London Ambulance Service NHS

NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 25th JUNE 2013 AT 09.00 – 11.30 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from: Richard Hunt – meeting to be chaired by Roy Griffins Caron Hitchen			
9.00	2.	**Staff Story** To hear an account of a member of staff's experience		SL	Oral
9.15	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RG	
	4.	**Minutes of the Part I meeting held on 4th June 2013** To approve the minutes of the meeting held on 4th June 2013	Approval	RG	TAB 1
9.20	5.	**Matters arising** To review the action schedule arising from previous meetings	Information	RG	TAB 2
QUALITY, GOVERNANCE AND RISK					
9.30	6.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	AG	TAB 3
9.40	7.	**Quality Report** 7.1 Quality Dashboard 7.2 Clinical Quality and Patient Safety Report, including Serious Incidents Update	Assurance	SL FM	TAB 4
10.00	8.	**Quality Committee Assurance Report** To receive a report from the Quality Committee meeting on 17th June 2013	Assurance	RG	Oral
10.10	9.	**Quality Account 2012/13** To approve the Quality Account 2012/13	Approval	SL	TAB 5
10.20	10.	**LAS Response to Mental Health and Policing Report** To approve the joint LAS and commissioner response to the Mental Health and Policing Report	Information	SL	TAB 6

10.30	11.	**Board Assurance Framework and Corporate Risk Register** To receive the Q1 documents	Assurance	SA	TAB 7
10.40	12.	**Finance Report** 12.1 Finance Report 12.2 Finance and Investment Committee Assurance Report from the meeting on 20th June 2013	Information Assurance	AG NM	TAB 8 Oral
BUSINESS ITEMS					
10.55	13.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 9
11.00	14.	**Update on Modernisation Programme** To receive an update on the Modernisation Programme	Information	AR	Oral
11.15	15.	**Foundation Trust Update** To receive an update on progress towards authorisation	Information	SA	TAB 10
11.20	16.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for June 2013	Approval	SA	TAB 11
	17.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	Information	SA	TAB 12
11.25	18.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 13
	19.	**Any other business**		RG	
	20.	**Questions from members of the public**		RG	
	21.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 23rd July 2013			

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 4th June 2013 at 10:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Trust Chair
Ann Radmore	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Andrew Grimshaw	Director of Finance
Steve Lennox	Director of Health Promotion and Quality
Beryl Magrath	Non-Executive Director
Nick Martin	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Director of Strategy and Planning
Jane Chalmers	Director of Modernisation
Tony Crabtree	Acting Director of Workforce
Francesca Guy	Committee Secretary (minutes)
Jason Killens	Director of Service Delivery (North Thames)
Bob McFarland	Associate Non-Executive Director
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Paul Woodrow	Director of Service Delivery (South Thames)
Vic Wynn	Acting Director of Information Management and Technology
Members of the Public:	
Colin Hill	Member of the Public
Dr AJ Kirk	
Dr David Zeiderman	
Patient	

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53. Welcome and Apologies

53.1 The Chair welcomed Bob McFarland to the meeting, who had joined the Trust as an associate non-executive director.

53.2 Apologies had been received from John Jones and Caron Hitchen.

53.3 The Chair noted that this was the last Trust Board meeting for Beryl Magrath, since she had completed her 8 year tenure as a non-executive director. The Chair thanked Beryl for her contribution to the Trust over the last 8 years. Beryl responded that she had enjoyed her time at the LAS. She was supportive of the Modernisation Programme and wished the LAS all the best in the future and with the Foundation Trust application.

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54. Patient Story

54.1 The Trust Board was joined by a patient who suffered from asthma. She explained that negative experiences of the ambulance service had led her to use taxi companies to convey her to hospital when she was having an asthma attack. The key issue with calling the ambulance service was that she found herself being asked the same questions by the call taker, first responder and ambulance crew, which was distressing to her given that her asthma attacks made it difficult for her to communicate. The patient also had atypical symptoms and she found that she was often not respected as an expert patient.

54.2 The patient explained that in order to overcome the difficulties in communicating with LAS staff, she had developed an asthma passport together with LAS, A&E staff, other asthma patients and asthma clinicians. The asthma passport had not only helped improve communication, but had also given her back some dignity and control over her situation. The patient had also explored the option of contacting the LAS using the text message service and she had saved a standard text message to her phone to send when she required assistance.

54.3 The Chair noted that this story illustrated the importance of having patient stories at the Trust Board. It demonstrated that the standard way of operating was not effective for all patients, but that simple solutions could be put in place which could improve patient dignity.

54.4 Caroline Silver stated that the concept of the expert patient was well-expressed and very interesting.

54.5 Paul Woodrow stated that patient stories should be put at the heart of student training. The patient responded that this happened at King's College Hospital NHS Foundation Trust.

54.6 Jessica Cecil thanked the patient for taking the time to talk to the Trust Board. It was a very moving story which touched on the issues highlighted in the Frances Report about dignity and putting the patient first. The story also demonstrated the difference that respect made to a patient's health. The concept of the expert patient was also interesting and demonstrated that clinical staff did not always know best.

54.7 The Chair thanked the patient for sharing her story with the Trust Board.

55. Declarations of Interest

55.1 Peter Suter noted that he had a professional relationship with Addenbrookes Hospital, which was part of Cambridge University Hospitals NHS Foundation Trust.

56. Minutes of the Part I meeting held on 26th March 2013

56.1 The minutes of the Part I meeting held on 26th March 2013 were approved.

57. Matters Arising

57.1 The following actions were discussed:

57.2 **131.3:** A proposal on the management of charitable funds was due to be discussed at the Charitable Funds Committee and Audit Committee on 2nd September 2013. The Chair stated that the Trust Board needed to understand the role of the community first responder better and asked for a presentation to be added to the forward planner.

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ACTION: SA/FG to schedule a presentation on community first responder activity into the Trust Board forward planner.

DATE OF COMPLETION: 25th June 2013

57.3 **135.1:** The action to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service was outstanding. The Chair agreed to follow this up with Ann Radmore.

57.4 **15.4:** Fionna Moore confirmed that she had written to Professor Keith Willett, Chair of Domain 3 (Urgent and Emergency Care), within the NHS Commissioning Board, offering to assist with the review of urgent care. Beryl Magrath thought that it was important that the LAS was involved in this review where possible.

57.5 **34.3:** Caroline Silver noted that the index for measuring value for money needed to take into account the matters discussed at the Nominations and Remuneration Committee this morning.

The following matters arising were discussed:

57.6 **31.6:** The Chair noted that the Integrated Board Performance Report had not been included in the Trust Board pack and noted the suggestion made at the last meeting for the report to be viewed electronically. Andrew Grimshaw responded that he was reviewing the format of the report and therefore an abridged report would be tabled at the meeting today. Andrew agreed to circulate the report following the meeting.

ACTION: AG to circulate the integrated board performance report following the Trust Board meeting.

DATE OF COMPLETION: 25th June 2013

58. Report from the Chairman

58.1 The Chair stated that he would take his report as read. The Chair commented that he had previously met with the chairs of the Primary Care Trusts on a regular basis and would need to consider how he would engage with the newly-restructured healthcare system going forward.

59. Integrated Board Performance Report

59.1 Andrew Grimshaw apologised for the late circulation of this report but explained that he was reviewing the performance structure to ensure that these reports could be produced on time in future.

59.2 Andrew noted the following:

- The Trust was performing well on quality;
- Performance was rated amber due to the fact that activity was in excess of expectations, not all of which was related to 111 activity;
- Workforce was an area of major concern, particularly in relation to staff vacancies, sickness absence and staff retention. The executive team was currently seeking clarity around these issues and what actions would need to be taken to recover this position;
- The finance position was broadly in line with the plan.

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59.3 The Trust Board noted that the snapshot report was very helpful in identifying the key issues.

59.4 The Trust Board agreed that Category C performance supported the need for the Modernisation Programme and noted that work was underway to understand the key drivers of demand. Paul Woodrow explained that Category C performance had been particularly poor in the first two weeks of April 2013 due to capacity, however it was now broadly in line with performance trajectories.

59.5 Ann Radmore commented that she would discuss with Paul and Jason the key lessons learnt from quarter 1 and how this would impact on planning for the rest of the year. The 2013/14 contract included a degree of variability and Category C demand was currently at a level that would trigger a discussion with the commissioners about additional funding. Ann added that attempts to control demand in the past had not been successful and therefore the Trust needed to use a different approach.

59.6 Ann reported that the executive management team had discussed the issue of sickness absence at its meeting last week and, whilst the level of sickness absence was lower than other ambulance trusts, it was still too high and was impacting on resourcing. The executive team would report back to the Trust Board on what actions would be taken to address this issue. Tony Crabtree added that this would include a review of the Managing Attendance Policy.

59.7 Ann stated that the Trust also needed to understand the reasons for staff leaving the Trust. Anecdotally, it was understood that two neighbouring ambulance trusts were offering new staff a cash payment. The LAS might therefore need to consider offering staff a retention payment. Jessica Cecil commented that, at a time when the LAS was looking to recruit, it was important to maintain the quality of staff and to ensure that the Trust was not driven by circumstances to cut corners.

59.8 Beryl Magrath asked whether there was any evidence of people joining the LAS from neighbouring ambulance trusts. Tony Crabtree responded that this did not happen often and that generally, the trend was of LAS staff leaving to join neighbouring ambulance trusts.

59.9 The Chair asked for a report on the actions to address workforce issues to come to a future Trust Board meeting.

ACTION: TC to present report on actions taken to address sickness absence to a future Trust Board meeting.

DATE OF COMPLETION: 23rd July 2013

59.10 In summary, Andrew reported that future reports would include more detail and the actions to address the issues highlighted. Sickness absence was a significant issue and was impacting on the Trust's capacity and ability to deliver training. Caroline Silver suggested that the local counter fraud specialist should have this in their line of sight.

60. <u>Quality Report</u>

<u>Quality Dashboard</u>

60.1 Steve Lennox talked through each of the red-rated indicators and gave an explanation of why the target had been missed for each of these areas. Steve noted that the comparison table demonstrated that the LAS was in the upper quartile for the majority of the national clinical quality indicators.

60.2 Roy Griffins questioned how the national performance was reconciled against the red-rated indicators in the quality dashboard. Steve responded that the targets in the quality dashboard were aspirational. However, the Trust Board was concerned, given the number of red-rated indicators, that it would lose sight of the key issues. Sandra commented that there should also be a focus on amber-rated indicators and what action could be taken to stop these becoming red.

60.3 Andrew Grimshaw suggested that there were broadly three different measures of success: the aspirational target; what the Trust was commissioned to do and what the public expected of the service. Andrew was in the process of developing a performance approach which would be presented to the Trust Board in September 2013. The performance approach would need to drive continual improvement.

60.4 Jessica Cecil asked whether the increase in on scene times was something that the Trust Board should be concerned about. Fionna Moore responded that this was a concerning trend and reflected the emphasis to reduce job cycle times and hospital turnaround times. Crews had been reminded to complete paperwork at hospital for time-critical patients.

Clinical Quality and Patient Safety Report

60.5 Fionna Moore reported the following:

- The 2013 UK Clinical Practice Guidelines had been published and circulated to all staff. Training on the new guidelines had been developed and would be rolled out next week. The Trust would go live with the new guidelines on 1st November 2013 at which point a critical number of staff would have been trained;
- CPI completion and compliance rates remained high, with the exception of the Mental Health CPI;
- March and April saw an increased use of the Demand Management Plan, although winter working arrangements were in place throughout March;
- 111 activity seemed to be settling down, although the Trust was still seeing an increase in calls at weekend mornings;
- Since the last Trust Board meeting, 4 serious incidents had been declared and are currently under investigation;
- The Trust had not received any new Rule 43 reports since the last meeting;
- The Trust had attended one problematic inquest, although did not expect to be part of the anticipated Rule 43 report.

60.6 Fionna stated that Category C performance continued to be the biggest concern, although this had stabilised to some extent this quarter. There were also concerns about the levels of training offered to staff, but it was anticipated that some of these concerns would be addressed this quarter.

60.7 Nick Martin asked why compliance with the Mental Health CPI remained low. Steve Lennox responded that a lot of work had been done to improve care to mental health patients, but that there were two measurements in this CPI against which the Trust did not perform well, particularly around safeguarding. Lord Adebowale had written a report on Mental Health and Policing which had made some recommendations around the conveyance of mental health patients. The response to this report would be considered at the Trust Board meeting on 25th June.

60.8 Roy Griffins noted that hospital handover times were currently receiving a lot of press coverage and suggested the Trust needed to ensure that it had sufficient input into these discussions. Ann responded that there were specific handover targets which had penalties attached. The indication from the commissioners was that the penalty fines would be reinvested however there was currently no clarity about how this would work in practice.

60.9 The Trust Board agreed that it needed a further discussion on demand and suggested that this would be aligned with the strategy discussion in September.

> **ACTION:** FG/SA to add demand management to the Trust Board forward planner.
>
> **DATE OF COMPLETION:** 25th June 2013

61. Finance Report

Finance Report

61.1 Andrew stated that the Trust had reported £178k deficit for month 1 which represented an adverse variance of £73k from the financial plan. This was due to higher levels of activity than planned and a slower start to some of the Cost Improvement Programme actions.

Update on the 2013/14 Financial Plan

61.2 Andrew stated that he would take the paper as read. Andrew was keen to ensure that there was ownership of the financial plan throughout the organisation.

Finance and Investment Committee Assurance Report from the meeting on 14th May 2013

61.3 Nick Martin reported that the timing of the Finance and Investment Committee meetings was being reviewed to enable the committee to provide assurances to the Trust Board. It was proposed that the committee would meet monthly for the first 6 months of the financial year. The Finance and Investment Committee had also reviewed its terms of reference and agreed these going forward.

61.4 At the last meeting, the committee had discussed the following:

- The Trust's financial position and noted that activity was above plan and at a level that, if it continued to the end of Q1, would prompt a discussion with the commissioners.
- The financial plan and the Grant Thornton baseline report;
- The monthly submission to the NHS Trust Development Agency. The Trust Board would be asked to approve the process for reviewing and approving future monthly declarations;
- The Fleet Strategy, which outlined a strategy for regular renewals of vehicles, rather than an ad hoc approach.

62. Audit Committee Assurance Report

62.1 Caroline Silver noted that the Audit Committee had met four times since the last Trust Board due to the process around year end procedures. The year end reflected a period of considerable change, with new external auditors and internal auditors and a new local counter fraud specialist. This was also the first year end with East Lancashire Financial Services. The Audit Committee was therefore pleased to report strong performance from the finance team, with the external auditors expecting to be able to give an unqualified opinion on the accounts.

62.2 The Audit Committee had reviewed the Annual Governance Statement and was able to provide the Trust Board with assurance on the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework. The Committee had discussed the fact that the Trust did not have a letter of representation from Peter Bradley and had agreed that, as the Trust Board had had overall responsibility during this period, there was sufficient assurance in place for Ann Radmore to sign the Annual Governance Statement.

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62.3 The Audit Committee had discussed the issues that had arisen in the course of the year end audit and was comfortable that the right approach was to not adjust the accounts. The Audit Committee was therefore happy to recommend the 2012/13 annual accounts to the Trust Board for approval.

62.4 The Chair noted, given the complexities of the year, that this was a very good position. Caroline commended Andrew Grimshaw and the new external auditors and noted that the year end process had been thorough.

62.5 Caroline noted that Andrew had also been working with Sandra Adams and Frances Field to review the governance structure, with a proposal to be presented to the next meeting of the Audit Committee. The Audit Committee would continue to monitor internal controls and the financial maturity of the organisation. The Committee would also be looking to review the charitable funds policy.

62.6 The Chair asked whether there were any issues with fraud. Caroline responded that there was nothing new to report, although there was a very thorough local counter fraud work plan in place.

63. Annual Report and Accounts 2012/13

63.1 Sandra Adams noted that, at its meeting yesterday, the Audit Committee had requested some minor amendments to be made to the Annual Report, which would be incorporated before the report was submitted to the Department of Health.

63.2 Andrew Grimshaw stated that he recommended that the Trust Board accept and sign the annual accounts prior to submission to the Department of Health. The Trust Board approved the annual report and accounts for 2012/13.

64. Draft Quality Account 2012/13

64.1 Steve Lennox reported that this was a draft version of the Quality Account for 2012/13. An updated version would be presented to the next meeting of the Trust Board, incorporating the stakeholder comments. Steve noted that the 2013/14 quality priorities were aligned with the modernisation programme.

64.2 Beryl Magrath stated that it would be useful to explain some of the percentages in real terms.

64.3 Roy Griffins asked for the final version of the Quality Account to be presented to the Quality Committee. Steve agreed, although noted that it would not include the stakeholder comments.

65. Report from Chief Executive Officer

65.1 Ann Radmore noted that her report provided updates on the Care Bill, Listening Into Action Programme, the NHS Trust Development Agency accountability framework; business development and information governance.

65.2 The Chair noted that outcome of the visits to Dubai and India would be discussed in more detail at future meetings as part of a wider discussion about business development.

66. Update on Modernisation Programme

66.1 Ann Radmore reported that the executive team had undertaken a series of staff roadshows and the consultation period had run until 24th May. There had been a lot of interaction with staff and the key issues raised would be considered formally. Consideration was currently being given to how to

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engage with staff on the outcome of the consultation period. The Modernisation Programme was now moving from the planning phase to the delivery phase and meetings were planned with the trade unions in June.

66.2 The Chair asked what issues had been raised by staff. Ann responded that rest breaks had been the most contentious issue, but there had also been an encouraging level of positive discussion around the clinical career structure. Tony Crabtree added that there had been no surprises with the concerns raised by staff as it had been anticipated that rest breaks and annual leave arrangements would be the most contentious issues.

66.3 Nick Martin asked what the reaction of the trade unions had been. Ann responded that the trade unions had welcomed the investment in the service and had asked whether the Trust should be seeking further investment. The trade unions had been advised that no more funding was available and that the LAS needed to do its part to bring about these improvements. The trade unions were currently looking at the individual impact of the changes to annual leave arrangements.

67. Board Declarations – self-certification, compliance and board statements

67.1 Sandra Adams explained that the NHS Trust Development Agency had published a new accountability framework to replace the Standard Operating Model. This would include the monthly submission of a series of Board declarations, the first drafts of which had been reviewed by the Finance and Investment Committee on behalf of the Trust Board. Sandra noted that there were two areas of non-compliance: the first relating to executive director contracts and the second to competition oversight. The Chair stated that the Trust Board needed to have a discussion on competition at a future Trust Board or Strategy Review and Planning Committee meeting and asked for this to be added to the forward planner.

ACTION: SA to incorporate discussion on competition to future SRP or board development session.

DATE OF COMPLETION: 25th June 2013

67.2 The Trust Board retrospectively approved the board statements for May 2013.

37.3 With regards to the process for reviewing and approving future monthly declarations, the Trust Board agreed that, where there was no Board meeting that month, sign off should be by the Executive Management Team in consultation with the Trust Chair. Subject to this comment, the Trust Board agreed the process for reviewing and approving future monthly declarations as set out in the paper.

68. Internal Audit and Local Counter Fraud Specialist

68.1 The Trust Board noted that KPMG had been awarded the contracts for internal audit and local counter fraud services.

69. Report from Trust Secretary

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

70. Forward Planner

70.1 The Trust Board noted the forward planner. The Chair stated that he would review the forward planner with Sandra Adams as part of the review of this meeting.

71. Any other business

71.1 The Chair noted that this was the last Trust Board meeting for Peter Suter as he was leaving the Trust. The Chair noted that the CommandPoint project was an example of a successful system implementation, which could not have happened without Peter. The Chair thanked Peter for his work with the LAS and wished him well in his future role.

72. Questions from members of the Public

72.1 There were no questions from the members of the public.

73. Date of next meeting

73.1 The next Trust Board meeting will take place on Tuesday 25th June 2013. The Chair noted that he would not be able to attend the next meeting and Roy Griffins had agreed to chair the meeting on his behalf.

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Signed by the Chair

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ACTIONS

from the Meeting of the Trust Board held on 4th June 2013

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	AG/SA to review all aspects of charitable funds and to report back to the Trust Board in September 2013.
25/09/12	**135.1**	Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.	**RH**	RH to discuss with AR.
29/01/13	**15.4**	FM/AR to write to Sir Bruce Keogh to ask the LAS to be involved with the review of urgent and emergency services.	**FM/AR**	FM has written to Professor Keith Willett, Chair of Domain 3 (Urgent and Emergency Care) within the NHS Commissioning Board, offering to assist with the review.
26/03/13	**32.5**	FW to ask SL to consider whether there was a qualitative way to monitor comparisons with other ambulance trusts.	**SL**	There is no structure currently in place, although SL is exploring options to do this on a quarterly basis.
26/03/13	**34.3**	EMT to develop an index for measuring value for money.	**AG/EMT**	Proposal to be presented to the Trust Board at end June, following discussion at the Finance and Investment Committee.
26/03/13	**37.5**	CH to ensure that the reporting of near misses was covered in the staff induction.	**CH**	Action taken forward by TC.
26/03/13	**45.2**	FG to add a presentation on the role of Health and Wellbeing Boards to the Trust Board forward planner.	**FG**	Commissioners to be invited to attend the Trust Board to give a presentation on how we are commissioned.
26/03/13	**45.3**	AR to send JC her presentation on the structure of the NHS Trust Development Agency.	**AR**	

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
04/06/13	**57.2**	FG/SA to schedule a presentation on the Volunteer Responder Charity into the Trust Board forward planner.	**FG/SA**	Added to the forward planner for 23rd July.
04/06/13	**57.6**	AG to circulate Integrated Board Performance Report to Trust Board members.	**AG**	Action complete.
04/06/13	**59.9**	TC to present report on actions taken to address sickness absence to a future Trust Board meeting.	**TC**	
04/06/13	**60.9**	FG/SA to add discussion around demand management to the Trust Board forward planner	**FG/SA**	Added to the Strategy Review and Planning Committee agenda for September.
04/06/13	**67.1**	SA to incorporate discussion on competition to future SRP or board development session.	**SA**	Added to the Strategy Review and Planning Committee agenda for September.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE
Trust Board

DATE: 25TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Performance report month 02 (May 2013)**
Report Author(s):	**Andrew Grimshaw, Director of Finance**
Lead Director:	**Andrew Grimshaw, Director of Finance**
Contact Details:	
Why is this coming to the Trust Board?	**To provide the Board with an integrated view on performance.**
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 ☐ Other
Recommendation for the Trust Board:	**The Trust Board is requested to note this paper.**

Executive Summary

This paper provides a summary of the Trust's performance across a range of quality, performance, workforce and finance metrics.

Key issues for the Trust Board

Quality	
Performance	`
Workforce	
Value for Money	

Attachments

Performance Report Month 2 (May 2013)

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

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☒ Helping People
☒ Quality of Life
☒ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
INTEGRATED PERFORMANCE REPORT 2013/14: MAY 2013 (MONTH 02)

Quality		**Largely on plan for the month**
Performance	`	**Activity levels marginally in excess of plan overall, but performance in line with plan.**
Workforce		**Continued high sickness, turnover and vacancies.**
Value for Money		**Some pressures resulting from high abstraction rates. CIP delivery below expectations.**

Summary commentary

Trust's performance remains consistent with last month, April. Operationally, Category A performance remains above plan for the month, with performance being consistently at this level all month. It should be noted that category A activity levels are lower than expected in May. Category C performance has remained largely in line with the levels commissioned. 111 activity is not seen as the major factor in the increase. Overall total incidents are up by 3.86% for the month. Quality measures are largely in line with plan.

Workforce measures continue to show high levels of sickness, increasing to 6.1% in May, with levels in frontline staff increasing to 6.5%. Turnover increased marginally to 9.6%. Vacancies have increased to 9.5% across the Trust, although significant numbers of these are being covered by overtime and the use of agency and contracted staff. These issues are a major concern for the Trust and represent a significant risk to the Trust, both operationally and financially. Increasing recruitment and addressing sickness are a key priority for EMT.Core skill refresher training for operational staff commenced in the last week of MAy and it is intendd to continue at a rate of 90 staff per week across Q2. Compliance measures against this target will appear in next months report.

Financial performance indicates a slight adverse variance from plan, £89k for May. The main reason for this relates to higher than relief (sickness), other abstractions and the slow start to CIP delivery. Cash remains in line with plan. Additional support has been engaged to support the delivery of CIPs.

