoped that the Core Skills Refresher on mental Health will see the care provided to this group of patients continue to rise to levels associated with other CPI audits. Edmonton, Kenton, Bromley, Greenwich and New Malden complexes all achieved >95% compliance to all CPI audits which is an excellent achievement.

Full CPI reports are available on request.

National Clinical Performance Indicators

The National CPI (cycle 12, data from March 2014) report on management of Febrile Convulsions in children has been released. The Trust remains at the bottom of all Ambulance Trusts, with cycle 12 receiving a poor 51.7% performance. This is almost certainly due to the required elements not being documented appropriately on the PRF. The LAS needs to improve the following:

- Recording a blood sugar level

- Recording oxygen saturations prior to administering 02.

It was hoped that the personal issue of BM kits and the roll out of vehicle issued portable saturation probes would improve the adherence to these specific criteria. However, it would appear that this is not the case. The Medical Directorate will work alongside Clinical Audit and Research to devise an action plan to address this.

NHS Central Alerting System (CAS)

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

In total during June there were 12 CAS alerts, none of which required any further action by the LAS, but all of which were acknowledged.

NHS Signals

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

NICE Guidance

The NICE guidance for May 2014 has been released.

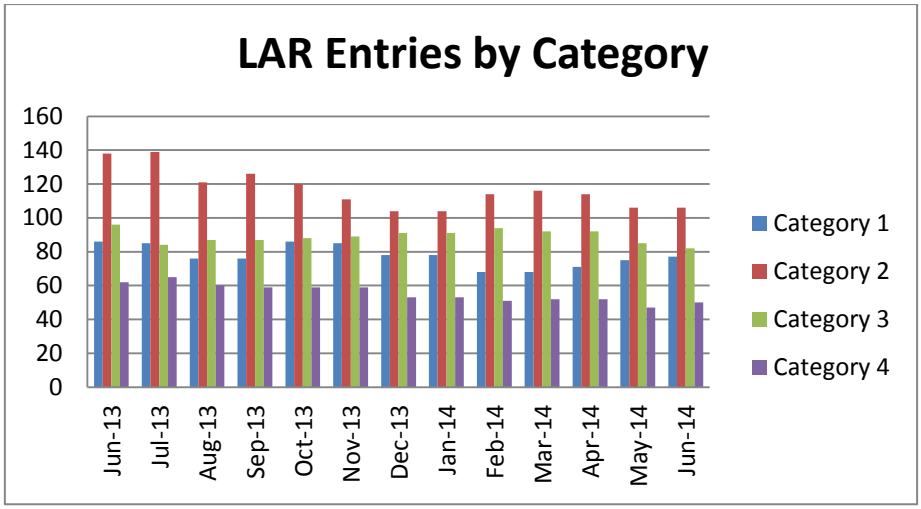
Of particular interest is the use of the HAS-BLED tool to score and assess the risk of bleeding in patients taking anti-coagulants. It recommends that the following risk factors should be monitored:

- Uncontrolled hypertension
- Poor control of INR (international normalised ratio)
- Concurrent medication use
- Anti-inflammatory drug use
- Harmful alcohol consumption

The whole report is available on request.

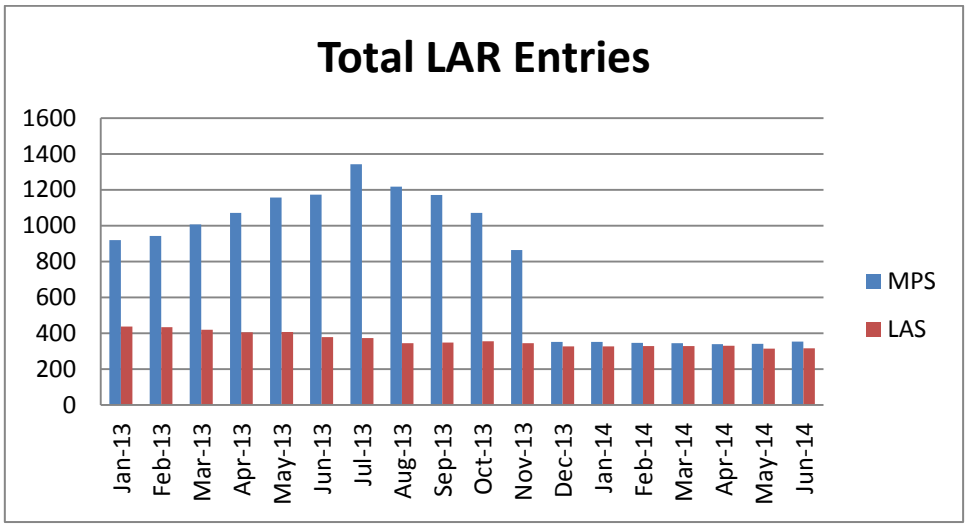
Locality Alert Register

There are currently 315 addresses on the Locality Alert Register (LAR). These are broken down as follows:
CATEGORY 1: 77
CATEGORY 2: 106
CATEGORY 3: 82
CATEGORY 4: 50



The Medical Directorate have been working closely with Complexes across the Trust to re-assess the requirement and safety of the category 4 locality alert flags. It is now evident that the numbers of these are now reducing which is a positive step.

The Trust has notification of 352 high risk addresses from the Metropolitan Police. This is a slight decrease on the previous month.



Demand Management Plan / Surge Plan

The Trust implemented the new Surge plan on 17th April 2014.
The purpose of The Surge Plan is similar to that of the former DMP. However, Surge looks at a greater number of parameters which indicate pressure across the wider London health systems. It aims to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to respond to periods of high pressure, due to unforeseen demands, poor resourcing or those occasions where capacity does not exist to absorb unexpected patient demand.

Surge enables the LAS to prioritise calls with a higher MPDS triage category, and to ensure those patients with the most serious conditions or in greatest need continue to receive a response. The

escalating stages of Surge (Green through to Black) reduce the response to lower call categories. The risk of this is mitigated by increasing clinical involvement in the Control Room as the levels increase, with clinical 'floor walkers' available to assist call handlers and by ringing calls back to provide advice, to re-triage and if appropriate to negotiate alternative means of transport or follow up. It is also mitigated by regular senior clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the Surge which is invoked.

Since the implementation of Surge, the Trust has been working at a minimum of Surge Amber; which is an equivalent within the Surge plan, to that of 'winter working' under the former Demand Management Plan, in place since December. However, despite Surge Amber being in place constantly, the Trust has seen a sharp increase in the use of Surge Red, and in June, the first implementation of Surge Purple in 2014.

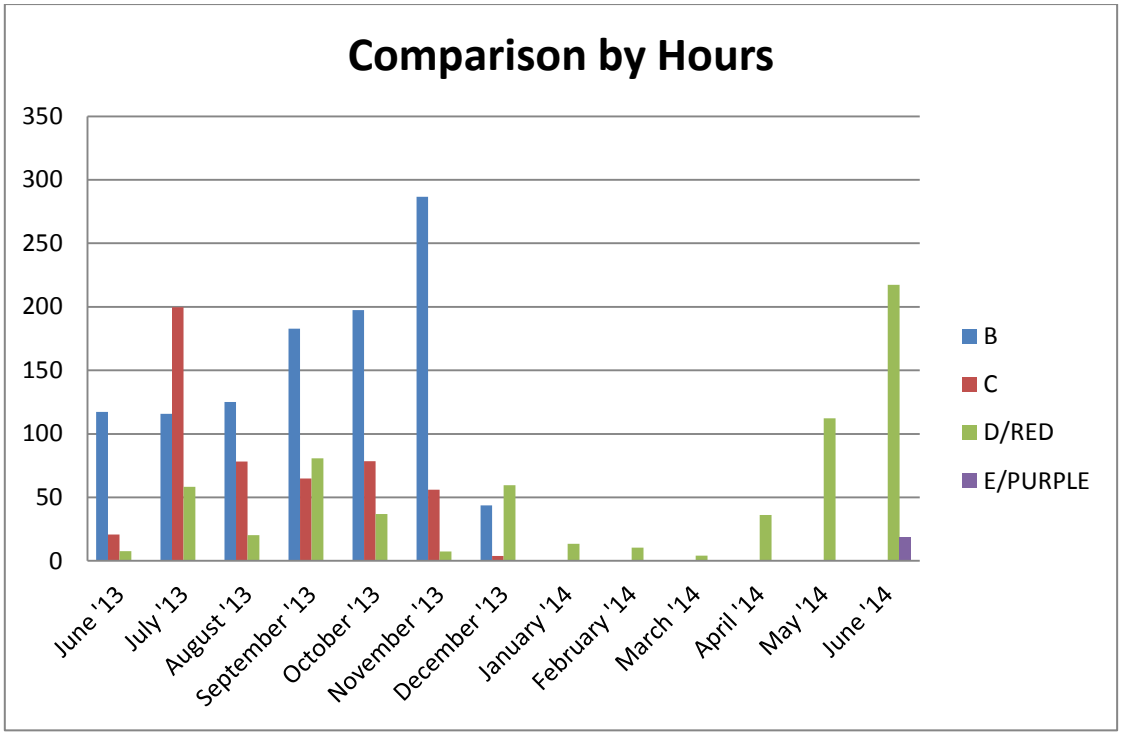
Purple was implemented at 16:45 on Monday 23rd June, and ran through until midnight, at which point the Trust moved to Red, until 0400. The Trust moved back to Purple the following day at 20:00 until 00:20. On the first implementation of Surge Purple, the Trust declared an internal major incident. Following a review, the decision was made that declaring an internal major incident didnot appear to provide additional resilience. EMT have reviewed the position regarding the use of working at Surge Amber as a minimum, and the decision was made to proactively use Surge Red, with Gold level telephone conferences 3 times per day.

With further experience of the use of Surge, a revision is underway, using the limited feedback from the use of Surge Purple and the extensive use of Surge Red.

To date no adverse comments have been received from NHS England (London) or our commissioners.

DMP and Surge use January – June 2014

Month	Number of occasions DMP/Surge invoked	Stage B (hours)	Stage C (hours)	Stage D (hours) Surge RED	Stage >D (hours) Surge RED (+)	Ambulances reprioritised
January	2	**Winter Working**		13.5	0	5770
February	3	**Winter Working**		10.5	0	6272
March	2	**Winter Working**		4.25	0	6591
April	10	**Winter Working / Surge Amber**		36.25	0	7163
May	18	**Surge Amber**		112.25	0	7881
June	26	**Surge Amber**		217.25	11.5	8687



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

The Trust has not received any Regulation 28, Prevention of Future Death reports since the last report to Trust Board. The same applies to the other Trusts across the UK.

Infection Prevention & Control

Deep Clean

Overall KPI of 90% for was achieved for ALL vehicle categories collectively. The monthly IPC performance dashboard however, measures VP deep cleaning compliance on A&E vehicles only. The April (84%) and May (82.8%) data highlighted under-performance for A&E vehicles, a pattern of under-performance, continuing from the preceding 6 months.

To address the underachievement for A&E vehicles, a mobile unit was initiated as part of an action plan to improve the situation together, with IPC and the contract manager working closely with Initial and daily progress monitored. This has resulted in marked improvements in the June data (89.8%). The situation continued to be closely monitored monthly and challenged at each quarterly IPCC. The contract KPI still needs review.

FRUs in Education, HART vehicles and new vehicles have also been added to the 6 weekly cleaning list. It should be noted that Initial does not provide high level cleaning service following Category 4 transfers. Terminal cleaning for Category 4 transfers is being clarified and enhanced as required, as part of a wider project with HART.

Post Infection Review investigation for MRSA Bacteraemia
The Head of IPC participated in a multi-agency Post Infection Review of a 44 year old bariatric case with MRSA bacteraemia, who subsequently died. It formed part of the Acute Hospital investigation. The report was shared in May and highlighted the need for clarity regarding emergency conditions of line insertion in LAS. This was discussed at the May IPCC. This is only the second multi-agency review that we have been involved in.

Communicable Disease Exposure Incidents April to June 2014
We have had an increase in the number of staff exposure incidents recently. We will continue to monitor to see if this is a symptom of any changes operationally. The incidents have been fully reported to EMT but the main theme emerging from the analysis is Trust staff not adhering to policies on how to protect themselves. Case studies are being developed for sharing across the service.

Emerging Issues
The Ebola outbreak in Africa is receiving attention as this is one of the worst outbreaks. There is a theoretical risk that someone exposed could travel to the UK prior to becoming symptomatic. Ambulance Trusts are considering the implications and issuing guidance for staff. For the Trust it would be out HART team that would convey symptomatic patients to Royal Free Hospital. IPC and HART are working collaboratively to ensure we are fully prepared for such an incident (Cat 4 work is extremely rare).

Domain 2 – Development and Practice

Medicines Management

1. There has been one mandatory reportable controlled drugs (CD) incident since the last report to EMT. On Saturday 28th June two ampoules of morphine were inappropriately signed out by a manager who was not a registered paramedic. The intention was to take morphine to a paramedic already deployed at an event. This was picked up quickly by the Team Leader on the station concerned during a routine Daily Audit Check. The actions of the manager were understandable, but in the circumstances misguided, and led to the CD Register sustaining "over signing" and loss of tracking of ampoules to individual staff for a short period. The manager concerned has been formally written to by the Medical Director. The incident has been reported to the NHS England (London) Controlled Drug Accountable Officer. The Chair of MMG has liaised with the Head of EPRR to have a short section inserted into the Operational Plan for Events to remind Event Commanders about the availability of the "Event CD Safe".

2. There have been no reported drug errors since my last report.

3. There have been no MHRA Drug Alerts since my last report.

4. The MMG meeting for 18th June 18th 2014 took place as scheduled – The main topics discussed at this meeting were:
   Delivery date for the 3,000 Flu vaccines is 23rd September. Chair of MMG will liaise with Paul Williams and Dr Daryl Mohamed to get the Flu Vaccine PGD prepared.
   Frimley Pharmacy (the LAS pharmacy supplier), reported back that a meeting had been held with two drug companies and representatives from DH, NHSE (London) Chief Pharmacist

(including Jan Ingle) to hold them to account over drug supply problems. Although the LAS has always managed to avoid harm to the supply chain to LAS, it was an opportunity, (through Jan Ingle), for the LAS to be able to have a say in this important meeting that Ambulance Service pharmacy supply lines are as vital as these to other arms of the NHS.

The solution to the ketamine shortage was resolved and the LAS have secured an alternative presentation that is now in use. The Chair of the MMG has negotiated a system that does not need a re-write, re-issue and re-signing of the PGD – but still maintains governance surrounding notification of the change to affected staff (15 APPs, 1 Director, and 1 Senior Manager).

The "Drug Asset Tracking" gating Template is still being worked through with the Chair of MMG and Sean Westrope. This now forms part of the "Getting the Basics Right" project.

Domain 3 - Effectiveness and Experience

Clinical Audit and Research

Cardiac

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

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

Key Findings:

- Defibrillator data download rate remains low, at just more than 1% *
- 32% of cardiac arrest patients that had resuscitation commenced, gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital. This is a decrease of 1% on last month. This percentage includes all arrest rhythms.
- 99% of the advanced airways placed during a cardiac arrest had end-tidal CO2 measured and recorded. 3 patients had no ETC02 noted and no printout of the waveform included with the PRF.
- 99% of STEMI patients attended by the LAS were transported to the most appropriate destination.
- Overall call to arrival at hospital time for STEMI increased to 71 minutes during May. The length of time on scene remains high at 43 minutes. Both of these figures are higher than expected.
- The number of patients receiving the full STEMI care bundle has increased to 77% in May.
- PRFs are now being identified, where there is no printout or data on the PRF relating to end-tidal C02 monitoring. A monthly report on these non-compliant PRFs is written, and sent to the Area Medical Directors. Each case is followed up with the individual crew. Interestingly, since the implementation of this, the number of cases has dramatically reduced.

* NB: The Advanced Paramedic Practitioners will soon be able to download data from LP15 and LP1000s, as the first change in implementing and testing the benefits of direct downloads and data review from cardiac arrests. It is hoped that the benefit of this will be visible over the coming months.

Stroke

The monthly Stroke report for May 2014 has been delayed due to on-going staffing issues within the CARU department. The report and findings will be shared once available.

Trauma

The quarterly (Q2) Major Trauma Care Pack has been released.

The full report can be accessed at:
Clinical Audit & Research Unit\Trauma Reports\April '13 - March '14\Major Trauma Care Pack (Q2 2013-14).pdf

Key Findings:

- There is an average of 14 patients who trigger the MT decision tool, attended to each day by the LAS.
- 1278 major trauma patients were attended during July-September 2013.
- 98% of the major trauma patients we attended were correctly triaged to a major trauma centre
- The average on scene time has remained above the Trust's ideal maximum. The current averages for blunt and penetrating injuries respectively are 34 minutes and 17 minutes.
- There was an increase of 26% on last quarter, of patients being conveyed to a major trauma centre despite not triggering on the decision tree.

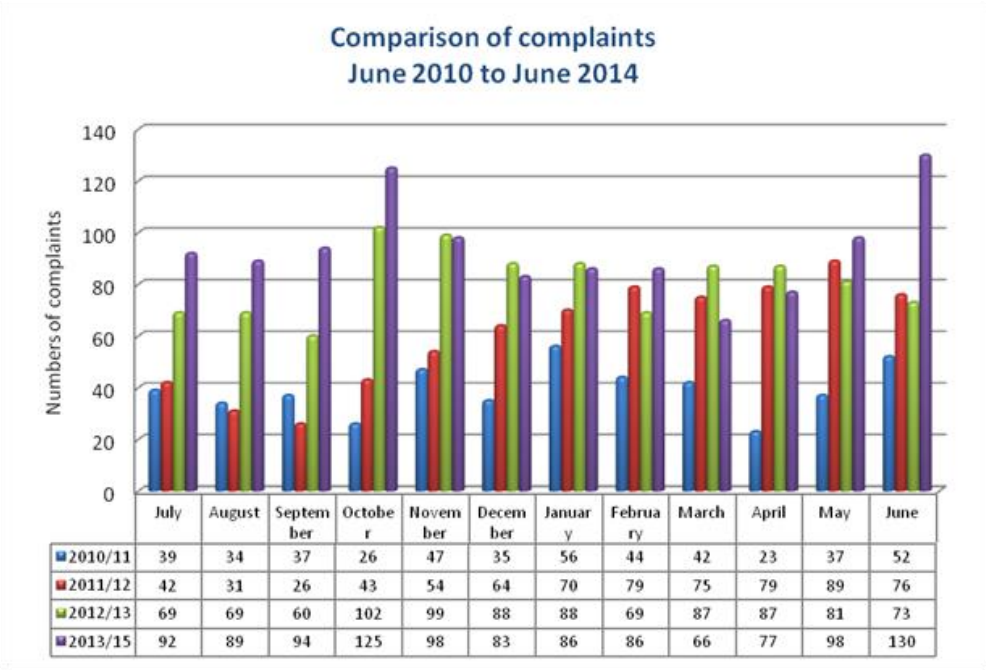
Patient Experiences

Complaints

Complaint Volumes

The number of Complaints this month was the highest ever recorded since the inception of the Patient Experiences Department (130), and significantly higher than May (98) and April (77). Of the June cases, 73 related to delays (56%) with complaints about staff conduct remaining constant (16 against 22 in May).

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



	July	August	September	October	November	December	January	February	March	April	May	June
2010/11	39	34	37	26	47	35	56	44	42	23	37	52
2011/12	42	31	26	43	54	64	70	79	75	79	89	76
2012/13	69	69	60	102	99	88	88	69	87	87	81	73
2013/15	92	89	94	125	98	83	86	86	66	77	98	130

21 complaints involved other Trusts/agencies including 10 x Acute Trusts, 2 x NHS 111 providers + 3 about LAS 111, 2 involved GP's, 1 a care provision service and 2 have been considered for SI. 1 has not been declared (C9102) and (9106) is awaiting further details.

Complaints by Area by percentage of total

Area	Number of complaints June	Ratio of total (% rounded)
Control Services	85	65
North Central	9	6.5
South West	6	5
South East	6	5
Not Our Service	6	5
North West	3	1.5
West	3	1.5
East Central	3	1.5
North East	2	2
PTS	2	2
111 Service	2	2

Unknown	1	1
Voluntary service	1	1
Central Operations	1	1
Contracted Services	0	0
Total	**130**	**100%**

Complaint Themes

Complaints relating to delay (73) and staff conduct (16) continue to be the main themes. REAP was reduced to Level 3 on 29 May in the light of less severe pressures than previous weeks and the national escalation triggers for REAP 4 were no longer being met. However, on a number of occasions in June, Surge purple has been implemented resulting in an internal Major Incident being declared. Category A performance averaged 60% throughout June and call rates continued to be higher than the annual daily average.

There has been an increase of 7% over May in complaints regarding non-conveyance (5 v 16).

Table 1 The following table shows the complaint subjects June 2013 to May 2014

Complaints by subject 2013 -2015	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Delay	38	30	50	53	41	38	22	29	24	33	50	72
Conduct	22	27	15	30	19	11	29	16	22	20	22	16
Road handling	15	12	9	10	8	9	8	12	7	8	9	9
Non-conveyance	5	5	7	8	11	10	10	11	7	5	5	16
Not our service	4	4	1	1	1	2	3	0	1	0	0	2
Treatment	4	4	5	13	11	6	12	13	4	8	7	12
Patient Injury or Damage to Property	3	0	1	4	2	1	2	0	0	1	0	1
Location Alert referral	1	3	1	2	2	1	0	0	0	0	1	1
Conveyance	0	4	2	3	1	2	0	3	2	1	1	1
Clinical Incident/Equipment	0	1	0	1	0	1	0	0	0	0	0	0
Assisting with external agency	0	0	2	0	2	0	0	0	0	0	0	0
Disputes safeguarding referral	0	0	1	0	0	1	0	2	0	1	2	0

Challenging paramedic qualification	0	0	0	0	0	0	0	0	0	0	1	0
Totals	**92**	**90**	**94**	**125**	**98**	**82**	**86**	**86**	**67**	**77**	**98**	**130**

There has been one further Locality Alert Register complaint in June

Case examples - cases closed in April/May 2014

Latex free equipment

The patient believed they had an allergic reaction to the ECG sticker dots we use as hospital staff seemingly supported the notion that these contain latex. The ECG packaging clearly indicates that the electrodes are latex free. A letter has been sent to the Acute Trust Medical Director to confirm this.

Call management

An ambulance was not sent to a patient who had a high risk pregnancy on the advice of a clinical floor walker. It transpired that the patient had been advised to call 999 by her midwife. To widen the learning an item will be included in a Team Brief, as a reminder about how such calls should be managed. A governance process is also being introduced to ensure we can identify the clinician involved and ensure any advice is recorded.

Treatment

Complaint hosted by Acute Trust about the care provided to a patient who had used cocaine. An ECG was not taken and the patient not assisted to the ambulance. The clinical evaluation found that staff should be reminded that cocaine can induce a heart attack.

Performance/Quality

88 cases were closed in June. The availability of a QA Manager to the department has been extended until the end of June at 1 day per week (as opposed to 3 days previously) so this will inevitably impact on performance.

Table 2 – closed complaints April 2013 to June 2014

2013/15	Number of closed complaints
April	94
May	92
June	80
July	95
August	54
September	102
October	85

November	74
December	114
January	75
February	95
March	127
April	71
May	91
June	88
Totals:	**1337**

As at 8 July, 198 complaints remain open or re-opened (compared to 170 on 6 June and 136 on 8 May).

This increase reflects a spike in volumes and reduced staffing (one member of staff has left 2 are on sickness absence and a further staff member is working towards her planned maternity leave). Proposals have been made to restructure the department with a fixed term contract and overtime being available (within existing budget whilst posts are being recruited) to manage the increase in demand.