QUALITY

	Target	Current month	Previous month	Year end forecast
1 Serious Incidents	1	**2**	**1**	
2 Complaints	80	**87**	**87**	
3 Call Answering	95.0%	**99.3%**	**98.5%**	
4 Treatment CPI	95.0%	**98.0%**	**98.0%**	
5 Infection control - hand hygiene	100.0%	**100.0%**	**100.0%**	
6 Infection Control - cleaning	100.0%	**77.9%**	**79.0%**	

PERFORMANCE

	Target	Current month	Previous month	Year end forecast
1 Category A	75.0%	**77.7%**	**75.8%**	75.3%
2 Category C1 (30 mins)	90.0%	**77.5%**	**75.0%**	
3 Cat A total incidents	45,883	**38,014**	**38,206**	
4 Cat A (red 1) incidents	1,376	**1,151**	**1,194**	
5 Cat A (red 2) incidents	44,506	**36,861**	**37,013**	
6 Demand Management Plan (A)		**73%**	**75%**	

WORKFORCE

	Target	Current month	Previous month	Year end forecast
1 Staff retention	8.5%	**9.6%**	**9.5%**	
2 Vacancies (%)	5.0%	**9.5%**	**8.7%**	
3 Vacancies (WTE)	241	**459**	**421**	
4 Sickness all staff	5.5%	**6.1%**	**5.7%**	
5 Frontline sickness		**6.5%**	**6.3%**	
6 Training	tbc	tbc	tbc	

VALUE FOR MONEY

	Target	Current month	Previous month	Year end forecast
1 EBITDA (£000)	2,937	**2,814**	**1,235**	18,450
2 Net surplus (£000)	71	- **18**	- **178**	262
3 Cost Improvement Programme (£(	1,116	**1,014**	**405**	9,800
4 Capital expenditure (£000)	1,304	**116**	**79**	10,250
5 Monitor FRR	3	**3**	**3**	3
6 Cash balance (£000)	16,087	**15,747**	**14,042**	5,500

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25 JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Quality Dashboard**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team (due 26 June) ✓ 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:	For noting

Key issues and risks arising from this paper
Quality of care.

Executive Summary

Structure
The dashboard remains the same but has been reformatted as part of the Francis review to make it clear which indicators are current and which are behind time. The Board are invited to comment on the new formatting.

Quality dashboard
The dashboard illustrates the Trusts performance for April 2013 against the identified Quality measures.

The dashboard illustrates 34 measures for quality and reveals 16 Red, 6 Amber and 12 Green.

The Red indicators are as follows;

On Scene Times
On scene times have seen a small increase with cardiac increasing by 2 minutes to 43 minutes.

STEMI Care
There are no new clinical concerns. Pain relief is the main factor for this indicator beign red (previously discussed at trust Board)

Not Conveyed to A&E
Whilst there has been a slight improvement in see and treat rates (30%) this is still below the 33%

that we have previously achieved.

Airway Management
End Tidal CO2 remains the reason why this indicator is Red. Compliance was at 92% against a target of 95%

Infection Control & Safeguarding
These have been RAG rated RED due to the compliance with training expectations. The programmes have been re-launched in June 2013 and this should improve during the year.

Category C
The heart of the modernisation programme is to reduce the delay to cat C patients. This group of patients continue to wait long times. Cat C3 saw a slight increase in performance during April.

Hospital hand Over
Hospital handover remains an issue across London and work is being undertaken locally and system wide to decrease the delay experience to patients waiting to be admitted to A&E.

Supervision of Staff
PPED numbers are extremely high but OWR remains below target.

Priority Training
CSR has recommenced for 2013-14. Trajectory yet to be established by Training Strategy Group.

Vacancy factor
RAG rated Red for the second consecutive month with a figure of 9.6%

3rd Party Providers
Use of third party providers is above target but this is due to the current vacancy levels.

Sickness
Currently at 5.82%.

Comparison Table
The Trust is currently upper quartile in 13 out of the 23 national clinical quality indicators.

Conclusion
A stable picture with training remaining the main concern but training plans in 2013-14 should address this. An emerging concern is the current vacancy and sickness levels within the Trust and the impact this could have on quality of care (either through staffing levels or increased third party provision).

Non conveyance remains unsatisfactory and concerns about Cat C are familiar to Trust Board but the Modernisation programme should increase our ability to respond better in the future.

Attachments
Response and Executive Summary of Report

****

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

- ✓ Staff/Workforce
- ✓ Performance
- ✓ Environment
- ✓ Experience
- ✓ Helping People
- ✓ Quality of Life
- ✓ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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

2013/14 Priorities
- ☐ Modernisation Programme
- ✓ Communication and Engagement
- ☐ Sustain performance to ensure safe service to patients
- ✓ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ✓ No

Key issues from the assessment:

QUALITY DASHBOARD (APRIL)

APRIL 2013			OLDER (Jan)		
Domain 1. Preventing people from dying prematurely					
DH	Red 1 (A8)	Green	DH	Outcome from cardiac arrest	Amber
DH	Red 2 (A8)	Green	DH	Return of spontaneous circulation	Green
DH	A19	Green	DH	STEMI Care	Red
LAS	On scene Time	Red	DH	Stroke Care	Amber
LAS	Basic Life Support	Amber			
Domain 2. Enhancing quality of life for people with long-term conditions					
DH	Not conveyed to A&E	Red			
LAS	Clinical Performance Indicators	Amber			
Domain 3. Helping people to recover from episodes of ill health or following injury					
DH	Time to Treatment	Green			
LAS	Airway Management	Red			
Domain 4. Ensuring people have a positive experience of care					
DH	Service Experience	Green			
LAS	Incidents	Green			
LAS	Lost Property	Amber			
DH	Time taken to Answer 999	GREEN			
DH	Re Contact Rate	Amber			
DH	calls Abandoned	Green			
Domain 5. Treating & caring for people in a safe environment and protecting them from avoidable harm					
LAS	Infection Control	Red			
LAS	Safeguarding	Red			
DH	A19	Green			
LAS	C1	Red			
LAS	C2	Red			
LAS	C3	Red			
LAS	C4	Red			
LAS	Handover at Hospital	Red			
Domain 7. Caring for the workforce					
LAS	Supervision of staff	Red	LAS	Sickness	Red
LAS	CPI Feedback Sessions	Green	LAS	Temperature Check	Green
LAS	priority Training	Red			
LAS	Vacancy factor	Red			
LAS	3rd Party Providers	Red			

Comparison Chart

	April					YTD	
	Compliance	Rank	Lowest	Highest	Direction of Travel	Compliance	Rank
A8 R1 Response Time	77.60%	3	71.70%	81.90%	↓	77.60%	3
A8 R2 Response Time	82.00%	1	67.10%	82.00%	↑	82.00%	1
A19 Response Time	98.00%	1	96.70%	99.00%	↓	98.00%	1
ROSC (all)	27.60%	5	27.30%	36.40%	↓	30.50%	2
ROSC (Utstein)	52.50%	2	45.70%	63.60%	↓	54.60%	1
Time Taken to Answer 50th Percentile	0.00%	1	0.00%	0.00%	↔	0.00%	1
Time Taken to Answer 95th Percentile	0.01%	1	29.00%	0.01%	↔	0.01%	1
Time Taken to Answer 99th Percentile	0.14%	1	1.46%	0.02%	↓	0.14%	1
Time to Treatment 50th Percentile	5.52	5	6.11	5.36	↓	5.52	5
Time to Treatment 95th Percentile	14.13	2	16.90	12.70	↓	14.13	2
Time to Treatment 99th Percentile	22.12	2	19.40	27.30	↓	22.12	2
Outcome from cardiac Arrest Survival	6.30%	9	6.30%	11.40%	↔	7.80%	4
Outcome from cardiac Arrest Survival (Utstein)	21.40%	7	16.30%	37.00%	↓	26.50%	4
STEMI Outcome 150 minutes	97.90%	2	84.30%	97.90%	↑	92.40%	2
STEMI Outcome Care Bundle	66.50%	10	63.10%	69.20%	↓	67.20%	12
Stroke Outcome 60 minutes	73.20%	3	61.60%	75.80%	↑	68.50%	4
Stroke Care Outcome Bundle	92.40%	11	92.40%	95.70%	↓	93.90%	11
Calls Closed with CTA	6.10%	6	5.30%	6.90%	↓	6.10%	6
Non A&E	30.10%	8	26.60%	33.30%	↑	30.10%	8
Re Contact rate CTA	3.20%	1	3.40%	2.20%	↑	3.20%	1
Re Contact rate See & Treat	6.80%	9	6.80%	4.90%	↑	6.80%	9
Re Contact rate Frequent callers	2.40%	5	2.40%	2.61%	↑	2.40%	5
999 Calls Abandoned	0.00%	1	0.00%	0.10%	↔	0.00%	1
Service Experience							

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Clinical Quality and Patient Safety Report**
Report Author(s):	**Fionna Moore / Steve Lennox**
Lead Director:	**Fionna Moore / Steve Lennox**
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: Elements of this report have been presented to other groups
Recommendation for the Trust Board:	**Information only**

Key issues and risks arising from this paper

- The most recent cardiac, stroke and trauma audit reports have been released.
- The Comprehensive Local Research Network Annual report is appended and the Trust is seen as a high achiever in a number of areas.
- CPI completion remains high for the eighth month running. The Mental Health CPI continues to be an area of real concern for the Trust.
- The most recent patient experiences department report is included which shows a similar number of complaints and queries to previous months.
- A safeguarding conference was held on 5th June which was very well attended and has been evaluated very positively.
- The locality alert register continues to have a similar number of addresses held on it. The number of addresses from the Metropolitan Police Service has risen since January 2013.
- DMP use has remained high throughout the months of April and May which poses some risk as the levels are escalated.
- There have been two medicines management incidents since the last report to Trust Board. Neither were reportable.
- The Trust has received a Rule 43 relating to an incident an HMP Wandsworth. A reply has been composed and is to be sent to the Coroner.

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. The report identifies both areas for improvement and also

success. The Trust Board can be assured that the service is providing high quality care for its patients. However, high utilisation and lack of training for frontline crew staff remains a significant concern.

Attachments

Clinical Quality and Patient Safety Report

****

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

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☒ Helping People
☒ Quality of Life
☒ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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2013/14 Priorities
☐ Modernisation Programme
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Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – June 2013

Clinical Directors' Joint Report

Summary

This report is structured using the Quality Domains of the Quality Dashboard. However, it also reports on issues wider than those measures.

This report identifies both successes and areas where improvement is required. The Trust Board can take some assurance that the service is maintaining a high quality service to its patients. However, there is concern over utilisation and increasing call numbers seen by the Trust in recent months. This concern is coupled with the need for training time and the introduction of the new National Clinical Guidelines and drugs which are due to be released. Without appropriate training time, the release of the guidelines will have to be stalled, as will the implementation of the new drugs the Trust is adopting. This will impact on the care that is provided to our patients.

Quality Domains

Quality Domain 1: Preventing People from Dying Prematurely

The Clinical Audit and Research Unit (CARU) produce quarterly activity updates summarising the progress of projects being undertaken within or facilitated by the unit. The Clinical Audit Activity update summarises the key changes in core clinical audits, continual audit activity, clinical performance indicators (CPIs) and national clinical audits. The Research Activity Update outlines new research projects and changes to active research and non-research projects, as well as any publications.

April's Cardiac Care Pack (Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Report April 2013) has been published. This report is currently only the cardiac arrest data, but will be updated with the rest of the data once it is available. The report can be found at:
Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '13-March '14\Cardiac Care Pack (April '13) - Cardiac Arrest only.pdf

April's Stroke Care Pack (monthly report April 2013) has been published. The full report can be found at:
Clinical Audit & Research Unit\Stroke Reports\Monthly Reports\Apr '13- Mar '14\Stroke Care Pack (April '13).pdf

The quarterly Major Trauma care pack for quarter 3 (October-December 2012) has been released. This details the use of the major trauma decision tree, care given, appropriateness of the destination and times taken to transport and treat these patients. The full report can be found at:
Clinical Audit & Research Unit\Trauma Reports\April '12 - March '13\Major Trauma Care Pack (Q3 2012-13).pdf

Cardiac Care

All the cardiac primary bypass pathways are continuing to be successful and see a good number of patients. Of particular interest:

Emergency Arrhythmia

There is now three months worth of data for this pathway. In total 43 patients have been conveyed (14 per month), so as predicted, small numbers, but a very important group of patients.

- If/when we move to this becoming a pan London service the total should reach around 30 per month i.e. one per day
- Of the 43 patients the break down was as follows:
    - 13 Complete Heart Block
    - 21 Ventricular Tachycardia
    - 9 Multiple shocks
- The LAS overall diagnosis accuracy was 70% which is good
- The difficult clinical group was the Ventricular Tachycardia group – 5 patients who were diagnosed as having Ventricular Tachycardia had Fast Atrial Fibrillation with Left Bundle Branch Block
- Two patients died in hospital – these deaths were related to respiratory failure i.e. co-mobility

Comprehensive Local Research Network (CLRN)

The CLRN Annual Report has been written and is available on request. The document reports on various specified elements, dictated by the CLRN, but shows the Trust as being a high achiever when compared to other ambulance Trusts. A large amount of the Trust's research is not portfolio related, and as such is not reported within the CLRN Annual Report. The Trust has however made a number of research applications recently and if accepted, the figures for research based practice will be further improved in coming years.

Quality Domain 2: Enhancing quality of life for people with long-term conditions

Mental Health

Separate agenda item.

Quality Domain 3: Helping people to recover from episodes of ill health or following injury

Clinical Performance Indicator completion and compliance

The CPI completion rates continue to be high, and this month have improved to 99%. In comparison to April 2012, this is a 13% increase. Completion rates of >95% have been seen for the past eight months. The mental health CPI remains the lowest within the Trust, this month remaining at 88%. This is a concern as this group of patients are potentially very vulnerable and the care we provide them must be seen to improve.

Full CPI reports can be accessed at:

Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2013-14\Monthly Reports 2013-14

CPI Completion April 2012 to March 2013.

Area	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
East	95%	82%	82%	79%	72%	88%	96%	97%	95%	95%	93%	97%	100%
South	67%	46%	42%	62%	87%	99%	98%	98%	100%	100%	100%	97%	100%
West	100%	93%	88%	92%	98%	98%	97%	99%	100%	100%	99%	100%	99%
LAS	**86%**	**72%**	**70%**	**77%**	**87%**	**96%**	**97%**	**98%**	**98%**	**99%**	**97%**	**98%**	**99%**

CPI Compliance April 2013

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	95%	95%	97%	85%	96%	97%
South	97%	96%	97%	98%	88%	97%	98%
West	98%	96%	97%	98%	89%	97%	98%
LAS Total	**98%**	**96%**	**96%**	**97%**	**88%**	**96%**	**97%**

CPI Compliance March 2013

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	97%	97%	96%	86%	97%	97%
South	98%	98%	97%	98%	88%	97%	98%
West	98%	98%	97%	98%	89%	97%	98%
LAS Total	**98%**	**97%**	**97%**	**97%**	**88%**	**97%**	**98%**

Quality Domain 4: Ensuring people have a positive experience of care

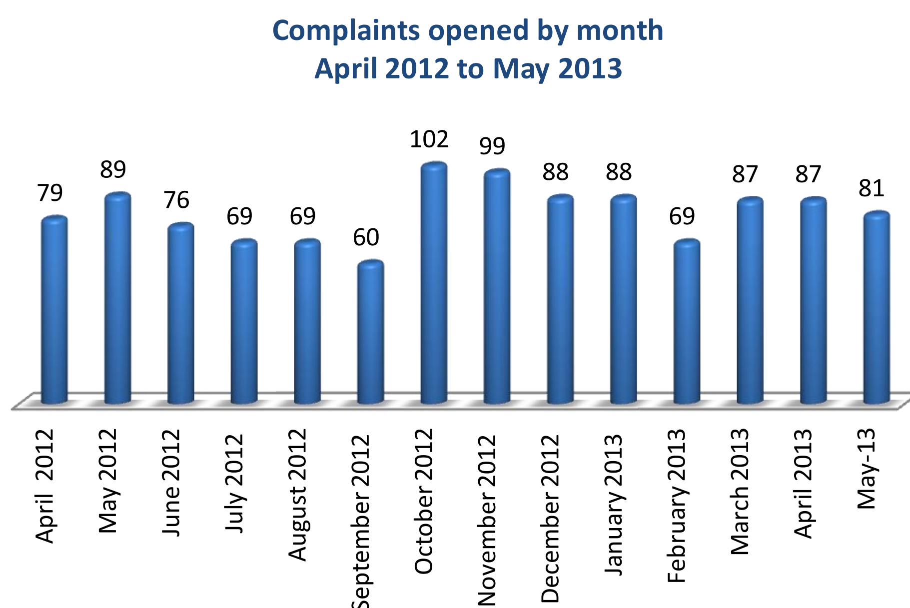
Patient Experiences

COMPLAINTS

Complaint Volume

The number of Complaints received totalled 81, slightly lower than April but reflective of the 2012/113 monthly average.

12 complaints involved other Trusts/agencies including 3 Acute Trusts, 3 x 111 providers and the remainder GPs, CCGs and maternity services.



12 related to driving issues and only one complaint was not our service. 6/81 are closed

Complaint Themes

Complaints relating to the delay and staff attitude & behaviour continue to be the dominant themes. There has been an increase in both this month.

Complaints by subject	April	May
Delay	30	37
Attitude and behaviour	21	26
Road handling	10	12
Treatment	10	2
Non-conveyance	7	0
Conveyance	3	2
Not our service	3	1
High Risk Address Referral	2	1

Patient Injury or Damage to Property	1	0
Totals:	**87**	**81**

Case examples

Validity of 999 call
A patient was upset that the ambulance crew questioned the patient about his symptoms; the patient felt them to be challenging the validity of his 999 call. (C7626). Feedback was provided to the crew about the importance of approaching the triage assessment questioning in a sensitive manner.

CommandPoint interface with MPDS
The Quality Assurances review of this 999 call found that the EMD should have used the 'shift' option to manually select a further option which would have determined a higher category and an ambulance would have been dispatched (C7785). Referred to IM&T who are currently in discussion with Northrup Grumman about CommandPoint specifications. The revised version will resolve this issue by making the call upgrade automatic.

Post Dispatch Instructions
It was identified that post dispatch instruction not to move the patient was literally observed for a lengthy period when there was a delay in an ambulance being sent. (C7791). 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.

Care pathway – Mental Health
Since March 2013 the LAS have had a care pathway agreement in place for patients in the Bexley, Bromley and Greenwich areas who are aged over 18, known to local mental health services and presenting in crisis. Unfortunately, the application remains confused and on this occasion the patient was refused assessment by the m/h provider. The LAS mental health lead is assisting further liaison between both agencies (C7878).

Performance/Quality

84 cases were closed during May. As of 4th June 145 complaints remain open or re-opened. The remainder are under enquiry pending further information from Complexes, the Medical Directorate or the Quality Assurances department. Complainants are advised by email or telephone call whenever a delay in responding is anticipated.

Closure rates year on year (below) show that in 2012 this was 46% closed within time frame and 46% in 2013 although a 35 day minimum has now been allocated, so this is not directly comparable. Similarly, a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = 27 June 2013.

Response time allocated March to May 2012	**Number of complaints opened this period**	**Closed within time frame**
Complaint 25 days	138	80
Complaint 30 days	32	7
Complaint 35 days	56	19

Complaint 40 days	17	7
Totals:	**243**	**113**

Response time allocated March to May 2013	**Number of complaints opened this period**	**Closed within time frame**
Complaint 25 days	5	5
Complaint 35 days	245	110
Complaint 40 days	5	2
Totals:	**255**	**117**

Comeback responses

Year	**Numbers of comeback responses recorded**
09/10	9
10/11	4
11/12	12
12/13	37
13/14	3
Totals:	**65**

In May 2013 there were 3 re-opened cases:

Datix	**Complaint summary**	**Outcome**	**Comeback outcome**
7387	Complaint regarding non conveyance of a patent	Full explanation of care provided and apology for delay in attending.	Further liaison with LAS Consultant Midwife – provided further details and re-iterated recourse availability
7733	Complaint from Acute Trust seeking explanation of delayed response	Initially provided response to hospital who later asked that LAS respond directly to the patient	Response provided to the patient with full explanation and apology
7875	Regular complainant (7 complaints) concerned at attitude of attending crew	Advised that due to the nature of her symptoms which would not be known to all LAS staff consideration for a PSP to be placed on her file	Following further allegations from the patient – we have offered to review the information in patient's PSP

Health Service Ombudsman

Recent activity:

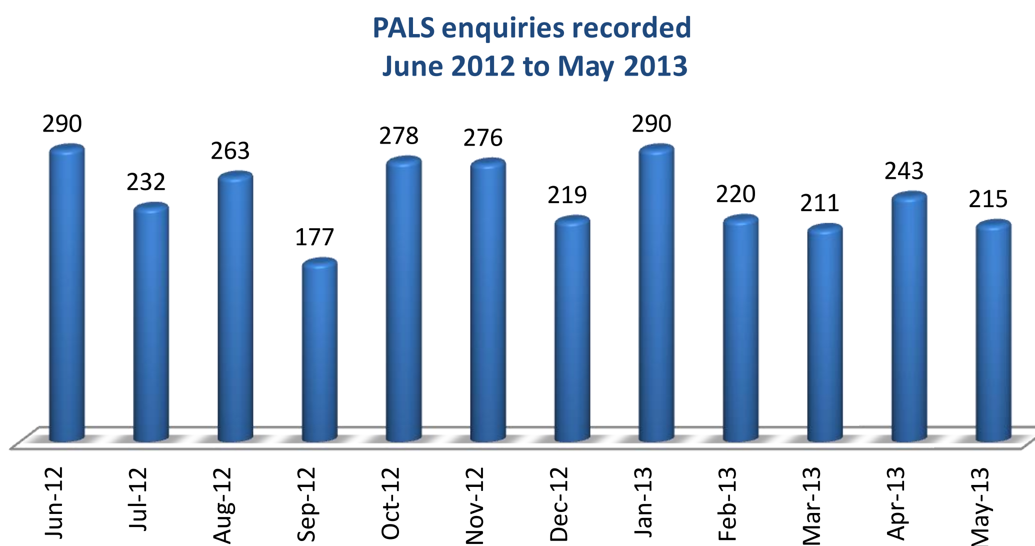
May-13		
Datix reference	**Current status**	**Outcome**
C6614	File requested by PHSO on 25 Feb 2013 – local resolution meeting held prior to this	Letter from Ombudsman 29 May stating that no further action will be taken
C7134	Further letter sent to PHSO clarifying issues 09 Jan 2013	Response awaited from PHSO (acknowledged 15 Jan 2013)
C7425	File requested by Ombudsman 18 March 2013	Acknowledgment from Ombudsman 08 April 2013 –awaiting response
C7461	File requested by PHSO 22/02/13	Letter from Ombudsman 23 May stating that no further action will be taken
C7528	File requested by PHSO 16 April	Documents provided 17 April. Request for DMP process 03 June
C7562	Complainant has approached the PHSO who has informed LAS	File with Ombudsman on 16 April 2013

More detailed analysis of HSC cases will be prepared on a quarterly basis from Q1 2013/14.

PALS

PALS Volume

The number of PALS enquiries remains stable.



The total PALS enquiries received in the past six years is as follows:

Financial Year	Total PALS
08/09	5606
09/10	5674
10/11	6031
11/12	6264
12/13	5714
13/14 (to date)	917
Totals:	**30206**

PALS Themes

Once again, consistent themes about destination hospital, medical record requests, information and requests for policy and procedure.

PALS May 2013	Total
Information/Enquiries	152
Lost Property	51
Appreciation	2
Incident Report - Other	2
Policy/ Procedure	2
Clinical	1
Delay	1
Information Technology	1
Incident Report - Social Care	1
Other	1
Road Traffic Collision/RTC	1
Totals	**215**

Lost property

In May = 51 requests; 7 items were traced by PED and the others referred to local stations. 14 referrals do not have a recorded outcome. The Performance Improvement Managers now have access to the lost property spreadsheet as part of their Quality of Care objective for 2013/14 to monitor lost property and the use of SMARTbags™. PED will provide monthly data for the PIM Top 10 Tracker data in collaboration with IM&T to monitor lost property and resolution.

Quality Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Safeguarding

The safeguarding conference was held on 5 June and was attended by over 100 staff who evaluated the day very positively. The day contained two "patient stories" on surviving abuse and safeguarding and mental health. Both stories had an element of mental health and this is part of the work in place to improve the CPI for safeguarding and mental health across the Trust.
The relocation of all the safeguarding team into the same environment has brought a strengthening to the portfolio and the team are identifying gaps in practice. For example

1. Frequent caller threshold currently felt to be set too low
2. Emergency Bed Service's resourcing is currently acting as a constraint to strengthening the referral process.
3. Difficulty in delivering the Trust guidance on referring non conveyed under 5s to GPs.
4. The issue of MARAC (multi agency risk assessment conference) resourcing is currently unresolved.

These issues will be assess and either replaced on the risk register with appropriate mitigation or be added to the safeguarding action plan.

ORSA (Organisational Readiness Self Assessment)

The ORSA form was submitted prior to the deadline of 10th May 2013 and is available on request.

Our one area of non compliance is the completion of the yearly appraisal on the 4 doctors who work part time for the Emergency Bed Service, all of whom have dates for appraisals.

NHS Central Alerting System (CAS)

There have been 19 CAS alerts from 01/05/2013 to date. Of these, two have relevance to the Trust and have been assessed.

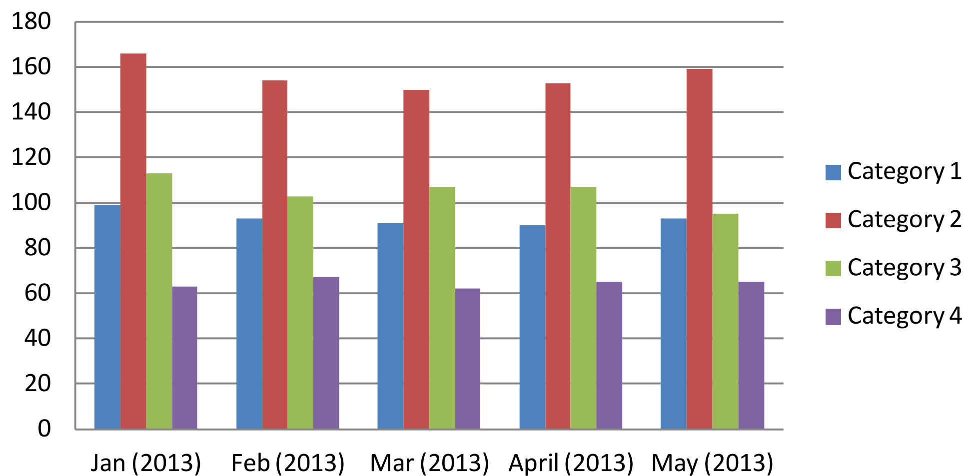
The first relates to a home use blood glucose monitor. Although the Trust itself doesn't use this monitor, it is recognised that on occasion, a crew may use a patient's own monitor instead of a Trust issued one. However, the likelihood of this is low, so the risk to the Trust is also low. The information was sent out to Complex level managers to make staff aware.

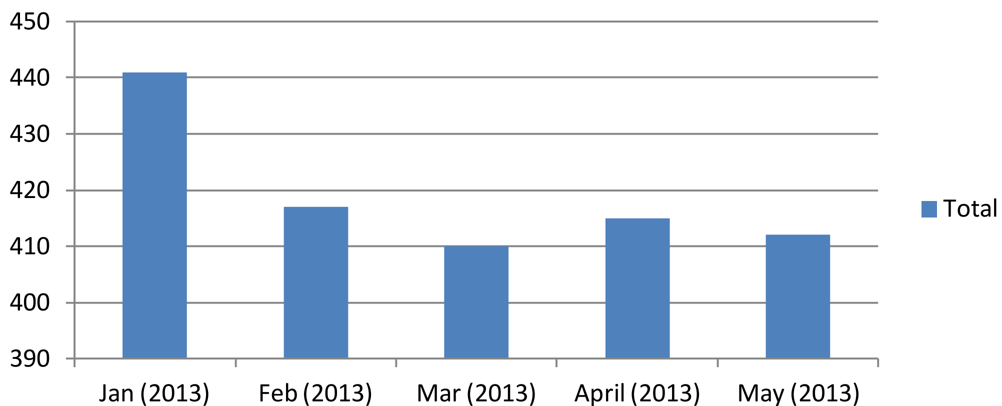
The second relates to the effectiveness of external pacing due to the factory settings of the devices used and the relative low current which is set as a default. This has relevance to the Trust as external pacing is a skill being rolled out to all team leaders. However, the Trust teaches that clinicians should start with the highest setting for current, and then reduce it. This method therefore removes the risk identified.

Locality Alert Register

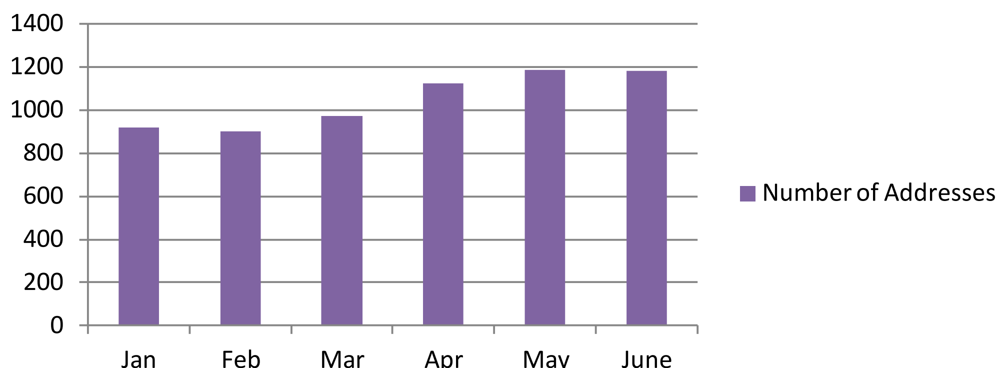
There are currently 412 addresses on the LAR register. These are broken down as follows:

CATEGORY 1: 93
CATEGORY 2: 159
CATEGORY 3: 95
CATEGORY 4: 65





The Trust has notification of 1183 high risk addresses from the Metropolitan Police. Crews are reminded to complete a dynamic risk assessment on their arrival to the address. The number of addresses received from the Metropolitan Police has risen considerably since January 2013.



Demand Management Plan

The purpose of DMP is 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 on occasion where capacity does not exist to absorb unexpected patient demand.
DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement in the Control Room, with clinical 'floor walkers' available to assist call handlers, and by ringing calls back to provide advice, to re-triage and on occasion 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 DMP invoked.

DMP use April and May 2013

Month	Number of Occasions	Stage B (in hours)	Stage C (in hours)	Stage D (in hours)	Stage >D (in hours)	Ambulances reprioritised	No-send at point of contact
April	17	108	79	22	0	4409	1139
May	13	136.5	7	6.76	0	3671	625

DMP use fell slightly from the April implementation of DMP, including falls in both stage C and D. However, the use of stage B has increased significantly. Also of note, the number of ambulances reprioritised both in total and at point of contact fell from the last reported figures.

Medicines Management

There have been no mandatory reportable controlled drugs (CD) incidents since the last report to Trust Board. However, there have been two incidences of morphine being taken home by paramedics with the consequence that the controlled drugs count was wrong. In one of the incidents staff were unsure of how to apply the CD policy, but by good fortune an Assistant Medical

Director happened to visit the Station and robust guidance was immediately given. In the other incident the Home Office and the Metropolitan Police were informed, after a thorough LAS investigation, the two ampoules were returned when a member of staff realised that they had them in their possession and had forgotten to sign them back in to the CD Safe prior to going on a couple of days off. These two incidents in quick succession led directly to the issuing of Medical Directors Bulletin No 126 dated 3rd June 2013.

There have not been any unannounced Visits by the Metropolitan Police, but given the above two incidents the Senior Clinical Adviser to the Medical Director has been in contact with the Metropolitan Police CD Liaison Officer and will be arranging some unannounced visits.

Following on from the item reported in the last medicines management report, we are arranging to have a face to face meeting with Aurum Pharmaceuticals to gain assurances regarding their supply chain and their quality assurance framework(s). This meeting has yet to be set, but it is hoped it will take place in late June.

Education and training on the "New JRCALC" drugs, (Ondansetron, Dexamethasone, Tranexamic Acid & IV Paracetamol), has started and it is intended to place all the new drugs into drugs bags from mid July.

The next meeting of the Medicines Management Group will be held on 24th July 2013.

Rule 43 Reports

The Trust has received one rule 43, not yet reported to the Trust Board.

This incident relates to the death of JB whilst residing at HMP Wandsworth. Both the Trust and HMP Wandsworth received recommendations from the Coroner with regards to the response to the incident in September 2011. The response that the LAS sent was delayed due to the relative inflexibility of the call taking triage system.

The Trust received a recommendation that it reviews its computer triage system (Medical Priority Despatch System (MPDS)) to 'ensure that where a call taker has an honest belief that a call should be prioritised despite insufficient information to satisfy the computer system, that the system can be overridden by the call taker directly, without having to go through multiple other persons and thus cause further delay'.

There were also recommendations that the Trust liaise with HMP Wandsworth to ensure that ambulances are appropriately called in emergencies and that HMP Wandsworth know what information is required by the Trust in order to appropriately triage each call.

The Trust has drafted a response to the Coroner, and has agreed that Commandpoint will be updated so that code 1 and code 2 calls from HMP are recognised and appropriately triaged as red 1 and red 2 calls respectively. The Trust has further agreed to make sure that all HMP within the London area are made aware of this and that they are provided with appropriate information with which to be able to decide on this coding. The Trust confirmed that there is already a system in place for call takers to escalate calls which they feel should be allocated a higher priority and reassured the Coroner that this would be reiterated to the call taking staff via training and bulletins.

Rising Tide

Public Health

The Trust had a measles case in May and as a result guidance has been reissued to staff. A new immunisation policy has been drafted and approved by the Infection Prevention and Control Committee and will be presented to the Senior Management Team for scrutiny and their recommendation for approval.

Clinical Professional Issues

A two week course for clinical team leaders and other clinical managers is being written and planned. All clinical managers will be expected to attend this course over the coming months in order for them to maintain their clinically focused managerial role.

Fionna Moore	**Steve Lennox**
Medical Director	**Director of Quality & Health Promotion**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25 JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Quality Account**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**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 (Commissioner)
Recommendation for the Trust Board:	To approve the response

Key issues and risks arising from this paper

Reputation and partnership working with Metropolitan and City police

Executive Summary

This is the final version of the Quality Account for publication at the end of June 2013.

Changes that have taken place since the previous draft was presented to trust Board
The graph on page 44 has been replaced
Percentages have been quantified on page 18
Paragraphs on Continuous Learning inserted on page 19 (at commissioners request)
Commissioners and stakeholder comments (from page 50)

Once approved this report will be published on NHS Choices.

Attachments

Response and Executive Summary of Report

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

- ✓ Staff/Workforce
- ✓ Performance
- ✓ Environment
- ✓ Experience
- ✓ Helping People
- ✓ Quality of Life
- ✓ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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

2013/14 Priorities
- ☐ Modernisation Programme
- ✓ Communication and Engagement
- ☐ Sustain performance to ensure safe service to patients
- ✓ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ✓ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25 JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Commission on Mental Health and Policing - Trust Response**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**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 (Commissioner)
Recommendation for the Trust Board:	To approve the response
Key issues and risks arising from this paper Reputation and partnership working with Metropolitan and City police	
Executive Summary The Commission on Mental Health and Policing was set up in September 2012 at the request of the Metropolitan Police Commissioner. The Commission's brief was to review the work of the Metropolitan Police Service (MPS) with regard to people who have died or been seriously injured following police contact or in police custody and to make recommendations to inform MPS conduct, response and actions where mental health is, or is perceived to be, a key issue. The commission spent time at the Trust in order to inform its review. Inevitably this has led to a small number of recommendations for the Trust's consideration. These recommendations are extremely challenging to deliver in the current climate and would require a large investment from commissioners. Therefore, the lead Director has prepared a joint response with commissioners that outlines why the recommendations are challenging to implement at the current time. Trust Board is invited to support the response.	
Attachments Response and Executive Summary of Report	

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Quality Strategy
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- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?
- ☐ Yes
- ✓ No

Key issues from the assessment:

Independent Commission on Mental Health and Policing

Report Executive Summary

MAY 2013

Executive Summary

The Independent Commission on Mental Health and Policing was set up in September 2012 at the request of the Metropolitan Police Commissioner. Terms of reference and membership are in Appendix 1.

The Commission's brief was to review the work of the Metropolitan Police Service (MPS) with regard to people who have died or been seriously injured following police contact or in police custody and to make recommendations to inform MPS conduct, response and actions where mental health is, or is perceived to be, a key issue.

While reports like this cannot take away the anguish families have suffered, it is the hope of the Commission, and the duty of those who receive this report, to ensure that the recommendations are implemented in the name of the families as citizens who have lost loved ones in terrible circumstances. By doing so, a level of reassurance can be given to the families that others may not suffer the same loss.

Although the Commission was focused on the MPS, the issues identified are national and the recommendations are likely to be applicable to all forces across the country.

The Commission independently examined 55 MPS cases covering a five-year period (September 2007 — September 2012). As some cases are still to receive judicial findings in those reviewed, we have been careful to avoid making any comments that would prejudice future findings. All cases, therefore, have been made anonymous[1].

We focused on the roles and responsibilities of the MPS in dealing with issues of mental health in custody, at street encounter and in response to calls made to police, including call handling processes when dealing with members of the public where there is an indication of mental health.

Everything which follows in this report must be seen through the lens that mental health is part of the core business of policing. The role of the police is not a clinical one but mental health issues are common in the population and will often be found in suspects, victims and witnesses. A person may commit an offence or cause a public disturbance because of their mental health issues. In addition, the police may be first on the scene of a person in mental health crisis or a potential suicide. It therefore cannot be a periphery issue, but must instead inform every day practice. As existing guidance[2] states: 'Given that police officers and staff are often the gateway to appropriate care — whether of a criminal justice or healthcare nature — it is essential that people with mental ill health or learning disabilities are recognised and assisted by officers from the very first point of contact. The police, however, cannot and indeed are not expected to deal with vulnerable groups on their own.'

Findings and evidence from case reviews, surveys, meetings and visits

The shortcomings in the police performance are the primary focus of attention in this inquiry. In many instances this is an issue of the systems and procedures as well as the behaviour of individual police officers. There are also issues identified in regards to how the MPS and other agencies, including the NHS and social services, work together and how roles and responsibilities are handled when responding to a situation involving an individual's mental health. For example, during the course of our meeting with the London Ambulance Service (LAS) we were told that their protocol states that if the call is in regards to someone with a mental health issue and the Police are on site, the priority is reduced for the LAS to attend.

It is important to note at the outset that in the case reviews we also found instances of prompt, efficient and expert responses to people with mental health issues.

Based on the Commission's review of the evidence a number of findings are highlighted, namely;

1 Cases within the report are referenced by numbers, rather than initials, to protect the identity of the individuals and families involved.

2 Joint ACPO/NPIA/DH guidance (2010) 'Responding to people with mental ill-health or learning disabilities.

Findings and evidence from case reviews, surveys, meetings and visits

1. Failure of the Central Communications Command to deal effectively with calls in relation to mental health
2. The lack of mental health awareness amongst staff and officers
3. Frontline police lack of training and policy guidance in suicide prevention,
4. Failure of procedures to provide adequate care to vulnerable people in custody
5. Problems of interagency working
6. The disproportionate use of force and restraint
7. Discriminatory attitudes and behaviour
8. Failures in operational learning
9. A disconnect between policy and practice
10. The internal MPS culture
11. Poor record keeping
12. Failure to communicate with families

Summary of Recommendations

The Commission's findings lead to 28 recommendations for change, falling under three areas for action:

- Leadership
- On the frontline
- Working together: Interagency working

LEADERSHIP

Mental health is core business and needs to be reflected in all policy, guidance and operating procedures;

Recommendation1: Implementation of the One Met Model for policing in London should reflect, at all levels, in day to day police business, the impact of mental health for vulnerable adults who are at risk.

Recommendation 2: The MPS should include a mental health-specific indicator as part of performance measurement of the 20% Mayor's Office for Police and Crime (MOPAC) target for improving public confidence.

Recommendation 3: MOPAC should hold the MPS to account for identification and delivery of a mental health specific performance indicator within the 20% MOPAC target.

ON THE FRONTLINE

Skills, awareness and confidence of frontline staff need to improve in regards to mental health and the MPS must become a learning organisation;

Recommendation 4: The Mental Health Liaison Officer (MHLO) role should be full time to at least co-terminous levels with mental health trusts and supported by expert teams based on assessment of local needs.

- The MHLO role should have explicit and accountable links with external agencies, including the NHS, Local Authorities and the voluntary sector.

- The MHLO role should be integrated and supported throughout the MPS, including with frontline police officers and neighbourhood teams.

- The MHLO role should be operationally accountable at senior management level; and should include provision for continuing professional development.

Recommendation 5: The MPS Commissioner should take personal responsibility for devising and implementing a strategy to ensure that the culture and working practices of the MPS demonstrably promote equality in relation to those with mental health conditions. This should include devising a strategy with key milestones and providing annual reports on progressing this strategy. This report should also detail complaints concerning the treatment of people with mental health conditions and action taken to address them.

Recommendation 6: The MPS needs to implement an organisational learning strategy in order to give lasting effect to the recommendations of external bodies, and the key findings of internal reviews. This strategy should include a named lead and clearly defined timeframe for implementation and review, ensuring that responsibility for the implementation process resides at Commander level and not within each business group.

Recommendation 7: The MPS should ensure that personal issues of mental health and wellbeing are incorporated into staff induction, and ongoing mental health awareness training.

- The MPS should ensure that processes for debriefing and supervision enable police officers and staff to discuss issues of concern and stress which may relate to their own mental wellbeing.

- The MPS should ensure that occupational health policies and procedures enable all frontline staff to access appropriate mental health support, without recourse to stigma or discrimination, if a need is identified.

Recommendation 8: The MPS should establish a high level expert group of stakeholders that can provide the MPS with ongoing and specific advice and review; which are aimed at improvements in outcomes with regard to race, faith and mental health. This group should report to the Commissioner.

Recommendation 9: That the MPS should create a comprehensive suite of mandatory training for staff and officers developed in partnership with experts, including from the voluntary sector, and individuals with mental health needs. This programme should be developed in conjunction with the London Mental Health Partnership Board; College of Policing and be independently evaluated.

Recommendation 10: The MPS should seek external experts in mental health to assist in the routine review of guidance, SOPs and information materials. This review should be a public report, available on the MPS website and submitted at six-monthly intervals to the London Mental Health Partnership Board.

Recommendation 11: The MPS should adopt a corporate approach to suicide prevention with both a strategic and operational focus. Suicide prevention training and guidance must be put in place immediately with the advice and assistance of external stakeholders.

The police need to develop a safer model of restraint

Recommendation 12: The MPS has to work with ACPO and the College of Policing on policy and training on restraint to ensure that the principles outlined in this report are enforced or utilised.

Better information and IT systems are needed

Recommendation 13: The MPS information systems need to be improved to provide:

- A central intranet depository to collect policies and protocols information, advice, news on mental health issues to be a resource to police officers and staff; and
- A centralised database and paper based collection of all internal and external case reviews involving mental health.

Recommendation 14: A new process needs to be introduced in the review of standard operating procedures and policies with relevance to mental health so that stakeholders from the statutory and voluntary sectors are involved as partners in the process.

Recommendation 15: Establish a system on Merlin for vulnerable adults which includes both a mechanism to record and a mechanism to refer incidents involving adults in mental distress.

Recommendation 16: The MPS should invest in technology for CCC which is fit for purpose.

- Guidance and protocols on vulnerable persons and mental health at CCC should be reviewed in collaboration with external sources, including service users and carers, as well as voluntary sector agencies, to improve their effectiveness at identifying relevant issues.

- Within the bounds of confidentiality information about carer/ family member and a health support person should be captured.

Improved health care in custody must be assured

Recommendation 17: Mental health nurses with experience related to offenders must be available to all custody suites as required. The MPS should conduct a 360 degree review every six months to ensure that they are accessing the proper advice from psychiatric nurses in the delivery of health care in custody suites.

Recommendation 18: Practices and policies in custody suites must acknowledge the needs of people at risk on grounds of their mental health issues as part of pre release risk assessment and take appropriate steps, to refer them to other services and to ensure their safe handover to relatives, carers or professionals.

Recommendation 19: The MPS should adopt the Newcastle health screening tool or one that meets the same level of effectiveness for risk assessment in all custody suites.

Recommendation 20: The MPS Commissioner should publish a public report on the care of people with mental health and drug or alcohol conditions in custody suites, the referral pathways and the outcomes of pre release risk assessments.

Recommendation 21: The MPS should transfer commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS.

WORKING TOGETHER: INTERAGENCY WORKING

There needs to be more effective interagency working

Recommendation 22: The Mental Health Partnership Board should have formal recognition and mandate specifically agreed with NHS England, the MPS, the Association of Directors of Adult Social Services (ADASS) and Mayor's Office for Police And Crime (MOPAC) as part of the Mayor's accountability for health. This would constitute a central oversight mechanism for improving mental health and policing in London.

Recommendation 23: NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:

- No person is transferred in a police van to hospital;
- Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car; and
- That demand management systems of the LAS be reviewed, and changes implemented in order to ensure parity of esteem between mental and physical health.

Recommendation 24: NHS England should work with Clinical Commission Groups to ensure sustainable liaison psychiatry services are set up, which are based on and reflect the needs of local populations.

Recommendation 25: The MPS should:

- Establish joint protocols to identify a basis for effectively sharing information London-wide with partner agencies for adults at risk with mental health problems;
- Work with the Mental Health Partnership Board to establish a multiagency mechanism for risk assessing, case managing and information sharing in relation to people with mental health problems who are perceived to be at high level of vulnerability.
- Ensure senior and authoritative representation on the Local Authority-led multiagency Adult Safeguarding Partnership Boards.

Recommendation 26: The MPS and its NHS partners should immediately implement the Bradley Report recommendation so that all police custody suites should have access to liaison and diversion services.

Recommendation 27: The MPS should urgently work with local authorities and mental health trusts to ensure existing protocols and procedures for information sharing; risk assessment and management are adhered to and monitored. This should include taking account of local authority led strategic safeguarding structures to promote public safety and wellbeing.

Recommendations 28: The MPS should agree protocols for joint working on service provision with reference to AMHPs, emergency duty teams and wider social care services.

Conclusion

If all our recommendations are implemented, it is the view of the Commission and the collective conclusion from our recommendations that the events that informed this inquiry, are far less likely to happen in the future.

We therefore hope the Commissioner takes on board these recommendations as a priority and implementation is seen within the timeframes we have outlined in this report.

Independent Commission on Mental Health and Policing Report

Published May 2013

Response to Independent Commission on Mental health and Policing Report

The London Ambulance Service supports the initiative to make improvements to the care and treatment of patients with mental illness in London.
The terms of reference of Lord Adebowale's independent commission was to address the matters of police intervention and in particular those of mental illness in:

a) custody
b) At street encounter
c) Call handling

As the London Ambulance Service is frequently involved in the first two areas we were also consulted upon and consequently there are recommendations for the London Ambulance Service to consider within the report.
This is the response to those recommendations that have a direct relevant to the ambulance provision..

Recommendation 22

The Mental Health Partnership Board should have formal recognition and mandate specifically agreed with NHS England, the MPS, the Association of Directors of Adult Social Services (ADASS) and Mayor's Office for Police and Crime (MOPAC) as part of the Mayor's accountability for health. This would constitute a central oversight mechanism for improving mental health and policing in London.

The London Ambulance Service agree that partnership working is a key ingredient to making improvements and we are currently represented at the identified Partnership Board. However, whilst the Mayor has a responsibility for the health of Londoners our parent authority is our commissioner. We are of the view that we are accountable to the public and welcome the suggestion that we could be held to account more widely. But we can not support the Mayors office to offer instruction to the Ambulance Service. This must come from our commissioners.

We would see this working similarly to a children's safeguarding board where the model has been working for a number of years.

Recommendation 23

NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:

- **No person is transferred in a police van to hospital.**

Whilst the London Ambulance Service agrees with the sentiment of the above recommendation we feel we are not able to support the implementation of this recommendation for the following reasons:

- We agree that it is inappropriate to treat people with mental health problems as a criminal by locking them in the back of a Police van. However, there are other ways that patients can be managed.
    - Where a patient's need is to be 'transport to a clinical service', as opposed to needing clinical 'treatment en route to a clinical service', then arguably there are more choices available, such as use of a Police car, or potentially other types of transport service that avoid the need for the

patient to be locked in the back of a Police van. Clearly if clinical intervention is required then there is a greater need to wait for the ambulance and clinician.

  - If Police are trained appropriately they are also able to participate in the conveyance for suitable people.