Currently 52% of 'open' complaints are awaiting a QA report (compared to 41% at the same stage in June and 28% at the same stage in May) and 15% awaiting operational input (12% in May and 15% in April). 6% await Executive Office sign off (against 12% in May).

Table 3 The following table shows the current stage of individual complaints by month to 08 July 2014

Current stage of complaints	**Cases open up to 30 April 2014**	**May**	**June**	**Overall**
Awaiting QA Report	0	17	76	103
Awaiting Operational Input	2	8	20	31
Case under enquiry with PED Officer	1	3	4	9
Draft Response with Executive Office	4	9	0	13
Draft response with PED Officer	0	3	0	3
Allocated	0	0	3	6
Awaiting Clinical Opinion	0	1	1	2
Draft Response with PED Management	0	1	1	2

Awaiting Allocation	0	0	0	15
SI Declared	3	0	0	3
Awaiting Clinical Hub review	0	0	1	1
Awaiting input from complainant	0	2	0	2
Awaiting input from other agency	0	1	0	1
Draft Response with involved parties	0	1	1	2
Comeback Response with Executive Office	0	0	0	0
SI Considerative	2	0	0	2
Awaiting information from Watch	0	0	0	0
Awaiting input from other LAS department	0	0	1	3
Totals:	**12**	**46**	**108**	**198**

Closure rates for 2013/15 are set out in the table below. This evidences that cases are being closed more quickly.

Table 4 The following table extracts data from the above and demonstrates the number of complaints closed each month within the 35 day target:

Date	0-25	0-35	closed within 35 working days	Total complaints per month
2013 07	34	7	41	92
2013 08	27	5	32	89
2013 09	20	4	24	94
2013 10	23	9	32	125
2013 11	17	9	26	98
2013 12	23	7	30	82
2014 01	16	22	38	86
2014 02	24	15	39	86
2014 03	24	14	38	67
2014 04	15	20	35	77
2014 05	28	14	42	98
2014 06	21	0	21	130

Totals:	**272**	**126**	**398**	**1124**

It should be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = minimum of 23 July 2014.

'Comeback' Activity

Table 5 This table evidences the numbers of comeback enquiries.

Year	Numbers of comeback responses recorded
2009/10	9
2010/11	4
2011/12	12
2012/13	35
2013/14	60
2014/15	12
Totals:	**132**

2 recent cases where a 'comeback' response was received (C8875) involved a complainant who asked for further clarification of call management following a fracture and another (C8902) where the complainant raised further concerns that the service is not fit for purpose.

Health Service Ombudsman

Table 6 The following table presents cases referred by the Ombudsman 2013 – 15 and remain 'open'

Datix reference	Current status	Outcome
C7169	File requested 18 Oct 2013	Legal action being pursued by family via Legal Advice Centre -further correspondence 03/04/14
C7685	Referred back to PED following extra information made available	Further EOC details to PHSO - CD requested of 999 call 08 May 2014
C7771	File requested 23 Dec 2013	Further details requested by the Ombudsman including A&E Support code of practice
C7855	File requested 26/03/14	File sent 10/04/14 -CD of 999 calls provided

		06/06/14
C7935	File requested by PHSO 23 January 2014	Further concerns raised by complainant- further response provided 25/05/14
C7938	File requested by HSO 26 Feb 2014	Acknowledged 03 March - file received
C8154	File requested by HSO 07 Feb 2014	File sent 21 May 2014
C8198	File requested by HSO 23/04/14	File sent 06 May 2014
C8370	File requested 09 June 2014	File sent 10 June 2014
C8379	File requested 05 Feb 2014	File sent 17 Feb 2014
C8749	File requested 10 June 2014	File sent 10 June 2014

PALS

PALS specific enquiries increased to 316 in June compared to 251 in May and 271 in April,

Average monthly PALS for 2013/14 = 287.

There has also been a steady increase in Solicitor requests year on year:

Currently there are 83 PALS cases remaining open, this includes medical records awaiting consent from the patient, cases awaiting QA reports and further supporting information.

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

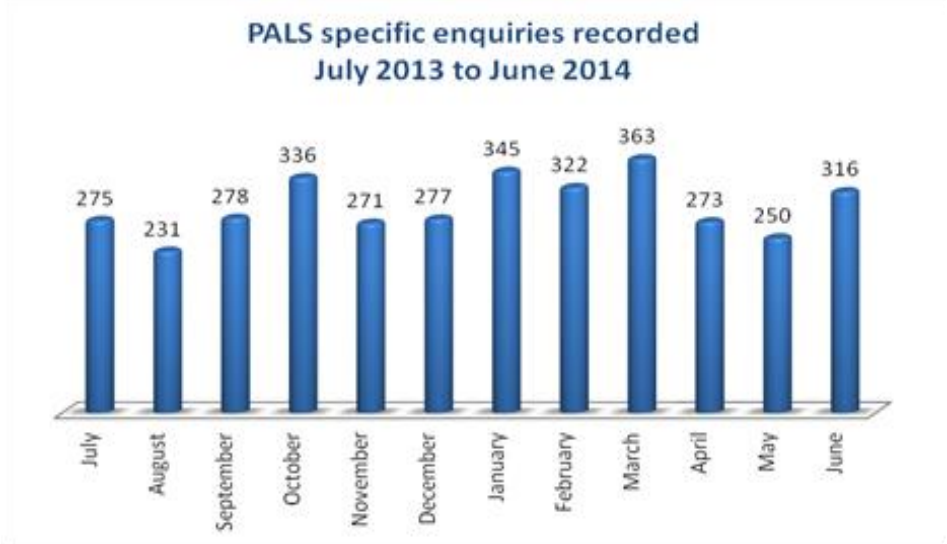


Table 7 Total PALS enquiries received in the past 6 years is as follows:

Financial Year	Total PALS
2008/09	5606
2009/10	5674
2010/11	6031
2011/12	6264
2012/13	5714
2013/14	6790
2014/15 (to June 2014)	1629
Totals:	**36079**

PALS Themes

Consistent themes as described above. Enquiries include signposting to other departments, policy and procedure requests and families seeking clarification of events.

Table 8 The following table breaks down the PALS specific enquiries in June 2014

Subject - April 2014	Number of enquiries
Information/Enquiries	204
Lost Property	62
Medical Records (patient request)	10
Other general	23
Appreciation	12
Safeguarding Adults/children	5
Totals:	**316**

Other

There is nothing else of note to report to Trust Board as part of this paper.

Fionna Moore Medical Director	Steve Lennox Director of Nursing and Quality	Mark Whitbread Director of Paramedic Education and Development

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR ASSURANCE

Document Title:	**Report from Quality Governance Committee**
Report Author(s):	**Bob McFarland, Non-Executive Director**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To ensure appropriate reporting between the committees and up to the Trust Board**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The recommendation to the Trust Board is to note the report**

Key issues and risks arising from this paper

The Quality Committee discussed the following:

Review of Category C determinants
Serious incidents
Definitions of safety and quality

The in depth review focussed on safeguarding for mental health patients.

Executive Summary

The attached paper provides an update from the Quality Committee meeting on 18th June 2014.

Attachments

Quality Committee Report from 18th June 2014

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☒ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the Quality Governance Committee on 18th June 2014

The committee is renamed the Quality Governance Committee.

The committee met on 18th June and will meet again on 27th August.

During the summer the executive sub-committee will meet three times as the Clinical Safety Development and Effectiveness Committee, considering each of the three elements in turn and will then report to the Quality committee in October.

The Quality Account 2013/2014 was approved and recommended for approval by the Trust Board.

Reports received:

- Clinical Quality, Safety and Effectiveness Committee
- Learning from Experience Group
- Clinical Audit Recommendations Progress Report
- Clinical Audit Work Plan 2014/15
- National Ambulance Non-Conveyed Audit

The Quality Dashboard being developed by Steve Lennox was also reviewed.

Category C review – Diagnostic categories have been reviewed in order to ensure those in the C1 category require an urgent (20 minute) response; patients in the C2 category were very likely to require a face to face assessment and/or conveyance; and the C3 and C4 categories include the "Hear and Treat" patients and those who could be managed by the Clinical Hub. The benefits of the review will be to provide a more consistent service to patients, increase productivity in the Clinical Hub and reduce estimated time of arrival (ETA) calls. The committee supported this initiative.

Serious Incident Tracker – The processes around the management of serious incidents have improved, however there are issues over the length of time taken to declare a serious incident and to undertake the investigation.

"Safety" and "Quality" - The committee was brought up to date on the key safety indicators that are used to provide assurance that safety is being maintained when calls are held for long periods of time. The committee noted that the word "unsafe" has a specific meaning and should not be used carelessly when describing, for example, performance under pressure.

Mental Health Action Plan - it was not possible to fully consider this report which was only presented at the meeting. Furthermore the document circulated was a draft with most of the workstream plans missing.

In Depth Review - Safeguarding for Mental Health Patients

The Quality Governance Committee received presentations on:

- Mental Health Clinical Performance Indicator (CPI) results since its introduction in 2010;
- Current Safeguarding referrals (currently over 2000/month, about 1 in 4 was a Safeguarding alert and about 1 in 3 required a Mental Health assessment including most of the Safeguarding referrals);
- The PREVENT initiative;
- The committee was satisfied with the overall position with regards to mental health patients. On most CPI criteria the compliance is better than 95%. However the committee was concerned that, having recognised there was an issue around safeguarding and that this needed to be addressed by a training initiative and a change in the PRF to highlight the need

to consider the safeguarding issue, neither action had been followed through and so only slight improvement had been seen against these two elements. However the committee noted that there were now a number of initiatives underway and expected to see progress against this.

The meeting also received but did not discuss:

- Board Assurance Framework
- Quality Risk Profile

The date of the next meeting of the Quality Governance Committee is 27th August 2014

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JULY 2014

PAPER FOR APPROVAL

Document Title:	**Annual Complaints Report 2013/14**
Report Author(s):	**Gary Bassett, Jacqueline Dawson & Steve Lennox**
Lead Director:	**Steve Lennox, Director of Nursing and Quality**
Contact Details:	**Steve.Lennox@Lond-Amb.nhs.uk**
Why is this coming to the Trust Board?	**Approve the annual report**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the annual report**

Key issues and risks arising from this paper

No risks arising from the report.

Executive Summary

Annual Patient Experience (Complaints) Report
The annual report discusses the work of the Patient Experiences Team and includes the annual complaints report.

The themes have remained constant during the year and this supports the report received monthly at Trust Board. Delay is the biggest theme arising from complaints.

The report also contains a detailed section on lessons leared through complaints and the actions taken to address the concerns.

Attachments

Annual Report

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☐ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Patient Experiences

Including Annual Complaints Report

Annual Report

2013/14

1. Introduction

We strive to ensure that patients have the best possible experience of our care but the Trust is committed to listening to and learning from patient feedback as a driver for change and improvement.

In keeping with that approach, this report provides an overview and analysis of activity from 2013/14 together with a summary of the patient experience for the last year, bringing together information from PALS, complaints and independent benchmarking information from a variety of sources including the National Quality Governance and Risk Directors Group and its subcommittee, the National Ambulance Service Patient Experiences Group. It also includes details of the numbers of PALS and complaints received during the year, performance in relation to complaint management, Parliamentary and Health Service Ombudsman investigations and action taken by the Trust in response to complaints.

The department has responsibility for the following work streams

- Complaints
- Patient Advice and Liaison Service (PALS)
- Incident reporting by LAS staff involving external agencies
- Incident reports made by external agencies involving the Trust
- Patients with complex needs who make repeated 999 calls
- Solicitor requests for medical records and witness statements.

We offer a single point of access for both PALS and complaints and aim to influence the organisational culture by adopting a patient-centred approach that recognises the value of our patients' experiences. This enables us insight into what matters to patients, what we do well and how we can improve.

The volume of complaints this year has increased by around 8% (a 30% increase was recorded in 2012/13). Each complainant received a response that was personally reviewed and signed by the Chief Executive (or a deputising Executive collegue when on leave). Patient complaints are reported to each Trust Board via the Joint Clinical Director's Report which integrates complaints data with patient feedback from PALS and the other clinical work streams indicated, enabling a holistic approach.

PALS offer immediate assistance giving accurate information, liaising with other departments and agencies, striving to overcome any problems lest they escalate. For 2013/14, PALS recorded 3448 direct contacts raised from patients, carers, relatives and the public.

Context

The Trust continues to receive a high volume of 999 calls. In 2013/14 the Trust managed 1,733,399 x 999 calls, approximately 1% higher than the previous year (1,713,963). Once again ambulance crews reached 75% of the most critically ill patients, such as those experiencing chest pains, within 8 minutes.

Staff numbers within the department reduced with the Patient Centred Action Team being limited to a skeleton service.

2. Overview

Summary of complaints and PALS

The total number of PALS and complaints received was 7160. This comprised 6185 PALS enquiries and 1060 complaints. This includes 50 complaints which were managed by treating the referring professional as acting on behalf of the patient[1]. Table 1 illustrates the volume of such cases since 2009 when the most recent complaints regulations were introduced. We believe our rationale here supports *openness and transparency*, the *duty of candour* and enables the patient a recourse opportunity and advocacy assistance.

Table 1 'Section 8' cases

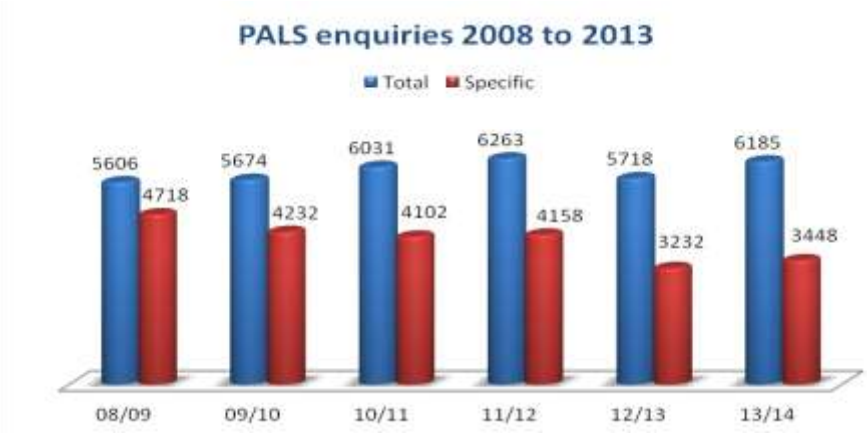
Title	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
s.8	2	79	51	78	19	50

The following graphs demonstrate total PALS and complaint cases received by year since 2008:

Graph 1 Complaints comparison 2008 to 2014

[1] This is considered best practice in the light of Section 8 of *The Local Authority Social Services and NHS Complaints (England) Regulations (2009*) as one *responsible body* (health and social care providers) cannot use the complaints procedure to 'complain' about another.

Graph 2 PALS since 2008 to 2014



Summary of agency referrals

There was a continued increase in the numbers of external agency referrals including Acute Trusts, midwives, GPs, CCGs and local authorities.

Table 2 represents external agency referrals from other health and social care professionals and incident reports by LAS staff that involved another external agency since 2008.

Table 2 Summary of agency referrals by year

Summary of agency referrals by year		
Year	External referral	Incident report LAS
2008/08	119	38
2009/10	102	276
2010/11	108	314
2011/12	72	78
2012/13	123	69
2013/14	181	77
Totals:	705	852

59 of these 'external agency' reports were midwifery-related (59). Since the vacancy arose in the Trust's Consultant Midwife post, in December 2013, such referrals have declined. An interim appointment has now been made.

PALS

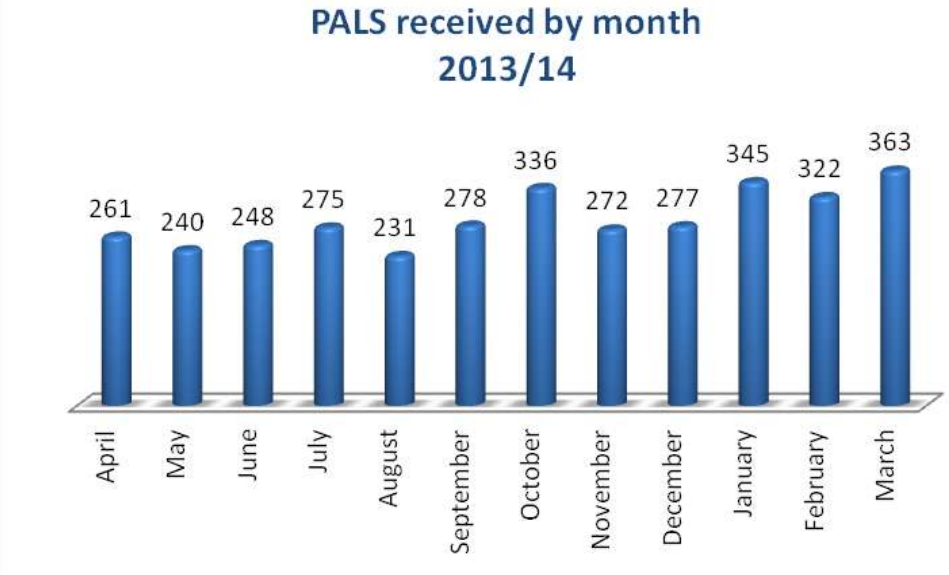
The total number of PALS enquiries during 2013/14 was 6185. This represents an 8% increase on the previous year and supports the importance of PALS especially in the light of the *Francis Report.*

The most common subjects of enquiry are the hospital destination of a relative, lost property and requests for medical records; policy and practice enquiries are also common from academics, students, other health and social care agencies and members of the public. The structure and delivery of emergency pre-hospital care is a complex phenomenon and not widely understood by the public or the health and social care economy. PALS makes a significant role in fostering improved awareness in this respect.

5 cases raised via PALS subsequently involved referrals to the Ombudsman and 11 cases related to Serious Incident Considerates, of which 6 were declared.

The following graph demonstrates that there has been a gradual increase in the monthly total of PALS enquiries we receive.

Graph 3 PALS specific enquiries by month



The following graph shows that during 2013/14 PALS enquiries by month increased over 2012/13

Graph 4 **PALS specific comparison 2012/13 to 2013/14**

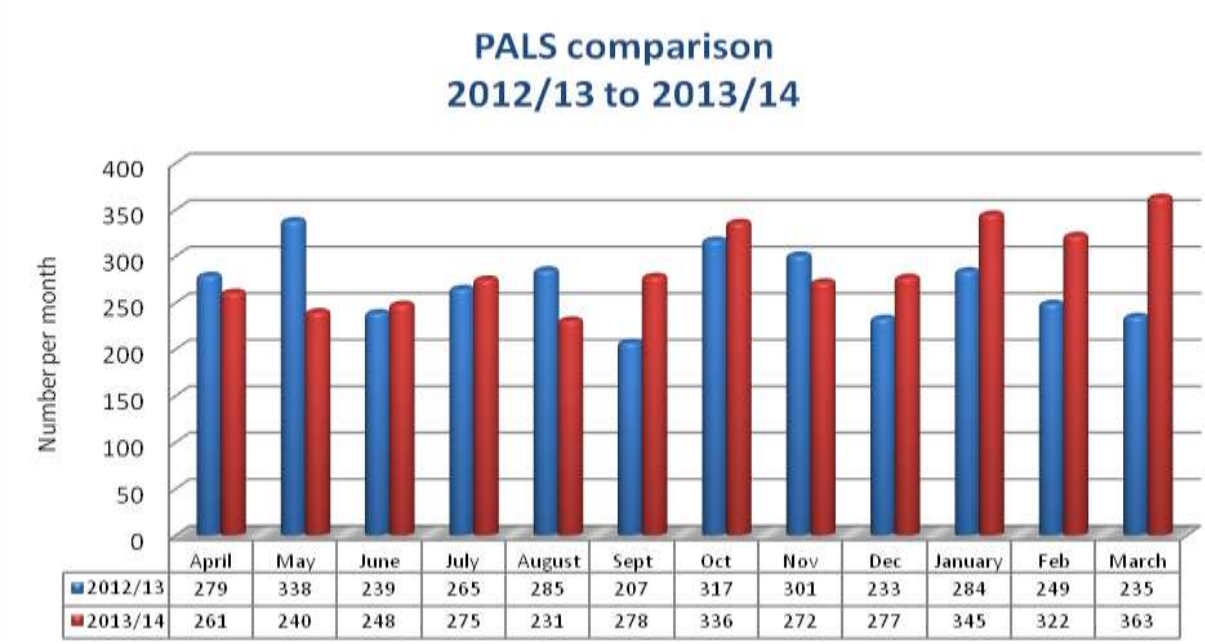


Table 3 **PALS cases by category.**

PALS received 2013/14	Totals
Information/Enquiries	2448
Lost Property	606
Medical Records	220
Appreciation	54
Clinical	21
Other	18
Safeguarding Adults	16
Delay	14
Policy/ Procedure	14
Incident Report - Other	10
Patient Injury or Damage to Property	9
Communication	8
External Incident Report - LAS Crew	8
Access	6
Non-physical abuse	5
Frequent Callers	5
External Incident Report - EOC	4

Incident Report - A&E	4
Incident Report - GP Surgery	4
Aggravating Factors	3
Conveyance	3
Dignity and Privacy	3
Incident Report - Hospital Midwife	3
Road Traffic Collision/RTC	3
Safeguarding Children	3
Explanation of Events	2
Information Technology	2
Incident Report EOC	2
Incident Report - Social Care	2
Non-conveyance	2
Physical Violence	1
Incident Report - Mental Health Trust	1
Social Services	1
Totals:	**3505**
Specialist subjects	
Medical Records	1415
Safeguarding Children	464
Safeguarding Adults	515
Frequent Callers	215
Request for Witness Statement	60
SUI Group Considerative	11
Total:	**2680**
Overall total	**6185**

Solicitor enquiries

The PED team process all requests for medical records, including those made by a solicitor acting on behalf of the patient or relatives, where legal action is not intended against the Trust. A charge of £50.00 is levied in keeping with the DPA (1998). Additionally, PED facilitate requests for witness statements, which are obtained via a face-to-face interview with staff. This service attracts an hourly charge of £119.00. During 2013/14, 1386 requests were made by Solicitors for medical records and 29 requests to interview operational staff.

Revenue raised was approximately £60,645.00. The future of the process is to be updated with the planned discontinuation of the use of cheques by the larger banks and greater use of BACS. We are also currently trialling a questionnaire for staff with specific questions based on typical requests, proposed charge £50.00.

Lost Property

In 2013/14 'lost property' was included as a Trust 'quality indicator' with the aim to encourage the use of the SMARTbags™. Local Performance Improvement Managers now have access to the lost property spreadsheet. Part of their Quality Objectives for 2013/14 involved monitoring lost property and the use of the property bags, it also forms part of the PIM's Top 10 Tracker data in collaboration with IM&T to monitor lost property and resolution. Now the process has been implemented and monitored for a period the indicator has been closed but the Patient Experience team continues to monitor compliance.

Graph 2 evidences the total lost property item enquiries received by year.

Graph 2 Lost Property.