- However, we believe that each patient and the presenting risk needs to be managed at that time of presentation rather than be bound by best practice guidance. Whilst we will always aim to deliver best practice there may be occasions when our inability to respond would mean the patient and the risk is better managed through conveyance in a Police owned vehicle than wait for an ambulance.

- An ambulance, due to the equipment and space, is not always the most appropriate vehicle to convey a patient and again this needs to be assessed at the time.

- **Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car: and**

The suggestion of a dedicated mental health response service is attractive. However, we do not believe that this would be cost effective as inevitable the geography and demands of health in London would mean a number of vehicles would be required and inevitably there will be times when the response is simply unavailable or in the wrong part of London. Again, this would require over commissioning. There is a potential that an emergency response could be operated out of a Mental health Patient Transport system but in order to build up sufficient critical mass it would almost certainly require all Mental health Trusts to purchase their transport needs from the same service. This function is of course currently open to competition from other providers.

- **That demand management systems of the LAS be reviewed, and changes implemented in order to ensure parity of esteem between mental and physical health.**

Mental health is not currently managed as a separate process both physical health and mental health are part of the same demand management system. However, we are currently reviewing the way we process calls from the police services and are likely to make changes that will lead to improvements

There is the suggestion that the current categorisation of calls does prioritise physical health conditions that are life threatening or potentially life threatening. There is need for further work and we need to understand how we identify those mental health patients that need a more urgent response; the LAS and commissioners would welcome the opportunity to work with organisations such as Turning Point to find ways that we can be more responsive to the needs of mental health patients.

Recommendation 24
NHS England should work with Clinical Commission Groups to ensure sustainable liaison psychiatry services are set up, which are based on and reflect the needs of local populations.

The London Ambulance Service is supportive of wider availability of psychiatric liaison and direct access to such services would assist us in our work.

Recommendation 25
The MPS should:

- **Establish joint protocols to identify a basis for effectively sharing information London-wide with partner agencies for adults at risk with mental health problems.**
- **Work with the Mental Health Partnership Board to establish a mutiagency mechanism for risk assessing, case managing and information sharing in relation to people with mental health problems who are perceived to be at high level of vulnerability.**
- **Ensure senior and authoritative representation on the Local Authority-led multiagency Adult Safeguarding Partnership Boards.**

The London Ambulance Service is supportive of the above recommendations.

Recommendation 26

The MPS and its NHS partners should immediately implement the Bradley Report recommendation so that all police custody suites should have access to liaison and diversion services.

The Bradley Report was the result of an independent review of the experience of people with mental health problems and people with learning disabilities in the criminal justice system. We believe NHS commissioners are better placed to make comments on this specific recommendation.

Recommendation 27
The MPS should urgently work with local authorities and mental health trusts to ensure existing protocols and procedures for information sharing; risk assessment and management are adhered to and monitored. This should include taking account of local authority led strategic safeguarding structures to promote public safety and wellbeing.

The London Ambulance Service is supportive of the above recommendation.

Recommendation 28
The MPS should agree protocols for joint working on service provision with reference to AMHPs, emergency duty teams and wider social care services.

The London Ambulance Service is supportive of the above recommendations.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Board Assurance Framework and Corporate Risk Register – June 2013**
Report Author(s):	**Sandra Adams, Director of Corporate Services**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Good governance – providing assurance to the Trust Board on the identification and management of risk and the sources of assurance that these are operating effectively.**
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 review the key risks and mitigations in place to manage these and to confirm whether there is sufficient assurance in place.**

Key issues and risks arising from this paper

a) One new risk added to the BAF for 2013/14
b) One risk removed from the BAF following amalgamation with a similar risk and a lower severity rating agreed
c) Progress against the CQC compliance issues incorporated
d) Review dates, new controls or issues have been highlighted in yellow

Executive Summary

The commentary on page 1 of the BAF identifies one new risk identified, articulated and assessed during Q1 2013/14 which reaches the threshold of gross rating of >20.

The CQC inspection report was published in December 2012 and the Trust submitted action plans for the two outcomes where non-compliance was identified. Page 2 of the BAF provides an update on progress as discussed with the CQC at a review meeting on 12th June.

The 2013/14 improvement priorities are now included in section A and have been mapped to the strategic goals, risks and themes. The Modernisation Programme is referred to throughout and the 7 key financial risks are also referred to. Risks relating to the communication and engagement improvement priority are yet to be identified and articulated. Those relating to category A & C performance are already included in the BAF as appropriate.

The BAF continues to be a dynamic document that is intended to bring to the Board's attention the progress on risks, mitigating actions and controls, and to identify where the Board can seek assurance on the effectiveness of these.

Attachments

Board Assurance Framework – June 2013; Corporate risk register – June 2013.

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☒ Helping People
☒ Quality of Life
☒ Preventing Death

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☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?
☐ Yes
☒ No – not applicable to this document.

Key issues from the assessment:

Board assurance framework
June 2013

The Board Assurance Framework (BAF) comprises the principal risks facing the Trust in 2013/14 and looking ahead within the strategic period 2013-18. The BAF is structured as follows:
Section A: Trust Vision – strategic goals – corporate objectives – strategic risks. The 2013/14 improvement priorities are now mapped across to the strategic goals and risks.
Section B: The key risk themes identified by the Trust Board for focus over the next two years. This section now includes the sources of assurance.
Section C: Key sources of assurance common to most corporate risks
Section D: The principal risks with relevant controls, assurances, gaps and action planned, each mapped to the corporate objectives and the requirements of the Care Quality Commission. Principal risks as defined here are those that have a gross severity rating (likelihood x impact) of >20, and a corresponding net rating of >15 as at 12th June 2013.

Commentary:

Risks closed in Q1 BAF:
There was one risk removed from the BAF: risk ID 327: re-use of linen/infection prevention and control guidelines. The risk has been merged with that of risk ID 322 and this has brought the risk severity rating to a level below the BAF threshold.

Risks opened in the 2013/14 BAF:
There in one new risk on the BAF in this quarter.

Risk 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.*
Controls and mitigating actions are in place.

The following risks are presented as agreed by the Trust Board in November 2012 although they do not reach the threshold for inclusion in the BAF:
Risk 369: there is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level. Gross impact – Major/Gross likelihood – Possible = 12.
Risk 370: there is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles. Gross impact – Major/Gross likelihood – Possible = 12.
Both risks are supported by mitigating actions and have been reviewed and updated for the June 2013 risk register. Further assurance was gained from the report on the refresh review of the board governance assurance framework and the action plan was reviewed by the Trust Board on 4th June 2013.

The CQC undertook an unannounced compliance review on 14th November 2012 and identified two areas of non-compliance requiring action: Staffing – moderate impact on patient care (risk 355 applies); and Equipment – minor impact on patient care (risks 352, 186, 303, 366 and 367 apply). Action plans have been submitted for both and are actively monitored by the Executive

Management Team. Progress was discussed with the CQC team on 12th June and is reported below. The CQC will be inspecting the LAS again during 2013/14 and will review compliance against these outcomes and the action plans as part of that visit.

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment
How the regulation was not being met:
Ambulances were not all suitably equipped to meet the care needs of people using the service.
June 2013 position 1. New LP1000 on every new Skoda FRU 2. 66 new ambulances in 2012 equipped with new LP1000 3. 160 LP1000s on older model FRUs 4. 400 new LP1000s are currently being issued to the remaining 360 ambulances and 40 FRUs. 5. 480 new Nonin finger probes (adult and child sensors) procured to be placed on every ambulance. FRUs carry a portable Nonin probe. 6. All LP1000s and Nonins have been bar coded and are on the asset database. Personal issue: a new Personal Issue Policy has been approved and is due to be implemented in July. New BM kits have been procured and will be issued in line with this new policy. Further discussion is to be held about the range of items that might fall under the remit of the policy. **In summary**: actions to implement the asset tracking project; monitor contractor's compliance with asset tracking and vehicle inventory management; and review portable equipment supply: - achieved or continuing work in progress.

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
How the regulation was not being met:
The provider had failed to ensure that there were a sufficient number of suitably qualified, skilled and experienced persons employed to meet the demands placed on the service. This had led to delays in responding to calls for an ambulance and a reduction in staff achieving mandatory training updates.
June 2013 position 1. Considerable investment in additional external resource – third party providers – enabled the service to provide cover at key times. 2. Modernisation programme brings range of key measures together to address whole system reasons for delays occurring, not just staffing issues. 3. Moving towards a model of service delivery that maintains an agreed vacancy factor that allows for flexibility ie headroom to manage demand. 4. All but 4 of the final cohort of student paramedics have completed their training and are 'in service'. Six more are due to quality

once they have completed their training.

5. The capacity review was completed and has led to a review of the recruitment plan. 240 new front-line – A&E support – roles are being recruited to currently.
6. The workforce development plan is being revised with plans for 2015 onwards being developed.

In summary: three key actions – recruitment plan; final cohorts of SPs; and the outcome of the capacity review informing the workforce and future recruitment requirements for 2013- 18: achieved and continuing work in progress.

The vacancy factor was 9% at the end of 2012/13. The shortfall was offset by the investment described in 1) above. This investment supports the recruitment of 240 additional front line staff in line with the requirements of the model of delivery and recommendations of the capacity review. Additional resource has been provided to the recruitment team to support the additional activity required to recruit these staff. Training plans and resource have similarly been reviewed.

We established the Modernisation Programme Board, chaired by the Chief Executive, to lead on the changes and there is a sub-group in place to review and report on all recruitment and training activity. This is a standing item on the programme board agenda.

The BAF now includes more substantial information about assurances. The key sources of assurance are indicated in Section C and this has been followed through into Section B – Risk themes – and against each of the risks on the BAF. This allows board members to see where they should be able to seek assurance on the management and mitigation of key risks.

Risks are monitored by the Risk Compliance and Assurance Group (RCAG) throughout the year and can only be added, amended or downgraded and removed from the corporate risk register on presentation to and approval by the RCAG. The Quality Committee will review the BAF and corporate risk register during the year and the Audit Committee will review the effectiveness of the control systems in place to manage risk.

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Board assurance framework
June 2013

Section A

Trust Vision: 'To be a world-class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.'

Strategic Goal 1	**To continually improve our delivery of safe and high quality patient care using all appropriate pathways**
Strategic Goal 2	**To have staff who are skilled, confident, motivated and feel valued and who work in a safe environment**
Strategic Goal 3	**To be efficient and productive in delivering our commitments and to continually improve**

This is then translated into the strategic goals and corporate objectives covering the period 2012-2017.

Strategic Goal	Key Corporate Objectives	Abbrev.	Strategic risk
Improve the quality of care we provide to patients	To improve outcomes for patients who are critically ill or injured	CO1	1 & 2
	To provide more appropriate care for patients with less serious illness and injuries	CO2	1 & 2
	To meet response time targets routinely	CO3	1 & 2
	To meet all other regulatory and performance targets	CO4	2 & 4
Deliver care with a highly skilled and representative workforce	To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population	CO5	1
	To create a productive and supportive working environment where staff feel safe, valued and influential	CO6	All
Deliver value for money	To use resources more efficiently and effectively	CO7	3

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Board assurance framework
June 2013

Strategic Goal	Key Corporate Objectives	Abbrev.	Strategic risk
	To maintain service performance during major events, both planned and unplanned, including the 2012 Games	CO8	1, 2 & 3
	To improve engagement with key stakeholders	CO9	4

		Strategic Goals			Risk themes and 2013/14 priorities	
		1. To improve the quality of care we provide to patients – improving our delivery of safe and high-quality care using all appropriate pathways	**2.** Deliver care with a highly-skilled and representative workforce – having staff who are skilled, confident, motivated, feel valued and who work in a safe environment	**3.** Deliver value for money – being efficient and productive in delivering our commitments to continually improve		
Strategic Risks	**1.** There is a risk that we fail to effectively fulfill responsibilities to deliver high quality and safe care	Strong link	Strong link	Strong link	BAU risks – quality Cat C Clinical supervision and training	✓ P1 ✓ P4 ✓ P5
	2. There is a risk that we cannot maintain and deliver the core service along with the performance expected	Strong link	Moderate link	Strong link	BAU risks – performance; quality; finance Demand management	✓ P1 ✓ P4 ✓ P5

Board assurance framework
June 2013

		Strategic Goals			Risk themes and 2013/14 priorities	
	3. There is a risk that we are unable to match financial resources with priorities	Strong link	Moderate link	Strong link	BAU risks – financial; quality	✓ P1 ✓ P4 ✓ P5 ✓ P6
	4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised	Strong link	Moderate link	Strong link	Cat C Modernisation programme Financial sustainability	✓ P1 ✓ P2 ✓ P4 ✓ P5 ✓ P6

Improvement priorities

Improvement priority	2013/14 improvement priorities
1. Deliver high quality care through improving the capacity and capability of the workforce	Modernisation programme
2. Improve on the benchmarked stakeholder results. 3. Improve on the staff survey and temperature check as benchmarked as at 1st April 2013	Communications and engagement
4. Category A8 75%: deliver and improve upon 75% as a minimum performance level 5. Category C: improve response times	Sustain performance to ensure safe service to patients
6. Deliver financial plan	Building a sustainable financial position for 2014/15 and beyond

Board assurance framework
June 2013

Section B: risk themes

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
1. There is a risk that we fail to effectively fulfill responsibilities to deliver high quality and safe care.	Failure to recognise specific and serious clinical issues; staff not receiving clinical training and development which impacts on their ability to carry out their role effectively;	**Themes**: Category C and non-conveyance; Obstetrics; Clinical supervision, education and training. **BAF? Yes:** Risk 31 – maternity care; Risk 355 – clinical and non-clinical mandatory training; Risk 22 – comprehensive assessment/non-conveyance; Risk 379 - Impact on Category C patients of meeting 75% Category A within the context of rising demand; Risk 269 staff changeover times/impact on performance Risk 378 MPS Locality Alert Register Risk 382 MPS triage	Programme of clinical and non-clinical mandatory training supported by PDR/OWR and clinical supervision; Review of incidents and complaints so that errors are addressed and learnt from; Networking with maternity units; Partnership working within the local health economy to manage capacity and direct responses accordingly. Implementation of the Modernisation Programme	Quality dashboard - clinical quality indicators Risk registers CPI compliance Clinical quality and safety report Patient voice and experience report Risk indicators: incidents, SIs, complaints & PALs, legal, inquests Clinical audit Internal audit report on training Integrated performance report Quality Committee report to the Trust Board Commissioners' clinical quality group Care Quality Commission registration & QRP NHSLA level 1 (minimum) Quality Governance Framework score of 3.0 Monthly Modernisation programme report to Trust Board

Board assurance framework
June 2013

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
2. There is a risk that we cannot maintain and deliver the core service along with the performance expected	Increasing demand; funding levels within the local health economy and a focus on 'more for less'; lack of capacity within the healthcare system.	**Themes**: Business as usual; DMP/demand. **BAF? Yes** Risk 265 – matching resources to demand; Risk 269 – staff changeover times; Risk 329 – financial penalties due to non-achievement of contractually agreed targets; Risk 379 - Impact on Category C patients of meeting 75% Category A within the context of rising demand	Strong cost improvement programme and focus on gaining efficiencies and driving up productivity; Service delivery model becomes the golden thread of the 5-year strategy; Partnership working within the local health economy to manage capacity and direct responses accordingly. Implementation and delivery of the Modernisation programme in 2013/14 and 2014/15.	Trust Finance Board report Cost Improvement Programme report to Quality Committee & Finance & Investment Committee Integrated performance report Patient voice and experience report 5-year strategic plan Risk registers Quality dashboard with clinical quality indicators Care Quality Commission registration & QRP Commissioning monitoring meetings + clinical quality group Monthly Modernisation programme report to Trust Board

Board assurance framework
June 2013

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
3. There is a risk that we are unable to match financial resources with priorities	Funding levels within the local health economy;	**Themes:** Business as usual; DMP/demand. **BAF? Yes** Risk 265 - matching resources to demand; **BAF? No** Risk assessment: building a sustainable future – 7 key risks identified and reported to FIC	Strong cost improvement programme and focus on gaining efficiencies and driving up productivity; Partnership working within the local health economy to manage capacity and direct responses accordingly.	Trust Finance Board report Cost Improvement Programme Board report Finance & Investment Committee assurance report to Trust Board Quality dashboard with clinical quality indicators Contract with commissioners External audit opinion Head of internal audit opinion Quality Governance Framework

Board assurance framework
June 2013

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised	Changes within London's health economy and infrastructure create a lack of overall strategic direction or conflicts within the system; we are unable to clearly articulate a strategy; management focus on delivering day to day performance; lack of headroom to release staff from core duties to undertake training and development/to transform the workforce.	No specific risks however risks identified within the Modernisation Programme and CIP could impact.	Clearly articulated strategic direction with planned developments across three to five years Implementation of the service delivery model Implementation of stakeholder engagement and communications strategy Ensure that partnerships within London's health economy (LHE) are maintained to support the development of appropriate clinical pathways and utilisation of the LHE	5-year strategy and financial strategy IBP/LTFM Cost Improvement Programme Integrated performance report Strategy Review and Planning group papers Commissioner support Board Governance Assurance Framework Quality Governance Framework Due diligence reports 2013/14 improvement priority 2 – communications and engagement Modernisation Programme and CIP reports to Trust Board

Board assurance framework
June 2013

Section C – Key sources of assurance

Committee minutes and papers	External	Internal
Trust Board	Care Quality Commission; NHS Trust Development Authority (TDA) oversight model; London Assembly; Externally commissioned reports eg National Audit Office – Transforming NHS Ambulance Services; Quality Governance Framework; Board governance assurance framework; NHS England (London)	Corporate risk register; Board assurance framework; Annual review of effectiveness of the Board and supporting committees; Annual Governance Statement; Annual reports – safeguarding/infection prevention and control/complaints management/corporate social responsibility; Integrated performance report: Modernisation programme; Monthly board reports from the COO, Director of Finance, Medical director, Director of Workforce, Trust Secretary; Board Governance Statements – Monitor Compliance and Board declarations – monthly.
Quality Committee	Care Quality Commission registration; DH Clinical Quality Indicators; CQC quality risk profile; Quality Governance Framework; TDA Quality assessments; Board governance assurance framework.	Corporate risk register; Local risk registers; Audit recommendations progress report; Clinical audit report; Modernisation programme; Quality impact assessment of CIP; Cost improvement programme reports; Minutes of RCAG, LfE, CQSEC; Quality indicators dashboard; Integrated risk management report; Observational ride-outs.
Audit Committee	NHS Litigation Authority level assessment of risk management standards; Head of Internal Audit Opinion; External Audit opinion.	Audit recommendations progress reports; Annual Governance Statement; Report from Chair of the Quality Committee.
Finance and Investment Committee	Independent working capital assessment Due diligence reports	LTFM reports; CQUIN and contract monitoring; Cost Improvement Programme reports;

		Monthly finance board reports; Finance risk report.
Risk Compliance & Assurance Group	Internal audit reports and recommendations; CQC quality risk profile.	Audit recommendations progress report Local risk registers; Risk register process and reports.
Clinical Quality Safety & Effectiveness Committee	Cluster clinical quality group minutes	Clinical risk register Infection control dashboard Safeguarding dashboard Clinical quality indicators Clinical audit
Learning from Experience Group	CQC registration Ombudsman reports Coroner Rule 43 reports	Integrated risk management report; Action plans and outcome reports from investigations (serious incidents, complaints, Rule 43 etc).
Executive Management Team	Internal audit reports CQC quality risk profile Patient Forum and LINKS feedback Members' feedback from events	Risk registers; Audit recommendations progress report; Patient experiences report; Performance reports; SMART targets/balanced scorecard; Modernisation Programme Board; Serious Incident reports.

Board assurance framework
June 2013

Section D: Principal Risks

Each of the principal risks has been mapped to at least one corporate objective and wherever possible to the Care Quality Commission's registration requirements.

Principal risk and headline	Corporate objective	Risk score	CQC map	Key controls	Assurance on controls			Action plan	Responsible officer	Net	Target
					Positive assurance	Gaps in controls	Gaps in assurance				
368 - 27th July 2012 There 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 **Sources of assurance:** Risk register; integrated board performance report and integrated risk report Risk reviewed and update 24/4/13	C03 C04 C07	25	**N/A**	Software adaptation; manual alert systems;	Technical solutions under development; Weekly director oversight – CP problem management review; Monitoring incidents – CP senior user group; Daily checks within the system	None identified	None identified	Technical solutions under development. Communications and training materials for EOC staff. Removal of false positive messages	**VW**	15	5

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265 – 31st July 2006 Service performance may be affected by the inability to match resource to demand **Update: potential underlying causes/source of risk** identified as reductions in front line establishment in 11/12 and 12/13 CIP and the current vacancy factor against establishment. **Sources of assurance:** RCAG review 9/7/12. Risk reviewed 27/2/13 – no change to ratings. Risk remains at current level pending action Daily operational reports. See BAF section B	C03 C05 C07	20	**16**	Ongoing recruitment; Use of VAS and PAS in peak demand; Agreed ToR for capacity review with commissioners Operational weekly demand and capacity review group; A&E resourcing group set up in Sept 12, chaired by Director of Workforce	Operational weekly demand and capacity review group; SMG weekly and monthly performance reports; Integrated board performance report			To be updated	**PW**	16	12
31 – 14th November 2002 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.	C01 C02 C05 C06	20	6 16 14	The Medical Director attends NPSA's Obstetric Pan London Forum. LAS Consultant Midwife provides advice to Control	CQSEC minutes Incident reporting, claims and inquests			Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012; Review	**FM**	16	12

Sources of assurance: RCAG review 9/7/12. Risk reviewed 26/4/13 13. Risk remains at current level pending action Weekly serious incident review group; ADG monitoring SI action plans See BAF section B				Services, Legal Services, Patient Experience, and Education and Development. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. Maternity care updates and ongoing training through direct contact and articles in the Clinical				incidents reported and legal and complaints.				

				Update. CTA now have maternity pathway to assist with triage of women in labour. Liaison with Trust midwifery units. Flow chart now in use in CTA							
355 – 23rd November 2011 Staff not receiving clinical and non-clinical mandatory training **Sources of assurance:** Risk reviewed on 28/5/12 – RCAG confirmed. Risk reviewed 4/3/2013. Risk remains. CQC compliance review – November 12 – identified minor impact of non-compliance relating to staffing levels and linking this to staff not receiving mandatory training. BAF Section B	C01 C02 C03 C05 C06 C07	20	**12** **14**	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5. Cluster arrangements in place on all complexes. 6. TNA updated and published May 2012	Clinical quality indicators; Quality dashboard; Clinical quality and safety monthly board report; Training records.			To be reviewed and updated	**TC**	16	8

269 – 8th December 2006 At staff changeover times, LAS performance falls as it takes longer to reach patients. **Update: underlying cause/source of risk:** Current rest break agreement permits staff to conclude shift by up to 30 minutes early where no break given by EOC. **Sources of assurance:** Risk reviewed on 8/7/12 by RCAG. Risk reviewed 27/2/13. BAF Section B	C01 C02 C03 C04 C07 C08	20	16	Daily rest break allocation to reduce losses at shift change over. Bridging shifts with VAS and PAS Staggered shifts included in roster reviews	To be reviewed and updated			To be reviewed and updated	**PW**	16	8
378 – 14th January 2013 Insufficient information is contained within MPS referrals for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses. **Sources of assurance:** clinical quality and safety report to Trust Board. Risk reviewed 16/4/2013	C01 C02 C03 C04 C06 C09		1 6 10 14 21	Crews carry out dynamic risk assessment before attending the address using all available information and knowledge.	Clinical quality and safety monthly report. CQSE papers. Reporting of incidents.			Meetings with MPS to agree changes to MPS entry criteria.			

379 – 11th March 2013 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. **Sources of assurance:** risk register; integrated performance report; integrated risk report;	C02 C03 C04 C07		1 4 16 17	1. MPDS call triage 2. Control services staff training 3. Enhanced clinical assessment through the clinical hub 4. Interim demand management arrangements in place through to the 31 March 2013 5. Existing LAS Demand Management Plan	Incident reporting; risk register; integrated performance and risk reports; CQSE papers; EMT and Trust Board papers.			1. Increases in operational efficiency 2. Increase in frontline resourcing levels 3. Reduction in the use of the Demand Management Plan	**PW/JK**		
371 – 14th January 2013 There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2013. **Sources of assurance:** IG toolkit submission 31/3/2013	C04 C05		13 21	1. ADOs have been reminded about the need for their staff to complete training 2. Training completion rates are being monitored by IGG 3. Directors have been provided with spreadsheets of staff who have completed training 4. ADG				Produce training plan to improve compliance by March 14	**VW**		

				members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.							
22 – 14th November 2002 Failure to clinically assess comprehensively may result in inappropriate conveyance or treatment **Sources of assurance:** Risk reviewed on 4/3/2013. SI weekly review group; inquests; integrated risk report; CQC compliance review – November 12. See BAF Section B	C01 C02 C05 C08	20	16 13 14	1. An enhanced patient assessment course has been introduced for paramedics. The training has been subject to a major overhaul and now includes a supervision element. Reflective practice has also been adopted into the majority of assignments. 2. Planned CPD delivery	Incident reporting; Operational workplace reviews; CQSE papers and minutes; Reporting of incidents via EBS shows improved take-up with this on LA52s.	Planned CPD delivery affected by operational pressures; Delays in incident reporting; impact of operational pressures on EBS pilot.	Review of effective-ness of incident reporting;	To review Delivery of CSR3	**FM**	15	9

				will cover all relevant staff. However, this may be affected by operational pressures. 3. Training Services monitor the level of training delivery. 4. CPIs are used to monitor the level of assessments provided. 5. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee. 6. The Operational Workplace Review has been reviewed and will now include rideouts. 7. A system for clinical updates is in place. 8. A system of closed round tables is in place.						

				9. The development of treat and refer pathways is being continued alongside the New Ways of Working project. 10. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 11. Monitoring the development of treat and refer pathways. 12. Introduction of reflective practice (as part of Module J programme).							

382 – 7th May 2013 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.	C01 C02 C03 C04 C09	20	16	1. LAS METDG (a trial being run from January - March 2013) will re-triage MPS calls via MPDS, to determine an accurate priority and facilitate more effective tasking of LAS resources. METDG will attempt to close lower priority calls by Hear & Treat. METDG only has limited times of operation at anticipated peak times of demand. 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 traiged and interrogate / upgrade the call priority if indicated.	To be defined			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 then be triaged via the LAS 999 system and MPDS	**PW**	15	5

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				3. EMDs can identify calls that appear to be mis-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.								

London Ambulance Service NHS Trust
Risk Register as at 12th June 2013

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
368	There 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	Following CommandPoint go live, several incidents have been reported to the CAD support team for investigation where out of sequence messages from MDTs have resulted in events showing with an incorrect status. On a number of these the event has been closed in error. The investigations have identified a number of ways that this scenario can occur. So far the identified possible causes are: • Preempt request/event updates crossing • Status change messages echoed • MDT status changes arrive out of order • Aged MDT status change messages appear • A&E resource 'cycles' through the button presses to close the job.	27-Jul-12			Clinical	Catastrophic	Almost Certain	25	1.Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. (Build 2.5.6) 2. Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks) 3. Software adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5.6)	Vic Wynn	24-Apr-13	Catastrophic	Possible	15	1. Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes. 2. Request for Change to MDT system to provide message sequence identification and processing as above. 3. Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling. 4. Removal of 'false positive' messages from unexpected status change warnings generated by CAD to area controllers and dispatchers.	1. J. Downard 2. J. Downard 3. K. Canavan 4. K.Canavan	1-6 July 2013	1. Technical solutions under development by tactical problem management team (led by John Downard) 2. Weekly director progress oversight in CommandPoint problem management review (led by Vic Wynn) 3. Ongoing assessment of alert monitoring and identification of further incidents for CAD support team investigation by CommandPoint senior user group (led by Richard Webber) 4. Daily checks of the following Alerting systems in place: • That the software running alerts is running	Catastrophic	Rare	5	
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	reductions in frontline establishment in 1/12 and 12/13 as part of CIP Current vacancy factor against 12/13 establishment	31-Jul-06	***	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Agreed terms of capacity review with Commissioners. 4. Scoping use of agency Paramedics to enhance bank scheme. 5.The Trust has implemented an Operational weekly demand and capacity review group. The group has been tasked to forecast demand by utilising historic data, capacity for the Trust to meet the predicted demand, monitoring the input measures and understanding influencing factors that potentially could have an adverse effect on Category A life-threatening calls.	Paul Woodrow	27-Feb-13	Major	Likely	16	1. Review ORH implemented rosters Pan London 2. Modelling being undertaken by the Operational Weekly Demand and Capacity Review Group (OWDaCR) 4.Implement outcomes of formal capacity review.	1. T. Crabtree 2. J. Killens 4. J. Killens 5.P Woodrow	1. Q3 12/13 2. Ongoing 4. Ongoing 5. Ongoing	1. joint LAS / Commissioners ORH review funded to report Q3 12 (ORH final report still not agreed (27/2/13), funding settlement from report outcomes still at negotiation phase) 2. ODaCR meeting weekly 3. Nationally implemented 4. A&E resourcing group chaired by Dir of Workforce now established Sept 12 forward 5. DMP levels monitored monthly	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	Clinical	Major	Almost Certain	20	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 3. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 4. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. 5. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update.. 7. CTA now have maternity pathway to assist with triage of women in labour. 8. Monitoring the delivery of the CPD obstetrics module.Re- review planned June 2012 9. Evaluated the flow chart used to enable the safe triage of women in early labour- To be slightly modified and modifications completed Sept 2012	Fionna Moore	26-Apr-13	Major	Likely	16	1. Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents-Ongoing	1. A.Stallard / F.Sheraton 2. A. Stallard	1. Complete 2. Ongoing	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	Major	Possible	12	

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
355	There is a risk of staff not receiving clinical and non-clinical mandatory training.	This may as a consequence cause:- • Failure to meet CQC and the Trust's TNA policy • Dilution of clinical skills • this includes the decentralising of operational training to New Ways of Working (NWOW)	23-Nov-11		5	Human Resources	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes. 6. 3/5/12 The TNA was approved by TSG and published	Tony Crabtree	04-Mar-13	Major	Likely	16	I. 3/5/12 The TNA was approved by TSG at the April meeting and will be published iminently. 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 commmence from October 2012.	1. G.Heuchan 2. K.Miller 3. B.O'Neil	1. Complete 2. Ongoing 3. Oct 2012	1. Reporting to TSG 2. Performance Accelerator 3. TNA Policy	Major	Unlikely	8	
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	***	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.	Paul Woodrow	27-Feb-13	Major	Likely	16	1. Implement changes to rest break arrangements 2. Outcome of capacity review 3. Rota changes to be implemented as result of ORH review stage 1	1. T. Crabtree 2. J. Killens 3. G.Hughes	1. Q3/4 12/13 2. Q3/4 12/13 3. Q3/4 12/13	Additional resource upto 60 AEU are currently funded to commence duty at 15:00 to maintain performance through shift changeover time. Interim demand management arrangements in place to more appropriately manage lower acuity calls which in turn reduces calls held	Major	Unlikely	8	
378	There is a risk that insufficient information is contained within MPS referalls for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses.	Police fail to set an appropriate criteria for inclusion on the LAS register	14-Jan-13			Operational	Catastrop hic	Likely	20	1. Crews carry out a dynamic risk assessment before attending the address using all available information and local knowledge	Paul Woodrow	16-Apr-13	Catastrop hic	Possible	15	1. Meet with MPS to agree changes to the police entry criteria	1. Ops Lead/Head of MI	End 2013		Catastrop hic	Unlikely	10	
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.	The Learning from Experience Group requested an analysis of delays to category C patients which resulted in Serious Incident reviews. During the period April 2011 - March 2012 the Trust reviewed 92 serious incidents 10 involved Category C calls. 4 incidents were declared 3 as delayed response, 1 staff attitude. 6 incidents were investigated internally. 1 incident is expected to be a problematic inquest and a claim.	11-Mar-13			Operational	Catastrop hic	Likely	20	1. MPDS call triage 2. Control services staff training 3. Enhanced clinical assessment through the clinical hub 4. Interim demand management arrangements in place through to the 31 March 2013 5. Existing LAS Demand Management Plan	Paul Woodrow / Jason Killens		Catastrop hic	Possible	15	1. Increases in operational efficiency 2. Increase in frontline resourcing levels 3. Reduction in the use of the Demand Management Plan	1. P. Woodrow 2. P. Woodrow 3. P. Woodrow / F. Wrigley	1.April 2014 2. April 2013 3. April 2013	1. Operational Demand and Capacity Review Group 2. CTA and Control room Quality Governance Committee 3. Risk Compliance and Assurance Group 4. Medical Directorate senior clinical advice; Clinical risk and Patient safety	Catastrop hic	Unlikely	10	
371	There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2013.	Service pressures during the year have meant that Operational training has had to be deferred in many cases and winter pressures may make this situation worse.	14-Jan-13			Governance	Major	Almost Certain	20	1. ADOs have been reminded about the need for their staff to complete training 2. Training completion rates are being monitored by IGG 3. Directors have been provided with spreadsheets of staff who have completed training 4. ADG members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.	Vic Wynn	29-Apr-13	Catastrop hic	Possible	15	1. Produce IG training plan to ensure that as many staff as possible complete refresher training and other IG training as required by 31/03/14. SA suggested action: implementation of protected training time for CSR etc to ensure operational staff undertake this training.	1. Stephen Moore	1. May 2013		Catastrop hic	Unlikely	10	

London Ambulance Service NHS Trust
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22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	***	5	Clinical	Major	Almost Certain	20	1. An enhanced patient assessment course has been introduced for paramedics. The training has been subject to a major overhaul and now includes a supervision element. Reflective practice has also been adopted into the majority of assignments. 2. Planned CPD delivery will cover all relevant staff. However, this may be affected by operational pressures. 3. Training Services monitor the level of training delivery. 4. CPIs are used to monitor the level of assessments provided. 5. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee. 6. The Operational Workplace Review has been reviewed and will now include rideouts. 7. A system for clinical updates is in place. 8. A system of closed round tables is in place. 9. The development of treat and refer pathways is being continued alongside the New Ways of Working project. 10. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 11. Monitoring the development of treat and refer pathways. 12. Introduction of reflective practice (as part of Module J programme).	Fionna Moore	04-Mar-13	Moderate	Certain	15	1. To review the effectiveness of the existing incident reporting system. 2. Pilot scheme where crew staff from 4 identified complexes will contact EBS via their airways radio. EBS will record incidents directly onto an electronic version of the existing LA52.(SA suggested taking these actions out and add actions concerning ability to do the job) 20/02/13 - DSW - These actions do not relate to this risk it is felt. It is suggested that the further actions are: 1. Delivery of CSR3	1. J.Selby 2. J. Selby 20/02/13 - DSW - Suggest the above is removed. 1. ? Gill Heuchan	1. Sep 2012 2. Sep 2012 20/02/13 - DSW - Suggest the above is removed 1. Refer to CSR3 plan	1. Incident reporting. 2. Operational workplace reviews. 3. Regular reports to CQSE.	Moderate	Possible	9	
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	07-May-13			Clinical	Catastrophic	Likely	20	1. LAS METDG (a trial being run from January - March 2013) will re-triage MPS calls via MPDS, to determine an accurate priority and facilitate more effective tasking of LAS resources. METDG will attempt to close lower priority calls by Hear & Treat. METDG only has limited times of operation at anticipated peak times of demand. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify	Paul Woodrow		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 then be triaged via the LAS 999 system and MPDS	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. April 2013 2. Dec 2013		Catastrophic	Rare	5	
7	There is a risk that we do not capture errors and incidents, and do not therefore learn from these and improve service provison and working practices.	Insufficient recorded evidence of reported incidents	13-Nov-02	***	4	Health & Safety	Major	Almost Certain	20	1. LA52 incident reporting form 2. Risk management policy and strategy has been updated and implemented 3. Incident reporting policy is implemented 4. The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated. 5. A review of incident reporting is underway and led by the PCMO. 6. Weekly SI control sheet and conference call updates. 7. Monthly reports to SMG. 8. Implemented policy on investigating and learning from incidents, complaint, PALs and claims. 9. Local risk registers have been introduced 10. Datix Coding Review has been undertaken 11. LFE group has introduced integrated reporting	Tony Crabtree	04-Mar-13	Moderate	Possible	9	1. Complete the review of incident reporting pilot and make recommendations to Corporate H&S and RCAG. - (Phase 2 of this project has commenced and is being led by CDB) 2. Implement the policies on investigating and learning from incidents, complaint, PALs and claims. 3. LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated. 4. Incident reporting project phase II commenced Jan 2012. - (JS 18th Feb 2013)	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. C.Dodson-Brown	1. Pilot Complete 2. 3. 4. - Project commenced Jan 2012	1. Completion of the review and recommendations to RCAG and SMG for implementation. 2. Reports and minutes from Learning from Experience, RCAG, SMG and Quality Committee. Consistent coding and reporting across the risk indicators	Moderate	Rare	3	
343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		4	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Safeguarding committee promotes practice guidance. 3. Practice guidance issues and supported by updates. 4. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments. 5. Monitor training uptake - monitored centrally on scorecard. 6. Safeguarding Children / Adults Gap Analysis.	Steve Lennox	04-Mar-13	Major	Likely	16	1. Capture safeguarding practice in bi-annual Operational Workforce review 2. Formulation of action plan based on completed safeguarding adults gap analysis 3. Provide monthly supervision sessions open to all staff. 4. Produce and issued individual safeguarding pocket books to all frontline staff.	1. P.McKenna, K.Millard, P.De Bruyn 2. Lysa Walder & Alan Taylor	1. April 2013 2. Dec 2012 3. Jan 2013 4. June 2013	1. Monitor at Safeguarding Committee	Major	Unlikely	8	
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	***	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	Paul Woodrow	29-Apr-13	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	1. R. Webber 2. R. Webber			Major	Unlikely	8	

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138	There is a risk that failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.		12-Nov-03	***	5	Clinical	Major	Likely	16	1. The new 'Mental Health' module has been designed and has been included in the training plan for 2009/10. 2. An e-Learning Manager has been appointed and will start work wih the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	16-Apr-12	Major	Possible	12	1. Development of mental health risk assessment tool 2. Roll-out of mental health e-learning training 3. Mental Health Committee to consider alternatives to e-learning 4. Mental health audit 5. CSR3 Training	1. S.Lennox 2. S.Lennox 3. S.Lennox 4. S.Lennox 5. K.Miller	1. Complete 2. Ongoing 3. TBA 4. Complete 5. Complete	1. CPD completion records 2. Monitor processes at CQSE 3. Monitor package completion data on e-learmng site	Major	Unlikely	8	
205	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system.	As a result of limited capacity of the Fulham archive stoes, as well as records needing to be stored at other sites Separate sites holding data which we do not have access to easily	01-Jun-05	***	7	HR	Major	Likely	16	1. Education and Development are to move to the scanning of training records. Plans from Estates for the development of the Fulham archive are awaited. 2. All staff are currently being migrated onto PROMIS with the aim of developing a centralised Learning Management System.	Tony Crabtree	24-Apr-13	Major	Possible	12	1. Review the process of archiving training records within the DoE&D (Initial work indicates there may be a need for a formal procurement and tender process for electronic archiving) 2. Pilot of OLM. 3. Plans are to be reworked due to the prohibitive cost of original proposals. 4. L&OD pilot has identified a range of issues requiring further work and development. Clinical Education to commence use of OLM for CSR1 programme.	1. P.Billups 2. IM&T/R.Clifford 3. P.Billups 4. IM&T/R.Clifford	1. July 2013 2. (TBA) 3. July 2013 4. (TBA)	1. Part of organisation & development of people workstream. 2. Progress of project report to workstream board.	Major	Unlikely	8	
211	There is a risk that drug errors and adverse events may not be reported.	Concerns that drug errors may not be reported	08-May-06	***	4	Clinical	Major	Likely	16	1. No evidence of any issue of significance from service users or stake holder feedback. 3. Complaints Manager to tracked back complaints to see how many have LA52's associated with them (drug errors and adverse events not being reported) 4. Medical Directors Bulletin to remind staff of importance of reporting drug errors and adverse events. 5. Article included in the Clinical Update highlighting the importance of incident reporting. 6. Importance of clinical incident reporting highlighted in the Team Leader Clinical Update Course and Team Leader Conference.	Fionna Moore	04-Mar-13	Major	Possible	12	1. CQSE suggest PIMs give some thought to how this is managed. 2. Continue to encourage reporting of all clinical incidents using LA52's. 3. Continue to reinforce that the LAS has a fair blame culture by providing feedback from outcomes of complaints to staff involved in incidents. 4. Updated policies covering the use of drugs used by the LAS to be put into the RIB. 5. The reporting of drug errors and adverse events in included in the CSR training programme which is to recommence in November.	1. J.Killens 2. J KIllens 3. D Whitmore 4. D.Whitmore 5. Keith Miller	1. Ongoing 2. Ongoing 3. Ongoing 4.Completed Oct 2012 5.Ongoing	1. CPI checks 2. Incident Reporting 3. CQC inspections 4. Clinical opinions provided on incidents 5. Learning from Experience Group review incident activity 6. Review of closed cases and claims. 7. Learner outcomes and	Major	Unlikely	8	
305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	Controlled Drugs Incidents arising from poor adherence to policy	21-Oct-08	***	4	Clinical	Major	Likely	16	1. Internal Audit carried out annually. 2. Procedure to be reinforced by bulletins from Director of Operations/Medical Director. 3. Independent audits to be carried out throughout the Trust. 4. Initial peer review pilot audit carried out in the south area with results and process amendments discussed at a morphine audit group quarterly	Fionna Moore	04-Mar-13	Major	Possible	12	1. Continue to highlight practice from the peer review audits. 2. Continue to review feedback from spot checks made by the MPS.	1. D.Whitmore 2. D.Whitmore	2. October 2012 3. June 2012	1. Internal Audit 2. Independent Audit 3. LIN oversight of system	Major	Unlikely	8	

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326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	***	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	07-Jan-13	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process 2. Decontamination Policy to be agreed by ADG	1. K.Merritt 2. S.Lennox	1. Oct 2012 2. Complete	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	
352	There is a risk that operational staff sustain a manual handling type injury whilst undertaking patient care. The consequence of injuries being:- -Increased staff absence through industrial injury. -Impact on service delivery.	Staff injured whilst manual handling patients	23-Nov-11		7	Health & Safety	Major	Likely	16	1. Manual Handling Implementation Group and Manual handling policy 2. Manual handling awareness is provided at corporate Induction; refresher training through e-learning is available through L&OD; Education and Training dept provide training to all operational staff during initial and subsequent	Paul Woodrow	04-Mar-13	Major	Possible	12	1. Implementation of LAS/HSE Manual Handling Improvement Programme Action Plan 2. Develop structured bariatric capability 3. Ongoing review of marketplace to identify new lifting aids 4) Complete Operational Workforce Review 5) Chair Transporter Pilot - (Interim report with CH	1. J.Selby 2. J. Killens 3. J.Selby 4. S.Sale 5. J.Selby 6. J.Selby	1. Q3 12/13 2. 2013/14 3. Ongoing 4. March 13 5. March / April 2013 6. Ongoing	1. Manual Handling Implementation Group 2. Manual Handling Policy 3. Central Health	Minor	Unlikely	4	
153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	Increasing fuel prices	06-Jan-04	***	8	Finance	Major	Likely	16	1. Monthly review as part of month end reporting process. 2. Prices will continue to be closely monitored by the Finance Department for 2012/13. The move to an all diesel fleet will further mitigate against fuel costs.	Andrew Grimshaw	04-Mar-13	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance. Further investigation of vehicle telemetry technology to manage fuel spend.	1. A.Grimshaw	1. Ongoing	Monitored at SMG and Trust Board	Moderate	Possible	9	
322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	***	1,2,4,5	Infection Control	Major	Likely	16	April 2013 update: infection prevention and control training remains in new entrant courses and CSR 1.13, including hand hygiene tuition. Staff will be issued the IPC training workbook as a CPD activity as well as receiving their core tuition. In addition, they receive ANTT, norovirus and sharps injury aide memoires for their PRF folders. Core subject areas (including IPC) will also undergo a quality assurance this year, to ensure they contain best practice information. IPC including hand hygiene is also included in all in one and induction sessions.	Steve Lennox	25-Apr-13	Moderate	Possible	9	To be fully compliant with CQC expectations and all staff to have up to date infection control training: 1. Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) 2. Monitor and implement hand hygiene training. 3. Need to capture the training of contracted staff on the scorecard.	1. C. Dodson-Brown / I.Bullamore 2. S.Lennox 3.	1. Oct 12 2. Oct 12 3. Oct 12	Reports from the central training register	Minor	Unlikely	4	
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		3,4,8	Finance	Catastrophic	Possible	15	1. 2012/13 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMG. 3. Extra financial provisions included for contract risk in 2012/13. 4. Communications with commissioners.	Andrew Grimshaw	04-Mar-13	Catastrophic	Possible	15	1. Review by Finance Investment Committee	1. A.Cant	F&I Committee 15/1/13	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	Catastrophic	Unlikely	10	

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373	There is a risk that crews will not carry out a comprehensive dynamic risk assessment when attending high risk addresses resulting in a delay in attending the patient	Custom and practice that crews do not do this as a matter of course	14-Jan-13			Clinical	Catastrophic	Possible	15	1. Recent new guidelines issued 2. Aide memoirs issued 3. Discussions taken place with ops, EOC and all interested parties including staffside reps 4. Policy reviewed and signed off by SMG	Fionna Moore	04-Mar-13	Catastrophic	Possible	15	1. Monitor delays results of existing controls through the numbers of assaults on staff attending know high risk addresses 2. Ongoing coms strategy to remind crews and EOC staff of the importance of dynamic risk assessment 3. Monitor delays as a result of staff applying a dynamic risk assessment and not entering a call as a result	1. J.Selby 2. Head of Control Services	1-2 Ongoing monitoring		Catastrophic	Unlikely	10	
362	There is a risk that the absence of a medical devices tracking system may result in the Trust being unable to maintain and track equipment which could result in equipment not being available for patient use.	Impact on Complexes not being able to manage allocation of medical equipment to vehicles. Impact on patient safety if medical equipment is not available possibly resulting in a serious	17-Apr-12			Clinical	Catastrophic	Possible	15	1. Occasional audits of equipment by complexes and logistics department. 2. Equipment lists are available from the company which maintains the medical devices, which includes services and non serviced items.	Paul Woodrow	05-Mar-13	Catastrophic	Possible	15	The Trust will ensure that appropriate equipment is provided on all front-line vehicles essential equipment = vehicle-based, portable, and personal-issue) 1. Implementation of asset tracking project 2. Monitor contractor's compliance with asset tracking process and vehicle inventory management 3. Review portable equipment supply	1. Ed Potter 2. Ed Potter	1. Closed		Catastrophic	Rare	5	
344	There is a risk that the Trust is unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding)		16-May-11		2,4	Governance	Moderate	Almost Almost Certain	15	1) Current contract stipulates all drivers must have CRB checks	Steve Lennox	04-Mar-13	Moderate	Almost Certain	15	1. Registration with the Independent safeguarding Authority needs stipulating in the contract 2. Contract monitoring 3. Currently reviewing contracts with providers ensure Safeguarding requirements are in new contracts. 4. Undertake audit of taxi company.	1.R. Deakins 2. Lysa Walder & Alan Taylor	1. 2011/12 2. 2011/12	1. Safeguarding Committee	Minor	Rare	2	
381	There is a risk that the service does not comply with DH guidance on the re-use of linen for patients and the quality of care delivered to patients may be affected which may have an adverse reputational risk to the Trust.	There is no service wide agreement for the provision and use of a sheet as a mattrress protector. Blankets are re-used on patients and there is no consistent process for the swapping of blankets or sheets at hospitals. This has an impact on the quality of care delivered to patients.	07-May-13			Infection Control	Moderate	Almost Certain	15	1. Laundry contract in place for blankets. 2. Some local arrangements in place for swapping of sheets at hospitals. 3. Additional capacity for re-usable blankets in stores. 4. Disposable blankets available.	Steve Lennox		Moderate	Likely	12	1. Swapping of mattresses by workshops to reduce risk from tears and damaged items. Elimination of repairs undertaken with tape. 2. Negotiation to increase return of sheets and blankets from laundry provider. 3. Options paper to be written and then discussed by working group.	1. C.Vale 2. C.Vale 3. C.Vale / K.Merritt			Minor	Unlikely	4	