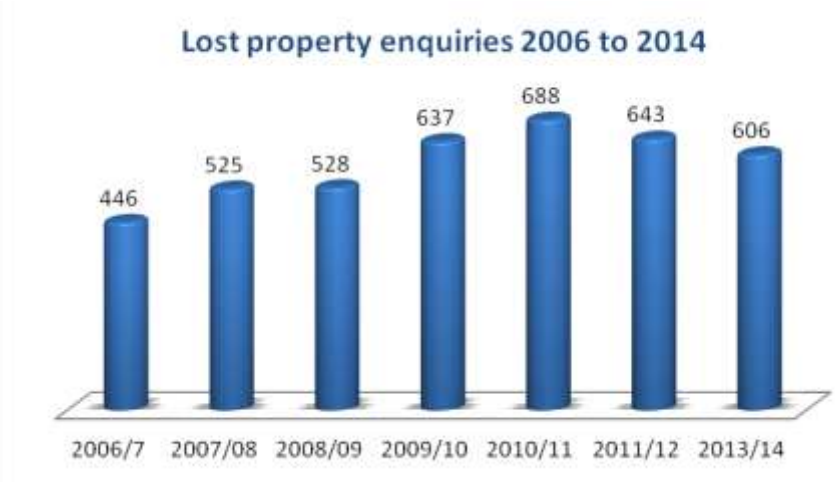


Table 4 – Monthly analysis of lost property

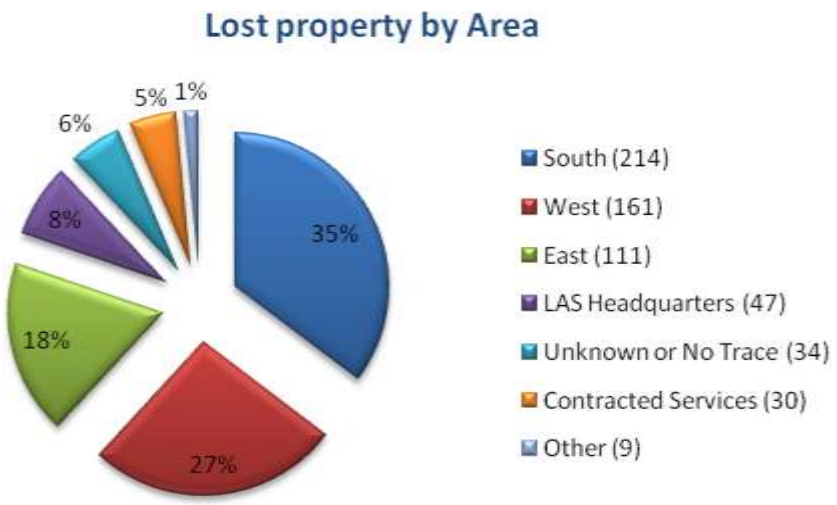
Month	Totals	Managed by PED	Referred locally
April	55	8	47
May	51	7	44
June	42	3	39
July	40	3	37
August	37	1	36
September	54	2	52
October	61	19	42
November	49	22	27
December	51	17	34
January	56	26	30
February	58	17	41
March	52	23	29
Totals:	**606**	**148**	**458**

An evaluation has shown that the interaction of PED and station administrators has improved throughout the year although it is not possible to accurately audit the outcomes from the data available.

Incidents of note include a payment of £500.00 made by one complex where the staff gave the patient's property to the receiving hospital but did not use a property bag or adhere to the Trust process, so we had no option but to assume responsibility when the items went missing. We also reimbursed £25.00 to an elderly patient whose walking stick was mislaid.

The table below identifies lost property cases by operational area. This indicates that the South Area received a higher proportion of lost property enquires during the 2013/14. Contracted Services do not have access to the shared spreadsheet and are managed by PED.

Graph 3 Lost Property by Area.



For 2014/15 the system is being reviewed and station administrators will be given restricted access to the case management system as per the Business Plan.

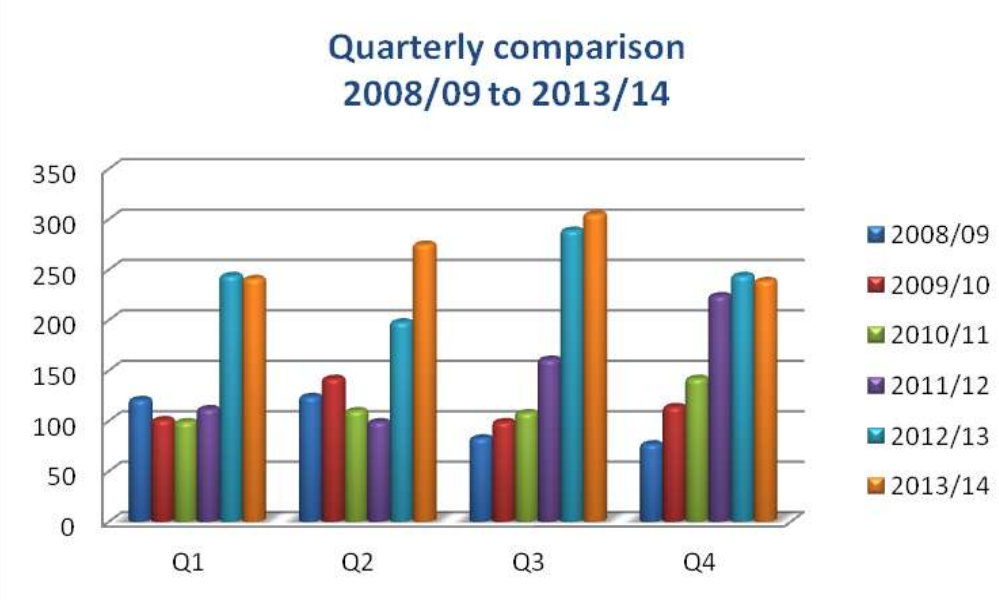
3. Complaints

During 2013/14 there were 1060 complaints including 50 referrals by other health and social care professionals managed as being made on behalf of the patient.

The graph below indicates volume by month. Graph 4 illustrates the complaints trend over the course of the year and Graph 5 takes a wider view and illustrates the rise across a number of years.

Graph 4 Complaints received by Month 2013/14

Graph 5 Complaints by Quarter



However, when the complaint volume is matched with the rise in demand we can see that we maintain a fairly constant rate of 0.6%. This is illustrated in Table 3.

Table 3 Complaints ratio against demand

Month	Total call rates	Complaints	LAS Ratio
April	141628	87	0.06%
May	140892	81	0.05%
June	140143	73	0.05%
July	157895	92	0.05%
August	145029	89	0.06%
September	143471	94	0.06%
October	150128	125	0.08%
November	143601	98	0.06%
December	152916	82	0.05%
January	138304	86	0.06%
February	132310	86	0.06%
March	147082	67	0.04%
Totals:	**1733399**	**1060**	0.68%

The highest volume of complaints about delays are attributed to the Emergency Operations Centre under the existing case management system. However, clearly much depends on the available resourcing, an operational responsibility.

Table 4 indicates complaints by department/area. The highest number of complaints by operational area is the South, which also has the largest geographic spread. 17 complaints involved contracted private and voluntary ambulance service providers, 19 related to Patient Transport Services.

Table 4 Complaints by Department Area

Complaints by Area	Totals
Control Services (EOC, UOC, CTA etc)	510[2]
South	188
West	115
East	105
Not our service	62
Unknown or No Trace	26
Patient Transport Services	19

[2] All complaints regarding a delay are attributed to Control Services. However, the cause is not due to processes within control they are mainly due to resourcing across all areas.

LAS Headquarters	17
Contracted Services	14
Volunteer Ambulance Service	3
Operational Training	1
Totals:	**1060**

On 13 January 2014 temporary changes to the senior operational structure were implemented to respond to the new governance arrangements amongst the 32 Clinical Commissioning Groups (CCG's). The aim is to improve local management capacity and enhance relationships with local commissioners.

For the purpose of this report, existing Area codings have been used pending the reconfiguration of the case management system and confirmation that the new structure will become permanent. Weekly reports by CCG area are submitted to the 7 Assistant Directors of Operations to apprise them of complaints received within their catchment areas.

Complaints: Analysis & Themes

Themes

The number of complaints has increased for a variety of reasons, not least the annual growth in demand to the Trust. Special operating arrangements were implemented as part of the Winter Pressure planning. Contrastingly, fewer complaints in March may be as a result of the end of year operational focus and increased resourcing.

There are 12 main themes arising from complaints. Table 5 illustrates the number of complaints by subject using the top 12 themes. They are ordered from left to right with the most common themes this year being first.

Table 5 Complaints by the main subject 2008/09 – 2013/14

Year	Delay	conduct and behaviour	Patient injury/property damage	Non conveyance	Treatment	Conveyance	Road handling	Location Alert referral	Not our Service	Clinical Incident	Aggravating factors	Clinical Equipment	Disputes regarding safeguarding referral	Assisting with external agency	**Total**
2007/08	138	222	38	23	70	5	0	0	45	4	5	1	0	0	551
2008/09	84	125	27	32	46	4	0	0	37	4	3	0	0	0	362
2009/10	96	147	29	74	66	18	0	0	16	6	2	1	0	0	455
2010/11	92	151	38	67	68	13	7	0	15	2	5	1	0	0	459
2011/12	193	152	45	64	62	27	10	0	33	5	2	3	0	0	596
2012/13	411	267	85	69	65	28	15	14	11	6	3	1	0	0	975
2013/14	421	250	15	86	91	24	119	15	31	2	1	1	2	2	1060
Totals:	**1435**	**1314**	**277**	**415**	**468**	**119**	**151**	**29**	**188**	**29**	**21**	**8**	2	2	**4458**

Other themes include

- Staff challenging the validity of the 999 call
- Sequential call management errors at times of significant demand
- Failure to re-triage repeat 999 calls about the same patient

The following represent issues identified from complaints and PALS. It is not possible to exclusively cite the frequency at which each of the following issues occurs as the case management system does not always enable discreet categorisation of the precise issues identified.

Call management

Recorded message

Issue: use of the recorded message by EOC is a routine subject of complaint, with a common experience of the caller being left to feel vulnerable and isolated. (C7803).

Action: the Control Services governance team have been asked to consider checking whether a patient is alone when using the recorded messages and the use of the recorded message is being reviewed.

Call triage

Issue: the call triage system MPDS was also the subject of a complaint (C7785) from a patient, a doctor, who had an injury which was bleeding heavily. Due to the way in which the call was managed (C4); the doctor was advised to make his own way to hospital. The Quality Assurance evaluation found that the call handler should have used the manual 'shift option' to select 'serious bleed' which would have prompted a higher priority categorisation (C2).

Action: the revised version (12.2) will automatically upgrade such calls and discussion is taking place between Quality Assurance and IM&T about possible changes to CommandPoint, although this would have a cost implication.

CommandPoint interface with MPDS

Issue: following a complaint about the delay in an ambulance response, the Quality Assurance review of the 999 call identified that the EMD should have used the 'shift' option to manually select a further option which would have determined a higher category, which meant that an ambulance could have been dispatched more quickly (C7785).

Action: the matter has been referred to IM&T who are in discussion with the manufacturers about CommandPoint specifications. The revised version of the software programme will hopefully resolve this issue by making the call upgrade automatic.

Pre Dispatch Instructions

Issue: pre-dispatch instructions not to move the patient were literally observed for a lengthy period when there was a delay in an ambulance being sent. (C7791). This is not intended to be applicable where leaving the patient in the position they are in is unsafe, for example at a road traffic collision incident where the patient is situated in the middle of the road.

Action: control Services Governance team have been asked to reconsider this instruction and/or whether contact can be resumed when there is a delay in dispatch.

Cross border 999 calls

Issue: there was a delay in attending a patient who was injured whilst playing sports at a remote location. The 999 calls were routed via a neighbouring ambulance service which caused confusion about the patient's symptoms and thus contributed to the priority category that was determined and thus the delay.

Action: the Trust is feeding this issue back to the National Control Services Group about improving liaison between neighbouring ambulance services.

Calling back when there is delay in ambulance being sent

Issue: calling patients back whilst they wait is a recurring theme. Capacity to call back remains a problem when we are very busy.
Action: this is a concern and an indicator has been included in the refreshed 'Quality Indicators'. Data collection in the form of a monthly audit of compliance is due to start in July 2014.

End of life care/DNAR

Example 1

Issue: several complaints were received involving end of life care. In this case, the family of a dementia patient with a terminal illness who was a resident at a care home were distressed when, after unsuccessful resuscitation, the patient was left *in situ* on the floor. (C7757) We found that the crew

should not have applied protocol so literally and that it would have been reasonable to consider moving the patient to a more dignified position.

Action: local liaison took place with the care home about end of life care management protocols.

Example 2

Issue: in another case, despite a DNAR agreement being in place, the volume of demand to the Trust caused information not being made available to a voluntary ambulance responder and a resuscitation attempt was erroneously made. (C7703). The palliative plan arrangements only became apparent thereafter.

Action: the Clinical Quality Directorate will be liaising with local palliative care leads towards establishing improved guidance and ensuring relatives are aware of what to do in the event of a patient's death. The project lead for voluntary responder practitioners will highlight the management of patients with end-of-life care plans. In addition we are planning to place a 24/7 palliative care expert within control services to help advise and liaise with End of Life cases.

Example 3

Issue: in a further case, a patient (who had a DNAR agreement in place), had died, with an approach being made to the GP to attend to certify an expected death. (C7697) Unfortunately, the GP was unable to attend for some time and EOC erroneously arranged for the police to attend to release the ambulance crew from the scene. The police are only usually required to attend an unexpected death and the family were concerned that the police treated the incident as a crime scene. We identified that when such calls are passed to the police, the menu, under the heading '*deceased – responsible adult on scene'* does not include 'expected death'.

Action: this issue has been drawn to the attention of our EOC Quality Manager and a bulletin is also being produced for dissemination to all EOC staff to try to prevent the unnecessary activation of the police to such incidents.

Example 4

Issue: complaint hosted by NHS 111 (NHSD) following death of patient in a hospice. The attending crew explained they are not authorised to provide a death certificate which the family required to arrange the removal of the patient's body by an undertaker. It was initially proposed that the crew would notify the GP surgery to arrange a retrospective death certificate. The family were unhappy with this and arrangements were made via 111 for a GP deputising service to attend to certify death. A copy of a *Verification of Fact of Death* form was left with the family to give to the deputising service doctor and the ambulance staff left the scene.

The advice that an undertaker cannot remove a body until the death certificate is issued was incorrect.

Action: an apology was offered and feedback given to the staff concerned. Revised guidance about managing expected deaths and arrangements for the removal of a patient's body will be disseminated throughout the Trust by Clinical & Quality Directorate.

Example 5

Issue: concerns were raised by a palliative care team about the arrangements for the transfer of terminally ill patients.

Issue: the enquirer was referred to the Commissioning Support Unit and the Medical Directorate to discuss the revisions and the effect on such journeys in the future.

Conduct and behaviour

Validity of the 999 call

Issue: this is another common theme with patients being upset that the ambulance crew seem to be challenging the validity of the 999 call. (C7626).

Action: as an action point, feedback is given to the staff involved about the importance of approaching the triage assessment questioning in a sensitive manner.

Others facets under this category include the following:

Example 1

Issue: a mother was upset that the ambulance crew appeared to be lacking in knowledge about the presenting symptoms of their 4 day old baby.

Action: an explanation was provided that Trust policy is to take every patient aged under 2 years to hospital for further assessment. It was further explained that as the child was so young it was advisable to seek the advice of a paediatrician as ambulance staff do not have the training within this specialism.

Example 2

Issue: this hinged on a misunderstanding about the purpose of triage questioning. The patient's daughter felt that the crew were disrespectful to her mother and made inappropriate comments.

Action: the crew apologised for any offence caused. Arrangements were made for them to participate in a reflective practice exercise to highlight the importance of effective communication and to ensure the rationale for triage questioning etc is made clear.

Delay

Example 1

Issue: a delay occurred in responding to an elderly patient who had experienced a fall in the street. We identified that EOC did not upgrade the incident following ETA calls from the police.

Action: Control Services Governance team are exploring ways of improving the information received via electronic link from the Police to ensure that there is sufficient information to re-triage the patient's condition.

A bulletin was subsequently disseminated to control room staff to ensure that they review any updates from the police and that where a patient has a reduced level of consciousness, it is brought to the attention of the Clinical Hub.

Example 2

Issue: a family were concerned at the delay in an ambulance arriving for their 97 year old mother. This is a common occurrence involving this patient group.

Action: the Trust has decided to increase the priority level to any patient within this cohort after 60 minutes, with a further upgrade if an ambulance has not been sent after a further 60 minutes, irrespective if the patient's condition has changed or not.

Treatment

Example 1

Issue: a complaint was received from a family whose daughter had experienced a home birth. The attending midwife was unable to stem the bleeding post-birth but despite requesting that the ambulance staff set up intravenous access, they declined to do so.

The delivery went well but after placental delivery, the patient lost approximately 350mls of blood. The midwife had given 2 doses of syntometrine but wanted the Fast Responder to cannulate the patient. The Fast Responder felt that there was no indication at that time to do this as the patient's observations were stable; he also wanted to wait for the ambulance to arrive.

Action: Whilst the crew were correct in citing the new protocol, they should have followed the advice of the midwife as the senior clinician at the scene with primacy of care and this was made known to them.

Example 2

Issue: concerns were raised by the patient's father about why they were referred to NHS 111 despite the patient being known to have leukaemia complications, which meant that any infection could be life-threatening.

Action: an explanation was provided and feedback given to the EMD. The family were asked to arrange for the clinician responsible for the patient's care to liaise with our Clinical & Quality Directorate to consider a patient specific protocol.

Duty of care

Example 1

Issue: an ambulance was not sent despite the patient becoming unconscious whilst travelling on a train with treatment being offered by British Transport Police medics at the next main station. Communication problems were identified.

Action: Control Services Governance team will prepare an instructional protocol so that external agencies can be regularly informed so that the patient can also be kept updated about what is happening.

Example 2

Issue: concerns were raised by the son of a patient about a safeguarding referral that was made. The son asked that we share the referral details with him but we did not receive any authorisation from the patient to do this and the local authority had some concerns about the situation.

Action: the complainant was advised that we are obliged to observe the provisions of the Data Protection Act (1998) which restricts the circumstances in which we can share information about a third party. A generic explanation about the purpose of a safeguarding referral was also provided.

Example 3

Issue: the family of a young infant cancelled their request for an ambulance after there was delay in responding, the family deciding to take the patient to hospital themselves. However, the ambulance crew arrived at the scene before they were cancelled and turned the vehicle around but were intercepted by the family. An exchange took place as the crew suggested the family should continue to the hospital with their daughter. At this point the father returned to his car and drove off.

Action: we found that the crew had a duty of care irrespective that the request for an ambulance had been cancelled. Feedback was given to the crew and responsibilities in this situation will be set out in a Clinical Update drawing on an anonymised account of this incident.

Vulnerable patients

Issue: the Trust has had a number of incident reports and complaints about the management of 999 calls about patients with mental health problems or suicidal ideation (C7004).

Action: EOC have prepared a revised process for the dispatch of LAS vehicles which now need to be booked once a Mental Health Assessment is underway and it is clear that the needs of the patient have been identified.

EMDs also now check if the patient is on their own and note 'ALONE' in the free text area of the call event log. When a response is delayed, these patients are then prioritised for ring back and if no contact is made, a series of checks takes place in EOC. Where a suicidal patient calls back to cancel the request for help, although an adult with capacity can refuse treatment, the assessment of their capacity cannot be undertaken by telephone and the request must not be closed.

Alternative Care Pathways

Issue: complaints about being referred to ACPs contributed to a review being undertaken of how this initiative arranged.

Action: the Learning from Experience Group made it a priority to learn more about ACP usage, whether referring patients to ACPs improves their clinical outcome and experience, and how this can be evaluated and improved across the Trust. An ACP Action Plan was developed and agreed by that group, with a number of recommendations (this work has not yet concluded).

Locality Alert Register

Issue: this reflects entries made on the 999 system where previous experience is that there may be a risk to the attending ambulance staff. Patients have the opportunity to comment and appeal the entry.

Action: 15 complaints were received of this nature. In the vast majority of cases, a referral was made back to the local ambulance station management team to undertake more work in liaising with other health and social care professionals to explore a care plan approach at a local level.

111 Services

Since assuming responsibility for NHS 111 in SE London there have been no complaints regarding this service up to March 2014.

4. Changes to Service Provision

Call management

1. The Trust has now implemented an initiative whereby an upgrade is made to the priority level is in relation to any patient who considered to be vulnerable where there is a delay exceeding 60 minutes in an ambulance being sent, irrespective of whether the patient's condition has changed or not. This is typically pertinent to elderly person who have experienced a fall.

2. Following discussion between Quality Assurance team and Clinical & Quality Directorate, consideration is being given to the triage of patients with known potentially life-threatening conditions such as Arteriovenous Malformation (AVM), in whom early and subtle symptoms could suggest impending rapid deterioration.

3. A complaint was received about being asked to listen to the recorded message when the caller felt that the EMD should have stayed on the line until the ambulance arrived. An explanation was provided about the purpose and rationale for the recorded message and the circumstances in which EMDs are expected to remain on the line. This matter has been brought to the attention of our Control Services Governance team to consider the possibility of asking call handlers to give instructions should the patient's condition deteriorate before the caller is transferred to the exit message.

Changes to clinical protocols

4. We identified that the triage of seizures did not successfully isolate those 999 calls where the patient was known to have epilepsy but was experiencing a seizure that was atypical for them.

   Changes have thus been made to the clinical protocol, including the identification of incidents where the patient has been given benzodiazepine which could impact on their level of consciousness or breathing.

5. A complaint was received from a pregnant patient who was full term, bleeding heavily and could not feel her baby move. The clinical advice we took was that while it is not within the skill set of an ambulance technician or paramedic to assess an unborn child, any bleeding in pregnancy is a serious indication of the need to assess the baby's wellbeing. Ante natal bleeding in late pregnancy should have prompted urgent transfer to hospital.

Whilst observations can be normal, pregnant women over compensate and maintain this for some time due to dilution of blood in pregnancy having a protective effect. This however delays symptoms and can lead to sudden collapse as the patient may look well while having a significant bleed, which can also be concealed.

To widen the learning, an article about bleeding in pregnancy was included in a Clinical Update which are disseminated throughout the Trust.

Ombudsman cases

30 cases were considered by the Health Service Ombudsman. This includes complaints where the incidents in question that may have occurred earlier but were considered by the Ombudsman during 2013/14.

We await notification on 9 cases, 19 have been completed. 2 have been partially upheld.

Care provided; complaint handling (interface with Serious Incidents investigations)

The complaint involved the care provided by the ambulance staff who attended a patient presenting with symptoms of vomiting, abdominal pain and feeling faint. The crew attributed the patient's condition to food poisoning and left the patient in the care of his partner. A further 999 call was received about the same patient later that day; the patient had experienced a cardiac arrest and he was subsequently declared deceased.

The incident was declared as a *Serious Incident* but there was long delay in this being completed.

In the post mortem report, the Coroner concluded that death was due to natural causes as a result of a coronary thrombosis.

The Ombudsman concurred with our findings that there were a number of shortcomings in the assessment and the way the assessment record was recorded. However, whilst understanding our rationale in treating the Serious Incident report as the substantive response to the complaint and recognising the problems in the interface between the complaints and Serious Incident procedures, the Ombudsman criticised the Serious Incident investigation practice, principally in not keeping case management records of progress and failing to keep the complainant informed.

We accepted the Ombudsman's recommendations and devised an Action Plan to address all the specific points the Ombudsman raised. We wrote to the complainant to apologise, as did the staff involved (although highly unusual, this was another recommendation the Ombudsman suggested). We also made a compensatory payment of £500.00 in recognition of the distress caused and a further £500.00 for the methodological shortcomings indicated.

Complaint handling (interface with disciplinary procedure)

The complaint involved the care provided to a patient who was experiencing severe leg and groin pain. Following a very problematic removal to the ambulance, the patient was taken to hospital and subsequently transferred to a specialist unit but later died.

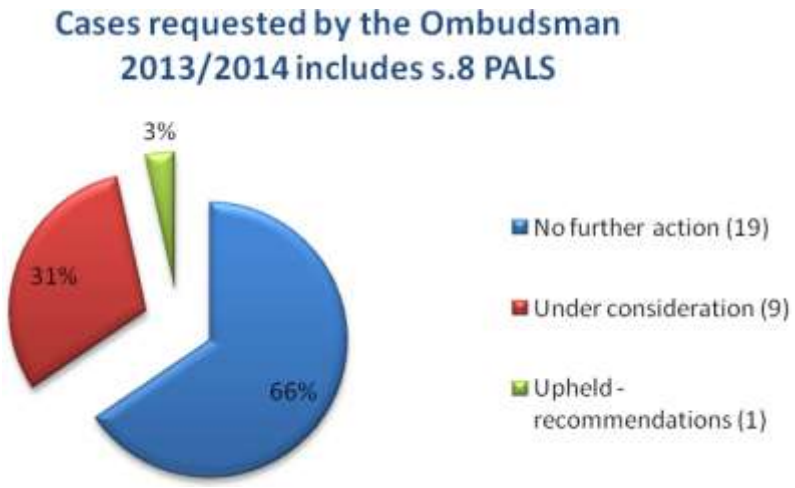
Based on clinical advice from Clinical & Quality directorate, the complaint response found that the ambulance staff would not be expected to make the clinical association between an aortic problem with possible leg ischaemia, especially when faced with a very distressed patient, although they could have done more to take control of the situation. It was also clear that their manner left those present feeling they did not accept the patient's behaviour was prompted by her condition.

The disciplinary procedure had been enacted but under our policy at the time, this and the outcome were not explained to the complainant.

The Ombudsman found that the Trust's policy on not disclosing the outcome of a disciplinary investigation was based on a misunderstanding of the law, in particular given the evolution of the principles of *openness and transparency* and *the duty of candour*.

We accepted the Ombudsman's advice that the Trust had historically overestimated the duty of confidentiality owed to staff in these circumstances and wrote to the complainant to confirm the outcome of the disciplinary process, including the action taken to address the shortcomings in the care provided that had been identified.

Pie chart 6 Cases Requested by the Ombudsman



Governance

We provided summary activity reports to the five internal Area governance forums as well as the quarterly reporting to Clinical Quality Safety & Effectiveness Committee, Safeguarding Group and Learning from Experience Group.

The standard of cross agency liaison, where a complaint is hosted by a single agency but involves multiple organisations, continues to vary as new providers become operational, for example 111 providers.

4. Patient Centred Action Team

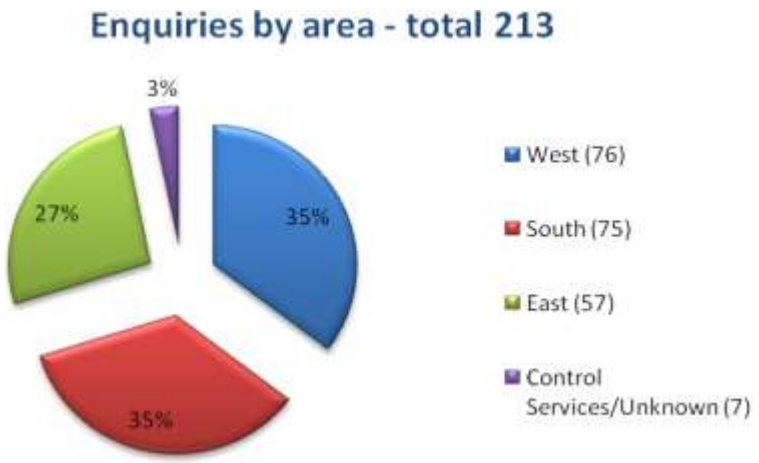
The Patient Centred Action Team is responsible for the management of 'frequent callers', a cohort of patients who present with complex health and/or social needs who place repeated 999 calls. A patient is deemed to be a frequent caller if they call 999 ten times per month, for three consecutive months. If callers have a profound impact on resources then PCAT will intervene as soon as possible.

We continue to use a care plan approach, developed in conjunction with other agencies and focusing on managing demand more effectively whilst continuing to meet the patient's needs.

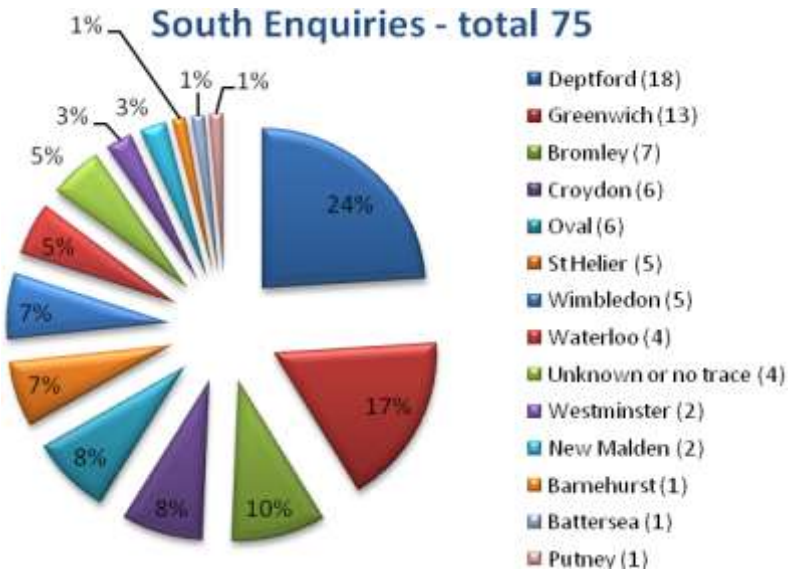
During 2013/2014 the team was reduced to a skeleton service owing to staff maternity leave and university commitments but 348 cases were reviewed and closed. There are currently 33 cases which are open and meet the current criteria. Casework also continued to be undertaken at local level with Community involvement Officers making a significant contribution.

PCAT is a participant in the Frequent Caller National Network (FreCaNN) which holds quarterly meetings hosted by ambulance trusts. FreCaNN discusses national procedures and policy and is working towards national standards and definitions. We are delighted that LAS policy and procedure will be used as the foundation model for national procedures.

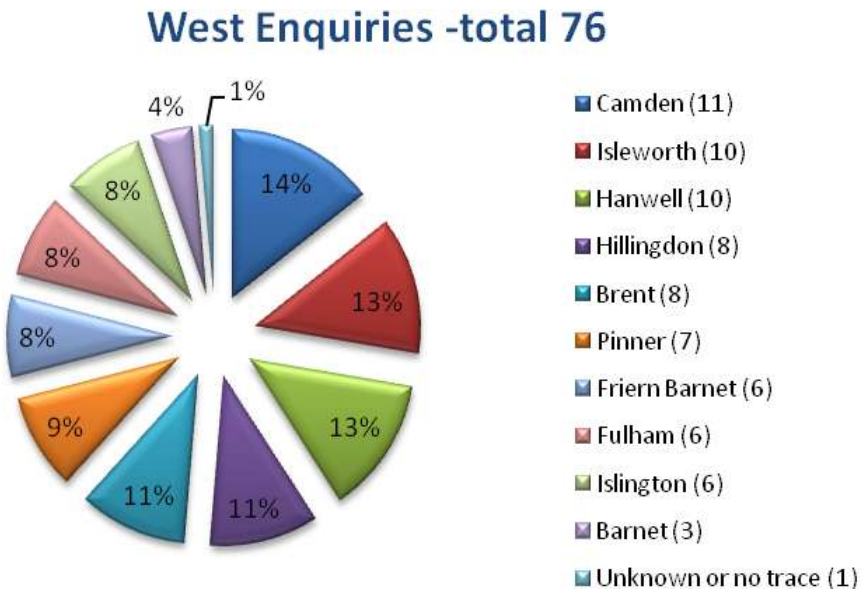
Graph 7 Represents Volume by Areas



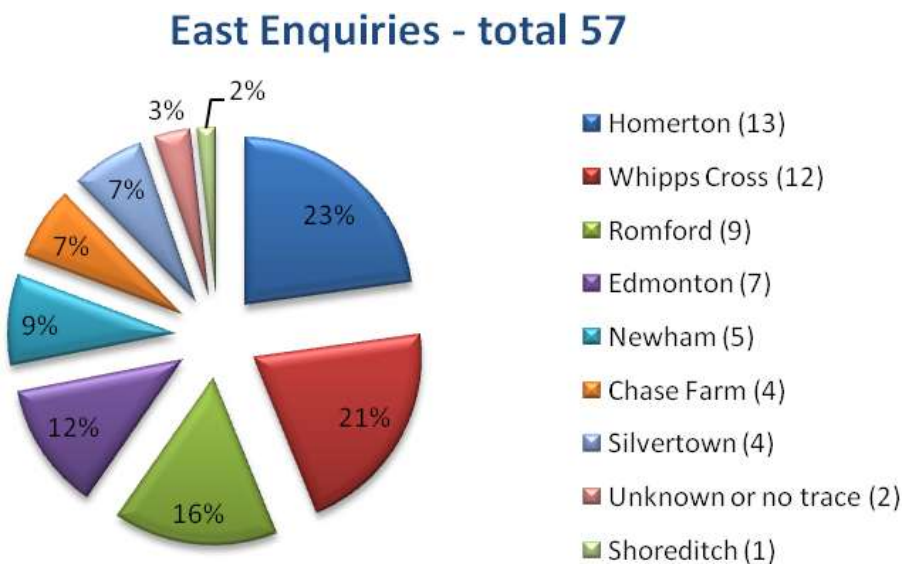
Graph 8 **Represents Volume by Areas (South)**



Graph 9 **Represents Volume by Areas (West)**



Graph 10 Represents Volume by Areas (East)



London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JULY 2014

PAPER FOR APPROVAL/ASSURANCE

Document Title:	**Annual Safeguarding Report 2013/14 & Savile Update**
Report Author(s):	**Steve Lennox, Director of Nursing and Quality**
Lead Director:	**Steve Lennox, Director of Nursing and Quality**
Contact Details:	**Steve.Lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Assurance**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the Annual Safeguarding Report for 2013/14;** **To note the Savile Update**

Key issues and risks arising from this paper

No risks arising from the annual report.

The gap analysis against the recommendations from recent NHS reports published in respect of the Savile allegations has identified some gaps, however these represent minimal risk.

Executive Summary

Safeguarding

The annual report demonstrates continuing improvements in safeguarding across the Trust and makes the following conclusions.

1. Overall a self-assessment reveals that the Trust is generally compliant with CQC standards for Safeguarding.
2. The Peer review provided areas for improvement that will continue to be explored.
3. The safeguarding team is working to capacity and the accommodation of MARAC is being added to the risk register.
4. Prevent training is a challenge and the Trust will need to regularly review its strategy.
5. The Safeguarding portfolio has significantly strengthened during the course of the year. The scorecard is embedded into the work of the committee and appears as a RAG rated measure on the Trusts Quality Dashboard.
6. The Indicators within the scorecard are demonstrating improvements during the course of the year.

7. All Action Plans are progressing well.
8. The gap in level 1 safeguarding training has been managed and the Trust is beginning to ensure all staff are trained to the required standards.

Savile Update
A second gap analysis has been undertaken for the lessons learned through the Savile investigations. There are five areas that the Trust needs to give further consideration to;

1. Policy.
2. Monitoring of staff equally
3. Engaging Stakeholders
4. Policy Compliance
5. Recruitment Checks

These areas will be considered and action monitored by the Safeguarding Committee

Attachments

Annual Report & Position Paper

****

Quality Strategy
This paper supports the following domains of the quality strategy:

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

LAS Objectives
This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☐ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Annual Safeguarding Report 2013/14

1.0 Introduction & Background

1.1 This report details the Safeguarding work that has been undertaken in the past year and provides assurance to the board on our compliance with statutory legislation. In addition to this report the Safeguarding team provide a quarterly report on safeguarding activity and training within the Trust which is shared both internally with managers and externally with safeguarding partners.

1.2 There have been significant changes arising from the Munro review, the Kennedy report, the Health and Social Care Act and a number of subsequent publications have also been made. This has resulted in a revision of Working Together, as well as a new accountability and assurance framework for the NHS in England. The following section outlines the main points from these publications.

PUBLICATIONS

Document 1: Working Together to Safeguard Children (2013).

1.3 This document outlines what is expected of individual organisations. This contains the statutory elements and these have been clarified as follows;

- a clear line of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children;
- a board-level lead to take senior leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to and engaging in dialogue with children and taking account of their wishes and feelings both in individual decisions and the establishment or development and improvement of services;
- arrangements to share relevant information;
- a designated professional lead (or, for health provider organisations, a named professional) for safeguarding. Their role is to support other professionals in their agencies to recognise and respond to the possible abuse and neglect of a child or young person; and
- appropriate supervision and support for staff, including undertaking safeguarding training;

- NHS Trusts and NHS Foundation Trusts to be members of their Local Safeguarding Boards in their local authority area;

1.4 We believe we are compliant with all these salient points and the spirit of Working Together.

Document 2; Safeguarding children and young people: roles and competences for health care staff. Intercollegiate document third edition (March 2014).

This document provides a competence framework and minimum training requirements.

1.5 The document describes six levels of competences that enable staff to effectively safeguard, protect and promote the welfare of children and young people. These have been revised in light of policy developments, including the Laming Review. Further reviews across the UK have also reinforced the need to further improve the safeguarding skills and understanding of health staff, and improve access to safeguarding training.

- It states the need for all NHS staff to receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance.
- Those who use the services are safeguarded and that staff are suitably skilled and supported. This includes private healthcare and voluntary sector providers.
- The Trust has a duty to ensure that all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.
- The document outlines the frequency and amount of training time that should be allocated to safeguarding training.

1.6 We have improved our position in training and now have level 1 training in place for all Trust staff. Level 2 training is for all clinical staff and we deliver beyond the minimum requirements. Level 3 training is recommencing in 2014/15. We expect to be compliant by the end of 2014/15.

Document 3: Statutory Guidance on Learning and Improvement:

This document proposes new arrangements for Serious Case Reviews of children. This piece of guidance outlines the role of the Serious Case Review and moves this process to the very centre of learning and analysis.

Safeguarding

1.7 In addition to the changes being made following the Munroe review there are changes taking place regarding the commissioning of Safeguarding. Clarity on safeguarding arrangements have now emerged and it now appears that Safeguarding will form part of the responsibilities for the Directors of Public Health and they will need to work closely with Clinical Commissioning Groups.

1.8 The Clinical Commissioning Groups will need to identify a lead for children and young people and will take the lead for commissioning safeguarding. They will be required to assure themselves that their provider organisations are adhering to best standards. These standards include;

- Present to their Board regular performance and activity reports as well as an annual report on safeguarding children that is published as a public document
- Make public declarations of safeguarding children arrangements posted on its website and updated every 12 months
- Participate in section 11 audits
- Submit a complete performance monitoring dashboard or other performance management data to Clinical Commissioning group on a quarterly basis (or as agreed locally)
- Provide assurance of CQC registration
- Compliance with any DH, CQC, NHS London or successor organisations requirements to make performance management information publicly available
- Inform designated professionals about any requirements imposed on them by the CQC
- Provide the designated professionals with any details of any referrals of allegations against staff to the Local Area Designated Officer (LADO)
- Be able to demonstrate evidence of working towards meeting standard 5 of the Children's National Service Framework (Safeguarding and Promoting the Welfare of Children and Young People).
- Undertake regular audits
- Demonstrate they have acted on recommendations from Internal Management Reviews, Serious Case Reviews and national enquiries.
- Ensure regular research based on safeguarding children supervision is provided for staff who have contact with children and young people.
- Contribute as required to the LSCB annual report.

1.9 We believe we are compliant with the expectations of this statutory guidance. This currently only applies to children but the new Social Care Bill will make this mandatory for adults in the near future.

NHS responsibilities for Safeguarding Adults at Risk

There has been considerably less documentation and guidance governing the safeguarding of adults but essentially the emerging methodology mirrors that of children. We are currently awaiting the Social and Care Bill to progress through parliament, which will put adults on a similar footing to children this is expected in May 2015.

1.10 Whilst we are waiting for the guidance we have been moving our adult safeguarding work to align with our children work. In response to the significant rise in the numbers of 'vulnerable adult' referrals being made by the Trust to local authority Social Services, a review was undertaken of all aspects of this process including; how those concerns are reported and processed and how The Trust's relationships with local authority department can be developed to ensure best practice in the care and protection of vulnerable children and adults.

1.11 This review found that mostly all the referrals were appropriate either as a Safeguarding or welfare referrals. The quality of some of the referrals were a concern and it is hoped this will be improved with the introduction of a new referral form and the progression to a telephone referral system.

1.12 We expect to be compliant with the Social Care Bill's recommendations.

Safeguarding Adults; the Role of Health Service Managers & their Boards (2011 but still the guidance used today).

Published in 2011 and in keeping with the Government's approach to decentralisation and local flexibility, this document does not prescribe processes or targets. However, the Government has agreed safeguarding principles that can provide a foundation for achieving good outcomes for patients.

1.13 On the whole the guidance follows a similar pathway to the guidance governing children. There are six fundamental principles underpinning the safeguarding of adults. These are;

- Use the safeguarding principles to shape strategic and operational safeguarding arrangements
- Set safeguarding adults within the services' strategic objectives
- Use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur
- Work with the local Safeguarding Adults Board, patients and community partners to create safeguards for patients.
- Provide leadership to safeguard adults

- Ensure accountability and use learning within the service and the partnership to bring about improvement

1.14 We believe we are compliant with these recommendations.

CONCLUSION of GUIDANCE

How is the London Ambulance Service responding to Safeguarding?

1.15 The new guidance has not made any specific demands on the Trust to change the way it undertakes safeguarding. The increasing demands means that the resource dedicated to safeguarding has to prioritise the workload and the priority is always given to safety.

1.16 During the year we combined the two part time safeguarding posts into a single full time role (there was no loss in resource) giving us a single lead for safeguarding.

1.17 The largest part of the Trust's safeguarding workload is the safeguarding adults; these generate more referrals than children. Within adults there are certain vulnerable groups in which we need to focus our improvement work; these are mental illness and learning disabilities. We are undertaking an audit of mental health/self harm referrals in the coming months.

2.0 Safeguarding Arrangements

2.1 The safeguarding committee drives the Trusts' action plans for safeguarding children and adults and the committee meets every two months.

2.2 The Trust has a number of roles within the organisation that have a specific safeguarding remit.

- Executive Lead: Steve Lennox, Director of Nursing & Quality
- Head of Safeguarding Alan Taylor
- Safeguarding Officer: Dawn Mountier
- Lead for referrals: Alan Hay, Emergency Bed Services Manager
- Lead for mental health: Kudakwami Dimbi, Clinical Advisor
- Training Lead for Prevent: David Williams, Emergency Planning Advisor

2.3 There are a number of roles at station level that have a specific remit in leading, championing or managing safeguarding for the Trust as well as

attending safeguarding meetings and feeding back to staff and the safeguarding team.

3.0 Safeguarding Governance Arrangements

3.1 The Safeguarding Committee reports to the Clinical Quality, Safety, and Effectiveness Committee and makes a short report at every other meeting. The Clinical Quality, Safety, and Effectiveness Committee reports safeguarding to the Quality Committee.

3.2 The Safeguarding Committee oversees the implementation of the action plan and monitors the safeguarding dashboard. It also considers new guidance, developments and lessons arising from Serious case Reviews. This committee has external representation and patient representation.

3.3 The Trust has an obligation to inform the Local Authority Designated Officer of concerns or allegations regarding the Trust's staff in relation to children and the Safeguarding Adult Manager where the concern relates to adults. This has occurred on two occasions during 2013-2014.

PARTNERSHIP WORKING

3.4 It is a statutory requirement for the Trust to attend Local Safeguarding Children Boards. The Director of Nursing & Quality is a member of the Tri Borough Safeguarding Board. Locally, at individual complex level, attendance at Local Safeguarding Children Boards and Safeguarding Adults Board has improved. The Head of Safeguarding receives feedback from local leads on attendance and local safeguarding issues. Attendance at meetings and local engagement is recorded in the activity report. The Head of Safeguarding has also attended the London Safeguarding Adults Chairs meeting and the London Safeguarding Adults Network to improve engagement with partners.

3.5 Partnership working during 2013-14 (see Appendix II).

4.0 Education & Training

4.1 Education requirements are broken into Level 1-5 training depending upon the degree of contact an individual employee has with children. The Trust undertakes both safeguarding adults and safeguarding children training within the same safeguarding session.

Level 1 Training

4.2 This training via induction and an on-line package began in February 2013. Training numbers are being monitored by the safeguarding committee, however, as a training database is still not available accurate reporting on those who have completed the training is limited.

Level 2 Training

4.3 This training is given to all of the Trust's clinical staff who come into contact with patient's either face to face or over the phone and this has been the Trust's priority.

4.4 The Trust has systems and processes in place to ensure a methodical & systematic approach to core training (which includes Safeguarding) for all 'front line' ambulance staff. This approach includes the processes to analyse training needs, plan, develop, deliver and evaluate core training, and assesses the implementation of the training on the Trust.

4.5 The Trust reviewed the core training requirements and produced a Training Needs Analysis (TNA) for all staff in line with legislation, national and professional guidance, in order to inform on going policy development and underpin design and delivery of appropriate core training programmes, in the correct volumes and at the correct levels.

4.6 A gap in training was identified with several staff groups, those who voluntarily respond for the Trust, Private Providers, Patient Transport Service (PTS), Taxis and Emergency Operations Staff. This has been addressed and training and/or guidance approved for some of these groups. Training for PTS staff is still outstanding. 111 level 2 and 3 training also needs to be developed further and included in the Trust's reporting.

4.7 In 2013-2014 174 Trust staff undertook the level one e learning safeguarding training and 373 had level one on induction course. This is 15.7% of non-patient contact staff within the Trust.

4.8 In 2013-2014 3296 79.2% of the Trust's staff who require level 2 received training

Level 3 Training

4.9 This training is for those within the Trust who are involved in contributing to assessing, planning, evaluating the needs of a child. These are namely Local Safeguarding Champions, EBS, and Clinical Hub staff. This training is delivered by the Named Professional (Head of Safeguarding) and external partners.

Level 4 Training

4.10 Is for specialist roles, named professional this training is accessed externally from the Trust.

Level 5 Training

4.11 Is for the designated professional for the Trust which is The Director of Nursing and Quality. This training is accessed externally and through links with safeguarding boards.

Board Level Training

4.12 The intercollegiate document (March 2014) Safeguarding children and young people: roles and competences for health care staff, states the standards of training for all levels including the Trust Board. The Trust Board should undertake level 1 training, and receive additional bespoke training on their roles and responsibilities.

4.13 The Trust board received training from the Designated Nurse in Jan 2013 and will receive additional training from the Head of Safeguarding during 2014.

5.0 Raising Awareness

5.1 One important aspect of Safeguarding is the need to raise awareness and a number of events and processes have taken place this year.

5.2 We held our first Safeguarding conference in June 2013 for staff from all levels of the service this was attended by 120 guests. Presentations were given by both external and internal speakers.

5.3 We have also produced a pocket Safeguarding guide book for all front line staff which is being rolled out across the Trust in June.

5.4 We also produce quarterly safeguarding bulletins as well as articles in the Clinical Newsletter.

6.0 Audit

6.1 The Trust Section 11 audit has been completed for 2013/14. This audit is essentially a self-assessment against the eight standards associated with safeguarding practice and is published on our website. We recognise whilst there is always more that can be done were compliant in all the standards and the assessment was seen by our commissioners. The eight standards are as follows;

- STANDARD 1 – senior management commitment to the importance of safeguarding and promoting children's welfare
- STANDARD 2 – A clear statement of the agency's responsibility towards children is available to all staff
- STANDARD 3 – A clear line of accountability within the organisation for work on safeguarding and promoting welfare
- STANDARD 4 – Service development takes into account the need to

- safeguard and promote welfare and is informed, where appropriate, by the views of children & families
- STANDARD 5 – Training on safeguarding & promoting the welfare of
- children for all staff working with or, depending on the agency's primary functions, in contact with children & families
- STANDARD 6 – Safer recruitment procedures including vetting
- procedures and those for managing allegations are in place
- STANDARD 7 - Effective inter-agency working to safeguard & promote the welfare of children
- STANDARD 8 – Effective information sharing

6.2 The Trusts Safeguarding Adults at Risk Audit Tool was completed in April 2014 and is being shared with NHS England and the Tri Borough Safeguarding Adults Board for scrutiny and is published on our website.