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377	There is a risk that the Trust will have to repsond to circa 110 to 120 additional calls a day (3600 a month) that are currently resolved by redirection from LAS to NHSD via an electronic link thus saving a vehicle response. There is currently no extra staffing provision or infrastructure focused with dealing with this level of additional activity. Any increase of this nature has the potential to impact on core service delivery especially at peak out of hours times and at weekends. There is potential for a reputational issue should the Trust be unable to fulfil this additional function. .	NHSD will cease to provide the national out of hours and primary care function it currently does as NHS111 assumes this responsibiilty. From April 2013 there is no existing agreement with the new NHS 111 providers on how these calls could be managed . Control services (EOC & CTA) Operations (A&E and Urgent care provision) Acute Hospital Tusts (increased patients) Patients (less choice)	14-Jan-13			Operational	Moderate	Almost Certain	15	National contractual agreement in place which ensures approximately 110 to 120 low acuity calls (C4s) are passed electronically to NHSD from EOC	Paul Woodrow	26-Apr-13	Moderate	Likely	12	1. Assess impact of re- contracting this cohort of calls to NHSD who will be a NHS 111 provider in south London 2. Assess impact of establishing process of transferring this cohort of calls to NHS 111 3. Consider case for increasing capacity to deal with these calls in house.	1. M.McTigue 2. M.McTigue 3. SMT/EMT	1. Complete 2. Complete 3. Oct 2012		Moderate	Rare	3	
380	The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls will not be recorded. THis could then impede investigations and clarification related to decisions made by control room staff and communication with patients and other agencies.	This relates to historic investigations in retrospect and clarification sought within the control room concerning the actual details of the conversation. Both Waterloo and Bow control rooms have	05-Feb-13			IM&T	Moderate	Almost Certain	15	1. Detailed investigataion by technology supplier. 2. Upgrade of Bow system to same software release as HQ (where we do not currently have the same issue) 3. Live monitoring during any event by technical staff. 4. Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2013/14.	Vic Wynn	24-Apr-13	Moderate	Likely	12	1. Non service affecting testing of FBC infrastructure to be undertaken to either prove cause of failure or confirm resolution. 2. Live testing of FBC infrastucture under load in combination with a live run for the East at Bow to prove that the fault has been resolved. 3. Introduction of alerts for the condition known to occour so that servcies can be restarted. 4. Validated explanation from supplier as to previous problems	1. V.Wynn 2. V.Wynn 3. V.Wynn 4. V.Wynn 5. V.Wynn 6. V.Wynn	1. Feb 2013 2. 19 Feb 2013 Go live	THis has been identified as the highest risk to allowing bow to going live on 27 Feb as planned, as go live cannot take place without a reliable recording system	Moderate	Rare	3	
345	The Trust currently recieves a sum of £7.7m non recrring funding to maintain a CBRN (Decontamination) Response. There is a risk that the funding may not continue. The funding is used to fund 143 WTE and the hours required for annual CBRN training	Public sector funding constraints. No formal service level agreement in place	16-May-11		1,2,3, 4,8	Finance	Catastrop hic	Possible	15	1. 2012/13 contract reflects this work, if there is a shortfall PCTs are liable. 2. Reviewed by Finance Investment Committee. 3. Discussions ongoing with DH to provide appropriate SLA.	Jason Killens	07-Jan-13	Catastrop hic	Unlikely	10	1. Trust to attempt to gain assurances from DH that this funding will continue. 2. Reviewed by Finance Investment Committee.	1. Lizzy Bovill 2. A. Grimshaw	1. Feb 2013	1. Service Line Reporting	Catastrop hic	Unlikely	10	
315	There is a risk of service failure during relocation to the FBC because effective arrangements for continuity have not been made between LAS and the Metropolitan Police.	Lack of robust BC arrangements in event of full scale evacuation of EOC HQ	17-Aug-09	***	17	Business Continuity	Catastrop hic	Possible	15	1. New arrangements agreed with surrounding Trusts to take LAS 999 calls in event of total loss of HQ during Olympic period which need formally agreeing via NDOG as a permanent solution. 2. 2nd Control room went live at located at Bow 27-2-13 2. Smart numbers implemented 20-2-13 which allow for a rapid transfer of calls in a case of total loss of a site	Richard Webber	04-Mar-13	Catastrop hic	Unlikely	10	Status Quo				Catastrop hic	Rare	5	

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353	There is risk that Operational ambulance staff and Emergency Operations Centre Staff are unsure of the safe systems of working/procedures in relation to railway trackside working, due to the rare occurrence of such incidents.	Lack of regular exposure to this risky enviornment	23-Nov-11		5,7	Operational	Catastrophic	Possible	15	1. Emergency Medical Despatchers (EMD) receive familiarization and procedural awareness during initial training and during their dispatch training course. 2. Work Based Trainers oversee adherence to procedure during placements Student Paramedics receive trackside awareness training during initial training. 3. "Trains Can Kill" card included in Major Incident Action Cards as point of reference. 4. Contingency Plans in place for calls on Network Rail, LUL, DLR and Croydon Tramlink calls including safety awareness information. 5. Operational bulletins available via The Pulse. 6. Trackside Awareness Training provided for all student paramedics and trainee emergency medical dispatchers including demonstrations of short circuit devices 7. Revised policy and procedure in place setting out requirements when attending railway incidents	Jason Killens	04-Mar-13	Catastrophic	Unlikely	10	1. Develop e-learning package for operational managers to enhance safety. 2. Inclusion of railway incidents session in Q3/4 12/13 ops managers EP updates.	1. W.Kearns 2. L.Lehane	1. Jan 2013 2. Q3/4 12/13	1. Manager briefings Undertaken 2. EOC briefings undertaken 3. Publications in RIB / LAS News / Pulse	Catastrophic	Rare	5	
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	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. Mark Whitbread stated that operational pressures, and therefore the availability of team leaders, may have an adverse affect on the number of cards read. 3. A performance update was incorporated in an AOM briefing session held at the Millwall Conference centre in March 2009. All AOMs were in attendance. 4. Monthly report to AOMs on areas of weak performance. 5. Messages given out at Team Leaders Conferences. 6. Encourage more routine downloading of information from data cards. 7. 147 LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units.	Fionna Moore	04-Mar-13	Moderate	Possible	9	1. To highlight the importance of clinical incident reporting in the Team Leader Clinical Update Course. 2. Physio Control to attend the T/L conference to confirm how downloading should be completed 3. Focus on Team Leaders at Oval to teach them the interpretation of downloads and hold case based meetings with staff following a cardiac arrest, to encourage staff presenting machines for downloads. 4. Audit of FR2 data cards and card readers. 5. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 6. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 7. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area.	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread 6. M.Whitbread 7. M.Whitbread	1. Complete 2. Complete 3. Ongoing 4. Ongoing 5. Ongoing 6. Ongoing 7. Ongoing	2. EOC briefings undertaken	Moderate	Unlikely	6	
226	There is a risk that the identified risks associated with lone working are not being uniformly mitigated as a result of inconsistent application of the Lone Worker Policy.		12-Jul-06	***	7,4	Health & Safety	Moderate	Almost Certain	15	1. The Lone Worker Policy has been reviewed. 2. The Trust received positive feedback from Internal audit on Lone Worker Policy: - all A&E operational Staff received Personal Safety conflict management training (1 day); - all Operational staff are issued with ECA mobile phones; - the Trust has a high risk address register; - Lone Working risk assessments are regularly reviewed; - appointed FRU coordinators at each at main stations ensure staff are aware of locally known hazards; - all operational vehicle have MDT and radio facilities; - Violence Prevention and Lone worker policies highlight specific procedures for reducing foreseeable hazards to staff.	Tony Crabtree	04-Mar-13	Moderate	Possible	9	1. Revised Lone worker policy reviewed ADG approved revised policy at 27th July meeting - (JS-27/06/12)	1. Martin Nicholas/ Tony Crabtree	1. Completed	1. Publications in RIB / LAS News / Pulse 2. Lone worker policy	Moderate	Unlikely	6	

London Ambulance Service NHS Trust
Risk Register as at 12th June 2013

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200	There is a risk of loss of physical assets due to the risk of fire.		01-Jan-02	***	1,2,3, 4,7	Health & Safety	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2.Annual Fire Risk Assessments are undertaken by the Estates Department. 3. Fire Fighting equipment is sited at all strategic locations. 4. Premises Inspection Procedures require all premises to be inspected on a three monthly basis. 5. Local Induction Training requires managers to identify fire precaution to all new staff. 6. Updates of health and safety issues are provided at the Estates Meeting monthly. 7. Estates department annual assurance of Trusts fire safety compliance. 8. Fire Marshals are appointed by Line Manager 9. Fire & Bomb evacuation Policy 10. Update on premises inspection reported to Corporate Health and Safety Group Quarterly 11. Core skills refresher 2 includes vehicle fire precaution awareness training. 12. All operational vehicles are fitted with appropiate extinuishers and crew staff fire awareness is included in CSR 13. Local induction includes fire safety awareness. 14. Local testing of fire alarm systems occurs on	Tony Crabtree	04-Mar-12	Major	Unlikely	8	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training.	1. J.Selby	1. Ongoing	- Corporate Health and Safety Group - Emergency Evacuation policy. - Annual assessment undertaken by Estates. -	Minor	Rare	2	
354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.	There could be an impact on service delivery, patient care and the Trust's reputation.	23-Nov-11		1,2,3, 4,7,8	Human Resources	Major	Possible	12	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff.	Tony Crabtree	04-Mar-13	Major	Possible	12	1. Implement recommnedations from N30 review. Note - Actions from N30 internal review are all complete, and actions from the NHSL integrated action plan are on track - (CH 27th June 2012)	1. Tony Crabtree	1. 2012/13		Major	Possible	12	
282	There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.		03-Jul-07	***	1,2,5,	Business Continuity	Major	Possible	12	1. The move of business information from hard drives to network drives. 2. Part of the 2010/11 audit programme will test this facility and give assurances. 3. IM&T Infrastructure Team to review and take actions as appropriate.	Vic Wynn	16-Apr-13	Major	Possible	12	1. Audit to be carried out on the status of the move to network drives. 2. Ensure central data servers are backed up. 3. Fundamentally review how data is stored on local drives and potentially not backed up.	1 - 3 Paul Sulja			Major	Unlikely	8	
293	There is risk that that Patient Specific Protocols (PSP) and palliative care, out of hours forms, etc. may not be triggered by the call taker when the patient's address is identified during 999 call.	Incident where call taker had not picked up patient specific protocol	18-Feb-08	***	1,2,4, 5	Clinical	Major	Possible	12	1. The Senior Clinical Adviser has lead responsibility to PSPs. 2. The Clinical Support Desk has delegated responsibility for the accuracy of PSPs but do not have access to update them. 3. Input and maintenance are performed by Management Information who have introduced a range of control measures. 4. The introduction of CAD 2010 will allow automatic flagging and for a range of status flags to be used. 5. The Senior Clinical Advisor liaises with Management Information for the appropriate access to be provided to Clinical Support. 6. All relevant staff are periodically reminded of the requirement to correctly trigger PSPs.	Fionna Moore	24-Apr-12	Major	Possible	12	1. Increase in use and functionality of the Coordinate my Care (CmC) system across all London. (The Senior Clinical Adviser, IM&T and Management Information are working with System C, (the company that developed the newly introduced Pan London EoLC Register, (Coordinate my CAre - CmC), that will be used by all 111 sites and LAS), to look at the possibility of CmC automatically placing a flag on the patient's address. This will obviate the necessity for it to be done manually.)	1. D.Whitmore	1. Sep 2013	1. Incident reporting. 2. Complaints monitoring. 3. Protocols and transfer procedure	Major	Unlikely	8	
369	There is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level.	a) Changes to NED appointments and b) substantive/temporary (i.e. maternity leave) changs to the executive team.	08-Oct-12			Governance	Major	Possible	12	1. New CEO, DoF and NEDs in post and induction underway or completed. 2. Interim executive structure in place to June 2013. 3. Refresh of BGAF confirms progress being made and does not highlight any new areas of concern.	Sandra Adams	05-June-13	Major	Possible	12	1. Executive structure and to be completed in October 2013. 2. Succession planning for NEDs to be reviewed and implemented by December 2013.	1. Ann Radmore 2. Richard Hunt/Sandra Adams	1. Oct 2013 2. Dec 2013	1. Interim arrangements in place for executive positions for the next 6 months. 2. Further associate and substantive NED appointments to be planned.	Major	Unlikely	8	

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370	There is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles.	The board of directors leads the strategic direction of the organisation and need to be able to articulate and support this both internally and externally to theTrust. New appointments to key roles such as the chief	08-Oct-12			Governance	Major	Possible	12	1. Trust Board has agreed the strategic direction to 2017/18 2. Plans to restructure the EMT are being finalised. 3. Interim executive team structure in place for 6 months 4. Induction programme for directors implemented	Sandra Adams	15-Apr-13	Major	Possible	12	1. Building the 5-year strategy into the IBP and LTFM.	1. Lizzy Bovill	1. October 13	1. Interim arrangements in place for executive positions for the next 6 months. 2. Overarching Trust strategy to be finalised, signed off and communicated.	Major	Unlikely	8	
360	There is a risk that the Trust will not achieve level 2 NHSLA compliance where there is a significant gap between policy/procedure and practice.	- some evidence which can be provided is not consistent with the processes outlined within the documents - non compliance with the related NHSLA standards may contribute towards overall non compliance with the NHSLA standards at a Level 2 assessment as the trust will not be able to	09-Jan-12		1,2,4	Corporate	Major	Possible	12	1. NHSLA Level 1 compliance with 48/50 standards. 2. Established meetings with leads for NHSLA and CQC standards where gaps in compliance are monitored and actions agreed. 3. Audits conducted by Governance and Compliance Team on current CQC and NHSLA to identify non compliant areas.	Sandra Adams	24-Apr-12	Major	Possible	12	1. Quality Performance Improvement Managers to be invited to attend compliance standards meeting on a regular basis. 2. Disemminate current compliance status with NHSLA and CQC standards at Directorate and Area meetings with actions required. 3. Level 2 gap analysis to be updated in conjunction with standard leads, including refresher training on PA and user guides circulated. 4. The first quarterly update provided by users, including uploading of all required evidence, as specified in the gap analysis. 5. The first of the quarterly governance audits,	1. GCT 2. GCT 3. Standard Leads 4. GCT and Standard Leads 5. GCT 6. GCT and Standard Leads	1. From Oct 2012 2. From Oct 2012 3. Completed 4. Dec 2012 5. Jan 2013 6. March 2013		Major	Unlikely	8	
63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	***	1,2,4, 5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	07-Jan-13	Major	Possible	12	To have a decontamination policy that meets CQC expectations: 1. Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. 2. Monitor decontamination compliance	1. C. Vale/ K. Merritt 2. T.Hubbard	1. Complete 2. Sep 2012	1. Incident reporting. 2. Complaints/ claims monitoring.	Moderate	Rare	3	
272	There is a risk that the LAS may not achieve the full CIP due to new/unforseen cost pressures.		03-Jul-07	***	8,10	Finance	Major	Possible	12	1. CIP has been agreed with SMG/ Trust Board. SMG/Trust Board review report monthly. 2. Monthly monitoring via Performance Accelerator. Monthly Finance Review includes detailed forecast. 3. 37 CIP related projects are integrated with the standard programme management arrangements through the Integrated Business Plan. 4. Continue to Identify further savings - monthly CIP reporting.	Andrew Grimshaw	04-Mar-13	Moderate	Possible	9	1. Review as part of CIP monitoring 2. Review by Finance Investment Committee	1. M.Salter 2. A.Cant	1. Ongoing 2. Ongoing	1. CIP reported monthly to SMG and the Trust Board. 2. Programme Governance Structure 3. Finance Investment Committee	Moderate	Possible	9	
309	There is a risk of fraudulent activity from staff, patients and contractors.		16-Feb-09	***	4,5	Finance	Major	Possible	12	1. An annual Counter Fraud work-plan is agreed with the Director of Finance and is approved by the Audit Committee. The work-plan ensures that time is allocated to the Local Counter Fraud Specialist to undertake work in the areas of the Counter Fraud Strategy, inclusive of Creating an Anti-Fraud Culture; Deterring Fraud; - Preventing Fraud; Detecting Fraud, - Investigating any allegations of fraud that are received against the Trust; - Applying Sanctions that can involve disciplinary, civil and/or criminal hearings; - Seeking redress - seeking to recoup money that has been obtained from the Trust by fraudulent means. 2. RSM Tenon - audit function	Andrew Grimshaw	07-Jan-12	Moderate	Possible	9	1. Promoting an anti-fraud culture amongst Trust staff by giving presentations, distributing Counter Fraud literature, holding fraud awareness events. 2. Creating deterrence by promoting successfully locally and nationally investigated fraud cases. 3. Preventing fraud by reviewing Trust policies and procedures. 4. Detecting fraud by undertaking Local Proactive Exercises into areas of concern. 5. Undertaking of a Fraud Risk Assessment.	1-5. A. Grimshaw (via Trust Counter Fraud Group)	1-5. As scheduled in the Local Counter Fraud Specialist Annual Work Plan for 2012 / 2013	1. Reported incidents. 2. Trust Counter Fraud Group	Moderate	Unlikely	6	
308	There is a risk that LAS staff may suffer emotional or physical injury as a result of being subject to physical or verbal assult, and this may adversely affect the delivery of the service that the LAS provides and/or the reputation of the LAS.	Injury and Sickness Absence	01-Apr-11	***	1,2,5, 7	Health & Safety	Moderate	Likely	12	1. The Local Security Management Specialist (LSMS) has developed a draft Trust Security Management Plan in accordance with Counter Fraud and Security Management guidance. 2. Serious Incident Reporting system will ensure information is regularly reported to NHS Protect. 3. Local management support, LINC and counselling services are available to staff	Tony Crabtree	04-Mar-13	Moderate	Possible	9	1. Conflict Resolution Training update is included in CSR 3 of core learning skills. 2.Reinforce existing responsibilities @ complex level by line management (Specified in Security management policy 3. MN has resubmitting requisitions for Institute of Conflict Management training and accreditation (Application to TSG for funding of physical skills tutor course submitted through GH) Funding for ICM accreditation/training has been agreed and is scheduled to occur prior to	1. M. Nicholas 2. M.Nicholas 3. M.Nicholas	1. Core Skills refresher 3 will include CRT 2013/14. 2. Awaiting direction following ADG meeting 24/02/2012 3. Approval of funding Dec	1. Monitoring of Incident reports by CHSG	Moderate	Unlikely	6	

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186	There is a risk that the inconsistent management of Medical Devices may lead to a higher rate of failure, which would in turn have an adverse effect on the provision of clinical care.	Equipment moved to satitisfy operational needs for patient care	10-Feb-04	***	1,2,4, 5,8	Logistics	Major	Possible	12	1.Servicing schedules for medical devices are agreed with suppliers and carried out within the specified timescale. 2.Supplier records are made available to the Logistics Department. 3.There is also a system of record cards for all medical equipment held within the Logistics Department. 4. Analysis of LA52s for any training issues. 5. Monthly defib audits - returns reported to VEWG	Paul Woodrow	24-Apr-13	Moderate	Possible	9	1. The project mandate for tracking medical devices has been approved by the VFM Programme Board and will take into account terms within the make ready contract once they have been agreed. 2 Electronic Equipment Maintenance database in preparation.to asist compliance with NHSLA level 2 - management of medical devices	1. M.Salter/ G.Gifford 2. C. Vale	1. July 2013 2. July 2013	1. Monitoring of service records for medical devices.	Moderate	Unlikely	6	
223	There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process.	Unable to produce sufficent capacity to meet current and ongoing demand levels	12-Jun-06	***	4,5	Operational	Moderate	Likely	12	1. Demand management strategies deployd to reduce overall activity. 2. Use of third party capacity at times of peak demand.	Paul Woodrow	01-May-13	Moderate	Possible	9	1. Capacity review with Commissioners with a view to reduce utilisation. (ORH jointly commissioned between LAS and Commissioners to undertake review)	1. P.Woodrow/ J.Killens	1. Q3/4 2012/13		Moderate	Unlikely	6	
164	There is a risk that Policies and Procedures are not adhered to due to lack of staff awareness and robust implementation plans.	Serious incidents often show that non-compliance with policy is often the root cause of an incident	04-Jan-05	***	1,2,5, 8	Corporate	Moderate	Likely	12	1. NHSLA level one achieved in October 2012 2. Incidents and serious incidents where policy has not been followed and action is required is monitored by the SMT. 3. All new policies and procedures and significant amendments are announced in the RIB.	Sandra Adams	06-Jun-13	Moderate	Possible	9	1.Policies and procedures required for NHSLA Level 2 are being reviewed to ensure that effective monitoring is in place to show that they are being followed. 2. Where there has been a breach of policy, Owners/E&D to be requested to arrange appropriate training and awareness for staff.	1. S. Moore 2. S. Moore	1. March 2014 2. Ongoing	NHSLA level 1 Review of incidents and complaints to ascertain any breach of policy. The SI action plan is reviewed and updated by the SMT.	Moderate	Rare	3	
356	There is a risk arising from no provision for protected training time for clinical and paramedic tutors. This may as a consequence cause:- • Dilution of training skill levels • Credibility and reputation concerns of trainers • Impact on the validity of clinical training	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	23-Nov-11		1,2,4, 5	Human Resources	Moderate	Likely	12	1. All tutors have recived a clinical update package. 2. All tutors have received major incident update training. 3. A clinical update training day has been provided to all clinical training staff. Additional clinical skills programmes have been run based on idnetifyied need and regular operational shifts will be incorporated into work pattern.Some staff are to receive additional training in order to support DMP	Tony Crabtree	04-Mar-13	Moderate	Possible	9	1. The training establishment is being reviewed and remodeled to ensure needs can be met. Additionally Training officers are being invited to attend clinial updates. The first of these took place in April 2012	1. GH	1. April 2013	Course review and feedback by Education Governance Manager	Moderate	Rare	3	
222	There is a risk that lack of frontline management at weekends may reduce the level of support/advice available to staff		13-Jun-06	***	1,2,4, 8	Operational	Major	Possible	12	1. DSO annual leave is restricted to ensure 5 are always available pan-London. 2. Team Leaders are also available to respond to incidents in support of crew members. 3. This risk is reduced by safety training for crew staff and the advice to await the arrival of police in high risk situations. 4. A requirement for on duty Silver officer to respond where appropriate, for this reason the Trust has a duty AOM and a on-call AOM avaialabe at all times.	Paul Woodrow	01-May-13	Major	Unlikely	8	1. Review new leave rules for DSOs. 2. Develop changes to ops management structure in the light of capacity review. 3. Operational mangement restructure to be prepared for consultation for Q4 post ORH review	1. P.Woodrow 2. P.Woodrow / J.Killens	1. Q3 2012/13 2. Q4 2012/13	1. Analysis of incident reporting	Major	Unlikely	8	
383	There is a risk that the processes and enabling technology for operating on paper across two sites are not sufficiently robust and resilient resulting in a delayed LAS response.	The CAD system logger software does not optimally support two site fall back to paper operations in its current configuration. This means that in the event of fallback to paper, there is a risk that any lost patient details could take longer to identify than if an enhanced configuration was adopted. The current logger	07-May-13			Operational	Major	Possible	12	1. PC Logger with current configuration now enhanced to more directly support fall back to paper by substantially increasing print speed. 2.OP/66 operational procedure updated for two site paper operations.	Paul Woodrow		Major	Unlikely	8	1. Further Enhancements to PC Logger - RFC29 2. Dry run exercises of paper operations on two sites. Table top exercises and rehearsals - OP66 checks. 3. Audit check of SMG recommendations from CommandPoint SI relating to paper operations.	1. J. Downard 2. S. Goodwin 3. Medical and CS	1. TBC 2. April 2013 3. April 2013		Moderate	Unlikely	6	

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365	There is a risk that Board Members are unable to commit time required to prepare for becoming an FT Board of Directors.	Unplanned changes to FT related meetings, particularly with external stakeholders, may not be accommodated by NEDs who have other time commitments outside the LAS	03-May-12			Governance	Major	Possible	12	1. Schedule of committees includes SRP for strategic focus. 2. NEDs have a time commitment to LAS of 2.5 days. 3. FT project team re-established. 4. Risk reviewed by FT Project Team. 5. Trust Board and SRP sessions extended to full day to incorporate development time	Richard Hunt	05-Jun-13	Major	Unlikely	8	1. With Healthskills, develop a programme of Board development that focuses on key items for preparation for an FT Board. 2. Chair and NEDs agree PDPs.	1. Sandra Adams 2. Richard Hunt	1. March 2014 2. March 2014	1. Attendance schedule for Board development. 2. PDPs in place for all NEDs.	Major	Rare	4	
376	There is a risk that the Trust Board fails to fulfil all its statutory duties.	NHS Trust Boards have many requirements placed on them by external organisations such as CQC, NHSLA, Department of Health and Monitor, following authorisation as a Foundation Trust.	14-Jan-13			Governance	Major	Possible	12	1. Trust Board forward planner 2. Board assurance framework and corporate risk register 3. Full understanding of regulatory requirements 4. Annual Reporting and external annual audit opinion 5. Monthly SOM submission to the SHA, signed off by the Trust Board	Sandra Adams	05-Jun-13	Major	Unlikely	8	1. On becoming a Foundation Trust, adherance to Monitor's compliance framework 2. Quarterly governance submissions to Monitor 3. Independent assessment of quality governance framework 4. Self Assessment for FT Board Statements and Memorandum	1. S.Adams 2. S.Adams 3. S.Adams 4. S.Adams	2. Ongoing		Major	Rare	4	
384	There is a risk that unsecured LAS equipment taken onto a third party Ambulance causing injury following an RTC	Injury to ambulance staff, patients or third parties	07-May-13				Major	Possible	12	1. PAS/VAS vehicles should comply with the construction in use and CEN regulations in respect to providing suitable and sufficient securing for equipment. 2. LAS operational staff when attending a patient in a third party ambulance, are required on occassions to dynamically assess the risk of transfering a critically ill patient using unsecured LAS medical equipment, against the forseable clinical risk to the patient. 3. LAS operational staff should use, where practicable, the third parties secured on board medical equipment	Paul Woodrow		Major	Unlikely	8	1. LAS operational staff should ,where reasonably practical, ensure that LAS medical equipment is secured on third party vehicles. 2. Operational bulletin reminder about securing, where possible, of LAS medical equipment on a third parties ambulance. 3. Purchasing have reviewed the existing PAS/VAS contract , with the aim to include the provision in future contract specification for stowage of a attending services equipment.	1. Operations 2. Operations 3. Purchasing	1. 2. ASAP 3.		Major	Rare	4	

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
358	There is a risk that the joiners and leavers process is not established, leavers still have access to LAS information or have assets belonging to LAS.	There is a dissconnect between HR processes and IM&T to ensure that leavers return all assest and accounts are disabled when the staff member leaves.	09-Jan-12		4	IM&T	Minor	Almost Certain	10	1. Removal of duplicate Employee IDs	Vic Wynn	17-Apr-13	Minor	Unlikely	4	1. Starters and leavers process documentation being created. 2. Complete and distribute 'Managers Guide to Administration' to Managers. 3. Ensure that assets held by the leaving member of staff are identified and returned on the last day of work; New leavers process starts 31/05/13. 4. Ensure that logical access to LAS systems is disabled when the staff member leaves. This is to include, as much as possible, this is to include all remote access and NHSmail accounts. Complete. New technology automatically removes access to LAS networks upon termination in the Electronic Staff Record (ESR).	1. A.Honour 2. G.Masters 3. A.Honour 4. A.Honour /G.Farquhar	1. Complete 2. 31/05/13 3. 31/05/13 4. Complete	1, Starters and leavers meeting held every 2 weeks The new leavers process will ensure that line managers confirm they have collected any sensitive or valuable assets and compliance can be audited	Minor	Unlikely	4	
331	There is a risk that the Trust will not achieve the target of reducing its carbon footprint by 10% by 2015 (based on 2007 carbon footprint)	Underlying cause is the legal requirement on the Trust (in line with the rest of the NHS) to deliver on the commitment to reduce carbon footprint by 10% by 2015 (based on 2007/08 carbon footprint Scope 1&2).	06-May-10	***	4	Finance	Moderate	Possible	9	The Trust's five year carbon management plan has been edorsed by the Carbon Trust. The Plan outlines how the Trust will achive reduction in carbon footprint primarily based on changes in response model - increased use of CTA, reduction in non-conveyance and Multiple Sends	Sandra Adams	08-Jan-12	Moderate	Possible	9	1. CMc 27/09/12: the Trust is exploring possibility of working external contractor re. Energy Services to continue to modernise our infrastructure and reduce our consumption by 15%. The Trust's Energy Manager is investigating joining the ReFIT programme which is a GLA sponsored inititiave with the objective of improving energy conservation in London. 08/01/13: this is work in progress. 2. Management action plan will be overseen by Carbon Reduction Project Board (chaired by Mike Dinan). 3. 6 monthly progress reports will be submitted to the Finance & Investment Committee. 08/01/13: This was done in November 2012, available data suggests Trust is on track with carbon reduction measures. 2012/13 will be submitted to the FIC in May 2013. 4. Pilot projects to be undertaken in the buildings that have half hour meters measuring electricity usage. 5.Travel plan and supporting survey to be undertaken 6. Recruitment of green champions.	1.C.McMahon 2.C.McMahon 3.C.McMahon 4.C.McMahon 5.C.McMahon 6.C.McMahon	1. March 2013 2.quarterly 3. May 2013 4. March 2013 5. March 2013 6. March 2013	1. Regular reports to Carbon Mgt Project Board & 6 monthly progress report to the Finance & Investment Committee	Moderate	Unlikely	6	
350	There is a risk that the establishment of a Clinical Commissioning Group and reconfiguration of the SHA and PCT's may result in a temporary reduction in stakeholder engagement and partnership working and subsequent delivery of improvements in the urgent and emergency care system.	Since the implementation of the Health Bill the following issues have been highlighted. 1) Impact on providing appropriate clinical care to patients. 2) Staff clinical decision making could be affected. 3) Impact on finance due to not achieving financial targets such as CQIN and Quality, Innovation ,	11-Jul-11	***	1,2,4, 10	Clinical	Moderate	Possible	9	1. Monthly monitoring of current care pathway usage. 2. Feedback mechanism in place of care pathways with commissioners. 3. Creating an evidence base and continuing a dialogue with commissioners to maintain clinically appropriate pathways and reported bi monthly to Clinical Quality Group. 4. A Clinical Quality Group to engage senior GPs from clusters in strategy and quality issues meets bi-monthly. 5. Membership and attendance at NHS London and cluster level unscheduled care boards and attended by CCG clinical commissioners provides further opportunity for engagement.	Jason Killens	18-Mar-13	Moderate	Possible	9	1. Attendance at cluster level clinical cabinets to gain support for LAS strategy and FT application.	1. J. Killens	1. April 2013	1. Established relationships with Senior Leads. 2. Commissioners and LAS CQG quarterly providing direct engagement with clinical commissioners 3. Stragetic commissioning board meeting quarterly and attended by CCG clinical	Moderate	Unlikely	6	
199	There is a risk to staff safety / vandalism/theft due to inability to adequately secure premises.	There is no overarching Security Risk Policy to coordinate and bolster existing security measures within the Trust and there is no identified specific group who oversee security issues.	01-Jan-03	***	7,8	Finance	Moderate	Possible	9	1. Operational managers in conjunction with H&S representatives carry out quarterly health and safety premises inspections. If there is a perceived security issue it will be reported to Estates who will investigate and take appropriate action. 2. OP/018 Procedure On Station Duties. 3. Bulletin reminding staff to secure premises when leaving unattended. 4. Security Management Policy has been developed and has been ratified by the EMT.	Sandra Adams	25-Apr-13	Moderate	Possible	9	1. Audit of security at stations has been undertaken and a schedule of full security audits has been drawn up and is being carried out. 2. To establish an internal security review group to monitor recommendations made following the outcomes of security audits. 3. Specific Security Section had been added to the Premises Quarterly Inspection schedule and is being roled out during the first quarter of 2013/14.	1. M. Nicholas / John Selby 2. M. Nicholas 3. to be agreed 4. M. Nicholas	1. May 2014 2. June 2013 3. 2013/14	The controls will be monitored by the Safety & Risk Dept, reporting to the Corporate Health & Safety Group and also the Trust Internal Security Review Group, reporting to the ADG.	Moderate	Unlikely	6	

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
303	There is a risk of unavailability of critical patient care equipment on vehicles.	Equipment moved to satitisfy operational needs for patient care	21-Oct-08	***	1,2,4, 8	Logistics	Moderate	Possible	9	1. New vehicle preparation contracts in place with new contract that will introduce electronic asset tracking in Q3/4 2012/13. 2. Regular equipment amnesty. 3. New capital equipment (defibs) purchased.	Paul Woodrow	05-Mar-13	Moderate	Possible	9	1. Trial of new LA1 forms to include equipment and VDI checks being carried in the West Area for 3 months commencing June 2011. 2. Following West area review, begin roll-out to East and South areas 3. New LA4 forms and Red Bags in place across trust 4. Surplus equipment held by make ready 5. Area based equipment stores to be established by logistics Q3/Q4 working with assest tracking				Moderate	Unlikely	6	
364	There is a risk that changes to the external commissioning and provider support environment cause uncertainty and delay in progressing the FT application	Transitional arrangements commence in 12/13 within the SHA provider/FT application support team and within commissioning. If there are changes within those teams this may create delay to the FT application whilst there are gaps or handover arrangements taking place	19-Apr-12			Corporate	Moderate	Possible	9	1. Engagement of lead commissioner in FT development 2. Strategic Commissioning Board provides the opportunity to reinforce the LTFM requirements 3. Cluster letter of support – October 13	Sandra Adams	04-Mar-13	Moderate	Possible	9	1. Strengthen the commissioner engagement in reviewing and developing the 5-year strategy through the IBP and LTFM 2. Engage commissioners in the development and sign off of the downside scenarios 3. Letter of convergence is clean and unambiguous	1. J.Killens / S.Adams / A.Grimshaw 2. A.Grimshaw / A.Cant 3. L.Bovill / A.Grimshaw/ S.Adams	1. 31 Aug 12 2. 31 Aug 12 3. Nov 12	1. Commissioner letter of convergence fully supports the LAS application and strategy 2. IBP and LTFM fully supported and signed off by commissioners 3. Downside scenarios updated and supported by the commissioners	Moderate	Unlikely	6	
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	***	4,7	Infection Control	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are	Steve Lennox	25-Apr-13	Moderate	Possible	9	Minimise the risk of sharps injury: 1. Participate in national ambulance audit 2011. 2. Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1.T.Hubbard 2. T.Hubbard	1. Complete 2. May 2013	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting.	Minor	Unlikely	4	
278	There is a risk that staff are not trained in Business Continuity and are unaware of their responsibilities and/or their departmental arrangements in the event that the Business Continuity Plan is invoked.		03-Jul-07	***	5,7	Business Continuity	Moderate	Possible	9	1. Tabletop testing programme of departmental plans is ongoing and has so far included IM&T, Communications, Estates, Logistics, Finance, Purchasing and HR (Safety & Risk and Staff Support). 2. Business Continuity is now covered in the Corporate Induction Programme and the 3 year all in one refresher for support staff. 3. Awareness raised of departmental BC plans ahead of Olympic Games 2012. Maintaining Service Delivery group also promoting need for departmental BC.	Jason Killens	08-Jan-13	Moderate	Unlikely	6					Moderate	Unlikely	6	
366	There is a risk that frontline staff may not be able to measure oxygen saturations on some paediatric patients, in particular infants due to an inconsistency in availability of paediatric pulse oximetry across the Service.	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them due to the high cost (paed probes are approx £175) and the fact that due to flexible fleet, probes that are ordered then go off to other areas of the Service. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak	Fionna Moore	04-Mar-13	Moderate	Unlikely	6	1. Discussion ongoing as to best way to overcome issue of stations not ordering paediatric probes 2. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 3. Discussion ongoing as to optimum way to overcome problem of lack of paed probes	1. F.Moore 2. ADO's 3.	1. 2. 3.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the	Moderate	Rare	3	

London Ambulance Service NHS Trust
Risk Register as at 12th June 2013

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
367	There is a risk that oxygen saturations may not be able to be measured immediately after arrival of the crew (at present oxygen saturations can only be measured using a Lifepak 12/15 which can be removed from the vehicle but, being a large piece of equipment is not usually taken in initially with the primary response bag, AED and oxygen bag).	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured. In addition, oxygen may be administered to COPD patients who do not require it (or higher levels than necessary may be administered).	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak 12/15s available on all frontline vehicles 4. Email sent to all station management by the Senior Clinical Advisor in June 2012 reminding them that the probes are available on Eseries and that they should be equipping their vehicles with them.	Fionna Moore	04-Mar-13	Moderate	Unlikely	6	1. Medical directorate and purchasing dept have looked into possibility of purchasing small, easily portable nonin pulse oximetry probes. A price of approx £100 each was secured funds may not available to purchase these (in addition, personal issue nonins may not be the answer). 2. Monitor the purchase of oximetry probes, both paed and adult, as a measure of success / impact. 3. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 4. Discussion ongoing as to best way to overcome this issue.	1. M.Whitbread 2. F.Moore 3. ADO's 4.	1. 2. 3. 4.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes.	Moderate	Rare	3	
275	There is a risk of loss of access to the Deptford Logistics Store may result in drug supplies being disturbed.		03-Jul-07	***	1,2,8, 10	Business Continuity	Moderate	Possible	9	1. The Trust has arrangements for Frimley Park Hospital NHS Trust to supply drugs on a 24 hour basis if required (but no formal arrangement is in place.). 2. London hospitals could supply drugs in an emergency.	Paul Woodrow	05-Mar-13	Moderate	Unlikely	6	1. Secure agreement with neighbouring Ambulance Trusts to access drugs in extremis.	1. E.Potter	1. Q3 12/13		Moderate	Rare	3	
271	All staff may not be in possession of a valid driving licence for the category of vehicle they are required to drive.	Seizure of licence by the courts, or attempting to drive a vehicle they hold no valid licence for	14-Mar-07	***	4,5,8	Operational	Moderate	Possible	9	1. All staff have their driving license checked upon recruitment. 2. Anyone with more than 3 points will not be appointed. 3. Driving licence checks should be undertaken for all service drivers on a 6-monthly basis (TP023a/TP065). 4. All staff claiming mileage must declare whether they have a valid driving licence.	Paul Woodrow	04-Mar-13	Moderate	Unlikely	6	1. The Trust is working inconjuction with staff side viewing options on how best to robustly manage driving licence checks. 2. The Trust is exploring an automated system to check licences directly with the DVLA.	1. & 2. J. Killens / G.Hughes	1. & 2. TBA (following review)	1. Internal Audit	Moderate	Rare	3	
372	Complex AOMs fail to write to addresses and inform individuals of their inclusion on the location alert register following initial inclusion and following review. This may result in an incorrect address being included thereby putting patients at risk. This also could lead to complaints and a reputational risk to the Trust	1. Failure to write letters 2. Failure to carry out regular, detailed and timely reviews	14-Jan-13			Operational	Moderate	Possible	9	1. Robust review process in place. 2. Policy reviewed. 3. Standard template letters are available for AOMs to use. 4. Monitoring in place by Management Information.	Paul Woodrow	27-Feb-13	Moderate	Unlikely	6	1. ADO's monotir letter writing at a local level.	1. ADO's	1. Jan 2013	1. ADOs will monitor compliance by AOMs	Moderate	Rare	3	

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Finance Report 2013/14 Month 2: May 2013**
Report Author(s):	**Andrew Grimshaw, Director of Finance**
Lead Director:	**Andrew Grimshaw, Director of Finance**
Contact Details:	**andrew.grimshaw@lond-amb.nhs.uk**
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

Executive Summary

- In month surplus £0.2m. Year to date small deficit.
- Year to date £0.1m adverse variance from plan;
  - Management of operational staff – especially relief factor
  - CIP delivery
- EFL variance due to lower than planned cash balance
- Cash remains in line with plan. Although delays in receipts from CCGs has resulted in reduced supplier payments in month. This is seen as a non-recurrent issue.
- The Trust would expect to score an FRR of 3 against the Monitor metrics.
- The Trust expects to meet its CRL target although the limit of £10.2m. Capital spend up to May has been limited and there was a delay in vehicles purchasing that will be resolved in Month 3.

Attachments

Finance Report 2013/14 Month 2: May 2013

****

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

- ☒ Staff/Workforce
- ☒ Performance
- ☐ Environment
- ☐ Experience
- ☐ Helping People
- ☐ Quality of Life
- ☐ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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

2013/14 Priorities
- ☐ Modernisation Programme
- ☐ Communication and Engagement
- ☒ Sustain performance to ensure safe service to patients
- ☒ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS Trust
Finance Report 2013/14
Month 2: May

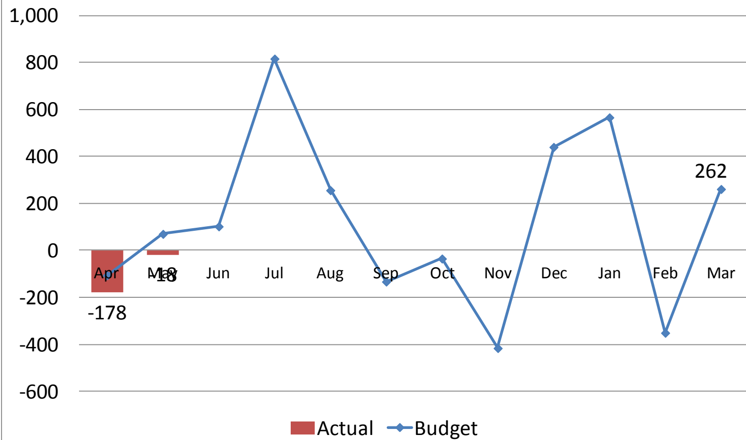
Trust Board: Part 1
26th June 2013.

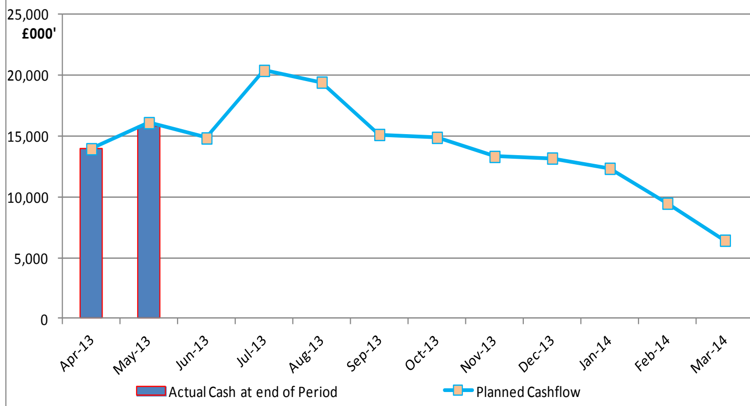
Andrew Grimshaw
Finance Director

Executive Summary

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the trust reported a £0.2m surplus which was marginally ahead of plan. YTD the trust is showing a breakeven position which is below the £0.1m surplus expected. The trust still expects to deliver its £0.3m year end surplus position. The shortfall in YTD surplus is driven by a number of factor including excess relief costs in operational staff groups and CIP delivery	**GREEN**	**AMBER**
Income	Income is £0.3m adrift in month and £0.5m adverse YTD. Risks to the full year position include shortfall in core income (currently managed through reserves), and Hospital Turnaround Penalties (YTD £59k impact adverse). Mitigation has been seen in the form of better than expected PTS performance due to additional contract income £0.1m	**GREEN**	**AMBER**
Expenditure	In month favourable £0.3m, YTD favourable £0.4m Operational Pay is currently £0.9m adverse YTD when 3rd Party is included and this is not sustainable in the longer term. The modernisation programme will look to address current front line delivery. If 3rd party is excluded Non Pay is expected to be broadly flat overall.	**AMBER**	**AMBER**
CIPs	Currently reporting behind schedule YTD of £101k due to delays in delivery commencing. Additional PMO support has been put in place to support the delivery of CIP going forward and further opportunities are being explored and developed.	**AMBER**	**AMBER**
Balance Sheet	Overall no major concerns at this stage, Debtors is slightly higher than plan due to delays in receipts from CCGs. This is seen as a process problem resulting from the move to CCGs rather than a reflection of non-payment.	**GREEN**	**AMBER**
Cashflow	Cash is on plan. However, delays in receipts from CCGs has resulted in the Trust slowing payments to suppliers. Delays in capital expenditure have also acted to retain cash.	**GREEN**	**AMBER**

Executive Summary - Key Financial Metrics





Description	Month 2 - May 2013			Year to Date			FY 2013/14		
	Budg	Act	Var	Budg	Act	Var	Budg	Fcast	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Dept Health									
Surplus	176	161	15	71	(18)	89	262	262	
EFL	(2,151)	(1,799)	(352)	(10,605)	(10,293)	(312)	(2,288)	(2,288)	
CRL	62	37	26	1,304	116	1,188	10,250	10,250	
Suppliers paid within 30 days - NHS	95%	44%	-50.9%	95%	39%	-56.1%	95%		
Suppliers paid within 30 days - Non NHS	95%	64%	-31.1%	95%	62%	-33.1%	95%		
Monitor									
EBITDA %	6.5%	6.6%	0.1%	6.0%	5.8%	-0.2%	6.4%		
Net Surplus	176	161	15	71	(18)	89	262		
Return on Assets	0.59%	0.55%	0.04%	0.59%	0.55%	0.04%	tba		
Liquidity Days	(8.44)	(8.37)	0.07	(8.44)	(8.37)	0.07	tba		
Monitor net rating		3			3				

- In month surplus £0.2m. Year to date small deficit.
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- Cash remains in line with plan. Although delays in receipts from CCGs has resulted in reduced supplier payments in month. This is seen as a non-recurrent issue.
- The Trust would expect to score an FRR of 3 against the Monitor metrics.
- The Trust expects to meet its CRL target although the limit of £10.2m. Capital spend up to May has been limited and there was a delay in vehicles purchasing that will be resolved in Month 3.

Statement of Comprehensive Income

Month 2 - May 2013			Description	Year to Date			FY 2012/13		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			Income						
22,259	22,200	(59)	Emergency & Urgent care	43,399	43,330	(69)	262,415		
2,706	2,462	(244)	Other	5,369	4,903	(466)	32,195		
24,965	**24,662**	**(303)**	**Subtotal**	**48,768**	**48,233**	**(535)**	**294,611**	**0**	**0**
			Operating Expense						
17,640	17,093	546	Pay	35,311	34,019	1,292	214,723		
5,713	5,943	(231)	Non Pay	10,520	11,400	(880)	61,178		
23,353	**23,037**	**316**	**Subtotal**	**45,831**	**45,419**	**412**	**275,900**	**0**	**0**
1,613	**1,626**	**13**	**EBITDA**	**2,937**	**2,814**	**(124)**	**18,711**	**0**	**0**
6.5%	6.6%	-0.1%	**EBITDA margin**	6.0%	5.8%	0.2%	6.4%		
			Depreciation & Financial						
1,065	1,111	(46)	Depreciation	2,123	2,123	1	13,990		
326	326	0	PDC Dividend	653	653	(0)	3,915		
45	28	18	Interest	91	56	34	543		
1,437	**1,465**	**(28)**	**Subtotal**	**2,866**	**2,831**	**35**	**18,449**	**0**	**0**
176	**161**	**(15)**	**Net Surplus/(Deficit)**	**71**	**(18)**	**(89)**	**262**	**0**	**0**
0.7%	0.7%	0.1%	**Net margin**	0.1%	0.0%	0.2%	0.1%		

- The Year end forecast is for a surplus of £0.3m
- Income is adverse due to lower than planned central income (£0.7m) offset by improved PTS performance
- Pay is showing a favourable position overall due to vacancies across the trust. However, frontline pay (including PAS usage) is showing £0.9m overspend YTD. A major factor in the total frontline cost overspend is the management of relief which is running significantly higher than plan (6000 hrs + per month = 37 WTEs)
- Non Pay is broadly in line with plan (if PAS is excluded)
- Depreciation and Financial Charges are on track

Divisional Expenditure (excludes Income)

Month 2 - May 2013			Description	Year to Date			FY 2013/14		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			Operational						
14,923	14,953	(30)	A&E	29,828	30,076	(248)	176,458	176,706	(248)
2,304	2,006	298	EOC	4,550	4,057	494	27,318	26,825	494
1,540	1,432	108	Operational Support	3,040	2,667	373	18,850	18,477	373
18,767	**18,391**	**376**	**Subtotal**	**37,418**	**36,799**	**619**	**222,627**	**222,008**	**619**
536	**546**	**(10)**	**PTS**	**1,071**	**1,076**	**(5)**	**6,372**	**6,376**	**(5)**
			Support Services						
293	291	2	Chief Executive	595	543	52	4,312	4,259	52
1,216	1,184	33	Corporate Services	2,433	2,514	(81)	14,490	14,571	(81)
185	184	1	Strategic Development	371	376	(5)	2,085	2,090	(5)
199	(98)	297	Finance	410	440	(30)	2,505	2,535	(30)
1,530	2,013	(483)	Central Corporate	2,207	2,511	(305)	16,656	16,911	(256)
947	963	(16)	IM&T	1,901	1,930	(29)	11,455	11,484	(29)
911	851	59	HR & OD	1,880	1,705	175	11,388	11,212	175
84	85	(0)	Healthcare Promotion & Quality	169	163	6	1,012	1,006	6
121	92	29	Medical	243	193	49	1,449	1,400	49
5,487	**5,565**	**(78)**	**Subtotal**	**10,207**	**10,375**	**(168)**	**65,350**	**65,469**	**(119)**
24,789	**24,502**	**288**	**TOTAL**	**48,697**	**48,250**	**446**	**294,349**	**293,853**	**495**

- The main driver of performance is the Operational division, this represents 76% of total expenditure.
- The main reason for Operational budget being favourable to plan relates to
  - Ongoing EOC vacancies (e.g. CHUB)
  - Operational Support – underspends in medical consummables and vehicle maintenance (this is under review)
- PTS is on plan
- Within support services
  - Central Corporate includes the adverse reserves position supporting income shortfalls and projected increases in non pay spend
  - HR & OD is favourable primarily because of vacancies across the department (including training officers and delays in spend in the modernisation programme.