6.3 This audit is structured differently to the Section 11 Audit. The areas identified as needing improvement were;

- Your organisation takes steps to ensure that information is obtained from staff about their experience of working in the service, including the practice of exit interviews. This information is used by the organisation to make improvements.
- Your organisation can demonstrate active engagement with raising alerts and multi agency partnership working for Prevent, including supporting the Channel process.
- Your organisation takes steps to ensure that information is obtained from individuals who use your service about what outcomes they wish from the safeguarding process and whether they have received this.

6.4 The necessary actions will be incorporated into the action plan.

6.5 The Trust was peer reviewed by representatives from the National Ambulance Safeguarding Group at the request of QGARD in June 2013. It produced approximately 20 recommendations many of which have already been implemented. The Trust is currently considering the outstanding recommendations and has prioritised them accordingly.

7.0 Quality

7.1 The Trust has undertaken a number of initiatives to improve quality. Quality controls in referrals have been introduced (this is reported in section 9) and a number of other initiatives have also been developed. These are as follows:

- The balance scorecard is now embedded into the work of the safeguarding committee and used to monitoring safeguarding practice
- The Trust has action plans in place for children and adults
- The Safeguarding Committee has representation from Operations

- The Trust has an external member from the Metropolitan police.
- A quarterly Safeguarding report is shared with leads within the Trust and partner agencies.

8.0 Supervision

8.1 The main vehicle for providing supervision is through the Operational Work place Reviews (OWR). These include Safeguarding elements and give an opportunity for Team Leaders to assess knowledge and awareness of safeguarding issues and the understanding of the policies and processes in place during an observational shift with frontline staff. It is recognised that it the past year OWR activity has been below the expected levels. The safeguarding team are currently considering how best to support staff and provide supervision with a review of all safeguarding supervision being undertaken during 2013-14.

8.2 Formal safeguarding supervision is being delivered for EBS, Clinical Hub and Local Safeguarding representatives. This is offered through group sessions quarterly at present.

8.3 Safeguarding supervision is provided for staff that have been found to have missed a safeguarding referral through the Staff Safeguarding Action Plan.

9.0 Referrals

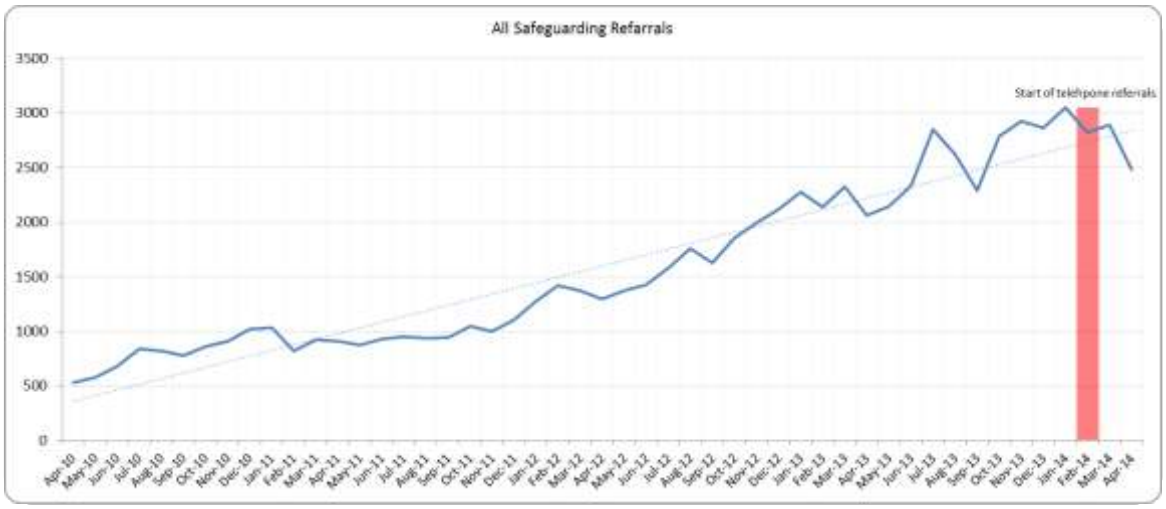
9.1 Referral is the Trust's main contribution to the wider safeguarding agenda. By identifying potential safeguarding issues in the exercise of their main duties, and notifying local authorities, the Trust is able to make a significant contribution to the welfare of children and adults at risk.

9.2 Referrals have continued to rise this year, both in absolute numbers and also as a share of all Trust incidents. The reasons for the increase are various but basically boil down to training, effective leadership of the Safeguarding agenda at complex level (particularly where new CIO's have engaged very effectively), and some external factors harder to quantify such as the cutting or withdrawal of some social services resources.

9.3 There is some evidence that a small downturn in referral volumes is associated with the commencement of the telephone referral trial, although this is in part due to an underlying drop in the total number of incidents the Trust attended during this period. Referrals as a % of incidents remains high at around 2.9%

Safeguarding

Figure 1: Total Safeguarding and Welfare Referrals 2010-2014



9.4 Delay in referral has again improved, and now only around 1% of referrals are delayed significantly, down from 3.5% last year and 6% the previous year. It seems reasonable at this point to say that any risk directly associated with this is effectively mitigated.

9.5 The Trust continues to receive very little in the way of feedback from Local Authorities. This is a statutory obligation and features highly in Munro's review. The Trust redesigned the referral form to include a feedback page for social services this has had a limited impact on feedback numbers. The Head of Safeguarding has raised the issue at Pan London meetings and work in this area is ongoing. We are exploring if a pilot project in the Tri Borough (where the Director of Nursing & Quality is a member) will help identify a more workable process. It is worth noting that other contributors, such as education, also receive poor feedback. We believe this is essentially capacity based rather than any lack of process but we will continue to try and improve this..

9.6 The main development this year has been the commencement of the telephone referral trial for Children and non-conveyed adults. Interim informal evaluation suggests this has been broadly successful with an increase in quality, legibility and uniformity of referrals and a considerable saving in Vehicle Off Road. There remain however complex questions to answer as to how this would be rolled out across the Trust permanently, as it would require a considerable investment in the Emergency Bed Services call-handling capacity.

9.7 The dataset for the referral of both adults and children has been thoroughly overhauled. We are now far better able to report against both protected characteristics and also types of referral.

10.0 Incidents

10.0 The Safeguarding Officer works with external agencies such as local authorities and other Trust departments, in order to ensure that the Trust is compliant with its statutory responsibilities set out in the Children Act 2004 and duties under the No Secrets guidance.

10.1 Of the 1099 enquires that were dealt with in 2013-2014, 480 resulted in the Trust being asked to undertake further enquiry; such as attending and contributing to meetings, the completion of reports for Incidents, Independent Management Reviews or the completion of a review form known as “Form B”.

10.2 11 of these progressed to be Serious Case Reviews and 7 Domestic Homicide Reviews. Two had recommendations for the Trust. These recommendations are essentially regarding missed opportunities to make referrals and are addressed with individual members of staff through reflective practice.

11.0 Serious Incidents

11.1 There was 2 Serious Incidents involving unexpected child death with a safeguarding element in 2013-14.

Incident 1. In 2013 a call was answered in the Emergency Operations Centre by the brother of a patient. Whilst the call was correctly triaged there were concerns that the call handler did not speak to the mother or the patient. This case was de-escalated on considering the findings of the investigation.

Incident 2. In 2013 we received a call regarding a person in a fight, police attended and gave first aid. The patient did not want to go to hospital and made his way to a friend’s house the patient subsequently died. . This case is still on-going.

12.0 Employment Practice

12.1 All appropriate Trust employees have undergone a VBS check. The Trust undertakes an enhanced VBS check on appropriate recruitment and relevant role changes.

12.2 The Trust needs to develop guidance on how to manage concerns regarding employees. Guidance is available from the London procedures but this need to be incorporated into our own Safeguarding Practice and a policy is being developed at the present time

12.3 As a result of recommendation from the Winterbourne View Serious Case Review attention is drawn to Whistle Blowing as part of the employment process.

13.0 Safeguarding Action Plans

13.1 The implementation of the safeguarding action plans is monitored by the Trust's Safeguarding Committee. This is divided into a number of work streams. All work streams are progressing well; the exceptions and highlights are reported below.

CHILDREN

Partnership Working.

13.2 Local representatives across London attend LSCB meetings. Data on level of engagement is attached (see Appendix II).

13.3 We still have work to do in ensuring consistency of local engagement taking place and this is a key area of focus for the Head of Safeguarding. Therefore this remains open on the action plan.

Education and Development.

13.4 Training undertaken as detailed in the previous training section of this report. (See dashboard in Appendix I).

13.5 Currently the Trust does not have the ability to easily capture data for all training undertaken for both clinical and non-clinical staff.

Supervision. (Commissioned Standards & CQC)

13.6 Safeguarding supervision is currently not embedded in all clinical roles. Supervision of clinical staff is through OWR but these were not consistently undertaken across the year but there has been a renewed focus in 2014/15.

Employment Practice.

13.7 Clarity is being sought on whether the Trust should meet the three year expectation to undertake DBS checks three yearly.

13.8 The development of a policy and procedure on managing allegations against staff is almost complete.

Procedures and Guidance

13.9 The Trust policy on conveyance in under 18yrs is not consistent with national policy. Current LAS policy is based on coroner's instructions. The Trust is currently in discussion with coroners in relation to our non-compliance with national policy.

Audit. (Commissioned Standards, CQC & SIT visit

13.10 The head of Safeguarding has completed the Section 11 Audit. This is our self-assessment against mandatory and statutory elements.

13.11 There are plans in place to undertake an audit of referrals for Children who self-harm this year.

Unable to assure that the current taxi contract accommodates the guidelines for regulated activity

13.12 Taxi contracts now have Safeguarding included.

Learning from Serious Case Review Recommendations

13.13 Articles providing information to inform staff about best practice in safeguarding children are regularly published in the LAS News. They are anonymous cases based on action plans that result from SCRs.

13.14 Children & Young People's Health Outcomes Forum 2013. Have two recommendations for the LAS to consider.

a. Demonstrate how we have listened to the voice of children and young people and how this will improve their outcomes.
b. All data about children and young are presented in 5 year age bands through childhood and teenage years. This will allow compassions of outcomes.

ADULTS

Safeguarding Adults and Assurance Framework

13.15 In March 2011, the Department of Health published a Safeguarding Adults and Assurance Framework to enable health Trusts to identify how well they are meeting their safeguarding adult responsibilities. This served as a gap analysis tool for the Trust and identified that (using a scale of 1 – 4, with 1 being 'not effective') 16 out of 20 measures were self graded as effective.

13.16 Areas for improvement include partnership working, improving transparency, contracts and procurement, all of which are included in the action plan for development. Although this is not validated externally (although it is submitted to the Tri Borough Safeguarding Board), it is indicative of the Trusts position and sets us on the right path for improvement given that the measurements are taken, in part, from the CQC Essential Standards for Quality and Safety.

Strategy and Planning

13.17 There is a Strategic Plan for Safeguarding Adults that includes Prevent (prevention of radicalisation training) and it is an integral part of quality. The Trust has action plans in place and are reviewed and monitored regularly at appropriate committees. The Trust currently only undertakes Prevent training to targeted staff groups and is in the process of producing a Prevent policy.

Systems for prevention; responses; reporting & learning.

13.18 The Trust has a Safeguarding Adult policy and supporting procedures that are consistent with the local multi agency Safeguarding Adults procedures. The revised Adult policy was published in September 2013.

13.19 The Trust has guidance and processes to govern the use of restriction and restraint and where DoLS should be considered. The Trust has guidance on assisting the police with restraint and is in the process of agreeing a restriction and restraint policy.

13.20 Services can demonstrate patient/user led decisions about their Safeguarding and that interventions are person centred. Staff are trained on consent and safeguarding.

Workforce, culture and capability

13.21 The Trust's workforce has the capacity and capability to meet the needs of patients who may be at particular risk of harm and respond to safeguarding concerns. This is actively monitored through the safeguarding scorecard.

13.22 The organisation has an approved Prevent Trainer and sessions are delivered to selected staff. We have a plan to roll out prevent awareness/ training which has been agreed with the commissioners. We are unlikely to meet the DH target for Prevent in 2015-2016 (all clinical staff to be Prevent trained).

Partnership & Collaborative working

13.23 The Trust works in partnership to Safeguarding adults. This includes local multi agency partnerships involved in the Prevent agenda, including channel, metropolitan police and local authorities. We have designated local Safeguarding leads on complexes who attend local board meetings, who feedback information to the Safeguarding team. The Head of Safeguarding has met with the chairs of Safeguarding Adults board (SAB). The Head of Safeguarding is also a member of the London Safeguarding Adults Network and the NHS England (London) Dignity and Capacity Group.

13.24 The Safeguarding Officer liaises with local authority colleagues to ensure attendance at Rapid Response Meetings, Serious Case Reviews and provides documentation including Individual Management Review, Form B's, and Incident Report etc. Representation from the Metropolitan Police and Designated Nurse from CCG attend our Safeguarding Committee Meetings. Prevent trainer attends multi agency Prevent meetings. The Head of Safeguarding has also been involved with NHS England Female Genital Mutilation working group and the NW London Pressure Ulcer working Group.

Learning from Incidents, SI's, SCR's, Complaints, Reports and Publications

13.25 There are a number of actions for the Trust from the Winterbourne View, Serious Case Review recommendations.

- Review contracts of employment and make whistle blowing a condition of employment. The Trust has included whistle blowing in contracts from this year.

- Develop Easy Read complaints information. The Patient Experiences Department is currently in the process of developing on line easy read pages.

- Share Safeguarding alerts and regular callers/attendance at the same location with other organisations. The Trust is now sharing data monthly on our attendance at care homes with Commissioners, Care Quality Commission and Social Services.

13.26 An Incident Sub Group of the Safeguarding Committee has been set up to look at incidents in more detail and ensure actions are being followed up.

14 Prevent

14.1 Prevent is one of the strands of the Governments counter-terrorism strategy, CONTEST. The PREVENT strand seeks to stop people from becoming terrorists or supporting terrorism.

14.2 The revised PREVENT strategy was released in 2011, and aimed to incorporate all of the partner organisations that could potentially influence radicalisation in the community. 16 of the 31 boroughs in London were identified as high priority in the new strategy, showing the importance of all London Health organisations in the overall delivery of the plan.

14.3 The health Workshop for Raising Awareness of Prevent (WRAP) training is currently delivered by one of the Emergency Planning Advisors in the trust, and is designed to illustrate the correct methods for raising concerns about individuals in the pre-criminal space, who are at risk from radicalisation.

14.4 The NHS requirement is that all Trust staff should be trained by a Health Wrap Trainer in PREVENT. The training is approximately 1 ½ to 2hours long the LAS has one Health Wrap Trainer.

As a result for 2014-15 the commissioners have agreed a phased Prevent awareness for Trust staff. This consists of:

- All staff receiving a information sheet on prevent with payslips
- Including 5 minutes on Prevent in Trust induction programme
- Adding 10 minutes to Safeguarding session in CSR for Prevent
- Continuing to provide full Prevent course on Operational Commanders Courses.

The Trust is currently in the process of writing a Prevent strategy and this work is led by EPPR Department.

14.5 The full training has been provided to 153 members of staff on two Operational Commanders courses and one Apprentice Paramedic course at the time of the report. The intent is that this training will be provided on all commanders courses, and will be incorporated as part of the Apprentice Paramedic programme.

15 Multi-Agency Risk Assessment Conferences

15.1 Looking ahead to 2013-2014 the requirements of MARAC will be introduced. Multi-Agency Risk Assessment Conferences (MARACs) are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year.

15.2 Clearly THE Trust's role in such cases is limited but is not insignificant. So far the Trust is successfully attending conferences for 5 London Boroughs. The Trust is obligated to share the information it holds in a similar way to undertaking an Independent Management Review.

15.3 It takes about 20 minutes to complete a request (this has been tested by MI with a few case studies). The numbers of information requests are expected to be approximately 693 a month (currently at approximately 100). This is based on the national MARAC figures for last year. The Trust is currently considering its options for this.

16 Summary

16.1 Overall a self-assessment reveals that the Trust is generally compliant with CQC standards for Safeguarding.

16.2 The Peer review provided areas for improvement that will continue to be explored.

16.3 The safeguarding team is working to capacity and the accommodation of MARAC is being added to the risk register.

16.4 Prevent training is a challenge and the Trust will need to regularly review its strategy.

16.5 The Safeguarding portfolio has significantly strengthened during the course of the year. The scorecard is embedded into the work of the committee and appears as a RAG rated measure on the Trusts Quality Dashboard.

16.6 The Indicators within the scorecard are demonstrating improvements during the course of the year.

16.7 All Action Plans are progressing well.

16.8 The gap in level 1 safeguarding training has been managed and the Trust is beginning to ensure all staff are trained to the required standards.

Appendix I

Safeguarding Balance Scorecard

COMPLEX	Adults Safeguarding	Adults Welfare	Children	TOTAL	Adults Feedback	Children Feedback	Total Feedback	Incidents	Referral % of Incidents	Delays	Delayed % of all Referrals	CSR Training Compliance	% of CSR Training Compliance	Mental Health (1 in 40 CPI Check %)
Brent	1179		237	1416	5	3	8	52100	2.72%	13	0.92%	26	18.4	320
Camden	1015		207	1222	5	2	7	51956	2.35%	19	1.55%	12	12.4	329
Friern Barnet	672		118	790	4	3	7	37473	2.11%	32	4.05%	20	19.3	263
Fulham	691		118	809	2	1	3	35583	2.27%	15	1.85%	14	12.9	340
Hanwell	1059		226	1285	8	8	16	38703	3.32%	19	1.48%	16	17.4	289
Hillingdon	692		138	830	5	5	10	41562	2.00%	7	0.84%	11	10.6	242
Isleworth	628		154	782	2	6	8	35304	2.22%	19	2.43%	8	7.4	232
Islington	191		41	232	1	2	3	0	0.00%	20	8.62%	6	8.6	0
Pinner	1011		270	1281	13	12	25	44574	2.87%	39	3.04%	24	21.6	473
WEST ^	**7138**	**0**	**1509**	**8647**	**45**	**42**	**87**	**337255**	**2.56%**	**183**	**2.12%**	**137**	**128.6**	**2488**
Chase Farm	424		121	545	1	10	11	25459	2.14%	3	0.55%	6	7.7	362
Edmonton	1439		339	1778	7	12	19	54118	3.29%	14	0.79%	36	24.4	283
Homerton	800		210	1010	2	15	17	49347	2.05%	64	6.34%	32	23.9	488
Newham	550		209	759	0	3	3	37329	2.03%	21	2.77%	23	22.5	373
Romford	804		305	1109	3	6	9	43539	2.55%	49	4.42%	15	12.8	461
Tower Hamlets	502		149	651	0	4	4	26373	2.47%	58	8.91%	19	27.3	488
Whipps Cross	1083		299	1382	7	26	33	65943	2.10%	24	1.74%	42	23.1	458
EAST ^	**5602**	**0**	**1632**	**7234**	**20**	**76**	**96**	**302108**	**2.39%**	**233**	**3.22%**	**173**	**141.7**	**2913**
Barnehurst	1380		253	1633	4	29	33	44994	3.63%	8	0.49%	25	18.7	273
Bromley	1055		261	1316	9	21	30	38260	3.44%	26	1.98%	28	23.3	499
Croydon	2002		603	2605	14	35	49	50679	5.14%	24	0.92%	32	21	370
Deptford	1547		286	1833	5	12	17	62720	2.92%	12	0.65%	18	21.4	367
Greenwich	1265		320	1585	7	35	42	47826	3.31%	17	1.07%	23	15.4	324
New Malden	892		174	1066	3	3	6	34093	3.13%	11	1.03%	2	2	426
Oval	240		51	291	3	2	5	10580	2.75%	24	8.25%	8	11.4	0
St Helier	1591		348	1939	6	13	19	42263	4.59%	21	1.08%	16	14	486
Waterloo	250		42	292	3	1	4	14623	2.00%	8	2.74%	20	26.7	0
Wimbledon	809		195	1004	2	3	5	28621	3.51%	8	0.80%	3	3.8	462
SOUTH ^	**11031**	**0**	**2533**	**13564**	**56**	**154**	**210**	**374659**	**3.62%**	**159**	**1.17%**	**175**	**157.7**	**3207**
CSD	9		13	22	0	3	3	0	0.00%	0	0.00%	0	0	0
CTA operator	40		23	63	0	0	0	0	0.00%	0	0.00%	0	0	0
EOC	96		65	161	1	3	4	0	0.00%	7	4.35%	45	364	0
Other	115		51	166	0	2	2	0	0.00%	11	6.63%	0	0	0
PRIVATE AMBULANCE	942		214	1156	3	5	8	0	0.00%	23	1.99%	0	0	0
St John	181		16	197	1	0	1	0	0.00%	1	0.51%	0	0	0
NULL	0		0	0	0	0	0	0	0.00%	0	0.00%	0	0	0
Unknown	328		109	437	2	4	6	0	0.00%	1	0.23%	0	0	0
#N/A				0			0		0.00%		0.00%			
TOTAL	**25482**	**0**	**6165**	**31647**	**128**	**289**	**417**	**1014022**	**3.12%**	**618**	**1.95%**	**530**	**792**	**8608**

Appendix II

Local partnership engagement

Complex	CCG	No. Children Boards Attended	No. Adult Boards Attended	Other Meetings Attended (RRM, DHR, SCR's etc)	Training	Other Activities	MARAC
South East							
Barnehurst	Bexley	3	3	6	1	2	12
Bromley	Bromley	3	1	6	3	0	0
Deptford	Lambeth Lewisham Southwark	4	3	15	1	0	0
Greenwich	Greenwich	4	2	9	0	0	0
South West							
Croydon	Croydon	2	3	27	7	2	2
New Malden	Kingston Richmond	0	0	8	0	0	0
St Helier	Merton Sutton	0	8	9	0	0	0
Wimbledon	Wandsworth	0	0	1	0	1	0
East Central							
City & Hackney	Hackney	0	0	8	1	1	0
Newham	Newham	0	1	7	0	0	0
Silvertown	Tower Hamlets	0	4	6	0	0	0
Whipps Cross	Redbridge	0	5	10	2	9	0
North Central							
Camden	Camden	1	4	6	0	0	0
Chase Farm	Enfield	3	3	9	2	0	0
Edmonton	Haringey	4	4	3	0	3	1
Friern Barnet	Barnet	3	4	15	2	4	1
Islington	Islington	3	4	0	0	0	0
North East							
Romford	Barking &	0	0	6	1	1	0

Safeguarding

	Dagenham						
	Havering	0	0	2	0	0	0
Whipps Cross	Waltham Forest	0	0	2	0	0	0
North West							
Brent	Brent	2	4	6	2	1	0
Hillingdon	Hillingdon	2	1	8	1	0	0
Pinner	Harrow	3	4	12	1	0	0
West							
Fulham	Central London Hammersmith & Fulham West London	0	0	3	0	1	0
Hanwell	Ealing	1	0	9	0	0	0
Isleworth	Hounslow	1	0	0	0	0	0

London Ambulance Service NHS Trust

Savile Second Update

July 2014

Introduction

The purpose of this status report is to build upon the status report in June 2013 and provide the Trust Board Trust Board with an overview of how the Trust is placed in relation to recommendations from recent NHS reports published in respect of the Savile allegations.

This report and update is based on the earlier report and the additional learning from the 28 NHS Reports published in June 2014.

Gap Analysis

A gap analysis has been undertaken jointly by the Head of Safeguarding and the Head of Human Resources and presented to the Executive Management Team.

The Trust is already compliant with many of the recommendations and the risks are minimal as we do not permit visitors to witness care without being fully escorted. There were four main themes that require further consideration and the Safeguarding Committee will oversee this work over the coming months.

1. Policy.

Process and practice for receiving visitors is not captured in a specific policy and this will be addressed over the coming months.

2. Monitoring of staff equally

The recommendations discuss the need to monitor the recruitment of contractors and visitors in a unified way to ensure consistency across all methods of employment. Again, the risks are minimal as we only work with a small number of alternative providers however we will give further thought to how we can strengthen this monitoring in the future.

3. Engaging Stakeholders

The recommendations suggest that policies should be developed by engaging a wider group of stakeholders than the NHS currently engages with. This is timely as we have just launched our new engagement programme and there are opportunities within this wok stream to consider this recommendation.

4. Policy Compliance

NHS Trusts were reminded that it is important to monitor compliance with policies. The Trust does have mechanisms for undertaking this and internal audit has been instrumental in supporting us with this work. However, we will consider if there is any further strengthening that we can do to monitor compliance.

5. Recruitment Checks

Finally whilst we undertake Disclosure and Barring checks on appointment for all clinical staff there is an increasing call to review these checks periodically. We are currently reviewing our requirements and are considering if there are ways we can meet the objective of regular checks.

The action will be monitored by the Safeguarding Committee and reported through the Action Plan.

Section 1 Review of LAS operational procedures in relation to the 28 NHS Trust report recommendations

Findings/ recomendations from NHS Reports	Current LAS position	Gaps identified	LAS Compliance	Recommendations	Owner
Leadership, organisational values & executive accountability					
The promotion of enquiring leadership at all levels in the organisation. Enable staff and volunteers to challenge any inappropriate behaviour witnessed in the Trust.	Under the leadership of the new Chief Executive and Board, the Trust has recently embarked on a major organisational development programme to refresh and strengthen its leadership, core values and behaviours.	Not all levels of management challenging behaviours. Whistleblowing policy at times poorly implemented or not used. Poor Trust record keeping of whistleblowing incidents. Lack of staff confidence that challenging inappropriate behaviour will be supported.		Review existing policies, knowledge and understanding about how staff and volunteers can effectively raise concerns, and a new approach that empowers them to speak out. Review whistleblowing policy and implementation giudance and record keeping. Publish figures on whistleblowing incidents in annual report.	Director of HR & Director of Operations
Organisational development programmes should incorporate the safety of patients, staff, volunteers and visitors as a central priority.	The Trust recognises the importance of putting the patient at the centre of all we do.Time for change and listening in action focuses on Staff support and providing a safe service for patients.	is the voice of our volunteers heard within the context of time for change and LIA.No current strategy for visitors		Executive and those leading on Time for change to engage with our volunteers, to improve safety and address any issues.	EMT

Patient-centred drivers; safeguarding patients

The Trust's safeguarding policies extend explicitly to the care and transportation of deceased patients	Both Trust Safeguarding Children and Adult at Risk policies have been reviewed and approved in 2013. they do not cover transportation of deceased patients.	Trust does not routinely transport deceased patient other than during an emergency providing immediate medical care.		Do not believe this is applicable to the LAS	Head of Safeguarding
Provide assurance on the quality of the Trust's safeguarding compliance in respect of adult and child patients, and its duty to protect staff. Working with the Safeguarding Boards for Children and Adults in London, an audit programme should include a review of the safeguarding of adults and children referrals,staff training; and employment checks	Trust referrals continue to rise. Our referral ratio to call rate is higher than any other Trust, however this figure also includes a high number of welfare/care referrals. Trust is still under reporting evidence from internal reviews and a number of missed referrals.Safeguarding Peer review undertaken in 2013.Safeguarding audit of training undertaken in 2013 and a further one on Mental health referrals planned for 2014.	Representation on both Adult and Child boards is not consistent across Trust.The Trust is consistenly being requested to engage in a growing number of safeguarding activities. The current safeguarding resources restrict our ability to full engage		Work with Operational Managers to improve consistency of engagement with Safeguarding Boards across London.Consider providing additional resources to safeguarding within the Trust.	Head of Safeguarding and Director of Operations

Current disclosure and Barring Service checks are in place for all relevant employees, volunteers and, where appropriate, contractors and is reviewed to inform each Board meeting.The NHS Employment Check Standards apply to the appointment of all staff within the NHS regardless of their position or term of contract. This includes permanent staff, staff on fixedtermcontracts, volunteers, students, trainees, contractors, highly mobile staff, temporaryworkers (including locum doctors), those working on a trust bank, and other workerssupplied by an agency.Trusts using agency, contractor or other external bodies to provide services must ensure,through regular audit and monitoring, that their providers comply with these standards.	CRB checks undertaken >5yrs ago on all fromtline staff. Checkes currently only undertaken on change of Job or new frontline staff.Staff with access to patient indentifiable data like Management information and Communications are not checked.Staff have obligation to report any change in situation since last check.Private and Voluntary Ambulance services. St John contract runs to 2015. Current private companies X9 and ERS contracts due for renewal Aug 2014. Safeguarding mentioned in contract but not a KPI. Looking to include in new contracts.Current providers being auditted on safeguarding training and arrangements.	The EMT is currently considering when to undertaking DBS checks and on who and actions to be taken.Not clear if all EOC staff have been checked.Some groups of staff with access to patient identifable data have not undergone CRB or DBS checks.Unaware of any audit of agency, contractorsVAS have been written to on 2nd July to request evidence of complaince with DBS and Safeguarding requirements		Board to consider the risks and implications for the Trust of not having robust DBS checks in place.Should consider who and when checks should be undertaken.Policy should be written and agreed giving clear guidance on actions to be taken. Including regular audit and monitoring of agency and external bodies.Including safeguarding training and compliance with Trust arrangements as part of KPI in new contracts.	Director of HR

A Visitor policy should be established and implemented across all sites of the Trust. It should set clear boundaries regarding the role of celebrities,VIPs and media contractors in the Trust, including access to premises. This policy should include robust processes for Board assurance and information about the rules of engagement with media, celebrity visitors and other VIP or non-essential visitors.	Have an ambulance observers policy and imdemnity form.Informal guidance for some EOC staff on visits. Communication Department currently writing a stakeholder visits guidance to link to exsisting policies.No checks currently undertaken on VIP or Celebrities engaged with the Trust.	No overall policy covering visitors to the Trust.No formal policy on visitors to EOC and access to patients.Current observer policy TP014 was due for review in June 2011. Current policy does not provide guidance for staff on limitation/ restrictions on observers.Policies also do not state observers must not be left alone with patients.		Board should consider the level of scrunity that should be undertaken for celebrities engaged with the Trust.Develop a Policy on Visitor to the trust that encompasses all areas of the Trust.Develop formal proceedure for visitor to EOC.Develop staff guidance on limitations and restrictions on observers. ensuring it is explicit that they should not be left alone was in contact with patients.	TBC

Board Corporate and system wide assurance. Strengthening the connection between the Board and the rest of the organisation across its multiple sites.

Development of strategies and actions should continue to improve the visibility of executive and non-executive directors across the organisation	Executive members have undertaken observation on ambulances and visited hospitals and stations and other support areas within the Trust.Several Executive members engage with staff via Facebook LIA site.Executive members undertaking webinars.Pulse and LAS News to inform staff of executive team engagement.	Covering the whole of London and with staff on 24hr shifts difficult to be visible to all of the organisation.Not aware of any current engagement strategy to improve visability across organisation.		Develop executive engagement strategy.Consider less well known Directors and Non Executives undertaking an undercover boss approach to engagement.Continue to build on current executive visits.	Chief Executive
The Board should develop an understanding of how it feels to be a patient in the Trust and identify methods of communication to share good practice and celebrate success, in addition to ensuring that concerns are addressed promptly	Patient experience shared at Trust board. Developing patient engagement strategy. LAS News, pulse and social media used to share good practice and celebrate success. Currently reviewing recognition and reward for staff. Looking at employee of the month award scheme.	Patient actively engaged in committees		Ensure initiatives are introduced and maintained.	EMT

Policy development and implementation

A unified HR system should be established across the Trust that fulfils the recruitment and employment requirements for all employees, volunteers and contractors in a consistent manner	Trust does not have one unified system. We have HR policies on recruitment and a separate First responders policy for volunteers. We do not have any policies in procurement related to employment, any requirements for employment checks, such as the contract for 3rd party transport (St Johns etc) are dealt with in the specification and backed up with terms and conditions. We don't currently audit the pre employment checks of companies we use/sub contract. we check their H&S records, financial status and professional qualifications in procurement. The Trust selection and recruitment policy covers all trust employees, it does not cover volunteers and contractors.	Not captured on HR System		consider benefits to LAS of unified HR system for all groups	TBC ? Procurement/HR

The Trust should review it's policy on gifts and hospitality and seek assurance that all staff (including volunteers and non-executive directors) are aware of their responsibilities and comply with the policy. Compliance should be reviewed at least annually by internal audit.	Standing Orders Reservation and delegation of powers of the Trust Board Directors, of which Section 10 refers to Gifts and Hospitality. This is the latest updated version, still tracked as final Audit Committee approval is needed in September but you will see from this that there has been no change to that section in this latest update. All Board members and senior managers should be aware of the Standing Orders and the updated version will be published once approved with a reminder sent to those staff.We send out an annual reminder as a minimum and this is usually around Christmas time and goes to the Trust Board and senior managers by email, attached. This is not audited annually and the last full audit was by the Local Counter Fraud Service in 2012.	Not annual audit		Consider annual audit and communication strategy to staff	Sandra Adams

The Trust should develop a volunteer policy that covers employment checks, inductions, training, access to the Trust and clarity about the boundaries of their roles.	Trust has OP/046 Community First Rresponder Policy that cover all responder schemes. Covers all elements identified.			Review due in September 2015	Director of Operations
The Trust should develop a major strategic plan for management of potentially catastrophic issues where public confidence may be at stake. This will enable greater clarity and consistency in matters of communication, accountability and action.	Have a Surge plan and Reap levels. Unsure if this encompasses wider communication, accountability and actions to be taken in the event of catastrophic issues.			Board to consider developing plan or enhancing excisting processes	EMT

All policies should be reviewed to ensure that they comply with statutory obligations about the retention of records.	Not all policies cover retention of records. Have a separate policy T/029 - Records Management and Information Lifecycle policy All policies and their major versions are kept as required by legislation and the NHS Records Management Code of Practice. It is down to individual policies to identify retention periods for specific document categories addressed by those policies. It is the responsibility of the owner and the monitoring committee of each policy to ensure compliance. The scope is identified in each policy though generally they apply to all staff plus volunteers and contractors as appropriate. We use a standard format (identified inTP001) for all Trust policies.	unsure if policies meet requirement. Have numberous policies on handling and sharing information. A number of policies have not been reviewed.		Undertake a review of policies.	Head of Governance
All Trust policies should extend in their scope to the broader community, including volunteers, non-executive directors and where appropriate contractors; and in time governors.	Trust has numberous policies held in different places Operational policies, Trust policies, HR policies and Standing orders.	Policies do not routinely cover the broader community.		consider all new policies incorporating requirement if approved	Head of Governance

The Trust should review how it seeks the views of a wider range of stakeholders in developing policies, and should ensure that all policies are patient centred. In doing so, it should draw best practice from other organisations within and outside the NHS.	Trust has numerous policies held in different places Operational policies, Trust policies, HR policies and Standing orders. Not aware that they are patient focussed, usually task orientated. Staff and managers have difficulty in locating policies and proceedures.	Review of policies has not been undertaken. It has become clear that we many policies and proceedures in various locations on the trusts website. We have 70 operational, 91 Trust, 24 HR, 23 H&S and additonal standing orders and other policies contained in other areas of the Pulse.		Consider stakeholder engagement in developing policies. Consider if current arrangments of having so many policies is fit for purpose	EMT
There should be mandatory compliance with policies designed to protect patients and staff. The role of the Trust's Internal Audit should be reviewed as part of this.	Trust has numerous policies held in different places Operational policies, Trust policies, HR policies and Standing orders. Not aware that they are patient focussed usual task orientated. Staff and managers have difficulty in locating policies and proceedures.	Review of policies has not been undertaken. It has become clear that we many policies and proceedures in various locations on the trusts website. We have 70 operational, 91 Trust, 24 HR, 23 H&S and additonal standing orders and other policies contained in other areas of the Pulse.		Review internal audit of policies. Review need and suitability of policies	Director of Corporate Affairs

Part 2: Savile report actions – Workforce and Recruitment checks

1. Disclosure and Barring Scheme – current situation

All applicants for patient facing roles are required to undertake (enhanced level) DBS checks prior to appointment. Once this has been undertaken, no further DBS check is undertaken unless the staff member applies for a different (eligible) role. This will most obviously be on promotion.

Although there is a widely-held belief that DBS checks should be repeated every three years, there is no requirement for repeat checks for the workforce at large, even in the eligible roles.

All staff in these roles have been subject to the former CRB check at least once, even if their employment commenced before CRB checking requirements were introduced. A "one-off" retrospective checking exercise was undertaken in 2007/08. This process resulted in action up to and including dismissal for a number of staff.

2. Scope and application of the DBS requirements

There is no requirement that all Trust employees are subject to DBS checks, although review of non-patient facing posts advertised on NHS Jobs suggest that it is the case that some NHS Trusts appear to require every employee to be checked.

DBS criteria, and the supporting NHS Employment Check Standards, confirm that checks should not be requested other than in regulated activity – broadly defined as those with regular access to patients in the course of their contracted duties.

Ambulance Trusts extend this to Control Services staff, as they have direct access to sensitive patient data.

Similarly, checks are required of Patient Experiences Department staff, and those employed directly in safeguarding roles.

DBS guidance allows checking of CEOs and "other senior managers", although these checks should be at the basic, not the enhanced level. In late 2013 all EMT members completed DBS checks.

3. Roles currently subject to checks

At present, the following posts/roles are subject to DBS checks:

- Operational: all posts – Paramedic, Team Leader, EMT, A&E Support, Emergency Ambulance Crew, Team Leader, DSO, AOM, ADO, HEMS, Resilience, HART, CRU, PTS; Training Officer
- Control Services – EMD's etc, EBS
- Other – Directors/Executive Management Team, Patient Experiences Department, Safeguarding roles.

Action: - review current arrangements and scope to consider inclusion of other job roles in DBS requirements/extending to all staff.

4. Record keeping

A pro forma is currently completed which confirms details of the DBS check. This is placed on the personal file, and an entry is made on the ESR record for each staff member.

Action – request from MI a report detailing all such entries to review consistency/identify gaps. **If no ESR confirmation, check personal file. If this check does not confirm DBS completion then a repeat check should be required.**

5. Future DBS arrangements

In addition to continuing the pre-employment checks, the Trust wishes to provide additional assurance by implementing a process of repeat DBS checks in subsequent years, to provide additional assurance for those staff who do not change roles.

The annual cost of doing so is not insignificant. A bid of c.£175k was made against service developments for the current year, but this has not yet been released. There are also resource implications in terms of administering these arrangements and management time in terms of dealing with any issues that might be identified (convictions). Each must be investigated and considered individually.

To allow these arrangements to be properly considered, planned and costed, it is proposed that a one-off "self-declaration" exercise be undertaken in quarter 3 of the 2014/15 financial year. Staff previously subjected to DBS checks will receive a letter asking then formally to confirm that there has been no change in their DBS status since the last check was undertaken. (It should be noted that staff are expected to come forward and declare/disclose any police action/conviction as part of their contracted terms of employment).

It will be necessary to have a clear process to follow up those who do not respond, as well as to deal with any issues that are identified.

Thereafter, a three-year cycle of checks be introduced so that the Trust is assured that all staff have a disclosure that is no less than three years old. This is more manageable in terms of cost and resource requirement.

Action: in 2014/15 undertake self-declaration exercise for all those who have been required to undertake DBS check. From 2015/16 introduce arrangements to ensure that all staff are subject to repeat check not less than once every three years.

6. Recruitment and Selection Policy

The requirements and standards for recruitment and selection of staff are set out in the Recruitment and Selection Policy. This was last amended in May 2013, although the changes introduced were minor.

The policy sets out that the Trust will apply the NHS Employment Check Standards. However, these were last revised in July 2013, so there is a need to review the policy against any updated requirements.

This also gives an opportunity to ensure that employment check requirements are consistently applied in addition to LAS staff to contractors, bank, agency staff and volunteers.

The most recent audit of recruitment practice focussed on process, not pre-employment checks. In future, internal audit should check compliance with pre-employment checks including DBS on an annual basis.

Action: review and revise Recruitment and Selection Policy to ensure compliance with current NHS Employment Check Standards. Annual internal audit plan to include checking of compliance against pre-employment standards, including DBS.

7. Staff Support

Staff who are subject to any reported concerns and safeguarding, or who raise concerns about such matters including as these may relate to colleagues or other healthcare professionals, may have difficulty in coping with the demands or emotions of the situation. Specific consideration will therefore be given to the support that can be made available via LINC workers, the EAP etc. and for inclusion in training of staff at induction and subsequently. This training should include guidance for managers in recognising isues and referring staff for support. This is recognised in the policy on managing safeguarding allegations which is shortly to be considered by SMT.

Action: Staff Support and Counselling Services manager to review support and training.

8. Action plan – summary

Action	Responsible	Time frame
Review scope of DBS checks	SMT recommend to EMT	September 2014
MI report current ESR compliance	AD HR	requested 8/7
Self-declaration all existing DBS-checked staff	HR team	Oct/Nov 2014
Introduce 3-year cycle of repeat checks	HR team	design by end Q4 14/15 commence Q1 15/16
Review recruitment policy	SMT/EMT	Sept 14
Audit pre-employment checks	KPMG	audit year 14/15
Review support and training for staff and managers	Staff Support Manager	initial review Oct 14

Tony Crabtree, 8 July 2014

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR APPROVAL

Document Title:	**Annual Revalidation Report**
Report Author(s):	**Fionna Moore, Medical Director**
Lead Director:	**Fionna Moore, Medical Director**
Contact Details:	
Why is this coming to the Trust Board?	**For approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the attached document**

Key issues and risks arising from this paper:

The LAS is a Designated Body for revalidation. 5 doctors have a registered connection with the Trust.

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.

Executive Summary:

The attached paper summarises the appraisal and revalidation process with regards to 5 doctors who have a registered connection with the LAS.

Each has had an appraisal within the past year and have personal development plans agreed. The LAS is working to actively support the efforts of each individual to provide evidence to support revalidation.

Should the Trust Board approve the attached document, a Statement of Compliance can signed by the Chief Executive.

Attachments:

Paper for approval

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	Quality Strategy This paper supports the following domains of the quality strategy: ☐ Safety and Standards ☐ Development, Education and Enablers ☐ Effectiveness, Experience and Evaluation
	LAS Objectives This paper supports the achievement of the following objectives for 2014/15: ☐ Improve patient care ☐ Improve recruitment and retention ☐ Implement the modernisation programme ☐ Achieve sustainable performance ☐ Develop our 111 service ☐ Simplify our business processes ☐ Increase organisational effectiveness and development
	Equality Analysis Has an Equality Analysis been carried out? ☐ Yes ☒ No Key issues from the assessment:

London Ambulance Service NHS Trust
Annual Board Revalidation Report July 2014

1. Executive summary

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.

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.

Three of these doctors work only with the Emergency Bed Service. They have no direct clinical contact with patients, or indeed with any other area of the Health Service outside this area, having been retired from active practice for some considerable period of time. Providing evidence to support a positive recommendation of their fitness to practice, to maintain their licence to practice, will be a very significant challenge for them. They have all acknowledged this, and the LAS is working actively to support their efforts to provide this evidence. In two cases the revalidation date has been deferred to allow additional time.

The remaining two doctors are in active clinical practice, up to date with appraisals and continuing professional development, and are unlikely to have difficulty in generating sufficient evidence for positive recommendations.

2. Purpose of the Paper

The purpose of this paper is to inform the Board of progress against the appraisal and revalidation process and to highlight the particular challenges that this has posed. For all of the doctors with a prescribed connection this is the first round of revalidation, although the appraisal process has been in place for some on a yearly basis for some considerable time.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams [delete as applicable] will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The LAS Medical Director is the Responsible Officer (RO) for the organisation, supported by the Deputy Medical Director who is a trained Appraiser.

Those doctors with a prescribed connection undergo a yearly appraisal, which is their responsibility to arrange. At this appraisal they are required to produce evidence against the various elements of good medical practice, either through an electronic or paper based portfolio. A Personal Development Plan is agreed, along with the resources required to achieve this.

The numbers of doctors with a prescribed connection, their status, and the timing of their expected date of revalidation is registered with the GMC and available for monitoring by the RO through the secure website GMC Connect.

Support for this process is provided through the GMC Employer Liaison Officer who visits the LAS on a regular (yearly) basis and who is copied into all correspondence to the doctors with a prescribed connection.

In the event of any of these doctors having a limitation on their practice this is monitored through the GMC Fitness to Practice Directorate. Currently one doctor with a prescribed connection has limitations on their practice.

The LAS reports progress against appraisals and revalidation through the yearly Organisational Readiness Self-Assessment (ORSA) report, previously reported through EMT and the Trust Board, and now replaced by the Annual Organisational Audit (AOA) reported on 19th May 2014 for the year 2013 – 2014. All reports have been completed and returned within the required timeframe.

a. Policy and Guidance

No new guidance or amendments to existing documentation to report.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Five doctors have undergone appraisal (four within the LAS, one prior to registering a connection with the LAS) in the year 2013-2014.

One doctor has limitations on their practice.
(For assurance see **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

The LAS has one trained appraiser (Deputy Medical Director). Training was undertaken through NHS England (London region) appraiser training. This number of appraisers is judged appropriate for the number of doctors with a prescribed connection to this organisation.

c. Quality Assurance

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

All appraisal and revalidation documentation is kept in a locked cabinet; any relevant on line documentation is maintained in password protected files on LAS computers.

There is no patient identifiable data in appraisal portfolios.

No information governance breaches have been identified.

e. Clinical Governance

See information in para 4 above.

6. Revalidation Recommendations

No recommendations due April 2013 –March 2014
All Doctors have an up to date appraisal and PDP.
Two Doctors with appraisal dates in July and August 2014; both interviewed and deferral requests made for 3 and 6 months respectively.
The remaining three Doctors have revalidation dates in 2015.

Of the two requests for deferral, both Doctors demonstrated engagement with the revalidation process but could not demonstrate sufficient progress against their PDPs.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

No concerns; one new doctor with a Designated Connection joined in the past 3 months with an up to date appraisal and PDP. No locums employed.

See **Annual Report Template Appendix E;** Audit of recruitment and engagement background

8. Monitoring Performance

Monitoring of performance is primarily through the appraisal process. Other supporting information is obtained through feedback from managers, staff, flagging of concerns from complaints, incidents and enquiries from members of the public and healthcare providers from without the LAS.

9. Responding to Concerns and Remediation

The relevant policies for responding to concerns and remediation have been developed.

10. Risk and Issues

There is a risk that three 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. All three doctors have expressed the desire to maintain their licence to practice, and are

engaged with the process of revalidation. All have recently discussed their personal development plans with the RO and have dates set for review.