The divisional structure will be adjusted to incorporate the new corporate structure as required

Statement of Position: Year End Forecast

	Mar-13	Apr-13	May-13	Mar-14		
	Act	Act	Act	Plan	Var	%
	£000	£000	£000			
Non Current Assets						
Property, Plant & Equip	119,021	118,240	117,414	116,610		0.00%
Intangible Assets	13,628	13,478	13,328	12,299		0.00%
Trade & Other Receivables	0	0	0	0		
Subtotal	132,649	131,718	130,742	128,909	0	0.00%
Current Assets						
Inventories	3,264	3,176	3,310	3,264		0.00%
Trade & Other Receivables	16,075	18,604	15,797	15,931		0.00%
Cash & cash equivalents	5,500	13,968	15,747	6,500		0.00%
Total Current Assets	24,839	35,748	34,854	25,695	0	0.00%
Total Assets	157,488	167,466	165,596	154,604	0	0.00%
Current Liabilities						
Trade and Other Payables	(24,546)	(34,792)	(32,694)	(23,308)		0.00%
Provisions	(2,098)	(1,000)	(1,000)	(960)		
Borrowings	(309)	(263)	(263)	(202)		0.00%
Working Capital Loan - DH	0	0	0	0		
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)		0.00%
Net Current Liabilities)	(28,197)	(37,299)	(35,201)	(25,714)	0	0.00%
Non Current Assets plus/less net current assets/Liabilities	129,291	130,167	130,395	(19)		0.00%
Non Current Liabilities						
Trade and Other Payables	0	0	0	0		
Provisions	(8,731)	(9,766)	(9,853)	(9,312)		0.00%
Borrowings	(641)	(661)	(641)	(641)		0.00%
Working Capital Loan - DH	0	0	0	0		
Capital Investment Loan - DH	(4,343)	(4,343)	(4,343)	(3,099)		0.00%
Total Non Current Liabilities	(13,715)	(14,770)	(14,837)	(13,052)	0	0.00%
Total Assets Employed	115,576	115,397	115,558	115,838	0	0.00%
Financed by Taxpayers Equity						
Public Dividend Capital	62,516	62,516	62,516	62,516		0.00%
Retained Earnings	20,053	19,874	20,035	20,315		0.00%
Revaluation Reserve	33,426	33,426	33,426	33,426		0.00%
Other Reserves	(419)	(419)	(419)	(419)		0.00%
Total Taxpayers Equity	115,576	115,397	115,558	115,838	0	0.00%

- Non current assets stand at £130.7m
- Non current assets will be amended by the Land & Buildings revaluation in Month 3
- Currents assets are £24.8m
- Cash position as at end of May is £15.7m, this is £0.4m below plan
- Receivables (Debtors) are mainly trade debtors £5.1m, prepayments £5.1m, Other debtors £3.5m and accrued income £2.1m
- Current Liabilities are £35.2m
- Current liabilities are mainly trade payables(creditors) £8.6m, Accruals £8.7, Deferred income £5.4m, Other Creditors £5.3m, HMRC £4.6m, Borrowings £1.5m and Provisions £1.0m
- No new loans were taken out during the year.
- The following page details the monthly run rate for the balance sheet.
- A forecast statement of position will be prepared at Month 3 (June)

Cashflow Statement

	In Month Movement		YTD Move	FY Fcast
	Apr-13	May-13		
	Actual	Actual		
	£000	£000	£000	£000
Opening Balance	5,500	13,968	**5,500**	**0**
Operating Surplus	1,187	1,625	2,812	0
(Increase)/decrease in current assets	(2,441)	2,673	232	0
Increase/(decrease) in current liabilities	9,316	(2,420)	6,896	0
Increase/(decrease) in provisions	1,035	87	1,122	0
Net cash inflow/(outflow) from operating activities	9,097	1,965	11,062	0
Cashflow inflow/outflow from operating activities	**9,097**	**1,965**	**11,062**	**0**
Returns on investments and servicing finance	(13)	(11)	(24)	0
Capital Expenditure	(590)	(155)	(745)	0
Dividend paid	0	0	0	0
Financing obtained	0	0	0	0
Financing repaid	(26)	(20)	(46)	0
			0	0
Cashflow inflow/outflow from financing	**(629)**	**(186)**	**(815)**	**0**
Movement	8,468	1,779	10,247	0
Closing Cash Balance	**13,968**	**15,747**	**15,747**	**0**

- The cash balance as at May 2013 is £15.7m, this is £0.4m below plan
- In the year to date the Trust is generating cash as a consequence of developing an operating surplus (£2.8m) and current liabilities increasing in excess of current assets. The primary driver for this is reduced creditor payments as a consequence of delayed receipts from CCGs. This has not impacted on current assets as the mix between cash and debtors has changed.
- Investing activity, capital expenditure has been low acting to help limit outflows.
- The following slide details the 13 week cashflow. This illustrates that the Trust has sufficient funds to support operations across this period. A 12 month rolling cashflow is being developed. Based on the financial plan as stated the Trust expects to have sufficient cash across 2013/14 to support operations.

London Ambulance Service NHS
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LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Foundation Trust update and timeline**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For information about the updated process for applications and for approval of the proposed timeline**
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 proposed timeline for formal commencement of the application in April 2014**

Key issues and risks arising from this paper

- The NHS Trust Development Authority (TDA) is now responsible for approving applications for NHS foundation trust licence.
- The TDA has reviewed the overall process and timeline and has suggested that the LAS application could commence in April 2014.
- Based on the three stages of application this could then see the LAS application being approved and passed to Monitor in Q4 of 2014/15.
- Detail on milestones for applicants will be published soon so the proposed timeline for the Trust Board provides headlines only at this stage.
- The TDA want to see evidence of delivery of the modernisation and workforce changes as well as progress towards operational and financial performance sustainability.

Executive Summary

Responsibility for managing and processing provider FT applications now sits with the TDA and is described in the Accountability Framework published in April 2013. There are 3 stages to the application process.

The quality review process has been considerably enhanced and is led by the TDA Clinical Development and Assurance team – Kathy McLean, Medical Director, and Peter Blythin, Director of Nursing.

The TDA require an agreed FT plan including timeline and milestones by the end of June 2013. As the LAS application is likely to be based on a ‘rolling start’ the timeline could be based on 4-4-2 months before being passed to Monitor. This is substantially shorter than the previous process but

just as involved and requires much more focus on the quality assurance aspects.

The TDA have indicated that a formal start date of April 2014 is preferred as there are a number of areas they wish to see delivered or advanced by then, including evidence of progress with workforce recruitment and the modernisation programme.

The timeline has been built into the TDA accountability framework stages attached based on an April 2014 start. A more detailed project plan and the governance arrangements will be developed over the next month against the milestones the TDA are due to publish shortly.

The Trust Board is asked to agree the proposed timeline taking into consideration the implications of working across the period and to identify where there might be peaks of executive activity on this or other priorities that would make particular stages at particular times of the year very difficult.

Attachments

Managing the Foundation Trust application
TDA Accountability Framework and Timeline

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

☒ Staff/Workforce
☒ Performance
☒ Environment
☐ Experience
☐ Helping People
☐ Quality of Life
☐ Preventing Death

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

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

Key issues from the assessment:

Managing the foundation trust application

1. Executive Summary

Responsibility for managing and processing provider foundation trust (FT) applications now sits with the NHS Trust Development Authority (TDA) and is described in the Accountability Framework published in April 2013. There are 3 stages to the application process:

Stage 1 – diagnosis and due diligence: from introductory meeting to draft Integrated Business Plan (IBP)/Long Term Financial Model (LTFM), Cost Improvement Programme (CIP) and Quality Impact Assessment (QIA); Board Governance Assurance Framework (BGAF) and Monitor's Quality Governance Framework (MQGF) and Historical Due Diligence (HDD)1. There are 2 quality assessments within this stage that are undertaken by the TDA, interviews with board members and commissioners, and board observation. For a Trust on a 'rolling start' such as the LAS this will take approximately 4 months.

Stage 2 – Diagnosis and due diligence: readiness review meeting; a further quality review by the TDA; committee observation; formal document submission for readiness review. This stage takes 4 months at the end of which the TDA approve clearance of the stage and commencement of HDD2.

Stage 3 – Assurance and approval: this is a further part of stage 2 now despite being badged as stage 3 and is expected to take approximately 2 months. This stage includes HDD2; a further TDA quality review; formal submission of key documents; TDA internal peer review; TDA and Trust Board to Board. This then leads to the TDA executive team approval and then on to the TDA Board to approve the application for passage on to Monitor.

2. Quality review

The quality review process has been considerably enhanced and is led by the TDA Clinical Development and Assurance team – Kathy McLean, Medical Director, and Peter Blythin, Director of Nursing. From the LAS it will involve the Chief Executive, Medical Director and Director of Nursing & Quality. At stage 1, following an introductory meeting, the TDA team build up a Quality Profile including 3rd party reports and wider intelligence. The TDA team then hold a clinical star chamber where they present to commissioners and their Board on the quality profile of the LAS.

At stage 2, following board and committee observation there is a second clinical star chamber. This reviews progress against stage 1 and any action plan agreed and shapes a clinical visit and key lines of enquiry for that. The outcome of the visit then leads into the FT readiness review meeting. Stage 2 flows into stage 3 and final assurance, a quality review, a visit from the TDA Medical and Nursing directors and then into the assurance and approval process.

3. Timeline

The TDA require an agreed FT timeline by the end of June 2013. This is under discussion with their team currently. The likely timeline is based on 4-4-2 months before being passed to Monitor and is substantially shorter than the previous process but just as involved and requires much more focus on the quality assurance aspects. At a meeting on 12th June clarity was sought from the TDA re what they require from the LAS in order to move into the formal application stages. This has been described as follows:

- Evidence of delivery of the workforce changes and modernisation programme
- Progress with board appointments
- Progress against the financial plan
- Progress against key performance targets and sustainability (headroom)
- Confirmation that commissioners are on board for year 2 of the modernisation programme.

The TDA team are working on a start date of April 2014 for the LAS to commence the formal application process. Headlines therefore are:

Stage 1: April – July 2014

Stage 2: August – November 2014

Stage 3: December 2014 – January 2015 (realistically this will either fall from November – January or January to February 2015.)

Monitor stage: March 2015.
At this stage the Monitor timeline is unclear and will depend on the number of applications they have in the pipeline and their system of batching, however if based on the previous 4 month timeline, this would take most of the Monitor review, interviews and assurance processes through from March to June 2015 with particular emphasis on Board time in May 2015. The outcome could then be the LAS being licensed as an FT from July 2015.

The challenge for the Executive Management Team (EMT) and the Board is to keep the momentum going from September this year. Much of the preparatory work can be started in 2013/14 including review and development of the 5-year strategy and enabling strategies; developing the IBP and LTFM; and inducting and developing board directors.

Conclusion
The Trust Board is asked to agree the proposed timeline. The EMT will be working through the potential implications and risks of this timeline, identifying where there might be peaks of executive activity on this or other priorities that would make particular stages at particular times of the year very difficult.

A more detailed project plan with milestones will be prepared once the Trust Board has agreed the start date for the formal application. The governance arrangements will be developed alongside this and a proposal for the programme board to be brought to a future meeting. The TDA will be publishing the key milestones for FT applications in the near future.

Sandra Adams
Director of Corporate Services
17th June 2013

TDA Accountability Framework – April 2013 and LAS FT timeline

LAS start date: April 2014 [Based on a rolling start application with 4-4-2 months across the 3 stages]

Appendix 6 – FT Application Approvals

- Sets out the actions that the NHS Trust and the TDA are to do.
- 3 Stages.
- Stage 1: Diagnosis and due diligence
- Stage 2: Development and application
- Stage 3: Assurance and approval. 2 month process – Board2Board (B2B) ⇨TDA Exec approval⇨TDA Board⇨Monitor

Additional Requirements over DH Single Operating Model (SOM)

- Sets out Quality requirements post The Francis Report. TDA quality team working on processes. There are 4 quality assurance processes, 2 in stage 1 and each in stages 2 & 3.
- TDA internal Peer Reviews before Readiness Review ① and B2B ② e.g. one of the other regional teams peer review London team.
- Interviews with additional clinical bodies – HEE, NHSCB, LETB, Quality Surveillance Groups, Midwifery Council.
- Interviews with BGAF/MQGF independent assessors.
- Media analysis identifying issues and actions plans.
- Quality accounts, auditors opinions and progress with Francis action plan.
- Extra stakeholder support letters.
- LAS Chair to confirm all Directors meet “fit and proper test”. Short paper from Richard Hunt. Board development appraisal and ongoing individual development to support board members deliver their role.

Stage 1 Diagnosis and due diligence – April 2014 to July 2014

- Introductory meeting – TDA and Trust.
- Trust drafts initial IBP/LTFM, CIPs and QIA’s. TDA feedback.
- Trust self assesses for BGAF and MQGF.
- Trust develops strategies and prepares for Public Consultation.
- Independent assessments – BGAF, MQGF, HDD1. Action Plans.
- TDA carries out 2 quality assessments. Detailed Trust quality delivery FT pipeline profile.
- TDA carries out initial Board interviews and Board observation. Feedback. Voting members only.
- TDA interviews commissioners.

Stage 2 Diagnosis and due diligence – August 2014 to November 2014

- Preparation for Readiness B2B meeting. One month e.g. submission on 1st and feedback by end of month and meet next month.
- TDA conducts further quality review.
- TDA observes Board and key sub committees. Feedback.
- Trust formally submits key documents for Readiness Review. TDS feedback.

- Trust delivers FT action plans. TDA feedback.
- TDA Peer Review, then Readiness B2B Review. Feedback.
- TDA approves clearance of Stage 2 and commencement of HDD2.

Stage 3 – Assurance and Approval (part of stage 2 now) November/December 2014 to January/February 2015

- Preparation for B2B.
- After Readiness Review, Trust updates IBP/LTFM.
- HDD2 independent assessment. Action plans.
- TDA conducts further quality review.
- Trust formally submits key documents for B2B. TDA assures documents and feedback.
- TDA interviews lead reviewers for HDD, BGAF, MQGF. Interviews commissioners.
- TDA internal Peer Review.
- TDA B2B with Trust. Feedback.
- TDA Executive Team. Verbal feedback to Trust.
- TDA Board – currently sits bi monthly.

London Ambulance Service NHS
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LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
Report Author(s):	**Sandra Adams**
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 2013**

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 remain fully compliant with each statement and condition except for the following:

1. Compliance Monitor

The Compliance Monitor document refers to the conditions within the new provider licence which comes into effect from 1st April 2014 but against which we are being monitored now.
http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-8

In terms of compliance, we declared compliance against all conditions with the exception of:

G4 – fit and proper persons as governors and directors: condition G4.3 will require amendment to executive director contracts;
C2 – competition oversight: the Trust Board has yet to discuss and consider competition regulation in the new NHS environment and this will be added to the board development or strategy sessions being planned for 2013/14.

2. Board Statements

This declaration is a series of statements against clinical quality, finance and governance. The description of each statement is included in the document and further detail can be found in the Accountability Framework.

We declared compliance against all with the exception of:

Clinical quality 2: CQC compliance: we identified this as a risk as the Trust is in the process of implementing the action plans to address the minor and moderate non-compliance issues addressed by the CQC in December 2012. A meeting is planned with the CQC for 11th June to discuss progress.

Attachments

None – submissions are the same as April and May 2013 as previously reviewed by Trust Board.

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Staff/Workforce
☒ Performance
☒ Environment
☒ Experience
☐ Helping People
☐ Quality of Life
☐ Preventing Death

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 25TH JUNE 2013

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy, Committee Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**francesca.guy@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 ☐Senior Management Group ☐Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ 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 28th May 2013 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 28th May 2013:

- Provision of Waste Services (General and Clinical Waste):
  Tenders received and opened on 21st May 2013

There have been two new entries to the Register for the Use of the Trust Seal since 28th May 2013:

- Trust Seal used on 6th June 2013 for the lease made between London Ambulance Service and Equisys Ltd for 3rd Floor, Southwark Bridge Road
- Trust Seal used on 6th June 2013 for the lease made between London Ambulance Service and Rencraft Ltd for Unit F2, Chaucer Business Park

The register of interests as at 19th June 2013 has been included as an attachment to this paper. The register of interests was reviewed by the Audit Committee on 13th May 2013.

Attachments

Register of interests as at 19th June 2013.

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

☐ Staff/Workforce
☐ Performance
☐ Clinical Intervention
☐ Safety
☐ Clinical Outcomes
☐ Dignity
☐ Satisfaction

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

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

2013/14 Priorities
☐ Modernisation Programme
☐ Communication and Engagement
☐ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

Risk Implications
This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No

Key issues from the assessment:

Trust Board Register of Interest

Name	Date	Nil declaration	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Richard Hunt	30/01/2013	✓							
Jessica Cecil	04/02/2013	✓							
Roy Griffins	31/01/2013		✓	Non-executive Chairman of Docklands Aviation Group.				Non-executive Director of NHS Blood and Transplant Authority.	
John Jones	14/02/2013	✓							
Beryl Magrath	04/04/2013	✓							
Nicholas Martin	15/02/2013	✓							
Robert McFarland	Pending								
Caroline Silver	14/02/2013		✓				Associate of BUPA. BUPA is a company limited by guarantee, and thus has no shareholders. It invites c.100 individuals to stand in as shareholders for governance purposes.		
Ann Radmore	28/01/2013		✓				Governor of Trinity School - Whitgift Foundation.	Nephew works for PWC Consulting including in health division. Medical director at ATOS is a close personal friend.	
Sandra Adams	30/01/2013	✓							
Lizzy Bovill	16/04/2013	✓							
Jane Chalmers	17/04/2013		✓	Creswell Barn Ltd.	Creswell Barn Ltd.	Creswell Barn Ltd.			
Tony Crabtree	28/02/2013	✓							
Andrew Grimshaw	12/04/2013		✓	Director of LSO Consulting Ltd. Provides financial management and design consultancy. Provided services to Adfirmo.	50% share holder in LSO consulting. Private company with wife.			Until recently was an associate with a consultancy group called Adfirmo. This provided financial management financial management support to NHS and private organisations. Adfirmo has ceased trading with most to the staff transferring to a new organisation called Red Clover. Was about to become a shareholder in a company called Red Clover, but withdrew when employed with LAS commenced. This is a financial consultancy specialising in recovery and transformation. Currently engaged at LAS through Allen Lane.	
Caron Hitchen	08/04/2013	✓							
Jason Killens	04/04/2013	✓							
Steve Lennox	22/02/2013		✓	Owner of Riad Al-Bushra (Morocco) not connected to healthcare provision in any way.					
Fionna Moore	30/01/2013		✓	Medical Director, Location Medical Services.					
Angie Patton	11/04/2013	✓							
Peter Suter	08/04/2013		✓	Peter Suter Ltd - IT Consultant (active from 03/04/13).	Peter Suter Ltd - IT Consultant (active from 03/04/13).	Peter Suter Ltd - IT Consultant (active from 03/04/13).		Peter Suter Ltd - IT Consultant (active from 03/04/13).	
Paul Woodrow	04/04/2013	✓							
Vic Wynn	Pending								

Register of Interest

Name	Date	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Ian Canning	30/01/2013	✓				Trustee of Lucy Air Ambulance for Children charity.		
Linda Cray	30/01/2013	✓					Casually employed by St John Ambulance to undertake paramedic duties.	
John Downard	30/01/2013	✓		Hold the position of Company Secretary for my wife's company Downard Consultancy Ltd registered at 8 The Drive, Hove, East Sussex.				
Mark Hales	30/01/2013	✓	Director Homemead Residents Ltd.					
Raymond Molloy	30/01/2013	✓				Justice of the Peace.		
Paul Tattam	30/01/2013	✓		Have a shareholding in a company that may provide technical equipment to Airwave and/or other radios.				
Paul Gates	30/01/2013	✓				National Ambulance Officer, St John Ambulance. Chair and Trustee of the charity BASICS Essex Accident Rescue Service, charity number 1142313. Examiner for Royal College of Surgeons of Edinburgh for the Diploma in Immediate Medical Care.		
Chris Reeves	31/01/2013	✓					Volunteer member with St John Ambulance SE region.	
John Selby	31/01/2013	✓				Deputy Chair of LAS Benevolent Fund.		
Nick Sillett	31/01/2013	✓					Volunteer member with St John Ambulance SE region.	
Shaun Rock	01/02/2013	✓						Instructor with Prometheus Medical Services, Herefordshire, HR6 0PW.
Richard Webber	01/02/2013	✓				National Ambulance Advisor for St John Ambulance.		
Michael Pearce	14/02/2013	✓				Board member - Past president Ambulance Service Institute.		
Tim Bowler	26/02/2013	✓				Sit on the fitness to practice panels for the HCPC.		
Martin Nicholas	28/02/2013	✓	Director of a food importing and distribution company - not trading.					
Neil Thomson	03/04/2013	✓					BASICS Immediate Care Doctor with South Central and East Midlands Ambulance Services. HEMS Doctor - Air Ambulance Charities in London, Thames valley and West Midlands.	
Peter Rhodes	14/05/2013	✓				Unit manager of St John Ambulance unit of volunteers (Highgate) and also an assessor/trainer of ambulance aid for the organisation.		
Dr Fenella Wrigley	18/05/2013	✓				Regional professional lead for Doctors, St John Ambulance London Region. Emeritus Doctor - London Air Ambulance (voluntary).	Consultant in Emergency Medicine, Barts Health NHS Trust (paid role). Regional professional lead for Doctors, St John Ambulance London Region (voluntary). Emeritus Doctor - London Air Ambulance (voluntary).	

TRUST BOARD FORWARD PLANNER 2013

23rd July 2013

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 FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Annual Infection Prevention and Control Report 2012/13** **Annual Patient Experiences Report 2012/13** **Annual Safeguarding Report 2012/13** **Francis Report Progress Update**	Report from Chief Executive Officer	Report from Finance and Investment Committee Annual Equality Report 2012/13 Annual Corporate Social Responsibility Report Governance Review Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee – 9th July Quality Committee – 21st August	

24th September 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **BAF and Corporate Risk Register – Quarter 2 documents** **Audit Committee Assurance Report** **Annual Report of the Audit Committee** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer HDD2 Report and Action Plan Performance reporting approach (AG)	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 2nd September Finance and Investment Committee – 10th September	

26th November 2013

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 FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Update on Safeguarding (Alan Tayler and Lysa Walder to attend)**	Report from Chief Executive Officer	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Audit Committee - 4th November Finance and Investment Committee – 12th November Quality Committee – 23rd October	

17th December 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents** **Reports from Executive Directors (COO, DoF, DoHR)**		Report from Trust Secretary Trust Board Forward Planner	Quality Committee – 11th December	

MEETINGS CALENDAR FOR 2014

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**22**		**23**		**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									**23**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													
Remuneration Committee	Trust Chair						**3**							14.00 - 15.00
Audit Committee	Caroline Silver (NED)			**x**		**x**	**x**			**x**		**x**		TBC
Finance and Investment Committee	Trust Chair	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	TBC
Quality Committee	Beryl McGrath (NED)		**x**		**x**		**x**		**x**		**x**		**x**	TBC (usually third Wednesday of the month)
Clinical Quality Safety and Effectiveness Committee	Medical Director	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually third week of the month)
Learning From Experience Group	Director of Quality and Health Promotion		**x**			**x**			**x**			**x**		TBC (usually first week of the month)
Risk Compliance & Assurance Group (RCAG)	Director of Finance	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually first/second week of month)
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00**												9.00 - 11.00