11. Board / Executive Team Reflections

Nothing to report

12. Corrective Actions, Improvement Plan and Next Steps

Nothing to report

13. Recommendations

The Trust Board is asked to accept this report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any needs/resources
To approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

Fionna Moore
Responsible Officer
London Ambulance Service NHS Trust
20th July 2014

Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the ‘appraisal due window’	0
Sickness absence during the majority of the ‘appraisal due window’	0
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	1
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
(describe)	
Appraiser factors	**Number**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**Number**
Administration or management factors	0
Failure of electronic information systems	N/A
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B

Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		Number
	Number of appraisal portfolios sampled (to demonstrate adequate sample size) **ALL**	All (5)
Appraisal inputs	Number audited	Number acceptable
Scope of work: Has a full scope of practice been described?	5	5
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	5	2
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	5	2
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes for 2 No for 3 (EBS); not achievable	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	5	2
Review of complaints: Have all complaints been included?	N/A	None received
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	Number	None relevant
Is there sufficient supporting information from all the doctor's roles and places of work?	5	2
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	Number 5 5 5	Number 2 2 2
Appraisal Outputs		
Appraisal Summary	5	5
Appraiser Statements	5	5
PDP	5	5

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2013 to 31 March 2014	
Recommendations completed on time (within the GMC recommendation window)	None due
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	None due
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	Number
New starter/new prescribed connection established within 2 weeks of revalidation due date	Number
New starter/new prescribed connection established more than 2 weeks from revalidation due date	Number
Unaware the doctor had a prescribed connection	Number
Unaware of the doctor's revalidation due date	Number
Administrative error	Number
Responsible officer error	Number
Inadequate resources or support for the responsible officer role	Number
Other	Number
Describe other	
TOTAL [sum of (late) + (missed)]	N/A

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				1
Capability concerns (as the primary category) in the last 12 months				0
Conduct concerns (as the primary category) in the last 12 months				0
Health concerns (as the primary category) in the last 12 months				1
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2013 and 31 March 2014 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				0
Other (including all responsible officers, and doctors registered with a locum				0

agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs	
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	N/A
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	Number
Were referred to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	Number
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	0
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	0
Temporary employed doctors	0
Locums brought in to the designated body through a locum agency	0
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	1 (Hon Contract)
TOTAL	1

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	BDS	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors																
Temporary employed doctors																
Locums brought in to the designated body through a locum agency																

Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)		1	1	1	1	1	1	1	1	1	1	1	1	1	1	N/A
Total (these cells will sum automatically)		1	1	1	1	1	1	1	1	1	1	1	1	1	1	

For Providers – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

NB: this section may change as a result of the SCL Project

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry					
Obstetrics/Gynaecology					
Accident and Emergency					

Anaesthetics					
Radiology					
Pathology					
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)	0				
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total	0				

London Ambulance Service NHS Trust
Finance Report 2014/15
Month 3: June

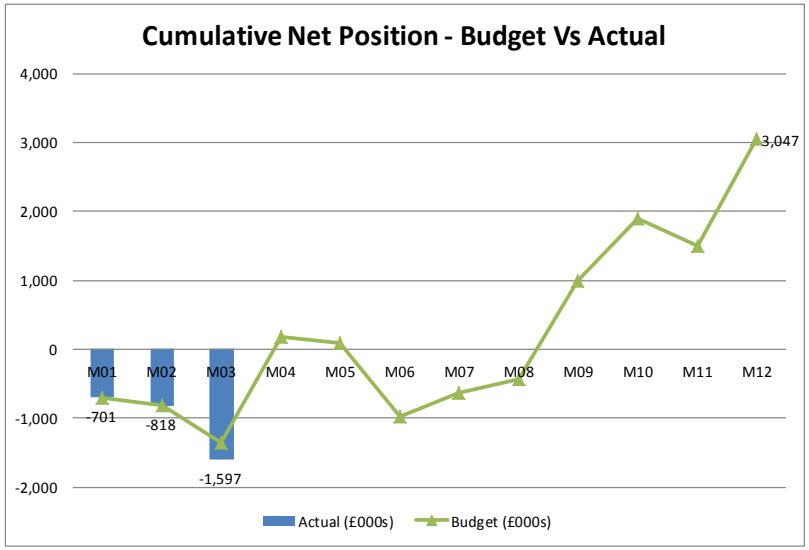
Trust Board 29th July 2014
Part 1

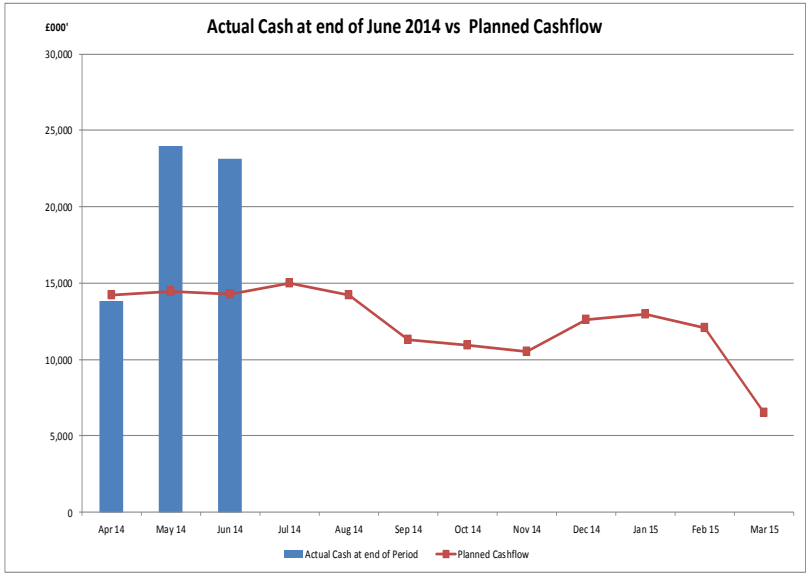
Andrew Grimshaw
Finance Director

Finance Summary: M03 (2014/15)

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the Trust is reporting adverse to plan results of £0.2m. YTD the Trust is adverse to plan £0.2m. The main drivers for this position are lower than planned income from LETBs (£0.1m) and higher than planned Frontline staffing costs (£0.1m). The delivery of the target surplus is at risk given the current performance position, and high use of overtime and private ambulances. The Trust has been spending in excess of plan on Frontline staffing across Q1 in order to support performance. This level of spend cannot be maintained within the current financial plan. Current performance on Category A activity makes the Trust potentially liable for penalties on the R1, R2 and A19 performance targets. LAS Commissioners are discussing the reinvestment of penalties, as such they have not been reflected in the reported position.	**AMBER**	**AMBER**
Income	Income is £0.04m adverse in month and £0.4m adverse YTD. The main driver for this is lower than planned 111 and PTS income. Both of these are offset by corresponding reductions in expenditure. The main concern within income is the lower than planned income from LETBs, £0.1m. Further work is ongoing to increase funding from these bodies.	**GREEN**	**GREEN**
Expenditure	In month total spend is £0.2m adverse, YTD there is a favourable variance of £0.2m; these are both driven by pay underspends, offset by the use of PAS and Overtime to cover frontline vacancies. Operational Pay is currently £1.9m adverse YTD when PAS and Incentives are included. As noted above, the financial plan cannot sustain this level of expenditure.	**AMBER**	**AMBER**
CIPs	Currently reporting on plan.	**GREEN**	**GREEN**
Balance Sheet	No significant issues in 2014/15.	**GREEN**	**GREEN**
Cashflow	Cash is £8.9m above plan.	**GREEN**	**GREEN**

Executive Summary - Key Financial Metrics





Description	2014/15 - Month 3			Year to Date			FY 2014/15
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(539)	(778)	(239)	(1,359)	(1,593)	(234)	3,050
EFL				(6,567)	(16,727)	10,160	3,692
CRL				5,936	159	(5,777)	20,900
Suppliers paid within 30 days - NHS	95%	80%	(15.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	88%	(7.0%)	95%	90%	(5.0%)	95%
Monitor							
EBITDA %	3.5%	1.6%	(1.9%)	3.8%	3.3%	(0.5%)	6.6%
EBITDA on plan	879	397	(481)	2,895	2,477	(418)	0
Net Surplus	(539)	(778)	(239)	(1,359)	(1,593)	(234)	3,050
Return on Assets	-0.34%	-0.49%	(0.2%)	-0.34%	-0.49%	(0.2%)	5.10%
Liquidity Days	0.50	0.50	0.0	0.50	0.50	0.0	0.52
Continuity of Service Risk Rating		3.5			3.5		4

- In month and YTD overall position is £0.2m adverse to plan.
- On-going pressures are:
  - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover the vacancies.
  - Transition to the revised operational model (Modernisation)
  - Management of operational staff – especially relief factor
  - CIP delivery in some areas
- Cash is £8.9m above plan. This is mainly due to an increase in trade and other payables and lower than planned capital expenditure from 2013/14.
- The EFL variance is due to higher than planned cash balances and PDC funding for the CommandPoint capital project not having been received due to a delay in the application for funding.
- The Trust would expect to score a Continuity of Service Risk Rating (CSRR) of 4 against the current Monitor metrics (maximum rating).
- CRL position – The capital plan is currently £5.8m behind plan due to programme delays but capital expenditure is expected to accelerate in the latter part of the year.

Statement of Comprehensive Income

2014/15 - Month 3			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Income				
21,531	21,513	(18)	Income from Activities	65,326	65,276	(49)	263,370
3,336	3,311	(25)	Other Operating Income	10,018	9,681	(337)	38,605
24,867	**24,824**	**(42)**	**Subtotal**	**75,343**	**74,957**	**(386)**	**301,976**
			Operating Expense				
18,094	17,770	324	Pay	54,750	53,855	896	214,061
5,894	6,657	(763)	Non Pay	17,698	18,625	(927)	67,849
23,988	**24,427**	**(439)**	**Subtotal**	**72,448**	**72,480**	**(32)**	**281,910**
879	**397**	**(481)**	**EBITDA**	**2,895**	**2,477**	**(418)**	**20,066**
3.5%	1.6%	1.9%	**EBITDA margin**	3.8%	3.3%	0.5%	6.6%
			Depreciation & Financial				
1,111	837	274	Depreciation	3,334	3,058	275	13,334
301	321	(20)	PDC Dividend	902	963	(61)	3,607
6	18	(12)	Interest	18	49	(30)	74
1,418	**1,176**	**242**	**Subtotal**	**4,254**	**4,070**	**184**	**17,016**
(539)	**(778)**	**(239)**	**Net Surplus/(Deficit)**	**(1,359)**	**(1,593)**	**(234)**	**3,050**
-2.2%	-3.1%	1.0%	**Net margin**	-1.8%	-2.1%	0.3%	1.0%

- The YTD result is £0.2m adverse against the planned deficit of £1.4m

Income

- YTD £0.4m adverse from plan. Primary reasons are uncertainty in some income streams (e.g. LETB funding shortfall of £0.1m against planned income of £0.25m), Lower than planned 111 (£0.2m) and PTS Income (£0.2m) offset with cost reduction. The Trust has also made a small provision for Hospital Turnaround penalties.

Expenditure

- Overall on plan YTD primarily due to Pay underspends.
- Pay is favourable by £0.9m due mainly to frontline vacancies offset by Overtime (Pay) and Private Ambulances (Non Pay).
- EMT has authorised additional spend across Quarter 1 to support performance. This has been funded through releasing reserves and provisions. However, the level of spend seen in month 3 exceeded expectations and as such there is some adverse pressure on the position of £0.2m net.
- This level of spend cannot be maintained beyond Q1 within the scope of this plan and a plan is in place to reduce these costs.
- CIPs are delivering on plan YTD but requires a significant increase to Month 6. Some Programmes will require further development.

Depreciation and Financial

- Currently £0.3m favourable to plan. The depreciation plan is currently under review to finalise actual forecast outturn. This will either be on plan or favourable to plan.

Divisional Expenditure (excludes Income)

2014/15 - Month 3			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Operational Divisions				
13,338	13,971	(633)	Core Frontline	40,464	42,972	(2,508)	157,157
206	231	(25)	Other Frontline	617	880	(263)	2,469
743	680	63	EPRR	2,228	2,255	(27)	8,911
214	1,064	(850)	Resource Centre	641	1,045	(404)	2,564
1,973	1,848	125	EOC	5,919	5,591	327	22,999
534	369	165	PTS	1,610	1,416	194	4,538
598	542	55	111 Project	1,793	1,581	212	7,173
17,605	**18,705**	**(1,100)**	**Subtotal**	**53,272**	**55,741**	**(2,469)**	**205,812**
			Support Services				
1,903	2,292	(389)	Fleet & Logistics	5,722	6,077	(355)	22,562
938	979	(40)	IM&T	2,818	2,745	74	11,081
357	426	(69)	HR	1,070	1,105	(35)	4,279
0	0	0	Education & Development	0	(1)	1	0
830	772	58	Estates	2,491	2,289	202	9,765
36	51	(15)	Support Services Management	108	144	(36)	432
4,065	**4,520**	**(455)**	**Subtotal**	**12,210**	**12,359**	**(149)**	**48,119**
			Corporate				
249	209	41	Chief Executive & Chair	748	652	97	2,810
232	297	(65)	Corporate Services	696	825	(129)	2,743
12	14	(2)	Business Development	37	49	(12)	146
74	81	(8)	Strategic Communication	221	211	10	1,034
217	186	31	Finance	650	611	40	2,599
139	125	14	Nursing & Quality	418	380	38	1,673
163	145	18	Transformation & Strategy	490	440	50	1,959
566	727	(161)	Clinical Education & Standards	1,694	1,731	(36)	6,971
108	93	15	Medical	325	262	63	1,264
1,761	**1,876**	**(115)**	**Subtotal**	**5,279**	**5,159**	**121**	**21,199**
			Central				
1,968	505	1,463	Central Corporate	5,920	3,282	2,638	23,712
7	(3)	10	Other Central Costs	21	11	10	84
1,975	**502**	**1,473**	**Subtotal**	**5,941**	**3,293**	**2,648**	**23,796**
25,406	**25,603**	**(197)**	**TOTAL**	**76,702**	**76,551**	**151**	**298,925**
24,867	*24,824*	*-42*	*Income Memorandum*	*75,343*	*74,957*	*(386)*	*301,976*
(539)	***(779)***	***(240)***	***NET POSITION MEMORANDUM***	***(1,359)***	***(1,594)***	***(235)***	***3,050***

Operational Divisions

- The main driver of performance is Core Frontline; this represents 56% of total Trust expenditure.
- Operations is currently overspent on budget but the additional spend has been planned for and agreed by EMT and mitigated through the release of reserves in Central Corporate.
- Operational Spend is under pressure due to on going high levels of activity, a shortage of substantive staff (leading to a reliance on Overtime and PAS) and transition to a revised operating model. This is the primary reason for the adverse position against plan.
- Overtime has now been largely allocated out to individual stations in Ops. Some overtime does remain in the resource centre hence the £0.4m YTD overspend)
- EOC underspends primarily occur in the Clinical Hub.
- PTS is broadly on plan overall as the reduction in cost (£0.2m) is matched by an equivalent reduction in Overtime.
- The 111 Programme is now included. 111 will report a small surplus as agreed with Commissioners
- 111 Cost offsets with income (other than by the agreed margin with Commissioners)

Support Services

- Support Services is adverse to plan £0.1m YTD due to pressures arising from maintenance on ageing vehicles in Fleet (£0.4m), offset by underspends in Estates (£0.2m) and IM&T (£0.1m)
- Support Services Management contains the Senior management costs for the identified Support Services Sub-divisions

Corporate

- Overall Corporate divisions are £0.1m favourable
- Currently Corporate Services is overspent YTD due to agency costs exceeding vacancies and Staff & Public liability claims. The Trust is currently reviewing the accounting processes around legal cases to mitigate the variation resulting from large one off legal costs.

Central

- Central Corporate includes the Trust's planned and general reserves, financial charges, depreciation and other non divisional costs.
- The favourable variance YTD relates to the release of reserves to support additional front line resourcing. Additional resourcing is due to be scaled back beyond Month 3 and mitigated via the modernisation programme.

Income

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

Statement of Financial Position: YTD

	Mar-14	Apr-14	May-14	Jun-14	Jun-14		
	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000			
Non Current Assets							
Property, Plant & Equip	121,627	120,742	119,923	119,385	118,373	1,012	0.85%
Intangible Assets	12,296	12,088	11,881	11,626	12,945	(1,319)	-10.19%
Trade & Other Receivables	0	0	0	0	0	0	
Subtotal	133,923	132,830	131,804	131,011	131,318	(307)	-9.33%
Current Assets							
Inventories	3,498	3,511	3,508	3,511	3,257	254	7.80%
Trade & Other Receivables	22,804	23,970	14,879	22,641	14,580	8,061	55.29%
Cash & cash equivalents	6,436	13,844	23,964	23,163	14,253	8,910	62.51%
Total Current Assets	32,738	41,325	42,351	49,315	32,090	17,225	125.60%
Total Assets	166,661	174,155	174,155	180,326	163,408	16,918	10.35%
Current Liabilities							
Trade and Other Payables	(22,840)	(31,932)	(31,939)	(37,869)	(28,890)	(8,979)	31.08%
Provisions	(4,750)	(4,750)	(4,750)	(4,750)	(1,272)	(3,478)	273.43%
Borrowings	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,834)	(37,926)	(37,933)	(43,863)	(31,406)	(12,457)	31.08%
Non Current Assets plus/less net current assets/Liabilities	137,827	136,229	136,222	136,463	132,002	4,461	156.68%
Non Current Liabilities							
Trade and Other Payables	0	0	0	0	0	0	
Provisions	(9,114)	(8,217)	(8,327)	(9,347)	(11,170)	1,823	-16.32%
Borrowings	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	(3,099)	(3,099)	(3,099)	(3,099)	(3,099)	0	0.00%
Total Non Current Liabilities	(12,320)	(11,423)	(11,533)	(12,553)	(14,376)	1,823	0.00%
Total Assets Employed	125,507	124,806	124,689	123,910	117,626	6,284	147.35%
Financed by Taxpayers Equity							
Public Dividend Capital	62,516	62,516	62,516	62,516	63,766	(1,250)	-1.96%
Retained Earnings	22,674	21,973	21,856	21,077	19,237	1,840	9.56%
Revaluation Reserve	40,736	40,736	40,736	40,736	35,042	5,694	16.25%
Other Reserves	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	125,507	124,806	124,689	123,910	117,626	6,284	23.85%

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

Non current assets

- Non current assets stand at £131.0m, a £0.3m reduction against plan.
- The movement from plan is related to variances between the plan (set in February 2014) and the actual year end position following the property revaluation exercise carried out at the year-end. Fixed assets increased by £7.7m. This increase was off-set by a £5.8m lower than planned capital spend in 2014/15, depreciation charge £2.5m above plan in 2013/14 and £0.3m depreciation below plan in 2014/15.

Current assets

- Current assets stand at £49.3m, a £17.3m increase against plan.
- Cash position as at June is £23.2m, a £8.9m increase against plan. This is due to a higher than planned trade & other payables and provision balances , and lower than planned capital spend in both 2013/14 and 2014/15.
- Receivables (debtors) are £6.6m above plan , accrued Income (£1.6m) is below plan and prepayments are £3.0m above plan. Receivables include £7.2m CBRN income invoiced in June offset by improved debt recoveries, plus pre-payments made in 2013/14 to manage the EFL position.

Current Liabilities

- Current liabilities stand at £43.9m, a £12.5m increase on plan.
- Payables and accruals are £3.5m above plan.
- Deferred Income is £5.5m above plan; this includes £7.2m CBRN income for the year to 31/3/15 being raised in June. The Trust has a high volume of unapproved trade payables at £2.2m. Current provisions are £3.5m higher than plan.

Non Current Liabilities

- Non current provisions are £1.8m lower than planned. This is due to a re-allocation of provisions between current and non-current

Taxpayers Equity

- Taxpayers Equity stands at £117.6m, a £6.3m increase on plan.
- PDC is £1.3m lower than planned due to slippage on the capital programme. PDC was the budgeted source of funding for the CommandPoint capital project.
- The revaluation reserve and retained earnings increase is due to the property revaluation exercise at the 2013/14 year-end. The data was not available when the plan was prepared.

Cashflow Statement YTD

	In Month Movement			YTD Move	YTD Plan	Var
	Apr-14	May-14	Jun-14	Jun-14	Jun-14	Jun-14
	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000
Opening Balance	6,436	13,844	23,964	**6,436**	**6,436**	**0**
Operating Surplus	742	1,327	396	2,465	2,893	(428)
(Increase)/decrease in current assets	(1,179)	9,094	(7,765)	150	4,845	(4,695)
Increase/(decrease) in current liabilities	9,547	(349)	5,638	14,836	5,258	9,578
Increase/(decrease) in provisions	(911)	95	1,006	190	(298)	488
Net cash inflow/(outflow) from operating activities	8,199	10,167	(725)	17,641	12,698	4,943
Cashflow inflow/outflow from operating activities	**8,199**	**10,167**	**(725)**	**17,641**	**12,698**	**4,943**
Returns on investments and servicing finance	(6)	4	(3)	(5)	10	(15)
Capital Expenditure	(785)	(51)	(73)	(909)	(6,141)	5,232
Dividend paid	0	0	0	0	0	0
Financing obtained	0	0	0	0	1,250	(1,250)
Financing repaid	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(791)**	**(47)**	**(76)**	**(914)**	(4,881)	**3,967**
Movement	7,408	10,120	(801)	16,727	7,817	8,910
Closing Cash Balance	**13,844**	**23,964**	**23,163**	**23,163**	**14,253**	**8,910**

The cash balance as at June 2014 is £23.2m, which is £8.9m above plan.

Current assets

- The ytd movement on current assets is £0.2m, a £4.7m reduction on plan.
- Current assets movement was lower than planned due to an increase in prepayments £0.6m and receivables £8.4, offset by a reduction in accrued income £4.3m.

Current Liabilities

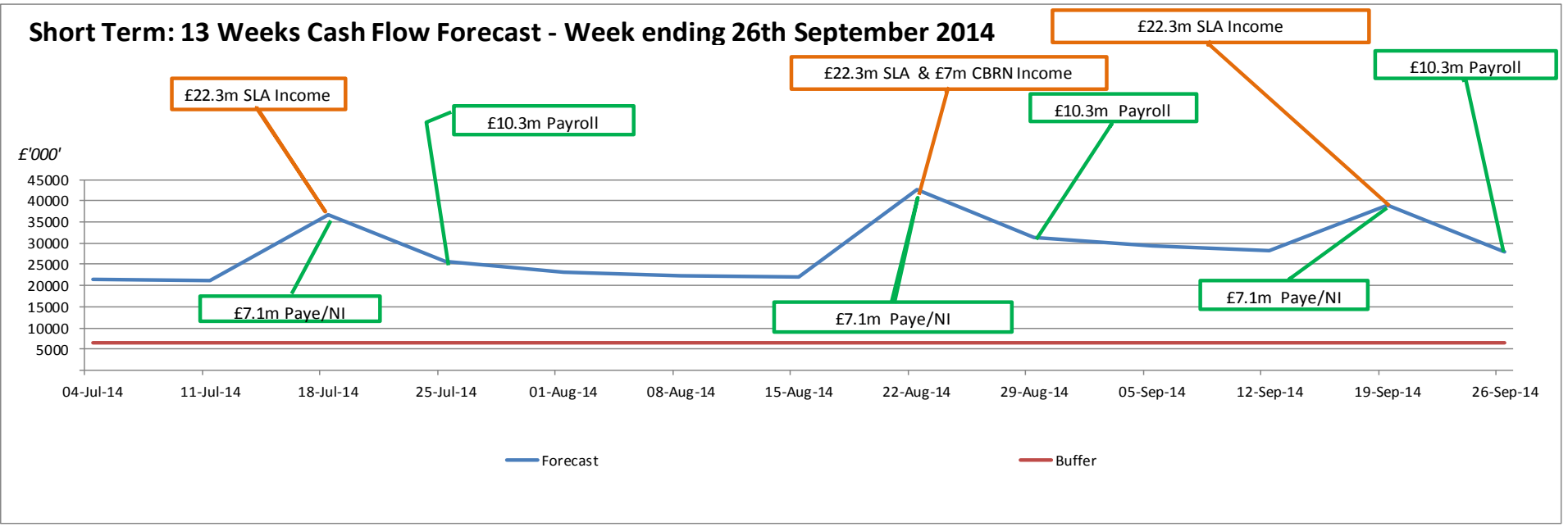
- The ytd movement on current liabilities is £14.8m, a £9.6m increase on plan.
- Current liabilities movement was higher than planned due to increases in trade & other payables £1.0m, accruals £3.0m and deferred income £5.5m. The trust has a high volume of unapproved invoices. The increase in deferred income includes a £7.2m CBRN invoice for the year to 31/3/15 raised in June 2014.

Provisions

- The ytd movement on provisions is £0.5m.
- The movement on provisions is due to the reclassification of accruals for VAT being transferred to the general provision.

Capital Expenditure

- The ytd movement on Capital Expenditure payments is £0.9m, £5.2m lower than plan.
- The lower than planned capital expenditure payments is due to slippage on the 2013/14 capital programme. Capital expenditure at June 2014 is £0.2m.
- The ytd movement on financing obtained is nil, £1.3m lower than planned. The application for PDC funding for the CommandPoint capital project has been delayed.



Short Term: 13 Weeks Cash Flow Forecast - Week ending 26th September 2014

Week Ending	04-Jul-14 Forecast £'000	11-Jul-14 Forecast £'000	18-Jul-14 Forecast £'000	25-Jul-14 Forecast £'000	01-Aug-14 Forecast £'000	08-Aug-14 Forecast £'000	15-Aug-14 Forecast £'000	22-Aug-14 Forecast £'000	29-Aug-14 Forecast £'000	05-Sep-14 Forecast £'000	12-Sep-14 Forecast £'000	19-Sep-14 Forecast £'000	26-Sep-14 Forecast £'000
Bank Balance b/f	**23288**	**21606**	**21262**	**36767**	**25736**	**23193**	**22389**	**22003**	**42521**	**31213**	**29403**	**28173**	**38913**
Receipts													
CCG SLA Income			22915					22316				22316	
Other NHS Related Income	560	1087	1650	160	137	650	1580	7390	160	160	160	640	560
111 Income			615					615				615	
Winter Pressures													
Assets Disposal													
Other Receipts	111	121	3	253	1	126	1	1	251	1	126	1	251
Total Receipts:	**671**	**1208**	**25183**	**413**	**138**	**776**	**1581**	**30322**	**411**	**161**	**286**	**23572**	**811**
Payments:													
Payroll Costs	(80)		(7109)	(9785)				(7109)	(9785)			(7109)	(9785)
Supplier Payments	(1933)	(1542)	(1649)	(1546)	(1542)	(1569)	(1657)	(1545)	(1635)	(1552)	(1515)	(1630)	(1665)
DD's and SO's	(340)	(9)	(306)	(17)	(1139)	(10)	(310)	(36)	(299)	(419)	(1)	(334)	(283)
Capital Payments				(96)				(500)				(500)	
PDC Dividend, Loan Repayments and Interest												(2644)	
111 Pay & Non-Pay Costs			(615)					(615)				(615)	
Winter Pressures													
Other Payments													
Total Payments:	**(2353)**	**(1551)**	**(9679)**	**(11444)**	**(2681)**	**(1579)**	**(1967)**	**(9805)**	**(11719)**	**(1971)**	**(1516)**	**(12832)**	**(11733)**
Net Receipts / (Payments)	**(1682)**	**(344)**	**15505**	**(11031)**	**(2543)**	**(803)**	**(386)**	**20518**	**(11308)**	**(1810)**	**(1230)**	**10741**	**(10922)**
Bank Balance c/f	**21606**	**21262**	**36767**	**25736**	**23193**	**22389**	**22003**	**42521**	**31213**	**29403**	**28173**	**38913**	**27991**

Acronyms

- A&E – Accident & Emergency
- AES – Adult Emergency Services
- BAA – British Ambulance Association
- BETS – Baby Emergency Transfer Service
- BPPC – Better Payment Practice Code
- CBRN – Chemical Biological Radiological Nuclear
- CCG – Clinical Commissioning Group
- CHUB – Clinical Hub
- CIP – Cost Improvement Plan
- CQUIN – Commissioning for Quality & Innovation
- CRL – Capital Resource Limit
- CTA – Clinical Telephone Advisors
- DD – District Details
- DCA – Dual Crewed Ambulances
- DH – Department of Health
- EBITDA – Earning before Interest, Tax, Depreciation & Amortisation
- EBS – Emergency Bed Service
- ECA – Emergency Crew Assist
- ED – Emergency Departments
- EFL – External Financing Limit
- EMD – Emergency Medical Dispatcher
- EMT – Emergency Medical Technicians
- EOC – Emergency Operations Centre
- FIC – Finance Investment Committee
- FRR – Financial Risk Rating
- FRU – First Response Unit
- FYE – Full Year Effect
- HART – Hazardous Area Response Team
- HMRC – Her Majesty's Revenue & Customs
- HR – Human Resources
- I&E – Income & Expenditure
- IFRIC – International Financial Reporting Interpretations Committee
- IM&T – Information Management & Technology
- MPET – Multi Professional Education & Training
- NI – National Insurance
- NTDA – National Trust Development Authority
- OD – Organisational Development
- ORH – Operational Research in Health
- OT - Overtime
- PAS – Private Ambulance Service
- PCT – Primary Care Trust
- PDC – Practice Development Centre
- PMO – Programme Management Office
- PTS – Patient Transport Service
- RFC – Request for Change
- RTA – Road Traffic Incident
- SCBU – Special Care Baby Unit
- SLA – Service Level Agreement
- SO – Specialist Operations Department
- SoCI – Statement of Comprehensive Income
- WCF – Weekly Cash Flow
- WTE – Whole Time Equivalent
- YTD – Year to Date

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR APPROVAL

Document Title:	**Terms of reference – Finance and Investment Committee**
Report Author(s):	**Sandra Adams**
Lead Director:	**Andrew Grimshaw**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**The Trust Board needs to approve the terms of reference of a reporting committee**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the revised terms of reference**

Key issues and risks arising from this paper

1. The Finance and Investment Committee will also have oversight of performance reporting (section 5)
2. Membership has been updated to reflect changes to job titles and to add new members (section 7)
3. The Finance and Investment Committee approved the revised terms of reference on 24th July 2014.

Executive Summary

The Finance and Investment Committee is a reporting committee of the Trust Board with the following purpose:
'The Finance and Investment Committee shall conduct independent and objective review of financial and investment policy and performance.'

The terms of reference have been reviewed and updated to include the committee's oversight of performance reporting and to reflect the changes to the Executive Management Team.

Attachments

Revised Terms of Reference – July 2014

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☐ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☒ Achieve sustainable performance
☒ Develop our 111 service
☒ Simplify our business processes
☒ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Terms of Reference
July 2014
Finance & Investment Committee

1. Authority

The Finance and Investment Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

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

2. Purpose

The Finance and Investment Committee shall conduct independent and objective review of financial and investment policy and performance.

3. Duties

3.1 Financial Policy, Management and Reporting

3.1.1 To consider the Trust's medium term financial strategy, in relation to both revenue and capital prior to its submission to the Trust Board.

3.1.2 To consider the Trust's annual financial targets and performance against them.

3.1.3 To review the annual budget before submission to the Trust Board of Directors.

3.1.4 To review performance against the Cost Improvement Programme focussing on specific issues raised by the Trust Board.

3.1.5 To review proposals and make recommendations to the Trust Board for major business cases and their respective funding sources.

3.1.6 To monitor progress with the capital programme making any recommendations for changes or re-allocation of capital.

3.1.7 To commission and receive the results of in-depth reviews of key commercial issues affecting the Trust on behalf of the board.

3.1.8 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and related contractual risk.

3.1.10 To consider the Trust's tax policy and compliance.

3.1.11 To annually review the financial policies of the Trust and make appropriate recommendations to the Board of Directors.

4. Investment Policy, Management and Reporting

4.1 To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy.

4.1 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and Monitor's requirements.

5. Performance oversight

The proposed remit of the Finance & Investment Committee in respect of this is:

5.1 To review the form and content of the Integrated Performance Report to ensure it is adequately focused and acts to highlight variation from intended performance, the reason for this and action to address it.

5.2 To receive assurance regarding the timeliness, relevance and accuracy of the data included within the Integrated Performance Report together with recommendations for improvement.

6 Other

6.1 To examine any other matter referred to the Committee by the Board of Directors.

7 Membership

7.1 The Trust Board will confirm the membership of the committee which as a minimum shall be:

3 non-executive directors one of whom shall be a member of the Audit Committee and one a member of the Quality Committee;
Director of Finance and Performance (Executive director lead)
Director of Quality and Nursing
Director of Strategy and Transformation
Director of Performance
Director of Corporate Affairs
Director of Support Services
Director of Business Development
Deputy Director of Finance

Voting shall involve both executive and non-executive directors with the Chairman of the committee (NED) having a casting vote in the event of a tie.

8 Attendance

8.1 The committee may invite other Trust staff to attend its meetings as appropriate.

8.2 The Deputy Director of Finance shall be Secretary to the Committee.

9 Accountability

9.1 The Committee will report to the Trust Board of Directors.

9.2 The Executive Management Team will report on finance and investment issues to the Committee.

10 Reporting

a. The Deputy Director of Finance will be responsible for taking the minutes of each meeting of the Committee and for monitoring any action arising from discussion.
b. The Deputy Director of Finance shall maintain the forward planner for the Committee ensuring that key reporting requirements are scheduled in a timely fashion.
c. The Committee will report after every meeting to the next meeting of the Trust Board of Directors, co-ordinated by the Secretary and Chair of the Committee.

11 Administration

11.1 The Secretary of the Committee will take responsibility for agreeing of the Agenda of each committee with the Chair and attendees, collate papers, take minutes and keep formal records of matters arising and issues carried forward.

11.2 The agenda and papers will be distributed 4 working days before the Committee meets.

11.3 Draft minutes and action points will be available to Committee members 7 working days after the meeting.

11.4 Agenda items, papers and updates be submitted to the Secretary 7 working days prior to each committee meeting.

11.5 The Chair and Secretary will decide which papers are tabled at the committee.

12 Quorum

The meeting will be quorate with a two non-executive and two executive members being present. The Chairman can delegate the chair to another non-executive. The executive directors can delegate to a nominated deputy as required.

13 Frequency

A minimum of 3 meetings will be held per year, with additional meetings as deemed necessary.

14 Review of Terms of Reference

14.1 The terms of reference will be reviewed annually and any changes agreed with the Trust Board of Directors.

14.2 In the first year the terms of reference will be reviewed after 3 meetings to ensure they are relevant and appropriate.

14.3 The Chair of the Committee may trigger a review of the Terms of Reference at any time and the Deputy Director of Finance will ensure the initial review and then annual review are scheduled in the Committee's forward planner.

Revised July 2014

Approved by FIC 24th July 2014

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JULY 2014

PAPER FOR INFORMATION

Document Title:	**Modernisation Programme Update**
Report Author(s):	**Jane Chalmers, Director of Modernisation**
Lead Director:	**Jane Chalmers/Paul Woodrow**
Contact Details:	**paul.woodrow@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide an update on the modernisation programme**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note progress to date.**

Key issues and risks arising from this paper

Nil

Executive Summary

This paper provides the Trust Board with an update on:

- The introduction of the Emergency Ambulance Crew (EAC) Role on 21 July
- Delivery of First 9 Week EAC Training Courses for Existing Staff
- Aligning Rosters with Demand
- Extending the Use of Active Area Cover

Attachments

Modernisation Programme Update

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☒ Implement the modernisation programme
☒ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☒ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

MODERNISATION PROGRAMME UPDATE FOR LONDON AMBULANCE TRUST BOARD MEETING HELD ON 29 JULY 2014

Introduction of Emergency Ambulance Crew (EAC) Role on 21 July

1. Following a consultation process with the affected staff (Accident and Emergency Support (A and E Spt) staff and Emergency Medical Technician1s (EMT1s) **the new Emergency Ambulance Crew (EAC) role was introduced to the Service on Monday 21 Jul.**

    - Having analysed the 150 written responses to consultation which were received from staff, it was clear that whilst there were a number questions and concerns which needed to be addressed, the overwhelming majority of staff (423 out of 462 as at 21 July) were willing and able to transition to the new EAC role. It was therefore concluded that the consultation process supported the move to the new role.

2. A total of 241 staff moved to the new role on 21 Jul as Trainee Emergency Ambulance Crew 1 (T/EAC 1). The remainder who wish to move will do so on 8 Sept when the new rosters 'go live.' T/EAC1s can work alongside paramedics

3. As at 21 July only 13 staff have indicated they do not intend to move to the new EAC role. Staff who indicate that they do not wish to transition to the new role will move into the re-deployment process in accordance with the Trust's Management of Change Policy.

Delivery of First 9 Week EAC Training Courses for Existing Staff

4. The first 3 nine week EAC training courses for existing staff started on Monday 14 July at Fulham, Cody Road and New Malden – a total of 37 students. When these students graduate they will be T/EAC2s and will able to work with EMT3s and 4s as well as Paramedics

Aligning Rosters with Demand

5. As previously advised (update to Trust Board on 24 June refers) new front line rosters will be introduced on 8 Sept 2014. These new rosters will better align existing resources with demand. Detailed implementation planning is underway

Extending the Use of Active Area Cover

6. On 1 July 2014, the active area cover period was extended to between 06.00 hrs and midnight from 1 July. The previous hours were between 08.00 hrs and 22.00 hrs.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JULY 2014

PAPER FOR INFORMATION

Document Title:	**Chief Executive Report to the London Ambulance Service (LAS) Trust Board**
Report Author(s):	**Jane Chalmers, Director of Transformation**
Lead Director:	**Ann Radmore, Chief Executive**
Contact Details:	**Jane.chalmers@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To keep the board informed of key issues**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

Nil

Executive Summary

This report covers the following items:

- Additional Funding to Support Operational Resilience and Emergency Care in 2014/15
- Association of Ambulance Chief Executives (AACE)
- NHS Technology Fund Bid – E Ambulance Project
- Meeting with Clinical Commissioning Groups (CCGs) on 30 June 2014
- Statement by Secretary of State for Communities and Local Government (Rt Hon Eric Pickles) on the Fire and Rescue Service

Attachments

Nil

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	Quality Strategy This paper supports the following domains of the quality strategy: ☒ Safety and Standards ☒ Development, Education and Enablers ☒ Effectiveness, Experience and Evaluation
	LAS Objectives This paper supports the achievement of the following objectives for 2014/15: ☒ Improve patient care ☐ Improve recruitment and retention ☐ Implement the modernisation programme ☒ Achieve sustainable performance ☐ Develop our 111 service ☒ Simplify our business processes ☒ Increase organisational effectiveness and development
	Equality Analysis Has an Equality Analysis been carried out? ☐ Yes ☒ No Key issues from the assessment:

CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 29 JULY 2014

1. Additional Funding to Support Operational Resilience and Emergency Care in 2014/15

The Department of Health has announced that an additional £400m of non-recurrent funding will be made available to support operational resilience and emergency care in 14/15 within local health economies. Of this £400m, £50m was to be retained nationally for centrally agreed use

Local health economy plans will need to be produced to secure this funding and these plans will be developed by System Resilience Groups (SRGs) as previously described in the CE Report of 24 June 2014 The Trust is working with all local SRGs in London to ensure that it plays its part in local system resilience and also to ensure that local plans both enable and support the Trusts pan London role as well.

It was announced on 16 July 2014 that £18M of the centrally retained £50m was to be allocated to those Clinical Commissioning Groups who commission ambulance services. The money must be dedicated to supporting ambulance services on the basis of plans that must balance specific actions to address current system pressures whilst encouraging behavioural changes and adoption of new models of care.

The £18m will be allocated to lead CCGs on the basis of call volumes (specifically 999 calls) for the relevant Ambulance Trust.

2. Association of Ambulance Chief Executives (AACE)

The Chief Executive (CE) has been asked to Chair a joint national Working Longer 'Task and Finish' group the membership of which will include senior Trade Union colleagues. The aim of the group will be to;

- Undertake further study of the impact of the ambulance role and working longer
- Develop new ideas on how to support the ambulance workforce into taking up alternatives within the NHS family as they move through life and their careers
- Explore and understand fully the comparison to fire and police colleagues
- Identify excellence in health and wellbeing and how the ambulance community might use this to support the existing and future workforce

3. NHS Technology Fund Bid – E Ambulance Project

The Integrated Digital Care Fund is Phase 2 of the Safer Hospital Safer Wards Technology fund which was announced in 2013. It is expected that this phase of the funding will make available £250m of Public Dividend Capital for NHS Trusts to spend on eligible projects across two years.

The Trust has submitted a bid for £9m of this funding to support the development of the e-Ambulance Project.

- Through a pan London integration, the e-Ambulance project will be the key enabler for the LAS to use and contribute to the integrated care record of patients they serve, providing end to end Emergency and Urgent integration and care.
- The overall aim is that an integrated digital e-ambulance capability will radically improve Emergency and Urgent patient care in the capital through better patient

outcomes, reduced bureaucracy, improved patient safety and back-office efficiencies, and will release savings in the overall London Care system due to reduced ED conveyance

4. Meeting with Clinical Commissioning Groups (CCGs) on 30 June 2014

On 30 June, the Chief Executive and a number Directors met with representatives of the 32 CCGs to jointly review the current performance challenge which LAS was facing. As a result of this meeting, LAS and the CCGs have committed to working together to identify what further actions could be taken at either local or regional level to help reduce demand for LAS services and to provide alternatives to Accident and Emergency Departments for patients where it was clinically appropriate to do so

5. Statement by Secretary of State for Communities and Local Government (Rt Hon Eric Pickles) on the Fire and Rescue Service

On 15 Jul, the Secretary of State for Communities and Local Government issued a written Ministerial statement on the Fire and Rescue Service

Within that statement reference is made to the other emergency services, specifically it refers to

- encouraging greater collaboration between fire and local authorities, and between fire, police and ambulance services to deliver better outcomes for the public

Full details of the statement can be found here:
https://www.gov.uk/government/speeches/fire-and-rescue-services

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Lead Director:	**Richard Hunt/Ann Radmore**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Approval of the monthly self certification requirements for submission to the NHS Trust Development Authority**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the submission of the Board declarations for June 2014**

Key issues and risks arising from this paper

The Trust Board will be held to account by the NHS Trust Development Authority for compliance with the new provider licence requirements and the Board statements.

Executive Summary

The Trust Board is asked to approve submission of the declarations, noting that we are making good progress to achieve full compliance before the end of 2014/15.

1. Board statements

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

The Board is unable to declare compliance with this statement having carefully reviewed performance since month one, together with current trending information for activity and capacity in month three and has put urgent work in train to seek to address issues and produce a revised plan.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☒ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☒ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JULY 2014

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 24th June 2014 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

No new tenders have been received since March 2014.

There have been no entries to the register for the use of the Trust Seal since June 2014.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy:

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

LAS Objectives

This paper supports the achievement of the following objectives for 2014/15:

☐ Improve patient care
☐ Improve recruitment and retention
☐ Implement the modernisation programme
☐ Achieve sustainable performance
☐ Develop our 111 service
☐ Simplify our business processes
☐ Increase organisational effectiveness and development

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

TRUST BOARD FORWARD PLANNER 2014

30th September 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman and Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Friends and Family Test** **Equality and Inclusion Strategy** **Audit Committee Assurance Report** **Annual Audit Letter 2013/14** **Annual Report of the Audit Committee 2013/14** **Finance Report M5** **Report from Finance and Investment Committee**	Modernisation Programme Business planning 15/16 Fleet Strategy including financial implications, assumptions and standards Capital Strategy Estates Strategy Modernisation Programme formal closure report (KB) Recruitment Update	Board Declarations Report from Trust Secretary Trust Board Forward Planner Annual Corporate Social Responsibility Report 2013/14	Quality Governance Committee on 27th August 2014 Audit Committee on 8th September 2014 Finance and Investment Committee on 25th September 2014	

Board Development Session
No board development session – the Trust Board meeting will be followed by the Annual Public Meeting at 14.00 – 16.00

25th November 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman and Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents** **Finance Report M7** **Report from Finance and Investment Committee**	Modernisation Programme Business planning 15/16 Recruitment Update Workforce Strategy Organisation development plan 6 month review of business plan	Board Declarations Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Quality Governance Committee on 29th October 2014 Audit Committee on 10th November 2014 Finance and Investment Committee on 20th November 2014	
Board Development Session					
TBC					

16th December 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman and Chief Executive	**Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Finance Report M8**	Modernisation Programme Business planning and commissioning 15/16 IT strategy Estates strategy	Board Declarations Report from Trust Secretary Trust Board Forward Planner		
Board Development Session					
TBC					

2014 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**29**		**30**		**25**	**16**	9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Strategy Review and Planning	Trust Chair		**25**		**29**					**2**	**28**			9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Annual General Meeting	Trust Chair									**30**				14.00 - 15.30
Annual C/Funds Committee	(NED)													TBC
Remuneration Committee	Trust Chair													TBC
Audit Committee	John Jones (NED)		**3**		**17**	**22**	**2**			**8**		**10**		
Finance and Investment Committee	Nick Martin (NED)	**24**		**20**		**22**		**24**		**25**		**20**		
Quality Committee	Bob McFarland (NED)		**26**		**23**		**18**				**29**		**19**	
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00 (except last Wednesday of the month)**												9.00 - 11.00

London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 29th JULY 2014 AT 09.30 – 13.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.30	1.	**Welcome and apologies for absence** Apologies received from: Karen Broughton Jessica Cecil			
	2.	**Patient Story** To hear an account of a patient story			
09.45	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	4.	**Minutes of previous meetings** To approve the minutes of the meeting held on 24th June 2014	Approval	RH	TAB 1
	5.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.55	6.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	Oral
PERFORMANCE REPORTING					
10.05	7.	**Integrated Performance Dashboard** To receive the integrated performance dashboard	Discussion and direction	PW	TAB 3
10.30	8.	**Board Assurance Framework and Corporate Risk Register** To receive the quarter 2 documents	Assurance	SA	TAB 4
10.45	**BREAK**				
QUALITY GOVERNANCE					
11.00	9.	**Clinical Directors' Joint Report** To note the report from the Joint Clinical Directors	Assurance	SL/FM/ MW	TAB 5
11.10	10.	**Quality Governance Committee Assurance Report** To receive the report from the Quality Governance Committee meeting on 18th June 2014	Assurance	BMc	TAB 6
11.20	11.	**Annual Patient Experience Report 2013/14** To approve the annual patient experience report for 2013/14	Approval	SL	TAB 7

11.30	12.	**Annual Safeguarding Report 2013/14 and Savile Update** 12.1 To approve the annual safeguarding report for 2013/14 12.2 To provide the Trust Board with assurance in relation to the recommendations from recent NHS reports published in respect of the Savile allegations	Approval/ Assurance	SL	TAB 8
11.45	13.	**Annual Revalidation Report** To approve the annual revalidation report	Approval	FM	TAB 9
FINANCE					
11.55	14.	**Finance Report** 14.1 To note the finance report for month 3 14.2 To note the report from the Finance and Investment Committee meeting on 17th July 2014	Discussion and direction	AG NM	TAB 10
STRATEGIC AND BUSINESS PLANNING					
12.05	15.	**Modernisation Programme** To receive an update on the Modernisation Programme	Discussion and direction	PW	TAB 11
12.15	16.	**Recruitment Update** To receive an update on recruitment	Discussion and direction	DP	Presentation
12.30	17.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 12
BUSINESS ITEMS					
12.40	18.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for June and July 2014	Approval	SA	TAB 13
	19.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Compliance with Standing Orders	SA	TAB 14
	20.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 15
	21.	**Questions from members of the public**		RH	
	22.	**Any other business**			
	23.	**Date of next meeting** The date of the next Trust Board meeting is on Tuesday 30th September 2014			
The public meeting will close at 13.00					